FACULTY OF PSYCHOLOGY
AND EDUCATIONAL SCIENCES

Supporting family members of mentally ill offenders: A strengths-based approach

Sara Rowaert

Supervisor: Prof. Dr. Stijn Vandevelde
Co-supervisor: Prof. Dr. Kurt Audenaert

A dissertation submitted to Ghent University in partial fulfilment of the requirements for the degree of Doctor of Educational Sciences.

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“In the midst of winter, I found there was, within me, an invincible summer.
And that makes me happy.
For it says that no matter how hard the world pushes against me,
within me, there’s something stronger – something better,
pushing right back.”

\- Albert Camus -

Preface

This dissertation is part of a more comprehensive project (concerted research action - 'GOA'-project) of Ghent University, entitled: 'Developing multidisciplinary strengths-based strategies for mentally ill offenders'. The project is carried out by the Faculty of Law (main supervisor: prof. dr. Tom Vander Beken), the Faculty of Psychology and Educational Sciences (supervisor: the late prof. dr. Eric Broekaert) and the Faculty of Medicine and Health Sciences (supervisor: prof. dr. Kurt Audenaert). It aims at developing multidisciplinary (legal, criminological, psycho-social and medical-psychiatric) strengths-based strategies to overcome the predominance of a risk-oriented approach towards mentally ill offenders. The project consists of 5 different research tracks (each leading to a doctoral dissertation) about (1) legal capacitation, (2) procedural justice, (3) desistance, (4) recovery and (5) family members of mentally ill offenders. The present dissertation focuses on the fifth theme and aims to gain insight into the experiences and perspectives of family members and how they can be supported in coping with both the mental illness and the criminal offence of a relative. The studies in this dissertation fill a gap in international research as they discuss the experiences of an understudied group and focus on 'giving voice' to the burden, strengths and experience of family members of mentally ill offenders. Besides, an intervention (Family Support Group) was set up to investigate the impact on the quality of life, burden, coping strategies and resilience of family members, to search for helpful therapeutic factors and processes and to get to know the expectations and experiences of the participants.

The dissertation starts with a general introduction (Chapter 1), describing the main themes, the problem definition and methodology of the study. Chapter 2 reports on a systematic review being conducted about perspectives and experiences of family members confronted with a mentally ill offender. Chapter 3 discusses a qualitative study consisting out of 24 interviews conducted with 27 family members in Flanders about how they experience both the psychiatric problems and the internment measure of their relative. Chapters 4 to 7 report on the Family Support Groups (FSGs) which have been developed in the context of this dissertation to support and empower family members of mentally ill offenders. The chapters respectively focus on the protocol used within the FSGs (Chapter 4), the results of a pilot study (Chapter 5), helpful therapeutic factors (Chapter 6) and the treatment expectations and experiences of family members of mentally ill offenders (Chapter 7). The dissertation ends with a general discussion (Chapter 8), focusing on the main findings considering all chapters and reflecting about the strengths and limitations of the study, recommendations for future research and the implications for practice and policy.

We hope the results and conclusion of this dissertation will help to focus attention on family perspectives and experiences in coping with a mentally ill offender. Questions like: who needs support and how can they be supported, are important to consider in research studies. In regard to this, we know within this dissertation, we only have reached 'a branch off the tree', as the participants were family members who are willing to do everything for their relative. We truly hope, this study can help to increase our knowledge, to break the stigma and to strengthen family members in gaining power in their quest for better care and support for themselves and their relatives.

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Voor wie liefhebben wordt Leven met een hoofdletter geschreven
Ondanks leed en droefenis, omdat Leven, Liefde is.

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Tijdens mijn studies werd mijn interesse aangewakkerd voor personen die in aanraking komen met de drughulpverlening of (forensische) psychiatrie. Na mijn afstuderen heb ik dan ook getwijfeld om verder te studeren en me in deze onderwerpen te verdiepen. Maar toen ik hoorde dat een nieuw project zou starten aan de Universiteit Gent over internering, heb ik mijn kans gegrepen en heb ik gesolliciteerd. Nu, bijna vier jaar later, ben ik nog steeds ontzettend verheugd dat ik dit doctoraatsonderzoek heb mogen doen. Vooral omdat het me meer inzicht heeft gegeven in internering en familiebetrokkenheid, me de academische wereld beter heeft leren kennen en me in contact heeft gebracht met ontzettend veel fantastische mensen, die allemaal een woord van dank verdienen.

In de eerste plaats een bijzondere en oprechte dank aan alle familieleden die hebben deelgenomen aan dit onderzoek. Zonder jullie interesse en moed om deel te nemen, was het niet mogelijk geweest om dit doctoraat vorm te geven. Bedankt aan alle familieleden die zich hebben geëngageerd om deel uit te maken van de Familieondersteunende Groepen en hiervoor vaak een verre verplaatsing maakten. Dankjewel voor jullie openheid en het delen van jullie verhaal. Ik heb ontzettend veel bewondering voor de kracht in ieder van jullie!

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Sara

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1 General introduction

Abstract

The introduction starts by describing the context of dealing with mentally ill offenders in Belgium; we successively address the judicial context, the characteristics of mentally ill offenders, and current (strengths-based) interventions simultaneously aimed at reducing recidivism and increasing quality of life. In the second section, we describe the particular situation of family members confronted with a mentally ill offender, focusing on their lived experiences. The third section reviews the current approaches to supporting family members of mentally ill offenders, with particular attention to strengths-based interventions. This introductory chapter concludes by describing the problem definition, research questions, and methodology of the dissertation in general.

1.1. Mentally ill offenders in Belgium

1.1.1. Terminology

In scientific literature, different terms are used to denote persons with a mental illness who have committed an offence, including: *'forensic psychiatric patients', 'patients with a forensic history', 'forensic clients/patients', 'offenders with mental illness', 'mentally disordered offenders' and 'mentally ill offenders'*. Considering the scope of the present research into supporting family members, the term 'mentally ill offender' was preferred, because: (1) 'mentally ill offenders' is commonly used in family research; and (2) this term corresponds with how family members regard their relative, i.e., as a person with mental health needs in the first place. Other terms, such as 'offenders with a mental illness' were considered less appropriate, as 'being an offender' was placed more central than 'having a mental illness'.

1.1.2. A judicial order and a mental illness

In Belgium, mentally ill offenders are placed under an *'internment measure'*, as they are considered simultaneously a danger to society *('offenders'*) and persons who need treatment and care (*'patients'*) (Vandevelde et al., 2011). Besides the term 'internment measure' also 'judicial order' is used within the dissertation to refer to judicial procedures related to the internment measure.

Since 1 October 2016 a new Law (5 May 2014, amended by the Potpourri III-law of 4 May 2016) has come into force, defining in Art. 2 an 'internment measure' as *"a safety measure to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires in view of his/her reintegration into society"* (Casselman, De Rycke, Heimans, & Verpoorten, 2017, p. 103; Heimans, Vander Beken, & Schipaanboord, 2015, p. 1051). This Law states that persons can be subjected to an internment measure: (1) if their criminal offence harms the physical and psychological integrity of a third party, (2) if they have a mental illness at the time of the offence, and (3) if there is a danger of committing new offences (Casselman et al., 2017; Vander Beken, Heimans, & Schipaanboord, 2016). Consequentially, only persons who have committed criminal offences can be 'interned'. Because it is not a sentence, but rather a 'safety measure', it can be enforced for an unlimited period of time (Casselman et al., 2017; Vander Beken et al., 2016). Furthermore, the new Law replaced the Commission of the Protection of Society into the Chamber of the Protection of Society, which means that the implementation of the internment measure is now followed by the court instead of an administrative department (Casselman et al., 2017).

Currently (d.d., 15/11/2017), in the Dutch speaking part of Belgium (i.e., the Chamber of the Protection of Society of Ghent, Antwerp and Brussels) there are in total 1970 mentally ill offenders who can be 'classified' into different levels of risk: 'low', 'medium' and 'high' risk (K. Seynnaeve, personal communication, November 2017). Persons classified as 'low risk' are usually admitted to regular inpatient or outpatient settings (e.g., assisted living, outpatient care). Medium risk mentally ill offenders are most often treated in medium-risk settings, with some additional safety requirements. High risk mentally ill offenders are usually admitted to mandatory treatment in secure forensic settings or penitentiary facilities (Vandevelde, De Smet, Vanderplasschen, & To, 2013; Vandevelde et al., 2011; Wittouck, Audenaert, & Vander Laenen, 2015). Of the total amount of mentally ill offenders in the Dutch speaking part of Belgium, 1278 are classified as low or medium risk offenders and 369 persons are admitted to high risk psychiatric facilities (e.g., Forensic Psychiatric Centre in Ghent and Antwerp or in long stay departments of psychiatric hospitals) (K. Seynnaeve, personal communication, November 2017)

Over the last several decades, Belgium has been subjected to 20 judgements by the European Court of Human Rights (ECtHR) for violating the human rights of mentally ill offenders as stated in the European Convention on Human Rights (ECHR) (Meysman, 2016). Today, still 625 mentally ill offenders are locked up in prison (of which 323 in the Dutch Speaking part of Belgium) often without appropriate treatment and care (K. Seynnaeve, personal communication, November 2017). For similar reasons, other European countries (e.g., France, the United Kingdom, Poland) have also been convicted by the ECtHR for violating the human rights of mentally ill persons who have committed offences (Meysman, 2016).

1.1.3. Challenges in the support and treatment of mentally ill offenders

Our current era is characterised by a de-institutionalisation movement of psychiatric care. This leads to an increased attention to care rendered in society (e.g., provided in outpatient services). Therefore de-hospitalisation and community oriented mental health care are central concepts of the 'socialisation of care' (in Dutch: 'vermaatschappelijking van de zorg') that challenge the more traditional service-oriented residential care (Liégois & Van Audenhove, 2001).

Yet, international figures seem to indicate that – due to the reduction of psychiatric beds and restricted development of community-based mental health services – more mentally ill persons who have committed an offence may end up in the criminal justice system (The Sentencing Project, 2002; Lamb, Weinberger, & Gross, 2004). Mentally ill offenders are often seen as a 'challenging group', for which not enough treatment facilities are available, causing many persons to languish in prison (Koenraadt & Mooij, 2007). In this perspective, the World Health Organization (WHO) stated:

> *"One of the difficulties in keeping mentally ill offenders out of prison is that many countries do not have appropriate facilities to house people as 'criminal and dangerous'. As a result, those with mental disorders are not only forced to stay in prison, but also are deprived of the necessary treatment there"* (WHO, 2005, p. 79).

Mental health services may be reluctant to admit mentally ill offenders because they are seen as a 'danger to society' and as difficult to treat. In this regard, forensic rehabilitation has long been underpinned by two theoretical approaches: the psychopathology approach and the risk-oriented approach. The first approach focuses on providing psychiatric services for patients by which their welfare is important. The second emphasises the protection of society by reducing the risk of recidivism. The Risk-Need-Responsivity (RNR) model has long been, and still is, dominant in forensic rehabilitation. Recently, strengths-based approaches have gained importance and represent a shift from the two dominant approaches to a more holistic view of the person, including his/her strengths, capacities, possibilities and hopes. Within this approach, the recovery model is a well-known model of rehabilitation in the field of mental health (Barnao & Ward, 2015).

It is most often defined as:

> *"A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness"* (Anthony, 1993, p. 527).

More specific, recovery models are client-centred approaches, with respect for the strengths and the needs of a person, rather than looking at their deficits and limitations (Aga, Vander Laenen, Vandevelde, Vermeersch, & Vanderplasschen, 2017; Thornton & Lucas, 2010; Vanderplasschen, Rapp, Pearce, Vandevelde, & Broekaert, 2013; Vandevelde et al., 2017). Professionals working with, amongst other populations, mentally ill offenders need a holistic framework that helps them integrate different treatment theories, perspectives and paradigms to understand the core rehabilitation needs of mentally ill offenders (Barnao & Ward, 2015; Robertson, Barnao, & Ward, 2011). In this perspective, the Good Lives Model (GLM) has been developed with the explicit aim of integrating aspects of both the psychopathology and risk-oriented approach, within a broader, holistic and strengths-based approach. Ward, Yates and Willis (2012, p. 95) describe the GLM as:

> *"A strengths-based rehabilitation theory that aims to equip clients with internal and external resources to live a good or better life – a life that is socially acceptable and personally meaningful. Criminogenic needs (i.e., dynamic risk factors) are conceptualized as internal or external barriers toward living a good life, and are thus addressed within the broader strengths-based framework."*

The GLM model focuses on the rehabilitation of offenders aiming to live a better and meaningful life by paying attention to their interests, capabilities and ambitions (Ward, 2012). Criminogenic needs are not seen as risks, but rather as barriers that influence living a 'good life'. The model has a dual focus: diminishing recidivism and increasing the person's quality of life (Barnao & Ward, 2015).

1.2. Family members of mentally ill offenders

1.2.1. Terminology

In addition to the mentally ill offenders themselves, social network members (family members, friends, neighbours, …) are also confronted with the consequences of having to deal with a mentally ill person who has committed a criminal offence. This dissertation uses the term 'family members' (instead of social network members) as the majority of caregivers are parents, siblings or children.

As a consequence of the psychiatric de-institutionalisation movement of the 1950s and 1970s and the socialisation of care, family members – usually mothers – had to take on a primary care role, often without having knowledge or skills in dealing with the psychiatric illness of their relative (Caqueo-Urízar, Gutiérrez-Maldonado, & Miranda-Castillo, 2009; Chan & O'Brien, 2011; Quah, 2017). Taking on this role may lead to a decrease in the caregivers' quality of life and an increase of feelings of distress (Foldemo, Gullberg, Ek, & Bogren, 2005; Gutiérrez-Maldonado, Caqueo-Urízar, & Kavanagh, 2005; Ochoa et al., 2008). In addition, research has increasingly focused on the limited support family members often received from friends, family or professionals in their caring role and the impact this had on the family members' quality of life (Baronet, 1999; Rose, 1996). Quality of life is a complex construct with many definitions, including concepts such as: *"well-being, satisfaction, achievement of personal goals, social relations and psychical goals"* (Foldemo et al., 2005, p. 134). The WHOQOL Group (1995, p. 1405) has defined quality of life as: "*individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns".*

1.2.2. Characteristics of family members of mentally ill offenders

When describing the characteristics of family members of mentally ill offenders, it is important to be aware of the varying bond that exist between the mentally ill offender and his/her family. In some cases, mentally ill offenders lack family or social support because family members often are victims of their relatives' aggression or have to deal with (mental) health problems themselves (Absalom, McGovern, Gooding, & Tarrier, 2010; Canning, O'Reilly, Wressell, Cannon, & Walker, 2009; Lamb et al., 2004; Roskes, Feldman, Arrington, & Leisher, 1999). In addition, some mentally ill offenders do not want to have contact with their family members, because of problematic relationships or because of stigma and shame (Giacco, Dirik, Kaselionyte, & Priebe, 2017). In other cases, family members do not always report violating events to police or mental health services and remain protective and supportive towards their relative (Ferriter & Huband, 2003; MacInnes & Watson, 2002). Considering the latter, a study conducted in Northwest England showed that 72% of mentally ill persons residing in a forensic psychiatric setting have contact with their family, with 56% of them being involved in the discharge planning (Absalom et al., 2010). Another study conducted in England and Wales also revealed that 70% of patients involved in secure settings have contact with their family members (Canning et al., 2009). Many families often travel long distances to meet their relative in a forensic psychiatric setting and keep on supporting and caring for them (Davies, Mallows, Easton, Morrey, & Wood, 2014). Therefore family members who keep in touch with their relative and family members not having contact anymore, could potentially benefit from some sort of support (Canning et al., 2009). Even though the above-mentioned studies indicate that 30% of the family members have no or a difficult relationships with the mentally ill offender, the focus in this dissertation is explicitly placed on the perspectives and experiences of family members who still maintain some sort of contact with their relative, analogous to international studies (e.g., Ferriter & Huband, 2003; MacInnes & Watson, 2002; Nordström, Kullgren, & Dahlgren, 2006; Pearson & Tsang, 2004).

1.2.3. Experiences of family members

Wynaden (2007) has indicated that family members confronted with a mentally ill person often go through a series of challenging periods in life. In a first period they are confronted with 'being consumed', meaning that they *"experience threats to their integrity, identity, self-esteem, and self-equilibrium"* (p. 383). This period consists out of two stages, the first one appearing before the diagnosis, as family members are overwhelmed by the mental illness. Family members enter the second stage at the moment of the diagnosis as they become aware of their caring role and are confronted with feelings of grief and loss which impact their quality of life. In a second period, family members 'seek balance', which consists of three phases. First, family members try to understand what is happening by seeking knowledge. Second, family members try to restore their identity by using coping strategies, seeking knowledge, regaining self-control and becoming empowered. When family members go through the first two phases successfully, their lives can become more balanced in a third phase, which entails family recovery. Family members are able to reach out to make a difference and feel a need to help others. They feel satisfied and experience hope when their relative's condition improves (Spaniol, 2010; Wynaden, 2007).

Family members can move forward and back through different periods as this is influenced by interactions and communications with mental health professionals and the support from social network members (Wynaden, 2007).

Taking care of a relative for many years led some family members to experience *'*family burden'*,* a concept introduced by Grad and Sainsburry in 1963 (see Marsh & Johnson, 1997). This concept is related to the de-instituationalisation of care and later on the socialisation of care (see 1.1.3.) which led family members to take on more caring responsibilities, influencing their self-care and autonomy (Liégois & Van Audenhove, 2001). Yet the integration of the patient in society should not only be a responsibility of the primary caretaker, but also professional support and the society in general should accomplish their caring task in order to reach inclusive citizenship of the patient (Dewaele et al., 2015; Kim & Salyers, 2008). In this perspective, Grad and Sainsburry investigated whether the patient's return to society negatively impacted the family's work, relationships and free time and enhanced in that way their family burden (Caqueo-Urízar et al., 2009; Magliano et al., 1998; Maurin & Boyd, 1990; Tsang, Pearson, & Yuen, 2002). Hoening and Hamilton (1966) later differentiated this concept into objective and subjective aspects. 'Objective family burden' refers to family members needing to cope with the symptoms of the mental illness, their responsibility in taking care of their relative and the stigmatisation by society. Research has shown that not only mentally ill people are stigmatised, but also family members become 'stigmatised by association' (Pryor, Reeder, & Monroe, 2012). Stigma is therefore not only a major obstacle for the mentally ill person's social integration, but also for their immediate family members, as they become socially isolated (Tsang, Tam, Chan, & Chang, 2003; van der Sanden, Pryor, Stutterheim, Kok, & Bos, 2016). Some family members avoid social activities while others feel ashamed and try to hide their relative's mental illness (Tsang et al., 2003). Furthermore 'stigma by association' and 'family burden' can cause psychological distress and diminished quality of life for family members for whom various adaptive (e.g., active coping, emotional support, positive reframing, use of humour) and maladaptive coping strategies (e.g., self-distraction, substance use, self-blame) are used (Rüsch et al., 2009; van der Sanden, Stutterheim, Pryor, Kok, & Bos, 2014; van der Sanden et al., 2016). 'Subjective family burden' is related to the intense emotions families have to deal with (e.g., sadness, despair, anxiety, (self-)blame, shame) because of being confronted with the mental illness of a relative (Baronet, 1999; Fadden, Bebbington, & Kuipers, 1987; Foldemo et al., 2005; Loukissa, 1995; Thompson & Doll, 1982; Wong, Lam, Chan, & Chan, 2012).

Despite the focus on family burden, research has also shown that when time passes, family members can adjust to their caregiving role by learning strategies for coping with the situation (Wong et al., 2012). They can go through a family recovery process, a circular process that contains despair and hopefulness. Through time, family members can become aware of how to support their loved one in the long-run (Spaniol, 2010). Eventually, feelings of grief, self-blame and guilt are replaced by strategies that enable family members to cope with the mental illness, the disintegration of their dreams and life, and their loss of faith in mental health facilities and contact with professionals (Foldemo et al., 2005; Spaniol, 2010). The latter refers to the fact that family members also report the limited contact they have with mental health professionals and the dissatisfaction about not getting correct information and practical advice or not being involved in the treatment of their relative (Marsh & Johnson, 1997; Spaniol & Zipple, 1988). Family members frequently feel not listened to by mental health care workers or psychiatrists and are not asked for their opinion as these professionals often base their professional practice on an expert-model. Moreover, when family members ask for information, many professionals raise the restrictions related to professional secrecy or the patient's privacy (Marsh & Johnson, 1997; Sales, 2003; Shankar & Muthuswamy, 2007; Tsang et al., 2003).

When a mentally ill person has also committed a criminal offence, family members experience even more burdens and stress. Tsang and colleagues (2002) have developed a model of the burdens of family members of mentally ill persons based on a comparison between burdens experienced by family members only confronted with a mental illness and the additional stress family members of mentally ill offenders experience (see Figure 1.1.).

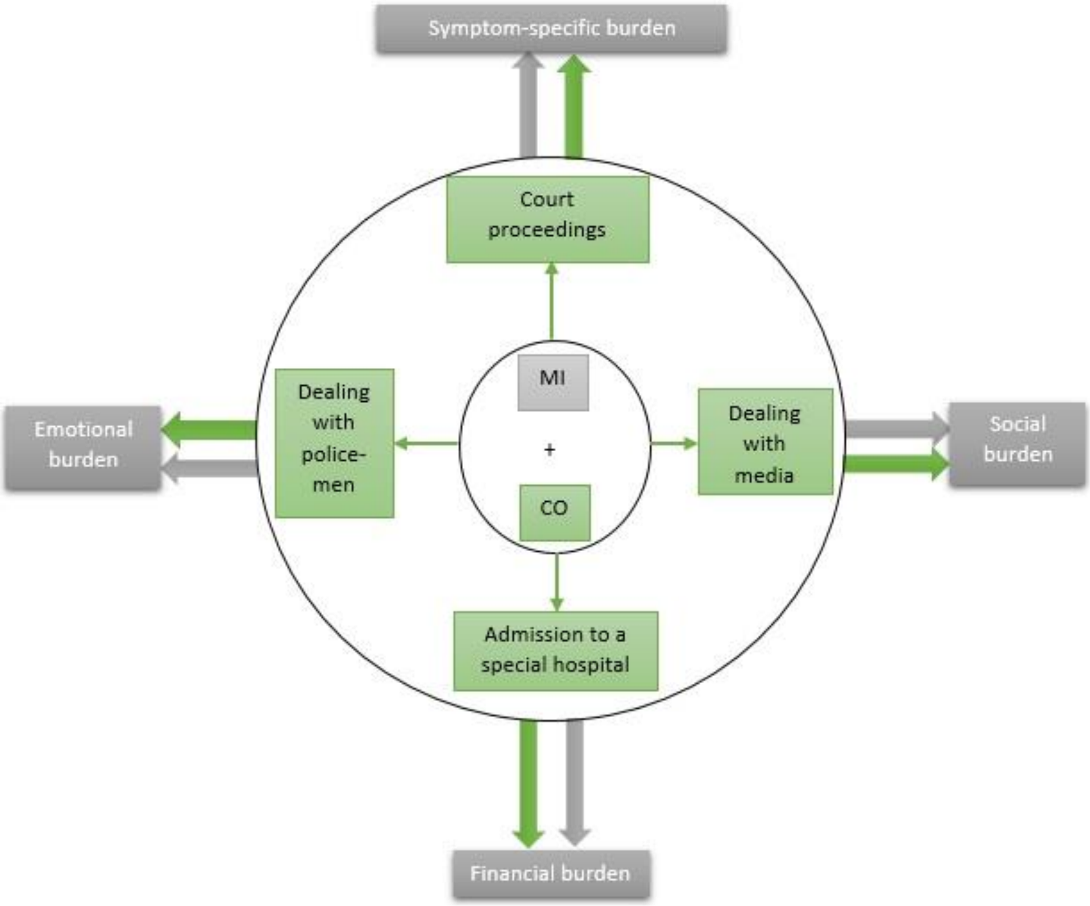

Figure 1.1. *Stress and burdens of family members of mentally ill offenders based on Tsang et al., 2002, p. 30.* MI = Mental Illness. CO = Criminal Offence. Grey – the burdens of family members of mentally ill persons. Green – the extra stress factors family members of mentally ill offenders have to deal with, leading to the same 'grey' burdens.

Figure 1.1. shows that family members of mentally ill offenders are confronted with emotional, social, financial and symptom-specific burdens. Family members have to deal with a double stigma, because society regards their relative not only as a 'patient' but also as an 'offender' (James, 1996; Tsang et al., 2002). Therefore family members experience different emotions (e.g., disbelief, grief, anger, sadness etc.) that are similar to family members not confronted with a relative's criminal offence. They are struggling with feelings of self-blame, shame, guilt and anxiety, which can affect the contact they have with their mentally ill relative (Absalom-Hornby,

Gooding, & Tarrier, 2011; Ferriter & Huband, 2003; McCann, McKeown, & Porter, 1996; Nordström et al., 2006; Ridley et al., 2014). Moreover, family members of mentally ill offenders are confronted with police and judicial procedures and with mental health services, which often do not provide help or information to family members (Absalom-Hornby et al. , 2011; Ferriter & Huband, 2003; MacInnes & Watson, 2002; McCann et al., 1996; Pearson & Tsang, 2004;).

In general, family members are also not involved in the treatment of their relative, although they can be an important resource for mental health carers by alerting them to potentially violent behaviour (Nordström et al., 2006). Furthermore, they can also be regarded as a positive resource willing to support their relative and cooperate with professionals (Ferriter & Huband, 2003; MacInnes & Watson, 2002). In this regard, McCann and colleagues have reported (1996, p. 351): *"relatives need to be engaged in the care and treatment of their family member and their skills given credence"*. Besides, many family members find it difficult to talk to other family members or friends, because they are afraid that talking about the crime and the mental illness would upset their relative. They also think that other family members and friends do not fully understand the situation, which causes them to become socially isolated (Nordström et al., 2006; Ridley et al., 2014).

1.3. Strengths-based approach

As described earlier, less attention is focused on supporting family members of mentally ill offenders as compared to family members of persons with a mental illness. A shift towards more strength-based approaches, analogous with the forensic mental health treatment of mentally ill offenders, could be supplementary to the current more burden-oriented focus. In this dissertation, burdens and strengths are not viewed separately but rather – from an orthopedagogical point of view – as complementary (see 1.5.).

1.3.1. Strengths and resilience of family members

Although the label 'burden' is commonly used in scientific research, there are some arguments against it. Especially for family members who remain protective and supportive towards their relative, the term in itself implies something negative and unwanted. Because some family members do not see 'giving care' to a loved one as a burden, for many it is experienced as a necessary, as well as desired, family role. Furthermore, the term 'burden' also ignores positive aspects such as the contextual, relational and affective roles that are linked to caregiving. Family members also can be satisfied giving care to their relatives, as they feel needed and have the companionship of the mentally ill family member (Sales, 2003). Therefore, it is important to focus on 'family strengths' in addition to the burdens, as the problems family members are confronted with offer an opportunity to change in a constructive way (Marsh & Johnson, 1997). Family members have different protective family factors that are internal (e.g., positive appraisal and cognitions and personal religiosity) or external (social support and psychoeducation programmes) and reflect their evaluation of their care and personal beliefs (Zauszniewski, Bekhet, & Suresky, 2015). Protective factors reduce the negative reactions towards risk situations and promote resilience by creating opportunities for family members to build up strategies for maintaining positive experiences (Rutter, 1987). Social support is one of the most commonly identified factors that contribute to family adaptation (Jonker & Greef, 2009). Moreover, a social network can be supportive in diminishing burdens (Chan & O'Brien, 2011). Therefore, it is important to focus on strengths in addition to the burdens and needs of family members. A strengths-based approach starts from the assumption that *“all the individuals and families have many capabilities, abilities and strengths. Each individual or family comes with a range of experiences, characteristics, roles, etc. that contribute to who the person is”* (Anuradha, 2004, p. 385). Furthermore, a strengths-based approach focuses primarily on the strengths and resources of a person for improving the problematic situation. It aims at boosting the factors that help individuals cope with the situation by building up resilience (Anuradha, 2004). In this perspective, family resilience is important and involves *“the potential for recovery, repair, and growth in families facing serious life challenges”* (Walsh, 2012, p. 399). Within research the strongest correlation was found between a family’s internal strengths and endurance suggesting that: *“the more the family is able to resist stress and endure their situation, the more able they are to adapt to a crisis”* (Bishop & Greeff, 2015, p. 469). Crises in families have an impact on the whole family for which key processes (belief systems, organizational patterns and communication/problem solving) are important in buffering stress, reducing the risk for dysfunction and supporting optimal adaptation. These processes, involved in the family resilience framework, are dynamic and imply strengths and resources family members can use to increase family resilience (Walsh, 2012). Research on family members of mentally ill offenders reports that only hope is mentioned as an important source of strength, which supports family members in overcoming obstacles and offers them new possibilities and resources (Nordström et al., 2006; Walsh, 2012).

1.3.2. Family interventions

From the 1990s on, the relevance of family interventions in forensic psychiatric settings is recognised by several authors (Absalom-Hornby et al., 2011; Cordess, 1992; Geelan & Nickford, 1999; Robinson, Vivian-Byrne, Driscoll, & Cordess, 1991). Various guidelines (e.g., National Institute for Clinical Excellence [NICE] or National Institute for Health and Care Excellence) indicate that family interventions are essential in providing mental health care. Especially for patients with a diagnosis of schizophrenia and psychosis (Davies et al., 2014). Furthermore, Absalom and colleagues (2010, p. 358) have stated that: *“frequent contact between families and patients, and in this population between families and the forensic services, is a prerequisite for family interventions”*. Earlier studies have indicated that low contact and engagement of family members are barriers to introducing family interventions in forensic settings (Geelan & Nickford, 1999).

Research has shown that there is a dearth of family interventions in forensic psychiatric settings (Absalom-Hornby, Hare, Gooding, & Tarrier, 2012). One study conducted in England and Wales, stated that only 11% of medium secure settings had trained family therapists, while other settings (37%) did not consider family therapy to be beneficial (Geelan & Nickford, 1999). Another study, conducted in Northwest England, investigated the needs of 137 mentally ill offenders who live in a forensic psychiatric hospital and the skills of 318 forensic health care workers. The results indicated that 2 of the 11 settings involved in the study made family therapy available for family members of mentally ill offenders (Absalom et al., 2010). A recent survey within 39 medium secure units in Wales and England (based on the survey of Geelan and Nickford in 1999) investigated whether secure units were using family therapy. The results showed that only 16 of 39 (41%) medium secure units offered family therapy (Davies et al., 2014). This may be explained by the fact that no, or insufficiently trained, staff members are available, although many staff members are committed and have a positive attitude towards family therapy (Absalom-Hornby et al., 2012). Still, when looking at staff skills in family intervention, only 7% have been trained, with a minority receiving clinical supervision for the application of the intervention (Absalom et al., 2010; Geelan

& Nickford, 1999). It is estimated that between 10% - 30% of staff should be trained to be able to provide family interventions in secure settings (Absalom et al., 2010). Other barriers to implementing family therapy in forensic settings are: the geographical distance between the patient and his/her family and the security measures that make it hard to access the facility (Absalom et al., 2010; Davies et al., 2014). Moreover, secure settings not only focus on family interventions, but also connect with family members in other ways to *"bridge the gap between the unit and the community",* as Davies and colleagues (2014, p. 527) have stated. Examples include: *"Family and Friends days, advocacy services, increasing the contact with families at the point of the patients' admission via 'welcome meetings' and 'family link meetings'"* (Davies et al., 2014, pp. 527-528).

Considering the above-mentioned challenges, family members of mentally ill offenders are often in need of support and coping strategies to deal with the different burdens and the double stigma. To meet these challenges, this dissertation specifically focusses on a therapeutic intervention based on Multi-Family Groups (MFGs) and Family Support Groups (FSGs) for family members of mentally ill persons. This explicit choice for a therapeutic intervention does not exclude that there are other, non-therapeutic, interventions that can support family members of mentally ill offenders (e.g., Family WRAP®[1], Family Psychoeducation) (Lobban et al., 2013; Sin, Jordan, Barley, Henderson, & Norman, 2015). These other interventions may be situated on the level of the individual (e.g., peer support groups) or society (e.g., volunteer aid strategy [in Dutch: mantelzorgplan], Mental Health First Aid). With regard to the latter, the government has a responsibility in providing the society -in general- with information, and carers -in particular- with the necessary support and opportunities to fulfil their caregiving task (Vandeurzen, 2016, 2017).

1.3.2.1. Multi-Family Groups

With regard to family-based interventions different therapies have been developed for family members confronted with a mentally ill relative. Interventions such as Functional Family Therapy, Brief Strategic Family Therapy, Multisystemic Therapy and Multidimensional Family Therapy focus primarily on developmental tasks and often use an individualised approach within one system or family. They are used with juvenile offenders and substance abusers, but not with mentally ill offenders and psychotic persons (Henggeler & Schaeffer, 2016; Liddle, 2010; Robbins, Alexander, Turner, & Hollimon, 2016; Szapocznik, Zarate, Duff, & Muir, 2013). This is in contrast with MFGs as this intervention brings family members together in one group. This kind of therapy was developed by Laqueur and his colleagues more than 50 years ago and was initially conducted with persons with schizophrenia. Laqueur's work inspired McFarlane and Anderson, who applied family psychoeducation to MFGs (Asen, 2002; Asen & Schuff, 2006; McFarlane, 2016). Within MFGs, because the focus is placed on family members advising and supporting one another, the therapists play a less central role and are regarded more as catalysts of the process (Asen, 2002). Because of the involvement of trained therapists and their roots within rehabilitation systems that are linked to (mental) health systems, MFGs are different from self-help and advocacy groups (McFarlane, 2002). More specific the MFG is long-term and merges treatment, rehabilitation and recovery approaches. The intervention aims to set up a context where family members can try out new behaviours and

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[1] Family WRAP® is like WRAP (Wellness Recovery Action Planning) a tool family members can use to enrich and empower their lives when confronted with a relative with mental health problems. Family WRAP helps each family member in making plans that will help to improve their daily interactions and challenges. It promotes support and mutual collaboration between family members (Copeland, 2013, 2015).

new relationships that may reduce stigma, relieve burdens and facilitate more tolerance between family and patient. Furthermore, an MFG also enables to participants to create 'a bridge' between the family context and the psychiatric hospital in which the relative resides. Nowadays, MFGs are also organized for a variety of psychiatric disorders (e.g., bipolar disorder, depressive disorder, obsessive compulsive disorder, medical disorders, substance abuse, …) (Asen, 2002; Asen, Dawson, & McHugh, 2001; Asen & Schuff, 2006; Jewell, Downing, & McFarlane, 2009; McFarlane, 2002). Within an MFG, family members are confronted with the 'lived experiences' of the other participants and are supported in reflecting on their way of dealing with the situation, which can be powerful in creating 'new stories' of their situation for themselves (Bishop, Clilverd, Cooklin, & Hunt, 2002).

Figure 1.2. shows that a family intervention has positive effects on the burdens of family members as they first experience an increase in their *coping strategies***.** They can receive information and 'guidelines' for dealing with the problems, which can influence the mentally ill person's recovery process (Bishop & Greeff, 2015; Jewell et al., 2009; McFarlane, 2002). Furthermore, they can observe others and learn from the participants' behaviours in coping with the situation (McFarlane, 2002). Second, a family intervention enables *solidarity* as feelings of social isolation and stigmatisation are diminished by coming into contact with other family members which encourages *peer support*. Third, family interventions introduce hopeful stories, which has an influence on their *(emotional) well-being* (Asen et al., 2001; Asen & Schuff, 2006; Jewell et al., 2009; McFarlane, 2002).

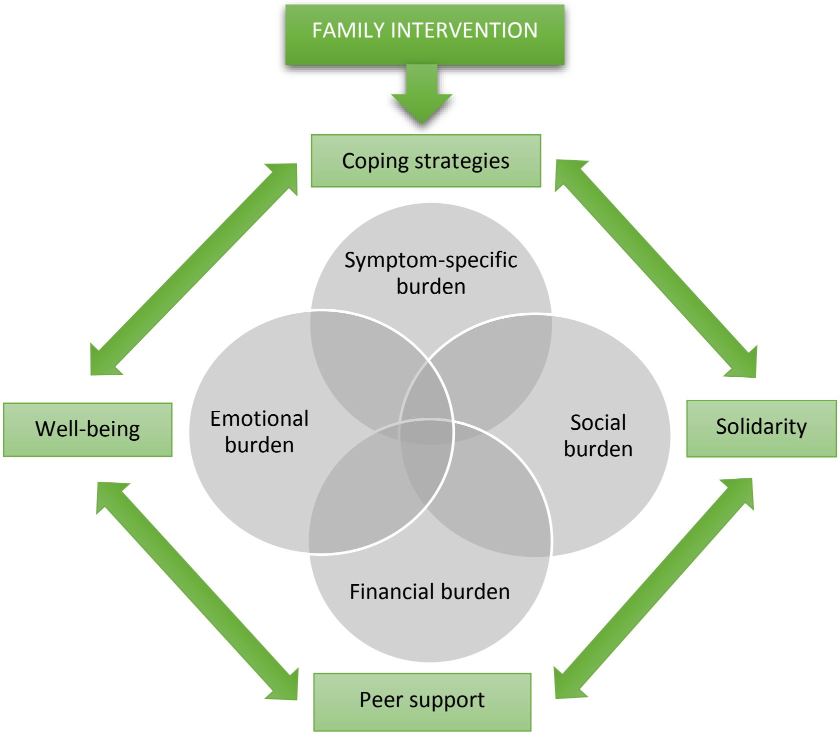

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Figure 1.2. *Important concepts in family interventions that can help family members decrease their burdens.* Figure based on the burdens mentioned by Tsang and colleagues (2002; see Fig. 1.1.) and the above-mentioned effects of a family intervention on these burdens.

1.3.2.2. Family Support Groups

Research has shown that support groups can help family members, because *"support groups play an important role as a nursing therapy to meet caregivers' psychological needs"* (Chou, Liu, & Chu, 2002, p. 713). Support groups can be seen as a resource for family members of mentally ill persons in need for support and information to cope with the situation (Heller, Roccoforte, Hsieh, Cook, & Pickett, 1997). These groups help family members of mentally ill persons to express their feelings by listening to others in a safe and secure atmosphere. This enhances their well-being and their sense of hope, as talking to others in a similar situation promotes a sense of belonging (Chou et al., 2002; Mokgothu, Du Plessis, & Koen, 2015). Especially emotional support is important to help family members in dealing with different feelings and to set realistic boundaries in caring for a relative (Chou et al., 2002). Moreover, family members who receive support (e.g., by being part of a support group and by acquiring knowledge) can better adapt to a situation in times of crisis (Bishop & Greeff, 2015). In this regard, spending time with the family in a group is also important, as 'togetherness' is found to enhance adaptation to the situation and acceptance of the mental illness of a relative (Bishop & Greeff, 2015). Walsh (2012, p. 422) concludes: *"Resilience-oriented services foster family empowerment as they bring forth shared hope, develop new and renewed competencies, and strengthen family bonds"*.

Available research on family support groups has shown that family members assign several benefits to attending a group. First, the guidance of support groups is considered valuable, because family members feel listened to by professionals and information and knowledge can be shared (Chou et al., 2002). Second, knowledge about the illness and the treatment is increased when participating in a support group. Third, family members experience reduced burdens and distress and an enhancement in their coping ability and social support (Chien & Norman, 2009).

1.4. Problem definition and methodology

Considerable research has been undertaken about family perceptions and experiences when caring for a relative with a mental illness. In general, these studies have focused on quality of life, burdens of care, (self-)stigma, and the needs of family members when confronted with a relative's mental illness (e.g., Foldemo et al., 2005; Sales, 2003; van der Sanden et al., 2016; Wynaden, 2007). The studies reported on the stress that family members experience, which is associated with the stigmatisation of society that threatens the family members' (social) identity and family life (van der Sanden et al., 2016). Stress is also associated with a lack of support from professionals, family members and friends, and with the fact that family members are seen as primary caregivers, fulfilling the roles of informal case manager and crisis intervention specialist (Marsh & Johnson, 1997; Shankar & Muthuswamy, 2007). Although research has principally focused on burdens, stress and stigma, some studies have also focused on family recovery processes, coping strategies and family resilience (Marsh & Johnson, 1997; Spaniol, 2010; van der Sanden et al., 2016). However, the perspectives of family members confronted with a mentally ill offender have received less investigation. The limited number of studies have shown that these family members experience burdens similar to those of family members confronted with a mental illness, but their stress is heightened because of the criminal offence and its consequences (e.g., James, 1996; MacInnes & Watson, 2002; Tsang et al., 2002). Only one study specifically focused on the strengths of these family members, mentioning the importance of experiencing hope (Nordström et al., 2006). Several studies reported recommendations for practice and future research, with attention to educational, emotional, practical and counselling support for family members of mentally ill offenders, which perhaps could be provided in a family intervention (Absalom-Hornby et al., 2011; MacInnes & Watson, 2002; McCann et al., 1996; Ridley et al., 2014).

In summary, the needs, burdens and strengths of family members of mentally ill offenders, as well as family support, are understudied internationally. The situation in Belgium is particularly interesting to investigate, because during the last years there have been some changes in the Law and in the mental health care of mentally ill offenders. However, a decreasing but still large number are still locked up in prison with no adequate treatment and care (see 1.1.2.). Therefore, it is important to enhance scientific knowledge of the influence of the internment measure on the experiences and perceptions of family members of mentally ill offenders and how they can be supported. The aims of the present study were twofold:

- First, we investigated the lived experiences of family members considering the internment measure, (forensic) psychiatric treatment, and the mental illness of their relative;
- Second, we examined to what degree an intervention based on Multi-Family Groups could support and empower family members of mentally ill offenders.

The following research questions were put forward:

1. How are the experiences, needs and burdens of families of mentally ill offenders described in scientific literature? *(Chapter 2)*
2. How do family members experience the mental illness, the interment measure, and the (forensic) psychiatric treatment of their relative? *(Chapter 3)*
3. How can family members be supported in dealing with both the mental illness and the internment measure of a relative? *(Chapter 4)*
4. What are the effects of a Family Support Group on quality of life, burdens, coping strategies, and resilience of family members of mentally ill offenders? *(Chapter 5)*
5. Which therapeutic factors underpin a Family Support group? *(Chapter 6)*
6. Which are the treatment expectations and experiences of family members before and after attending a Family Support Group? *(Chapter 7)*

Data were collected by making use of three different research methods: (1) a systematic review; (2) semi-structured interviews; and (3) mixed methods research consisting of qualitative (semi-structured interviews) and quantitative (standardized questionnaires) research methods (Denscombe, 2008; Johnson & Onwuegbuzie, 2004).

1.4.1 Study design

This PhD thesis is subdivided into 3 main work packages. Within the *first work package,* a systematic review (Chapter 2) on the perspectives and experiences of family members of mentally ill offenders was carried out, in line with the PRISMA guidelines for systematic reviews (Moher, Liberati, Teztzlaff, & Altman [PRISMA Group], 2010). The ISI Web of Science, PubMed, ProQuest and Elsevier databases were examined in relation to studies about family roles, needs, burdens and the strengths of family members of mentally ill offenders.

The *second work package* entailed a qualitative study, using semi-structured interviews (n = 24), of how family members of mentally ill offenders (n = 27) experience the internment measure and the (forensic) psychiatric treatment of their relative (Chapter 3).

The *third work package* consisted of 4 studies of Family Support Groups (FSGs) that were organized for family members of mentally ill offenders (cf. Figure 1.3.). Chapters 4 to 7 discuss the development of the protocol (Figure 1.3.: blue; Chapter 4), the outcomes (Figure 1.3.: grey; Chapter 5), the therapeutic processes (Figure 1.3.: orange; Chapter 6), and the expectations and experiences (Figure 1.3.: green; Chapter 7) of family members who participated in different Family Support Groups (FSGs). In total, two FSG cycles were organized: from February 2016 until May 2016, and from October 2016 until December 2016, respectively. Twenty family members agreed to participate in the FSG and were interviewed one week before the start (T0). However, before the start of the first session, one father dropped out and, during the intervention, another two mothers dropped out after the first or second session. Therefore, 17 persons were interviewed one week after the last session (T1).

More specifically, the FSG protocol is described in Chapter 4. The concepts on which the FSG is based are discussed and the organization of the FSG is described by using clinical vignettes to illustrate the therapeutic process. Chapter 5 is based on pre- and post-intervention studies which investigated the impact of the FSGs in relation to quality of life, burden, coping strategies, and resilience. Family members completed several questionnaires (i.e., WHOQOL-bref, ZBI-22, CERQ, RS-nl), both before and after the group intervention. In Chapter 6, therapeutic factors of the FSGs are investigated by making use of the Group Therapeutic Factors-Client Questionnaire (GTF-CQ-28) which family members filled out after each session. After the last session, every participant received a Post-evaluation Family Support Group Questionnaire (Post-evaluation FSGQ) to measure treatment satisfaction during the course of the intervention (from session 1 to session 4). These questionnaires were collected during the post-intervention interview. Further, correlations between therapeutic factors and outcome measures are discussed. Chapter 7 includes qualitative interviews with participants in both FSG cycles. The interviews were carried out before and after the intervention and focused on treatment expectations and experiences, respectively. Within this chapter, the views of family members are considered with regard to the changes the FSG brought into their lives.

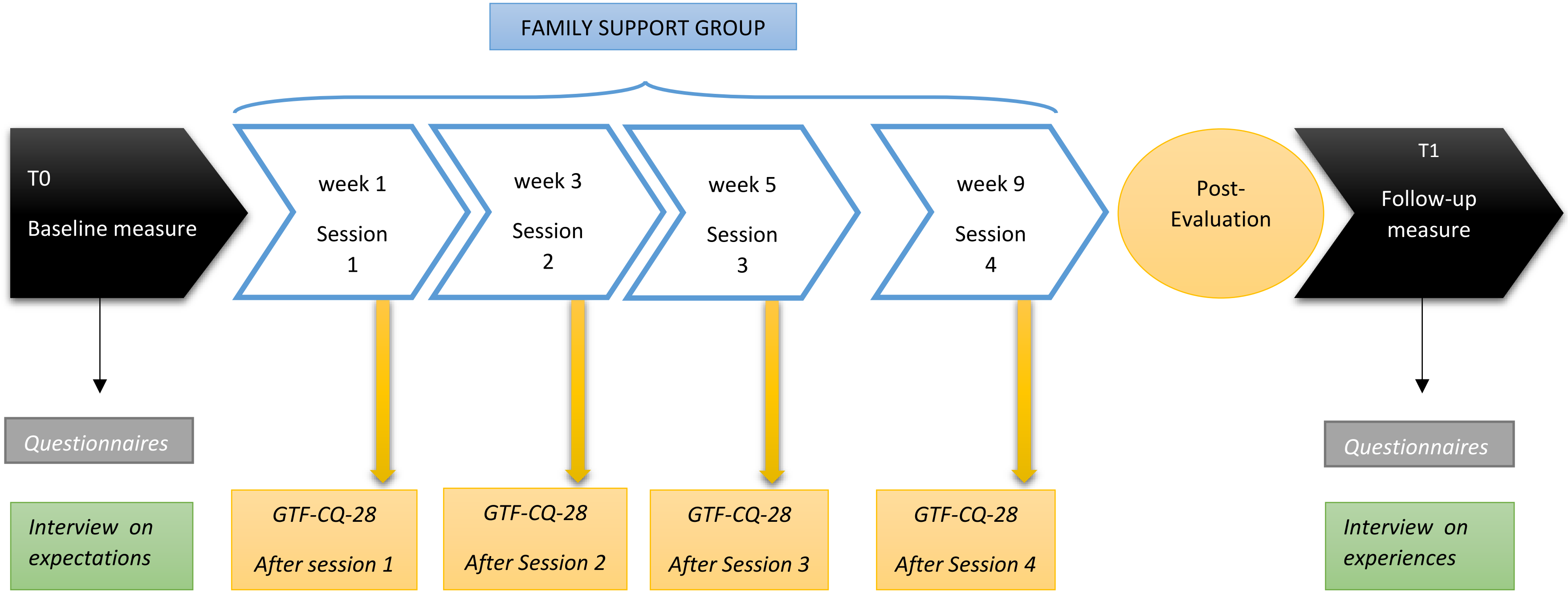

Figure 1.3. *Study flow chart of the Family Support Group.*

GTF-CQ-28 = Group Therapeutic Factors-Client Questionnaire. Questionnaires = WHOQOL-bref, ZBI-22, CERQ and RS-nl. Blue = Chapter 4 – Therapeutic protocol; Grey = Chapter 5 – Outcome study; Orange = Chapter 6 – Therapeutic process; Green = Chapter 7 – Family expectations and experiences about the FSG.

1.4.2. Outline of the dissertation

The dissertation contains several papers that are under review or have been published. Consequently, and especially for Chapters 4-7, the content may slightly overlap. More in particular Chapters 5 and 6 are quantitative studies based on the same sample. Both investigate two different aspects of the FSG, with Chapter 5 looking at the pre- and post-intervention aspects and Chapter 6 at the therapeutic factors. The dissertation is divided into a general introduction (Chapter 1), 6 chapters based on the above-mentioned work packages (Chapters 2-7), and a general discussion (Chapter 8) (cf. Figure 1.4.).

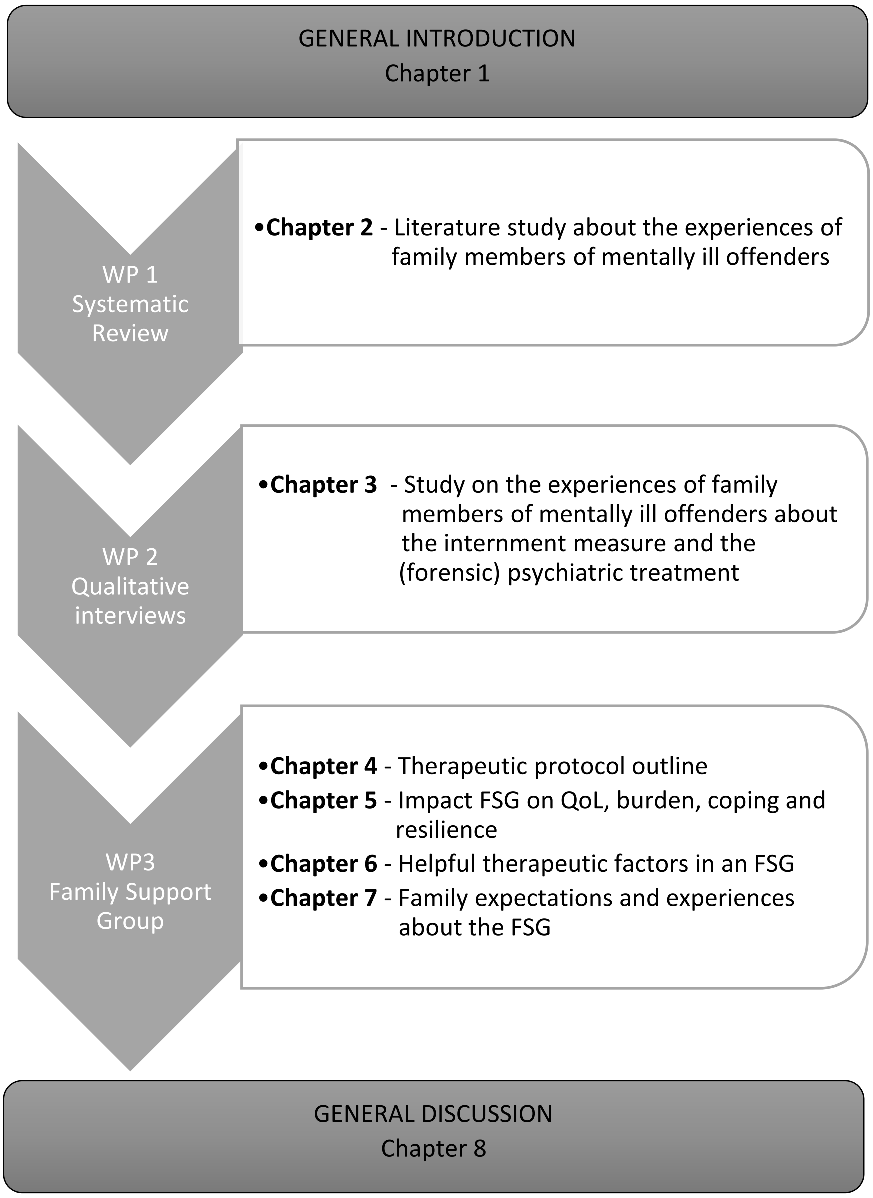

Figure 1.4. *Structure of the doctoral dissertation*

1.5. Situated within the field of special needs education

The dissertation has been conducted in the Department of Special Needs Education (‘Orthopedagogics’; see Vanderplasschen et al., 2017) at Ghent University and is a cooperation between three faculties (Faculty of Law, Faculty of Medicine and Health Sciences, and Faculty of Psychology and Educational Sciences). As the research is situated within the field of special needs education, some aspects relating to the ‘orthopedagogical’ nature of the study are briefly outlined below.

Education and research in the orthopedagogical field can be described as a practice-oriented and integrative approach that is characterised by working closely with children, adolescents or adults and their social network aiming to improve educational practice. Both professionals and researchers try to build bridges between those persons, their life stories and the social contexts in which they live (Vanderplasschen, De Schauwer, & Vandevelde, 2015; Vanderplasschen et al., 2017). The holistic integrative approach, introduced by Broekaert and colleagues (2010), states that:

> *“The integrative scientific point of view searches for the integration of diverse types of interventions, as well as methodological approaches. It means that various treatment modalities, paradigms of care and research methodologies can alternatively go together”* (p. 233).

This accords well with how Vander Laenen and Vander Beken (2017, p. 164) describe: “*the central aim of orthopedagogy (and of practice) [that] should be to empower vulnerable people, improve their quality of life and challenge aspects of society that alienate and exclude them”.*

The studies in this dissertation focus on ‘giving voice’ to the ‘lived experiences’ of family members of mentally ill offenders, with attention to their coping strategies and capabilities for handling the situation they are confronted with. The focus on lived experiences is particularly relevant, since research has shown that, in order to improve someone’s quality of life, interventions should consider their clients and his/her context as experts of their own experiences (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2016). However, with regard to the research in this dissertation, it is important to keep in mind that the family members and the mentally ill offenders can have different ‘life stories’. Withal, reflecting on these ‘life stories’ is important when considering concepts like ‘multiperspectivism’ and ‘multidirected partiality’. The latter is a concept developed by the contextual therapy of Boszormenyi-Nagy and explains the importance of taking into account the concerns of everyone involved in therapy (Boszormenyi-Nagy, 2000). Pluralism, sincerity and critical reflection are important as the reality is much more complex than we (can) experience. These concepts are also in line with the classic ideas of the pioneer Ter Horst, who describes orthopedagogical action as a holistic approach in which ‘the whole person’ needs to be addressed and understood (Ruijssenaars, van den Bergh, & Schoorl, 2008; Broekaert, 2005). Moreover, from an orthopedagogical approach, it is not possible to carry out research about vulnerable persons without giving attention to the social, cultural and political context they live in. Research within the field of special needs education starts from the assumption that every person has a life story, in which the roles of family members or other social network members should be acknowledged, understood and supported (Vanderplasschen et al., 2015).

Considering this, the research within this dissertation, focuses on the experiences of family members, and on how they cope with the judicial and mental health care system they are confronted with. The purpose is to empower family members and to acknowledge and discuss their situation in society. In research and practice, it is important to make coping strategies, emotions and strengths of family members and mentally ill offenders discussable. In this perspective, ‘action-oriented orthopedagogics’ is important, as the research emphasises the ‘actions’ of family members by looking for new opportunities, changes and possibilities in their lives (Vanderplasschen et al., 2015). Therefore, the central part of the dissertation scrutinizes an intervention (Family Support Group) for family members of mentally ill offenders. Linked to the integrative approach developed by Broekaert, this intervention is based on an integration of different theories, perspectives and methods (Broekaert, 2009). It focuses on a systemic and narrative approach, as family members of mentally ill offenders are often living in dominant ‘stigmatised’ stories of the psychiatric illness and the criminal offence (Nordström et al., 2006; Pearson & Tsang, 2004). In addition, it is based on a MFG format that aims to reduce stigma and social isolation and to increase social support (McFarlane, 2002). By combining both quantitative as well as qualitative research, we reflected on the intervention, the experiences and the support needs of family members and their ideas for the future.

The different studies in this dissertation focus on the strengths of family members – a concept that is receiving more attention in current orthopedagogical theory and practice. The strengths-based approach is central to this concept, in that by supporting and helping them, it aims to impact people by giving them insight into their own power to affect their lives (Broekaert, Van Hove, Bayliss, & D’Oosterlinck, 2004; Vandevelde et al., 2017).

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2

The role and experiences of family members during the rehabilitation of mentally ill offenders

This chapter is based on:

Rowaert S., Vandevelde S., Lemmens G., Vanderplasschen W., Vander Beken T., Vander Laenen F., & Audenaert, K. (2016). The role and experiences of family members during the rehabilitation of mentally ill offenders. *International Journal of Rehabilitation Research*, *39*(1), 11-19. doi: 10.1097/MRR.0000000000000152

Abstract

Introduction – Taking care of a family member with a mental illness imposes burden on various aspects of family life. This burden may be enhanced if the mentally ill individual has a criminal history. This paper aims to summarize the scientific literature dealing with the experiences, needs and burdens of families of mentally ill offenders. We aim to explore the roles that family members play in the rehabilitation of their relative and review the families' needs and burdens. Finally, we aim to investigate whether or not the family strengths are considered in the literature.

Methods – A literature search in line with the PRISMA statement for systematic reviews and with the recommendations for an integrative review was performed in the ISI Web of Science, PubMed, Elsevier Science Direct and ProQuest databases.

Results – Limited research has been conducted into the experiences, needs, and burdens of families of mentally ill offenders, with only eight studies meeting the inclusion criteria. Families of mentally ill offenders experience more stress than those of mentally ill individuals with no judicial involvement. This is due to the fact that these family members have to deal with both mental health services and judicial systems. The eight retrieved studies focus on needs and burdens, with little reference to strengths or capabilities.

Conclusions – The review has highlighted the need for further research into the needs and burdens of families with mentally ill offenders, with a focus on strengths rather than an exclusively problem-oriented perspective. It is important that families become more involved in the health and social care of their relatives to avoid being regarded as 'second patients'.

Key words

Family, Mentally ill offenders, Needs, Burdens, Strengths

2.1. Introduction

Worldwide there are over 10 million prisoners, a number which is still growing (Fazel & Seewald, 2012). Many offenders in general and prisoners more in particular are facing (severe) mental health problems, with prevalence rates ranging from 10% to 70% according to different studies in the United States and Europe (Dressing & Salize, 2009; Sarteschi, 2013). Although the figures widely vary, e.g., due to differences in used definitions, we could conclude that the proportion of mentally ill persons in offender populations is substantial; moreover, mentally ill offenders are described as a population for which treatment services are not adequately equipped (Dressing & Salize, 2009; Koenraadt & Mooij, 2007; Sarteschi, 2013;). Yet, during the last decades, the support of mentally ill offenders has received increased attention, both in research as well as in clinical practice (Adshead et al., 2013; Lamb & Weinberger, 1998; Roskes, Felman, Arrington, & Leisher, 1999). However not only mentally ill offenders themselves, but also their family members are affected by the particular situation offenders find themselves in, although research about the resources, strengths, needs, difficulties, and coping strategies of family members of mentally ill offenders is only scantly available. Moreover, it often concerns studies with small and limited samples (Nordström, Kullgren, & Dahlgren, 2006; Pearson & Tsang, 2004; Tsang, Pearson, & Yuen, 2002).

Taking care of a relative with a mental illness imposes various challenges or ‘burdens’ (a concept developed by Grad and Sainsburry in 1963) on families (Lautenschlager, Kurz, Loi, & Cramer, 2013; Marsh & Johnson, 1997). Because the concept of ‘burden’ is often used in the literature on family members of mentally ill persons (cf. Baronet, 1999; Maurin & Boyd, 1990; Wong, Lam, Chan, & Chan, 2012), it is also used in this paper, although we are aware of the fact that it may be perceived as potentially stigmatizing; a connotation which certainly is not intended in the scope of this paper. Families experience difficulties both objectively and subjectively; they have to deal with both the symptoms of the mental illness, caregiving responsibilities and social stigma (objective burden) and intense emotions such as grief, disbelief, anger, guilt, anxiety and shame (subjective burden) (Baronet, 1999; Fadden, Bebbington, & Kuipers, 1987; Foldemo, Gullberg, Ek, & Bogren, 2005; Loukissa, 1995; Marsh & Johnson, 1997; Maurin & Boyd, 1990; Thompson & Doll, 1982). Most studies have focused on families experiencing difficulties, although others have shown that families can change their lives and build family resilience over time (Marsh & Johnson, 1997; Mokgothu, Du Plessis, & Koen, 2015; Wynaden, 2007). This shows that, given time, family members can become empowered by recognizing family strengths. These strengths have been defined as: “*the set of relationships and processes that support and protect families and family members, especially during times of adversity and change; they help to maintain the family cohesion*” (Moore, Chalk, Scarpa, & Vandivere, 2002, p. 1). Hence, families are now increasingly considered as a critical source of support during the rehabilitation process of their mentally ill relative and are regarded as crisis intervention specialists because they handle relapses and emergencies and protect vulnerable family members (Loukissa, 1995; Marsh and Johnson, 1997; Wynaden, 2007). However, supportive families have to overcome cycles of hope and despair and this can create greater levels of personal advocacy and assertiveness (Spaniol, 2010). Despite this, research into the participation of families in support and treatment rarely discusses the family strengths (Ewertzon, Lützen, Svensson, & Andershed, 2010; Marsh & Johnson, 1997; Spaniol & Zipple, 1988; Tsang, Tam, Chan, & Cheung, 2003; Wynaden, 2007).

Family members that are providing support to a mentally ill relative experience emotional stress, which is often enhanced if the relative is also involved in criminal activities (Ferriter & Huband, 2003; Marsh & Johnson, 1997). Families of mentally ill individuals without a criminal record face burdens such as (1) dealing with different emotions (e.g., guilt, shame, stigmatisation, denial, frustration, anxiety, and helplessness), (2) financial concerns (early retirement or having to quit their jobs) and (3) social isolation and discrimination (Marsh & Johnson, 1997; Schene, van Wijngaarden, & Koeter, 1998; Tsang et al., 2003). Preliminary findings in a narrative review show that family members of mentally ill individuals with a criminal record face similar issues and have to deal with a variety of stressors, including court proceedings, the media, admissions to special hospitals, contact with police and judicial systems and violent behaviour from their ill relative, which creates symptom-specific, social, financial and emotional burdens. In addition to these burdens, the needs of families are affected by diminishing work, leisure and social activity (Tsang et al., 2002). Families of mentally ill offenders have to participate in caring for their mentally ill relative. Although most family members feel unprepared, they continue to support their mentally ill relative during their rehabilitation process (Loukissa, 1995; Marsh & Johnson, 1997; Wynaden, 2007). Families do not see themselves as controlling and remain protective towards their relative, for example by not involving the police if the person is violent (Ferriter & Huband, 2003; Nordström et al., 2006). However, a recent study about the experiences of family members of persons subjected to Electronic Monitoring indicated that family members sometimes see themselves as assistants, social workers and 'controllers' of their relative (Vanhaelemeersch & Vander Beken, 2014). When confronted by the forensic services, families actively support their relative both practically and emotionally. Yet, they sometimes feel inadequate, institutionalised and intimidated in their role, which affects their life-course, identity and well-being (Ridley et al., 2014). Nonetheless, resilience is also an important factor within these families, because it allows the development of self-coping strategies in the face of stressors and difficulties (McCann, McKeown, & Porter, 1996).

The aim of this article is to review the recent literature on the experiences, needs and burdens of families of mentally ill offenders. Firstly, we aim to address the role of the families during the rehabilitation of their relative. Secondly, we aim to review the families' needs and burdens and finally we aim to examine if and to what degree the retrieved literature has explored the families' strengths. We discuss the gaps in our existing knowledge and pose suggestions for future research.

2.2. Methodology

A literature search was performed applying the guidelines of the PRISMA statement for systematic reviews as the basis for reporting (Moher et al., 2010). In line with the recommendations for an integrative review (Soares et al., 2014; Whittemore & Knafl, 2005), the different steps of the review study are clearly described in order to underpin the reliability and validity of the results (Figure 2.1.). The ISI Web of Science, PubMed, Elsevier Science Direct and ProQuest were examined, using the following search terms to identify studies about the role of families in supporting mentally ill offenders and their experiences, perceived needs and burdens: 'mentally ill/mentally ill offender/forensic' and 'family/social network/caregiver/informal network'. This yielded a total of 1466 papers, 223 of which were duplicate studies. Studies were included if they contained the perspectives of families and focused on the experiences, needs and burdens of the family or the social network. Studies were excluded (n = 1212) based on the following criteria: (1) focusing only on the perspective of mentally ill offenders or describing drug addict offenders, (2) describing children and adolescents under 18 years of age, (3) pure medical contexts, or dealing with physical diseases such as cancer, or comparing the effect of pharmaceutical products, (4) investigating community re-entry and community treatment with exclusive focus on the mentally ill offender, (5) describing specific concepts (e.g., recovery) without considering the needs and burdens of caregivers and (6) investigating family interventions and social support. The titles and abstracts were carefully and independently read and assessed by the first author of the paper and another researcher in order to guarantee the reliability of the analysis. In case of divergent opinions, both assessors discussed these differences until agreement was reached. Based on this scrutiny, 21 articles on families of mentally ill (offenders) or reviews of these studies were selected. Screening the reference lists of the selected articles revealed an additional 49 articles meeting the inclusion criteria. A total of 70 selected articles were further processed by excluding 59 papers that were not situated in a forensic context. A further three papers were excluded because they were not empirical studies. After processing, only eight studies were evaluated; these were seven scientific articles and one report (Table 2.1.). During the study, meetings between the first author and the co-researchers (who have experience in conducting review studies) were regularly organized, in order to discuss the planning and implementation of the different research phases.

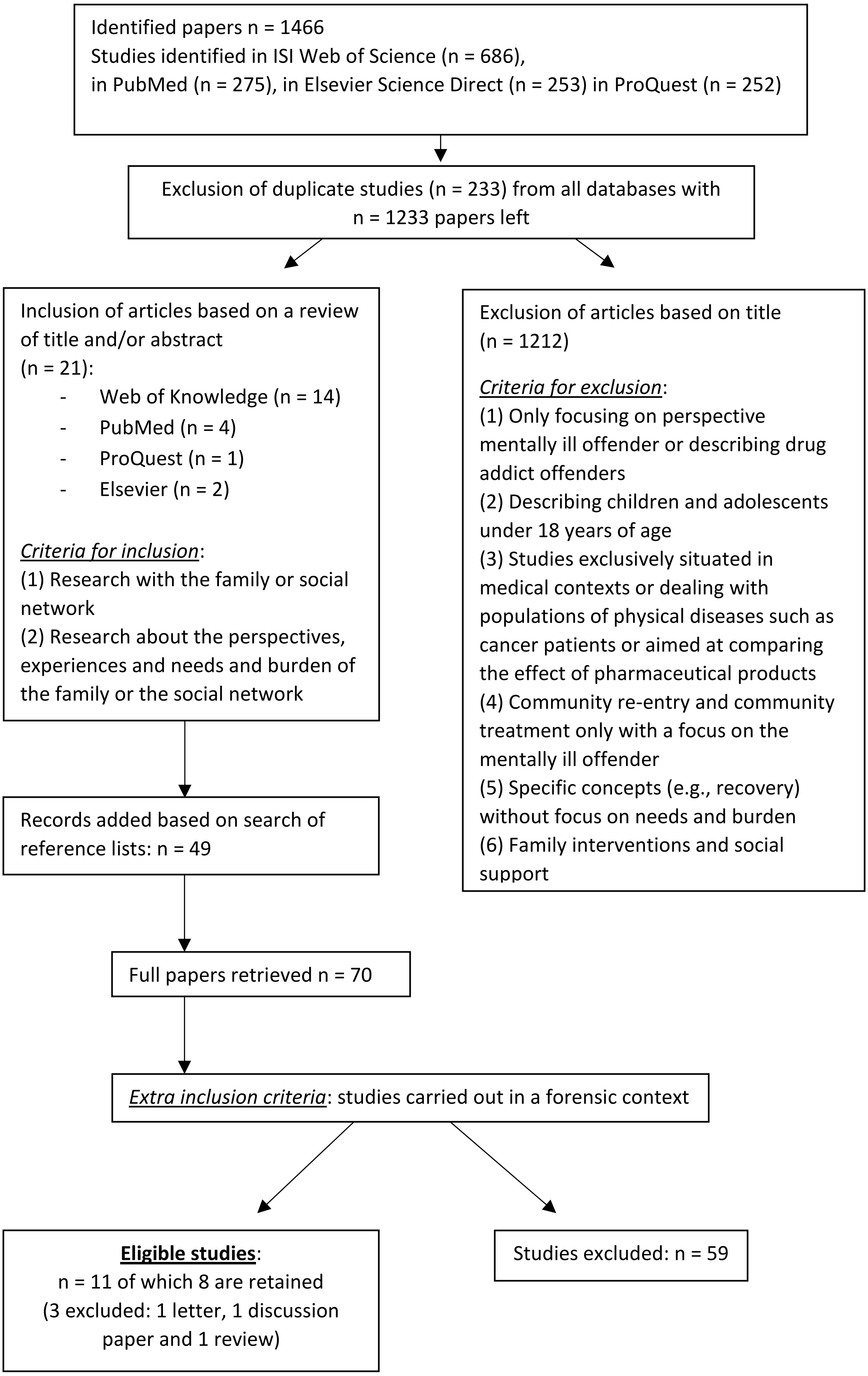

Figure 2.1. *Flow chart of studies relative to inclusion and exclusion criteria*

2.3. Results

The retrieval of only eight suitable studies from our literature search demonstrated that research into the experiences, needs and burdens of families of mentally ill offenders is limited. In two of the articles, the needs and burdens of non-forensic and forensic families were compared. Two articles described findings from a secure setting and four studies described the experiences of the families. It is clear that very little research has been carried out to disclose the perspectives of the families of mentally ill offenders. Sample sizes in the articles are limited (15-23, 79 and 72 participants). Qualitative methods including in-depth interviews were used in six studies. In five articles, the mothers and other relatives of persons with schizophrenia were interviewed. All reviewed studies were conducted within a (secure) forensic psychiatric hospital or a forensic unit. The studies all involved family members, but study eight also included a limited number of friends (5%). Different terms were used to describe the family members, including carers, caregivers, parents and relatives.

2.3.1. Role of families in the rehabilitation process of the mentally ill offender

Families of mentally ill offenders are considered primary caregivers and as the main source of care and aftercare for their relative; however they receive little or no formal training for this and many are ill-prepared to take on this responsibility (James, 1996; MacInnes & Watson, 2002). As a caregiver, one assumes responsibility for another person, which may disrupt normal life cycle activities, such as participation in social events, employment opportunities and family relationships. The performed studies indicate that family members are considerably burdened, because of the impact on their identity, life-course, welfare and well-being. They also feel psychologically affected, defining themselves as feeling institutionalised, intimidated and inadequate by caring for a mentally ill offender. Family members may also have to provide support to mentally ill relatives living in a secure setting. Some families assume that their caring role is suspended if their relative is living in a secure setting; however, most families still provide support in these cases by visiting and acting as informants for professionals (Nordström et al., 2006; Pearson & Tsang, 2004; Ridley et al., 2014).

2.3.2. Needs and burdens

Half of the papers described that families of mentally ill offenders experience more stress and burdens than families confronted with psychiatric problems alone. The main source of this extra stress comes from confrontation with police and judicial systems. This affects family members because they are confronted with violent behaviours, dual stigmatisation and, in some cases, a disintegration of family relationships. The potential causes of increased stress in families of mentally ill offenders are shortly summarised below:

2.3.2.1. Violent behaviours

Violence from mentally ill relatives and the consequent confrontations with the police, and the judicial system are considerable sources of stress for family members (McCann et al., 1996). These confrontations cause feelings of disbelief and devastation, making it harder to manage and causing more stress. Some study participants reported that media coverage of their situation caused the most stress, which could make stigma a more damaging stressor than legal proceedings (Pearson & Tsang, 2004).

2.3.2.2. Double stigmatisation

Families of mentally ill offenders are confronted with a double stigma, because their relatives are seen as ‘mad and bad’. This increases the emotional burden on families; desperate feelings, such as guilt, hopelessness, frustration and shame have been reported, including media contact. These often cause further stress, which leads to self-blame and social isolation (McCann et al., 1996; Nordström et al., 2006). Opinions on mentally ill persons who commit offences have also been voiced by the general public, as well as the media. In a Chinese culture, where ‘good manners’ are seen as very important, attitudes of the neighbours are described as a major issue. Furthermore, families find it difficult to discuss their problems with friends because of the associated stigma (Absalom-Hornby et al., 2011; Pearson & Tsang, 2004;).

2.3.2.3. Disintegration of the family and diminishing social contacts

Relatives of mentally ill offenders often withdraw from group activities in response to hostile reactions from people in society. This may isolate and exclude them from social activities, although they do want to share their stories and perceive contact with family, self-help groups and police as supportive. Study participants have reported these sources of support as more helpful than contact with psychologists, social workers and psychiatrists. Despite this, most families were unaware of community-based support for their ill relatives after their release. Family members also reported little contact with mental health professionals and consequently did not feel well advised, despite that they mentioned the hope to be more involved as informal caregivers if their mentally ill relative would agree on this. This refers for example to participating in family meetings organized by the setting their relatives stay in (e.g., a forensic psychiatric hospital). Mental health professionals were perceived as unreliable when confronted, causing emotions such as anger.

Yet, some positive feelings were reported by the family members, such as not being blamed or not feeling neglected; however, on the whole, family members were disappointed with the treatment and information they receive. Study participants were hopeful for an improved quality of life for their relative in the future, which was an important source of strength. Family members believed that early and suitable psychiatric treatment could prevent violent behaviours and criminal offences, signifying that family members of mentally ill offenders often want increased support from forensic services and organizations (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; James, 1996; MacInnes & Watson, 2002; Nordström et al., 2006; Pearson & Tsang, 2004).

2.3.2.4. Feelings

Families of mentally ill offenders often struggle with blame that they are responsible for the problems of their relative, which leads to guilt, anxiety and grief. Guilt is often reported, particularly by parents and partners; some believe that the outcome would have been better if they had recognised the illness earlier or had been better able to handle the situation, while others believe that they are the cause. Families often search for explanations for the disorder, which often leads to feelings of helplessness and anxiety when no answer can be found. This creates feelings of negativity between the mentally ill offender and their family and also between the family members and professionals. Consequently, maladaptive self-coping strategies may arise, characterised by the inability to discuss problems, social withdrawal and hostile reactions (Ferriter & Huband, 2003; James, 1996; McCann et al., 1996; Nordström et al., 2006).

Table 2.1. *Overview of selected articles: aim, study design, participants and instruments used in the study*

Authors, date, country	Aim	Study design	Participants	Instruments used in the study
1. McCann, McKeown, & Porter (1996); England	Evaluate the needs of relatives of patients within a forensic setting by exploring the needs and discussing the rationale upon which a more effective service for relatives could be developed.	Qualitative study with semi-structured interview at home or in a high security hospital (Ashworth Hospital).	17 participants: 14 relatives (mothers, fathers, brothers and sisters) and 3 friends of patients at Ashworth Hospital.	1. RAISSE (Relative Assessment Interview, Schizophrenia in a Secure Environment, McKeown & McCann, 1995) a semi-structured interview based on RAI (Relative Assessment Interview, Tarrier et al., 1988) and SNAP (Schizophrenia, Nursing Assessment Protocol, Brooker, & Baguley, 1990). Concentrates on the relatives' perceptions and beliefs they experience in contact with the patient in a forensic setting. 2. KASI (Knowledge about Schizophrenia Interview, Barrowclough et al., 1987). A semi-structured interview assessing the functional knowledge of relatives about several themes.
2. James (1996); Australia	Describing issues that are arising from a National Mental Health Project funded programme.	Evaluations of topics that have been found to be of particular relevance to forensic psychiatry clients and their families.		
3. MacInnes & Watson (2002); United Kingdom	Examining levels of burden experienced by caregivers of people with schizophrenia, making a comparison between caregivers of forensic and non-forensic patients.	Survey design with in-depth interviews.	107 caregivers were interviewed, of which 79 were forensic caregivers.	Interview schedule focused on the following thematic areas of burden: - Specific difficulties faced by caregivers - Frequency that burdens were faced - Most worrying burdens for caregivers - Coping with the burdens - Cause of the burdens

4. Ferriter & Huband (2003); England	Exploring the opinion of parents on the cause of the disorder, the emotional burden and the helpfulness of others when seeking support over a number of years.	Qualitative study with an interview.	22 parents of forensic patients selected at random. Criteria: patients diagnosed with schizophrenia and receiving treatment in a secure forensic hospital in the UK.	The participants' experience of their child's illness was determined via three methods: 1. Endorsement of items from a list of behavioural problems commonly associated with schizophrenia (Kaplan & Sadock, 1989) 2. Completion of the degree of burden scale (Thompson & Doll, 1982) 3. Participation in the focused life story (Tagg, 1985)
5. Pearson & Tsang (2004); China	Offering relatives a voice, which would permit a greater level of understanding of professional interventions that would be both relevant and feasible.	Exploratory, qualitative study: in-depth interviews.	23 participants: parents, siblings and spouses.	Relative Assessment Interview (RAI) (developed by Barrowclough & Tarrier, 1992) based on the Camberwell Family Interview. Semi-structured and provides information about the problems and needs of the caregivers who are coping with patients with schizophrenia. The information is then used to guide family intervention.
6. Nordström, Kullgren, & Dahlgren (2006); Sweden	Disclosing the parents' experiences and emotional reactions about having an adult son with schizophrenia who has also committed a severe violent crime.	Qualitative study with semi-structured interviews.	15 participants were contacted of which 11 participated. Parents of adult sons with schizophrenia who had been recently referred to forensic psychiatric treatment.	
7. Absalom-Hornby, Gooding, & Tarrier (2011); England	Two main aims: 1. Determining the needs of family members with a schizophrenic relative who resided in a forensic service.	Cross-sectional design using questionnaires.	18 relatives of people diagnosed with schizophrenia: parents, siblings and spouses.	Family Questionnaire (FQ, Quinn Barrowclough, & Tarrier, 2003): a 48-item measure that is administered via interview.

	2. Comparing the needs of family members who had a relative diagnosed with schizophrenia and who lived in a forensic service or were treated in a community mental health service.			Relative's Cardinal Needs Schedule (RCNS, Barrowclough, Marshall, Lockwood, Quinn, & Sellwood, 1998) is an interview questionnaire and comprises 14 sections gaining information about the relative's support, coping, relationships, hardships, and emotions in relation to the family member with schizophrenia.
8. Ridley, McKeown, Machin, Rosengard, Little, Briggs, Jones, & Deypurkaystha (2014); Scotland REPORT CHAPTER 3	Exploring carers' perspectives on the support provided by forensic mental health services and their experience of being a forensic carer.	Qualitative study with a questionnaire survey and in-depth interviews.	66 carers replied to the questionnaire survey (62% female, 54% parent carers). Afterwards 13 participants were interviewed and another 6 were recruited through various forensic mental health services, giving a total of 19 interviewees of which 15 were women and 12 were parent carers.	

The combined results concerning roles, needs and burdens, strengths, and outcomes are summarised in Table 2.2.

Table 2.2. *Overview of the findings and conclusions of the selected studies*

Authors, date, country	Role	Needs and burdens	Strengths	Outcome
1. McCann, McKeown, & Porter (1996); England	- ***Actual contact time*** of the family members with the patient when in hospital can be significant and has an impact on his/her clinical management.	- ***Life event stress*** (the offence and surrounding aspects, long court cases and media involvement leads to long-lasting stress and to feelings of disbelief and devastation).	- ***Adaptive coping methods*** (attribution of the offence to the illness, ability to use others to reduce stress and visiting the patient).	- Families need more involvement in the care and treatment of their relative; they need support and information about schizophrenia and its effects.

	- ***Family members are the first people to detect changes*** in the patient's behaviour prior to any offence being committed and enlisted the help of psychiatric professionals.	- ***Continual stress*** (worry and anxiety about the patient's general welfare). - ***Maladaptive coping methods*** (bottling up feelings, withdrawal, feelings of revenge).		- Providing educational programmes is positively evaluated and if organized within a group context, emotional support is generated.
2. James (1996); Australia	- ***Taking care of the relative*** because of the decanting of hospitalized psychiatric patients into the community. ***Family members are considered primary caregivers. Attempt to 'set limits'*** often leads to threatened or physical abuse. - Telling their relative to move out needs to be balanced against the need not to feel rejected by the only remaining companions they possess; ***maintenance of the relationship*** is important.	- ***Violence*** (family as victim, anxiety and fear among the general public). - ***Prejudice and stigmatisation*** (sensationalized media) ***and raised emotional feelings*** (guilt, shame, responsibility, forgiveness and tolerance). - ***Disintegration of family relationships***	***- Intervention*** aims to ***empower families*** to make decisions that they have been too frightened or exhausted to make before ***- Psychoeducational programs***: giving information about the mental illness, its effects and the medication as well as problem behaviours. However, relatives may be resistant to information.	- Burden leads family members to beg for professional help to ease their strain. - Providing treatment, accommodation and support is an essential component in preventing recidivism and relapse and is vital for the well-being of the clients, their families and the community as a whole.
3. MacInnes & Watson (2002); England	- Families are seen as the ***main source*** of care and aftercare of mentally ill clients. - The caregivers assume an ***unpaid and unanticipated responsibility*** for their relative.	- ***Violence*** (experienced over a considerable period of time and also before forensic services are aware of it, can be considered the most severe burden). - ***Annoyance*** (towards services and professionals).		- Forensic caregivers recount a similar number of burdens to non-forensic caregivers but are likely to experience more severe difficulties and more burdens relating to violence and annoyance. - Services and professionals need to be aware of the difficulties and the severe burdens caregivers are experiencing and need to be

		- ***Emotional feelings*** (hopelessness, anger and frustration). - ***Financial burdens*** - ***Burdens relating to family relationships.*** - Burdens about ***symptomatology*** → ***Need for psychoeducational approaches.***		ready to support them at certain times, so that they can cope with the burdens that are placed on them. - Professionals have to work with them as partners in care to ensure they are able to develop appropriate interventions.
4. Ferriter & Huband (2003); England	- Parents remain ***protective*** of their child. - To ***guide their approach***, parents ***need information*** about the disorder and what to expect.	- ***Emotional burden*** (fear, grief, shock, confusion, guilt, distress and depression). - ***Financial burden*** ***- Violence*** - ***Stigmatization or self-blame and stress*** - ***Seeking help and support***: family, self-help groups and police are the most helpful sources; psychologists, social workers and psychiatrist are the least helpful sources. - ***Need for appropriate help or advice.***	- Need for therapeutic interventions (e.g., psycho-education). - When family members receive the information they seek, their self-confidence improves and only a minority find the material too technical.	- The parent group experienced significant emotional stress, which was exacerbated when their child had been involved in crime. Their burden was poorly alleviated by contact with professional staff. - Further research should investigate what is effective in supporting parents?
5. Pearson & Tsang (2004); China	- Some of the parents ***will take care of the patients at home after discharge***, while others would not. - ***Sensitive*** for the patients signs and symptoms but experience	- ***Media and legal proceedings*** cause most stress (public exposure, police and courts).		- It should be recognized that relatives have needs of their own, and some ideas are presented to help families cope with their problems.

	problems with persuading patients to seek treatment. - Family members are ***dutiful and supportive.***	- ***Lack of social and medical services*** that could help families to cope. - ***Less contact with other family members*** (reduced social network). - ***Need for information and psychoeducational programs***. - ***Emotions*** (sad and affectionate)		- In the future it would be feasible to have a few formal feedback sessions between staff and relatives of the forensic patient.
6. Nordström, Kullgren, & Dahlgren (2006); Sweden	- ***Searching for an explanation*** for the onset of the mental disorder. - ***Initiate psychiatric contacts*** and ***persuade their son*** to go to a psychiatric clinic. - ***Parents did not involve the law***; a complaint to the police was only made after a physical injury. - ***Supportive*** and ***important role*** to play.	- ***Emotions about onset and diagnosis*** (guilt, anxiety, fear, helplessness, sorrow, grief, and concern). - ***Feelings of disrespect*** when meeting professionals. - ***Violence*** and criminality leads to anxiety, social isolation disappointment regarding earlier psychiatric care.	***- Hope*** is an important source of strength.	- Relatives must be viewed by professionals as a resource; contact is described by relatives as disappointing. - Difficult to cope with the double burden, therefore the initiative and responsibility for information, education and support of family members ought to be taken by psychiatric healthcare professionals.
7. Absalom-Hornby, Gooding, & Tarrier (2011); England	- Relatives have ***reduced time*** with the patient ***because of the forensic limitations.***	- ***Antisocial behaviour and negative emotions*** are the most difficult to cope with (loss, guilt and stigma). - ***Criminal offence*** (concern and coping are heightened). - ***Upset, stress and confusion*** because of not getting the information about their relative.	- In the results there is no focus on strengths, but the conclusion mentions that relatives found it useful to talk about their experiences which demonstrates that they are willing to receive psychological support.	- Needs of the forensic population are heightened in comparison with the general mental health sample. Based on the results it seems suitable to offer forensic families a tailored family intervention, which can help families to understand the illness and to learn some coping and problem solving strategies. - Future research: should investigate whether visiting patients ameliorates or exacerbates stress, burden and stigma for relatives and

		- Increased ***need for support services*** because of severity of illness and criminal behaviour.		which problems families face away from the forensic service.
8. Ridley, McKeown, Machin, Rosengard, Little, Briggs, Jones, & Deypurkaystha (2014); Scotland REPORT CHAPTER 3: Experience of being a forensic carer	- ***Supporting*** a relative in the community or in a hospital ***provides practical and emotional support.*** - Within forensic services, carers have to ***forge relationships*** and ***communicate with new staff*** at every stage. - Role has an ***impact on life-course, identity, psyche, welfare and well-being.*** - Forensic caring role is difficult to define because ***they feel inadequate, institutionalised and intimidated.***	- ***Emotional burdens*** (traumatised, sadness, grief, frustration, anger, shame, anxiety, uninformed, left out, a shock or a relief and concern). - ***Stigmatization*** (losing friends and becoming isolated, while others felt no stigma). - ***Financial burdens***	- Research design focuses on detecting strengths and what works and why, and considering how this could be extended. - Supportive friends and family or sharing the responsibility of care helps to mitigate the stress. - Despite all the stress carers could identify personal growth from the experience (e.g., more empathetic and learning to know someone better).	- Stigmatization is a challenge and being a forensic carer has an impact on all the aspects of people's lives. - Carers do not always feel supported by forensic mental health services and highlight gaps in information.

2.3.3. Family strengths

In the face of all these problems, relatives of mentally ill offenders can still develop adaptive self-coping strategies, including contact with other families to reduce their stress and visiting their relative, encouraging feelings of forgiveness, responsibility and tolerance. All the articles mentioned adaptive coping methods, whereby five articles focus on family interventions that were reported to be empowering (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; James, 1996; McCann et al., 1996; Nordström et al., 2006;). Psychoeducational programs were the most widely discussed method of intervention; relatives disclosed a lack of information and support from professionals and a lack of knowledge regarding the services available to them. None of the questionnaires or interviews enquired about strengths; only by analysing the material could one learn about family strengths. Only one study explained that hope is an important source of strength for families (Nordström et al., 2006).

2.4. Discussion

We have reviewed the published literature from 1996 to the present and conclude that limited findings have been published regarding the families of psychiatric relatives with a forensic history, despite the substantial number of mentally ill offenders reported in the literature. Our review has shown that studies investigating the needs and burdens of families of psychiatric relatives with a forensic history often investigate small sample sizes, which compromises the relevance of the findings to the entire population. However, most of the reviewed findings were comparable and conclude that families of mentally ill offenders are confronted with raised levels of stress because of the violence, the dual stigmatisation and the disintegration of family relationships (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; James, 1996; McCann et al., 1996; Pearson & Tsang, 2004; Tsang et al., 2002). The criminal offence makes contact with the police, lawyers and the media obligatory, which causes increased burdens. Public exposure to the situation by the media and confrontation with the judicial system have been described as particularly burdensome (Pearson & Tsang, 2004). Families often feel left alone to cope with these burdens, without help and support from friends, relatives or professionals (McCann et al., 1996). Interaction with psychiatric professionals is usually reported to be inadequate. MacInnes and Watson (2002) described that professionals should be aware of the severe burdens families are confronted with so appropriate support can be provided. Studies have also indicated that families are eager to discuss their experiences, suggesting that relatives are open to receiving psychological support (Absalom-Hornby et al., 2011; Ridley et al., 2014).

Families need the strength to make difficult decisions and this could be accomplished by developing therapeutic family interventions, such as psychoeducational programs, formal feedback sessions within mental health services and psychological support (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; James, 1996; McCann et al., 1996; Nordström et al., 2006; Pearson & Tsang, 2004; Ridley et al., 2014). Educational programs have been positively evaluated; when families receive the information they need, their self-confidence often improves. This information must be understandable and not too technical to be useful (James, 1996). Additional services that provide treatment and support are also considered important for the well-being of the patient and their family. As mentioned before, most studies included in this review discussed the inadequate contact families have with psychiatric professionals. This indicates that families would like to be more involved in health care practices and family interventions, by having a need for clear communication between health care professionals and them (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; James, 1996; MacInnes & Watson, 2002; Nordström et al., 2006; Pearson & Tsang, 2004; Ridley et al., 2014). However, it remains unclear whether this applies to all families.

In summary, research into the needs and burdens of families of mentally ill offenders is very limited. Investigations into family strengths are particularly scarce. This may reflect our search approach and exclusion criteria; strengths-based perspectives may have been mentioned in some of the excluded literature. Hope has been reported to be an important source of strength, along with the need for therapeutic intervention (Ferriter & Huband, 2003; James, 1996; Nordström et al., 2006). Therefore further research into the organization of interventions and the role of professionals would be useful. Additionally, the burdens and needs of relatives require further investigation in order to develop appropriate interventions (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; MacInnes & Watson, 2002; Tsang et al., 2002).

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3

How family members of mentally ill offenders experience the interment measure and (forensic) psychiatric treatment in Belgium: A qualitative study

This chapter is based on:

Rowaert, S., Vandevelde S., Lemmens G., & Audenaert K. (2017). How family members of mentally ill offenders experience the internment measure and (forensic) psychiatric treatment in Belgium: A qualitative study. *International Journal of Law and Psychiatry, 54*, 76-82. doi: 10.1016/j.ijlp.2017.05.003

Abstract

Mentally ill offenders in Belgium can be subjected to mandated care under an ‘internment measure’ if they are viewed as a danger to society. This study investigated how family members of mentally ill offenders experience this internment measure and view the (forensic) psychiatric treatment of their relative. Semi-structured interviews were conducted with 24 different families and analysed using Nvivo 11. Six different themes emerged: (1) the criminal offence and the internment measure as an additional stigma, (2) ambivalent feelings towards the judicial system, (3) prison is not the right place to be, (4) mental health support as an answer to problems, (5) fight a losing battle, and (6) while there is life there is hope. The experiences of family members indicated the need for improved treatment guidelines that allow earlier compulsory interventions to prevent crime and preferential admission to (forensic) psychiatric facilities rather than prisons. In addition, family members expressed the need for better communication from mental health professionals and the judicial system during the process and greater availability of peer support.

Key words

Mentally ill offenders, Family experiences, Internment measure

3.1. Introduction

About 3% to 10% of mentally ill persons commit criminal offences due to their illness (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014). In most Western countries, mentally ill offenders may be judged as 'not criminally responsible' for their actions and subject to specific criminal justice legislations (Abracen, Gallo, Looman, & Goodwill, 2015; Sheehy et al., 2016). In Belgium, such mentally ill offenders are placed under an 'internment measure' as they are – at the same time – seen as a danger for society ('criminals') but also as persons who need treatment and care ('patients') (Vandevelde et al., 2011). The internment measure is defined as *"a safety measure to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires in view of his/her reintegration into society"* (Heimans, Vander Beken, & Schipaanboord, 2015, p. 1051, translation by the authors). It is an indeterminate measure that, at the time of the study, was decided by a multidisciplinary commission, the Commission of the Protection of Society, chaired by a judge (Bal & Koenraadt, 2000; Vandevelde et al., 2011). Since 1 October 2016 a new Law (5 May 2014) has come into force which replaced the Commission of the Protection of Society into Chambers of the Protection of Society. The new Law states that mentally ill offenders can only be subjected to an internment measure if their criminal offence harms the psychical and psychological integrity of a third party, if they have a mental illness at the time of the offence and if there is a danger to commit new offences. The Law aims at providing mentally ill persons with opportunities to acquire appropriate mental health care leading to successful integration in society (Vander Beken, Heimans, & Schipaanboord, 2016).

Mentally ill offenders are not held responsible for the crimes they have committed and are regarded as persons in need of treatment. Therefore the protection of society and the basic rights of mentally ill persons to receive adequate psychiatric treatment are equal aspects within the internment measure (Meysman, 2016). However, mentally ill offenders are often incarcerated in correctional settings (e.g., prison), for a lengthy period of time, because places in (forensic) psychiatric settings are scarce and often unavailable (Abracen et al., 2015; Bal & Koenraadt, 2000; Melamed, 2010; Peterson et al., 2014; Sheehy et al., 2016; Vandevelde et al., 2011). Belgium, as well as other European countries (e.g., France, United Kingdom, Romania, Poland, Hungary etc.), have been sentenced several times by the European Court of Human Rights (ECtHR) for violating the rights of mentally ill offenders. Until today and despite the new Law, more than 750 mentally ill offenders (K. Seynnaeve, personal communication, March 15, 2017) who are subjected to the internment measure are still living in prison without appropriate care (Meysman, 2016).

Mentally ill offenders frequently report that the internment measure (including the frequent incarceration) and the lack of mental health care are painful and burdensome (De Smet et al., 2015; Morgan et al., 2012; Sarteschi, 2013; To et al., 2014). Further, some studies indicate that family members are also burdened by the internment measure, the mental illness, and the criminal acts of their mentally ill relative (Rowaert et al., 2016; Tsang, Pearson & Yuen, 2002). They experience double stigmatisation as their mentally ill relative is seen as both 'mad and bad' (Tsang et al., 2002; Tsang, Tam, Chan, & Cheung, 2003) and frequently require professional support themselves (Gavois, Paulsson, & Fridlund, 2006; Jankovic et al., 2011; Muralidharan, Lucksted, Medoff, Juan Fang, & Dixon, 2014; Nordström, Kullgren, & Dahlgren, 2006). Moreover, close family members play primary roles in supporting the re-entry of their relative from prison or psychiatric hospital back into society and in enhancing the well-being of both the mentally ill relative and their family network (Hairston, 2015; McKay, Comfort, Lindquist, & Bir, 2016; Pearson & Tsang, 2004).

Few studies have reported on these burdens of family members, the limited contact between family members and forensic mental health professionals, and family members' need for involvement in the mental health care of their relative (Bolkan et al., 2013; Hayes, Hawthorne, Farhall, O'Hanlon, & Harvey, 2015; Rowaert et al., 2016). Therefore, the aim of this study is to investigate how family members experience the mental illness, the internment measure, and the (forensic) psychiatric treatment of their relative.

3.2. Methodology

3.2.1. Procedure

To recruit family members of mentally ill offenders, an information leaflet was spread in several settings in Flanders (e.g., psychiatric facilities, prisons, non-profit organizations for family members of persons with a mental illness, and outpatient mental health services). Forty-eight persons agreed to participate in the study. The following inclusion criteria were used: having a relative with a current or past internment measure and age 18 or older. Mentally ill offenders (n = 2), family of people with non-forensic mandated care (n = 11), and family of convicted persons (n = 3) were not included. Further, five persons did not answer their mails or telephone when the researcher tried to contact them and of one person the contact address was incorrect. 26 interviews were conducted from February to June 2015. Two of the 26 interviews were conducted with volunteers in an organization to support mentally ill offenders in prison (cf. Figure 3.1.) and were excluded from the analysis. In total, 24 interviews were analysed.

All participants provided informed consent for publication of their interview responses. The study was approved by the Ethics Committee of the Ghent University Hospital (EC decision: B670201422070).

3.2.2. Participants

The mean age of the participants was 58.8 years (SD[1] = 11.3, range: 27 to 80 years). The sample (n = 27 family members) consisted primarily of mothers (n = 13; 48.1%) and fathers (n = 6; 22.2%, of which 3 were interviewed together with their spouse). Other participants included siblings (n = 4; 14.9%), daughters (n = 2; 7.4%) and uncles and aunts (n = 2; 7.4%).

At the time of the interviews, the relatives of the family members being interviewed were staying at different locations. Some of the mentally ill offenders lived in residential psychiatric care (n = 13; 54.2%), others in prison (n = 5; 20.8%), or in a community-based setting (n = 6; 25%). In 19 (79%) of the 24 cases, the internment measure was still ongoing. Family members reported the following psychiatric conditions of their relatives: psychotic disorders (n = 18), intellectual disability (n = 1), autism (n = 5), bipolar disorder (n = 1), personality disorder (n = 4), and unknown (n = 1). Mean age of the mentally ill offenders was 41 years (SD = 12.3, range: 27 to 77 years). Most of the mentally ill offenders were male (n = 23; 88%).

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[1] SD = Standard Deviation

3.2.3. Data collection

A topic list based on a literature review and a theoretical model about family burden were used to conduct the interviews (Rowaert et al., 2016; Tsang et al., 2002). The topics related to the experiences of family members regarding the psychiatric history of their relative, the legal proceedings and the internment measure they were confronted with. Furthermore the topics included the impact of the psychiatric problems and the internment measure on family members. To end the interview, attention was paid to coping strategies, strengths of family members and future perspectives. All interviews (except one because of refusal) were audiotaped. Interviews lasted on average 2 hours (range: 0.5 and 3.5 hours). Notes were taken of the interview that was not audiotaped.

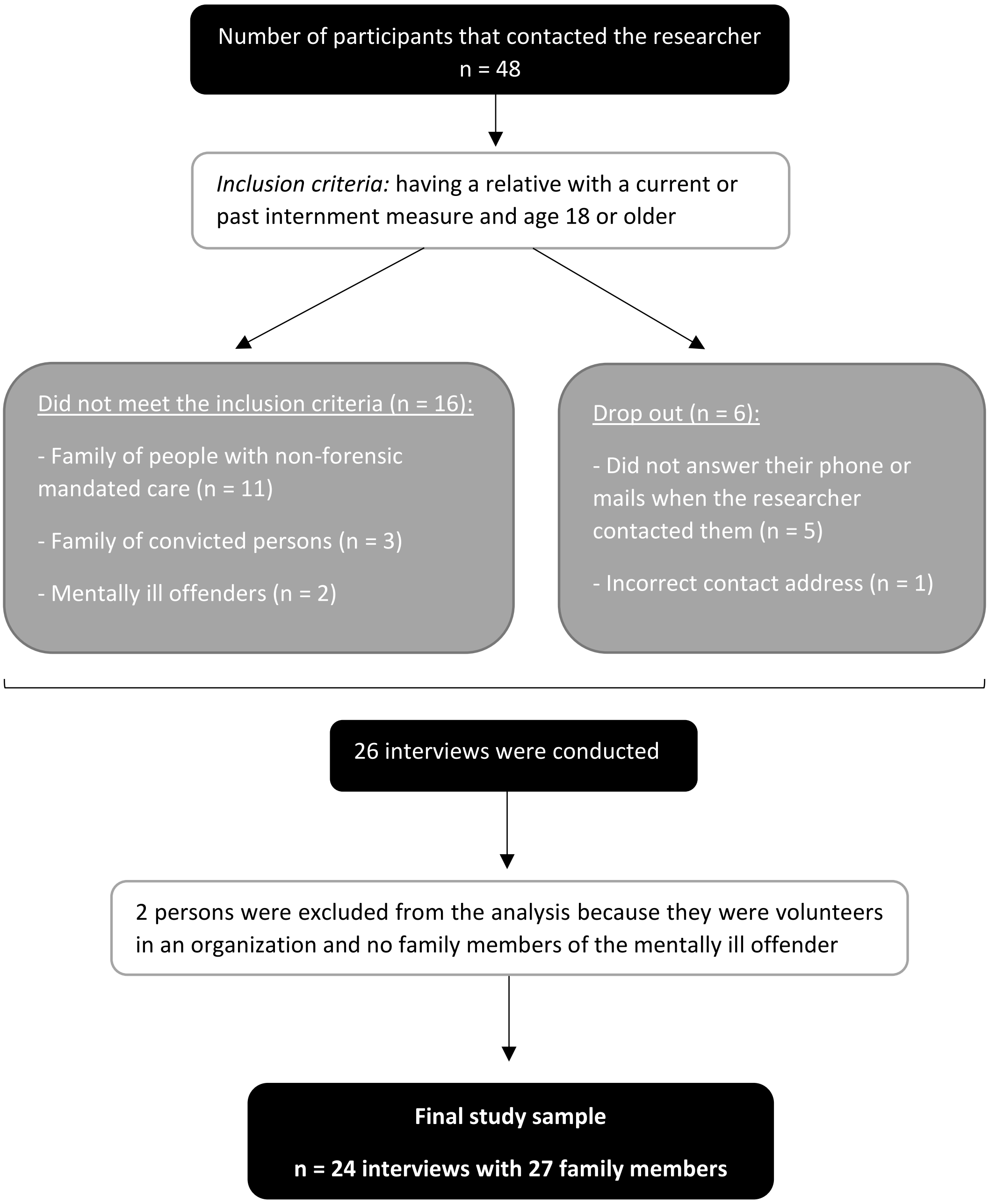

Figure 3.1. *Flow chart of response and participation.*

3.2.4. Data analysis

Interviews were transcribed verbatim and together with the notes of one interview, thematically analysed in Nvivo 11 (QSR International Pty Ltd., 2015). Thematic analysis is been described as: *"a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail"* (Braun & Clarke, 2006, p. 6). Using a thematic analysis offers the possibility to '*give voice*' to the participants and *"involves carving out unacknowledged pieces of narrative evidence that we select, edit, and deploy to border our arguments"* (Fine, 2002, p. 218).

Because research about family members of mentally ill offenders (especially when subjected to an interment measure) is only scantly available, we have conducted the analysis starting from an inductive approach to derive themes closely linked to the data. This provided us with a rich description and gave us an idea about the experiences of family members of mentally ill offenders. Simultaneously, a deductive process was used, as it was important to know how the topics found in our study were comparable to findings in previous research studies (Braun & Clarke, 2006, 2012; Mortelmans, 2011; Rowaert et al., 2016). Furthermore within this study we aimed to investigate sources of strength and coping strategies of family members, as this was not yet studied before.

The thematic analysis followed the six steps suggested by Braun and Clarke (2006, 2012). Phase 1 involves familiarisation with the data by reading the transcriptions several times. The data were first analysed by two master-level students in Special Needs Education and resulted in a tree structure, which was further discussed with the first author of this paper. This was the start of an ongoing reflexive dialogue typical for thematic analysis. The first author re-analysed the data using an open coding process and generated initial codes (e.g., emotions, behaviours, prison, forensic psychiatry, …) closely linked to what family members experience when confronted with a mental illness and an internment measure of a relative (inductive approach; phase 2). In phase 3, the first author searched for themes that combine codes generated in phase 2 and compared this tree structure to the themes generated by the two students. Consequently themes were linked to others, resulting in broader themes such as judicial procedure, internment measure, perceptions, … Phase 4 reviewed the themes of phase 3 to come to an accurate reflection of the content of the data set. In phase 5, discussions and meetings with the 3 co-authors about the themes found in phase 3 and 4, identified 6 main themes regarding family's experiences: (1) the criminal offence and the internment measure as an additional stigma, (2) ambivalent feelings towards the judicial system, (3) prison is not the right place to be, (4) mental health support as an answer to problems, (5) fight a losing battle, and (6) while there is life there is hope. In phase 6, the results were written down.

3.3. Results

3.3.1. Theme 1: The criminal offence and the internment measure as an additional stigma

Family members mentioned that the internment measure is perceived as taboo by their mentally ill relative and by themselves, leading to an additional stigma for both. Mentally ill offenders are seen by society rather as criminals than as patients with mental health needs. This is a source of stress for both the mentally ill offender and their families as these labels cause an intricate search for appropriate mental health treatment. Moreover because families perceive that many professionals often hesitate to admit a mentally ill offender to their psychiatric hospital because of their criminal label.

> *"That's taboo. There exists a very negative image about psychiatry but the internment that is an additional and double taboo... they are stigmatised, they are more seen as criminals and consequently treated that way. Once they have being labelled, it is very hard to detach the illness from the label."* (mother)

Family members often experience feelings of guilt. Particularly, parents expressed feelings of having failed in raising their children. Furthermore, they often feel ashamed when confronted with the dual stigma of the mental illness and criminal offence.

> *"We first thought: it might be our fault. As this is the first thing parents think. They blame themselves for what is happening."* (mother)

> *"You have something like: I have to bite my tongue, because if I am going to say something about it, I will not be able to stop and then they will know it all. Yes, I have felt a lot of shame."* (daughter)

The family members felt socially isolated or discriminated against by society, partly because friends were shocked by the detention and did not respond appropriately to it. As a result, they became more hard-hearted and bitter over time, and some participants said they avoided talking about the situation or their problems.

> *"Telling to friends was difficult. They were shocked and did not know how to behave and what to say. You notice that it is for them partly unknown."* (brother)

Other family members, however, reported that sharing their stories with others helped them to better cope with the situation.

> *"I have never, never hidden it. […] I thought if I have to conceal it, I cannot handle it anymore. It was all, it was overwhelming for me. And if you then have to tell lies to everyone. I find it difficult. Subsequently they will notice me lying."* (sister)

3.3.2. Theme 2: Ambivalent feelings towards the judicial system

Family members had ambivalent feelings about the Commission of the Protection of Society. The lack of information about when and how the case of their mentally ill relative was handled led to frustrations, particularly when the family members had no influence on the decision process. However, some family members felt that being heard after contacting the Chairman of the Commission led to better care for their mentally ill relative.

> *"Everyone is talking about the Commission and about how they do not take into account what we are saying. Well, I experienced it differently. Not in the beginning, but at the time I have written that letter, they have taken it into account. And that is why our son could go back to the psychiatric hospital that he previously was admitted to."* (mother)

Despite this ambivalence, many family members believe that the internment measure is the starting point of change for their relative, eventually leading to adequate treatment of the mental illness. Many mentally ill persons follow a long-term trajectory within forensic facilities. Eventually, most are admitted to psychiatric hospitals or permitted to live independently with outpatient help, which aids in their reintegration back into society.

> *"Now I say openly, I think that the internment was his salvation. Otherwise we would not be where we are today." (mother)*

About one third of the family members had hired a legal aid counsellor to support their relative's case in court. In their opinion, however, most counsellors lacked sufficient knowledge about mental illness, the needs of the mentally ill relative, and current mental health status. The counsellors were seen as particularly helpful when they succeeded in getting their relative out of prison and into the care of a psychiatric clinic. However, they were generally regarded as quite expensive, often leading to a financial burden.

> *"Also the lawyers and the legal aid counsellors should be educated about mental health problems. They all know little about it."* (mother)

> *"A few weeks ago his lawyer suddenly contacted us and said that our son had to appear in court again and that he managed to get him into the new psychiatric hospital in Ghent. […] In the past we have paid all the lawyers which sometimes in the long run means that people have to sell their house and still nothing changes."* (mother and father)

As part of the internment measure, some mentally ill offenders are no longer allowed to manage their financial resources and are placed under financial administration. Most of the time, an independent lawyer or sometimes a family member will be placed in charge of the offender's financial affairs. In case of a lawyer, the family members may be left unaware of the financial situation of their relative. When family members are responsible, however, they may feel unqualified and unprepared to take on the role of financial administrator.

> *"I questioned certain costs. A yearly visit to prison was 75 euro for just going around the corner, as it was really close by. My brother had to pay for a visit of a complete stranger, without any support from a confidant."* (brother)

> *"I'm his financial administrator. Actually I have never received any explanation of how I have to do it. It is something that I don't understand very good."* (mother)

3.3.3. Theme 3: Prison is not the right place to be

Mentally ill offenders are often incarcerated in prison due to the internment measure. Prison is regarded by the family members as inappropriate as the offender will not receive adequate support and treatment. Even if some care is provided, it is often perceived to be limited to psychopharmacological management. Further, the prison staff often lack competence in dealing with mentally ill persons. Family members feel that their relative is treated more as a criminal than as a mentally ill person. They also believe that some prison staff misuse their power as they do not know how to interact with mentally ill offenders. Therefore, family members report that prison employees should be educated about mental illnesses and trained on how to interact with persons with mental illnesses. Finally, the family members also experience the procedures required to visit their relative in prison as difficult and burdensome.

> *“The only thing that happened was prescribing medication, medication, medication. That’s it. It's little less than scandalous. And what happened next? It didn’t help or it was too little to stop the psychoses. They gave him more heavy medication and at the end nothing helped anymore.”* (father)

> *“A visit to prison is on the one hand a mix of: ‘He sees us and he is happy’, but on the other hand we feel like: ‘See us sitting here’. […] And then those moments of: ‘We almost have to go, we need to run down the conversation.’ Subsequently they have to stand again one by one at the door. And then again, the procedure to go back outside, where you first have to pick up your passport and ask for your belt and jacket. Afterwards you are feeling like: ‘What is this?’ After a while you don’t like to go there anymore, but still I have to, because I know it is to support my brother.”* (brother)

As family members regard prison as inappropriate for their relative, most use every possible means (e.g., contacting different mental health services) to get their relative out of prison and into more appropriate mental health care facilities.

> *“At one moment, I begun working and searching until I have found somebody, a psychologist. I have put pressure on him to find an organization for my son and to get him out of prison.”* (mother)

3.3.4. Theme 4: Mental health support as answer to the problems

Most mentally ill offenders and their family members in this study had a longstanding history with the mental health care system before the criminal offence. The family members’ relationship with mental health professionals was often difficult because they did not receive sufficient information about the condition and its treatment, and had little involvement in the treatment of their mentally ill relative. This stems partly from medical confidentiality of the professionals.

> *“That is such a pity, that you as a parent are so little involved. And that you see things going wrong, but you cannot do anything. […] He shall always be our son for who we intend the best. And as a parent you are locked out.”* (father)

Consequently, many family members searched for relevant information on the internet or in books about the medical condition of their relative and the internment measure. Some also participated in activities organized by a non-profit organization for family members of mentally ill persons to gather more information about the illness or the judicial system. If mental health professionals did provide information, it was often regarded as incomplete or incomprehensible ‘physician talk’. Further, family members reported insufficient support from mental health professionals in their search for daily social activities and housing accommodations for the mentally ill relative.

> *"I have always searched for information, because it are tempestuous moments you go through and that leaves a lasting impression. […] You always search for the next steps that are going to happen or when it is going to end."* (mother)

> *"Eventually the patients themselves or we, the family, has to do it. Social housing, I have submitted the application. I've went two, three times to the social housing company."* (mother)

Finally, although they were relieved that their mentally ill relative was admitted to a psychiatric clinic, family members often worry about a possible relapse or new criminal offences, which would automatically lead back to imprisonment. The latter eventuality was a particularly strong source of anxiety.

> *"He is out of prison, but it is something double, because the risk exists that he will again be incarcerated. And I will not survive it a third time. […] Waiting three years for a place in psychiatry and then be sent back to prison because of what?"* (mother)

3.3.5. Theme 5: Fight a losing battle

Over the years, most family members learned to deal with the mental illness of their relative. However, they experienced the internment measure as unpredictable due to its indefinite duration. Family members indicated feeling sad and angry that the relative had to commit a criminal offence before legal measures were taken for mandatory treatment. Thus, they believe that the mental health care system has failed to prevent the criminal offence.

> *"It is not only accepting and trying as much as possible in order to deal with the disease that it makes it difficult. But frequently the confrontation with the failing of the mental health care services. I experienced it like this. I had hope that sometimes more would be done."* (mother)

In addition to this constant battle for better care and respect for their relative, many family members are also fighting for personal recognition and support.

> *"An equal dialogue between family, patient and social worker is an aim to strive for and to work on. As a social worker it is important to have an eye for the relationship between the client and his family and to support this."* (mother)

3.3.6. Theme 6: While there is life there is hope

Some family members felt supported by 'fellow-sufferers' they had met during their prison visits or meetings of a non-profit organization for family members of mentally ill persons over the years. The sharing of similar stories indicated that they were not alone and made them fell less stigmatised even though it was sometimes difficult to open up to others.

> *"We are sitting here as companions in adversity, all about the same thing. One even worse than the other. More painful… Pain is pain, but you notice… Yes, he is handling it like that, I am managing it like*

> *this. You are all stirring in the same jar. You receive recognition, but at the same time you make someone face the facts."* (brother)

Family members are sometimes afraid to look too far in the future and prefer to live day by day. Especially if there is no future perspective because their relative is still incarcerated or the admission in a (forensic) psychiatric hospital is not what they had hoped for. Yet, many family members maintain hope that their relative can eventually live a happy and normal life in the community.

> *"We have seen him become 'human' again and we hope he can be happy and can get a perspective towards the best possible life. That is like I see it, that he can be happy, but that he also can get chances, because he is not an old man."* (mother)

Family members sometimes experience a 'roller coaster of emotions', but still hope that although the mental illness may last, the internment measure will end one day.

> *"The entire period alternates with different feelings. But loving and adoring him as mother has never been gone. These feelings were constantly accompanied by a lot of other impressions and thoughts that are hard to describe in one sentence. To name a few: disbelief, astonishment, disappointment, grief, powerlessness, incomprehension of the environment causing social isolation, shame, desperation, sometimes hope if we thought or imagined there was a revolution."* (mother)

In due course, family members are sometimes able to report positive events that help them better cope with the situation. Most of these positive events are related to successful treatment of their relative, feedback from mental health professionals about their relative, a good relationship with the psychiatrist or psychologist, and the positive impact of the professional on the recovery process. These helpful events strengthen the family members and help them carry on supporting their relative. They further report personal coping strategies such as reading books, watching movies, walking, or listening to and playing music.

> *"I have read a lot and I think that was something that gave me grip. It was more fleeing in literature, books and so. And I also did like to watch movies."* (daughter)

> *"Don't take away our walking and especially not our music and our music instrument. […] Playing on my oboe I can get rid of my sadness, but also my anger."* (mother and father)

3.4. Discussion

This study has investigated the experiences of family members of mentally ill offenders with regard to the confrontation with the mental illness, the internment measure and the (forensic) psychiatric treatment of their relative. It reveals that family members of mentally ill offenders placed under an internment measure experience a double stigma, in accordance with earlier reports that mentally ill offenders are seen as both 'mad and bad', conferring a double burden on family members (Nordström et al., 2006; Tsang et al., 2002; Tsang et al., 2003).

Consequently, family members experience feelings of guilt and shame as they often attribute their relative’s problems to themselves (e.g., parents feeling failed in the raising of their child). Sometimes they avoid disclosing their problems to friends and family and become isolated from social activities. The stigma as well as emotional and social burdens are major sources of psychological distress that can lead to social isolation (Muralidharan et al., 2014; Tsang et al., 2002; van der Sanden, Stutterheim, Pryor, Kok & Bos, 2014). Furthermore, this isolation and not being taken seriously by other family members, friends, or mental health professionals can have a negative impact on their quality of life (Hayes et al., 2015; Ridley et al., 2014; Tsang et al., 2002; van der Sanden, Pryor, Stutterheim, Kok, & Bos, 2016).

Family members report ambivalent feelings and frustrations towards the judicial system and the internment measure. Family members are often confronted by legal aid counsellors and lawyers handling the financial affairs of their relative whom they perceive as lacking sufficient knowledge about mental illness and the specific treatment needs of their relative. Previous studies reported that families experience additional stress and frustration in dealing with police, the courts, and the judicial system (MacInnes, & Watson, 2002; McCann, McKeown, & Porter, 1996; Tsang et al., 2002).

Family members in this study reported visits to prison as burdensome and expressed hope that their relative would eventually be transferred to a (forensic) psychiatric hospital. Compared to previous studies, this research also focuses on the opinions and needs of family members of incarcerated mentally ill persons. Studies on imprisonment indicate that in many cases it causes a decline in family interaction and support, suggesting that relatives and the offender may benefit from strategies that focus on restoring or maintaining family ties (Hairston, 2015; McKay et al., 2016). Family members in this study indicate that mentally ill offenders should not be incarcerated because prison is experienced as ‘not the right place to be’ for their relatives.

Furthermore, family members reported sorrow and anger as their relative had to offend before legal measures were taken for mandatory treatment, especially because many, in our and other studies, had a longstanding history with mental health care services and describe the treatment and relationship with mental health professionals as disappointing (Nordström et al., 2006; Pearson & Tsang, 2004). Indeed, many family members disclosed troubled relations with mental health professionals because they did not receive adequate information and felt they were not sufficiently involved into the treatment process. This is consistent with previous findings that families want to be engaged in the treatment of their relative by collaborating with mental health professionals. ‘Medical confidentiality’ is often mentioned as a barrier to contact between family members and treatment staff of their relative (MacInnes & Watson, 2002; McCann et al., 1996; Ridley et al., 2014; Rowaert et al., 2016).

In the present study, many family members declared that they ‘fight a losing battle’ most of the time. They perceive the internment measure as troublesome because of its indefinite duration. Many family members believe that the current mental health care system has failed in taking appropriate measures to prevent the criminal offence of their relative. The negative attitudes of family members towards the judicial and care systems often prevent them to see some positive aspects. Therefore it is often hard for them to affiliate with the systems involved. However, an important finding of this study is that some participants experience the internment measure as a starting point for help as it has led to adequate treatment for their relative. This is often experienced after years of grief and suffering, because many mentally ill offenders are first locked up in prison without adequate support or treatment.

Previous studies recommended that professionals should take more initiative to inform, educate, and support family members as well as mentally ill offenders (Nordström et al., 2006; Rowaert et al., 2016). Despite this enduring battle, families keep on fighting for their relative. The powerlessness regarding the internment measure and its infinite duration are identified as reasons to keep on fighting for recognition of the needs of their relative and themselves. Family members in this study have developed coping strategies to deal with the problems they face and draw strength by focusing on occasional positive events, such as getting feedback from professionals and the positive impact professionals have on the recovery process. Consequently, they experience renewed hope, which in previous research is mentioned as a critical source of strength (Nordström et al., 2006).

Compared to other research studies with family members of mentally ill (offenders), similar results are found. Family members experience a rollercoaster of emotions when they are confronted with a relative with mental illness placed under an internment measure. Yet, new recommendations for future research can be mentioned, as the experiences of the family members in this study underscore the need for changes in the treatment system of mentally ill offenders. First, family members expressed a strong desire for mechanisms to initiate mandatory treatment and support earlier in the life course of the relative, as they consider criminal offences likely to be prevented if more appropriate care is given. This relates to the concept of what is called the "*bonus for delict*"-mechanism, developed by De Bock already in the 1960s within the context of child protection (as cited in Verhellen, 1998). De Bock stated that effective treatment and care are initiated by judicial interventions, but only after the criminal offence has occurred (Verhellen, 1998). This concept is inherently paradoxical as it refers to mandatory treatment, before any (criminal) offence has taken place. Obviously, this requires careful reflection, as mandated care may have negative consequences as well. If an offence does take place, mental health care should be provided in specialized (forensic) psychiatric facilities rather than in prisons. Second, both mentally ill offenders and family members should be empowered, supported, and heard by mental health professionals early in the mental health and judicial trajectory (Ridley et al., 2014; van der Sanden et al., 2014). This could lead to more family involvement in treatment and to a mutual collaboration where families are not seen as 'second patients' needing treatment, but rather as 'partners in care'. Yet, we must be cautious not to hand over all of the care responsibility to family members, as this may neglect structural aspects related to (the lack of) professional care and support, e.g., in prison settings. Third, family members reported the value of sharing their personal stories with peers in for example peer support groups to better cope with the double stigma associated with being the family of a mentally ill offender (Gavois et al., 2006; Mokgothu, Du Plessis, & Koen, 2015).

The study results should be considered in light of several limitations. First, only 24 families willing to disclose their situation were involved in the study, a sample size in the range (17 and 23 participants) of previous studies (Absalom-Hornby, Gooding, & Tarrier, 2011; Ferriter & Huband, 2003; McCann et al., 1996; Nordström et al., 2006; Pearson & Tsang, 2004). Second, the study sample may be biased because family members were recruited by a non-profit organization for family members of persons with a mental illness, many of whom suffer from schizophrenia or psychoses. Consequently, families of offenders with other mental illnesses (e.g., personality disorder, intellectual disability, etc.) may be underrepresented. Third, most of the family members had a longstanding history with the mental health care system and the internment measure, so the experiences of family members recently confronted with this problematic situation were not documented. Their reticence may stem from the double stigma associated with having a mentally ill relative in the Belgian criminal justice system.

Future research should pay more attention to the experiences and needs of family members of mentally ill offenders and how they can be involved more often as 'partners in care' in the treatment of their relative. Consequently, peer support as well as mutual collaboration between mental health professionals, patients and family members is regarded essential and more research is warranted in relation to the development of family strengths and family quality of life.

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4

A Family Support Group for family members of mentally ill offenders: concepts and therapeutic processes

This chapter is based on:

Rowaert, S., Hanssens, F., Audenaert, K., Vandevelde, S., & Lemmens, G. (submitted). A Family Support Group for family members of mentally ill offenders: concepts and therapeutic processes.

Abstract

Family members of mentally ill offenders experience serious emotional, social, financial and psychological burdens. They have to deal with both a rollercoaster of emotions and a double stigma for which they need support. However, until now, few family interventions have been developed in forensic settings because they face particular challenges. Therefore, a Family Support Group (FSG) has been developed to support family members in dealing with both the mental illness and the judicial order of a relative. The present article reports on an FSG which is based on a Multi-Family Group format that integrates systemic and narrative approaches and is adapted to the forensic context. The organization of the FSG is described and clinical vignettes are used to illustrate the therapeutic process. Finally, some reflections about the FSG are discussed.

Key words

Family Support Groups, Family, Mentally ill offenders, Forensic psychiatry

4.1. Introduction

During the last decades, research has increasingly focused on the experiences, needs and burdens of family members of mentally ill offenders (Nordström, Kullgren, & Dahlgren, 2006; Ridley et al., 2014; Rowaert et al., 2016; Tsang, Pearson, & Yuen, 2002). Family members confronted with a relative's psychiatric problems and a criminal offence, experience serious emotional, social, financial and psychological burdens (McCann, McKeown, & Porter, 1996; Tsang et al., 2002). They indicate having to deal with a rollercoaster of emotions ranging from grief to hope, social discrimination by other family members and friends, depressive symptoms, and financial problems caused by often having to quit their job to care for their relative (Rowaert et al., 2016; Tsang et al., 2002). A double stigma is placed upon their relative by society, as mentally ill offenders are seen as 'mad and bad' (Pearson & Tsang, 2004; Tsang et al., 2002). Further, family members report being engaged in a struggle with judicial and mental health services as they are confronted with a judicial order, legal procedures, lawyers, policemen and (forensic) mental health professionals. This further increases their levels of stress (Rowaert et al., 2016). Despite these burdens, and the lack of support from family, friends and professionals, many family members continue to support their relative, which only increases their needs (Loukissa, 1995; Marsh & Johnson, 1997; Rowaert, Vandevelde, Lemmens, & Audenaert; Wynaden, 2007).

Until now, few interventions have been developed to support family members of mentally ill offenders (Absalom, McGovern, Gooding, & Tarrier, 2010; Absalom-Hornby, Gooding, & Tarrier, 2011; Geelan & Nickford, 1999). This might be due to the fact that family interventions in forensic settings may face particular challenges, including: their separate living arrangements; the distances between forensic services and the family members' residence; the traumas family members experience (e.g., violence within the family, court proceedings, visits to prison) that are linked to the criminal activities, and the relative's mental health problems (Fadden, 2006; Rowaert et al., 2016; Rowaert et al., 2017). Forensic professionals often lack training in family-based support, and appropriate facilities and/or time are often not available (Fadden, 2006). Nevertheless, family therapy interventions in forensic settings may offer opportunities to enable clients to build up meaningful relationships, to help family members distinguish the psychiatric problem and the offending behaviour from the person, and to guide professionals in seeing strengths and challenges of both clients and families and their coping strategies (Davies, Mallow, Easton, Morrey, & Wood, 2014). Offering family interventions in secure settings may also help to reduce burdens and improve the well-being of family members of mentally ill offenders (Absalom et al., 2010).

For all these reasons, we have developed a Family Support Group (FSG), which specifically focuses on the needs and burdens of family members of mentally ill offenders. It aims at supporting family members in dealing with both the mental illness and the judicial order of a relative. This paper outlines the therapeutic concepts that underpin this FSG. The organization of the FSG and the therapeutic exercises are described and illustrated with clinical vignettes.

4.2. Therapeutic concepts of the FSG

4.2.1 Systemic and narrative approach

The FSG is based on a systemic Multi-Family Group model (Lemmens, Eisler, Migerode, Heireman, & Demyttenaere, 2007; McFarlane, 2002). In this model, a person's behaviour − and, especially, mental health symptoms − are affecting the family context and its interactions and patterns. The family context often becomes organized by the mental illness and then, in turn, influences the illness' symptoms and their presentation. The FSG-model described in this paper focuses on: (1) the impact of the mental illness and the judicial order on the family members' lives, (2) supporting the coping skills of the family members, and (3) (re)discovering strengths and resources and re-authoring the family members' lives. Many family members of mentally ill offenders are living in dominant 'stigmatized' stories of the psychiatric illness and the criminal offence (Nordström et al., 2006; Pearson & Tsang, 2004; Rowaert et al., 2017). Not only acknowledging these burdens and supporting their coping skills, but also (re)discovering their resources and strengths may instil hope in the group participants and may help them re-author their lives (Saleeby & Pont, 2008). Exchanging the unique powerful stories among the group members may encourage and empower family members in their coping process and provide them with new perspectives for the future (Mokgothu, Du Plessis, & Koen, 2015).

4.2.2. Multi-Family Group format

Multi-Family Groups (MFGs) bring family members together for the purpose of reducing stigma and social isolation. They increase the social support network, as participants can learn from each other, and they may act as a forum for building up strengths, coping strategies and hope through mutual examples and experiences (Jewell, Downing, & McFarlane, 2009; McFarlane, 2002). As many family members of mentally ill offenders often feel socially isolated because of the double stigma and the prejudices they are confronted with, the family group perspective is indispensable (James, 1996; Rowaert et al., 2017; Tsang et al., 2002; van der Sanden, Pryor, Stutterheim, Kok, & Bos, 2016). Group members can express emotions and disclose their experiences, and in turn receive support and encouragement from other participants (McFarlane, 2002). Within the FSG, family members have the opportunity to re-examine their own lives by learning directly and indirectly from each other. They can pass on information to each other as a kind of informal psycho-education. As Asen and Schuff (2006, p. 62) explain*: "Families inspire each other and some of the best (unscripted) psycho-education is 'family to family'"*. Peer support is known to be powerful in promoting change, and families are seen as consultants, as they have developed coping strategies for dealing with the positive and negative symptoms of their relative's mental illness (Asen, 2002; McFarlane, 2002).

4.2.3. Adjustments to the forensic context

The present FSG differs from MFGs for psychiatric disorders in that it is not focused on the psychiatric illness or the rehabilitation of the mentally ill offender, but on supporting the family members in dealing with the mental illness and the judicial order. Thus, it is primarily a family-focused group with the goal of enhancing the well-being of the family members. This is partly because the involvement of the mentally ill offenders is difficult, due to the often secured environments they live in and to the geographical separation of the families and their relatives (Geelan & Nickford, 1999; Rowaert et al., 2017). To embed both forensic and family expertise into the FSG, the group is led by a forensic psychiatrist and a MFG therapist. Moreover, we also developed a treatment protocol based on a literature review and on a qualitative study on the burdens and needs of family members confronted with a mentally ill offender (Rowaert et al., 2016; Rowaert et al., 2017). This treatment protocol was used to guide the sessions. The first session focuses on the impact of the mental illness and the judicial order on the lives of the family members. The second session focuses on how the family members are dealing with the situation. The third session is about (re)discovering the family members' strengths and resources. The fourth, and last, session is a reflection upon the previous sessions and a looking forward to the future lives.

4.3. Organization of the Family Support Groups

Participants were recruited by distributing an information leaflet in several settings in Flanders (e.g., psychiatric facilities, prisons, non-profit support organizations for family members of persons with a mental illness, and out-patient mental health services). The inclusion criteria were: (1) having a relative with a current or past internment record, (2) having a relative with a (primary) diagnosis of schizophrenia, psychotic or bipolar disorder, and (3) being aged 18 or older. The FSG was organized once 6 family members had given written informed consent to participate in the group.

Two FSG cycles were organized: one from February 2016 – May 2016 and a second from October 2016 – December 2016. In total, 20 family members were willing to participate. During the sessions, 3 persons dropped out. Most of the participants were mothers of mentally ill offenders, but fathers, sisters, a brother and a daughter also participated. A cycle consisted of 4 sessions: the first 3 sessions were held every 2 weeks, and the fourth session a month after the third one. The sessions lasted approximately 120 minutes with a coffee break after 90 minutes. Every session was audio- and videotaped. During the breaks, the recording was paused and the therapists left the room to consult each other. The last part of the session lasted approximately 15 minutes. The content of the sessions was guided by a treatment protocol. Every session was similarly structured and started with (1) a go-round, which is a reflective moment during which participants can talk about how they are doing and discuss (from the second session onwards) the homework assignment they received in the previous session. The session continued with (2) a group discussion in relation to a specific theme mentioned in the treatment protocol. Next, there was a (3) break of 15 minutes, and a (4) therapeutic reflection about the previous session. To conclude, participants received a homework assignment.

4.4. The therapeutic process

Across the different sessions, the therapists stimulate the exchange of the participants' experiences. Similarities between the participants' stories may increase support and reduce stigmatization, while differences may stimulate new insights. No formal psycho-education is given, except in the exchange of experiences and tips between family members and therapists. The therapists facilitate the therapeutic process by making use of different family therapeutic techniques, such as reframing techniques, focusing on coping strategies and resilience, asking reflective questions about the past, present and future, and making use of metaphors. This can help family members feeling acknowledged and supported. The therapists also gave family members enough space to disclose their situation. Furthermore, attention was paid to the participants' non-verbal language *("I see you nodding")* and to exploring differences and similarities between the group members *("I hear from the parents' position that they care a lot for their relative, how do you experience this as the daughter of? And do the* *others also find visiting prison is the most difficult or the hardest thing you have to do? How is that for you as a sister?"*). The therapists tried to let the family members reflect on the content of the session by asking illness-recognizing questions *("How do the mental illness and the judicial order impact your life?"*) and health-promoting questions ("*Who is supporting you? Can you sometimes clear your head and take a leave from care?")*.

4.4.1. Session 1: Impact of the mental illness and the judicial order on the lives of family members

The first session started with an introduction of the organization of the FSG and its rules. The therapists emphasized that the participants were free to either talk or listen to the other group members (rule 1). Furthermore, the therapists stressed the absolute confidentiality of the group sessions (rule 2).

During the go-round, the participants (family members and therapists) briefly introduced themselves and their family situation. At the end of this introduction, the therapists acknowledged the time and effort family members were investing in the relation with their relative: *"You are sitting here from different positions − parents, children, brothers, sisters − but all of you have very long stories and histories".* Both therapists further encouraged the group members to discuss the impact of the mental illness and the criminal offence on their lives.

> Many participants talked about the physical and psychological impact of the judicial order. A mothers says: *"I sleep badly. Three to four nights in a week I am wide awake."* A brother reacts: *"For me, it is the comparison I make − I call it 'comparison-pain' − of what I have and I know my brother does not have."* Another mother explains: *"The fighting for your relative is at the expense of your social life."* For many family members, the judicial order feels like a punishment: *"The boundary is thin between being convicted and getting a judicial judgement. Actually, it is not a punishment, but in the perception it is."* (father) – *"For me, it is a punishment."* (mother) – *"Yes, of course, but judicial services describe it as an intervention. […] And I think in the perception of my brother it will feel like a punishment, because they do not know when it will end."* (brother) This causes many uncertainties with the family members, because, for them, it's a punishment without a termination date. Many are taking care of their relative and find it difficult to take care of themselves. As a brother mentioned: *"There is a lot of care towards others, but the care for yourself is difficult. However, it is very important to be able to manage it all."*

The therapists stimulated the discussion with the following questions: *"What is most difficult about the situation? What drive do you have to keep on caring and fighting for your relative? You are very supportive of your relative, but who is supporting you?"* These questions helped family members reflect on their internal and external support systems.

> Many family members mentioned the visits to prison as very difficult. A father said: *"When I visit my son, I also feel like a criminal myself, I have the feeling of being treated that way."* Other family members had the same opinion about prison and described it as '*horrible*'. When asked what drove them to keep on going, many family members answered: *"The love for our child".* The therapists acknowledged that the family members were very supportive of their relative and to proceed, they focused on who took care of the family members. Some reported that, at first, they did not want to tell anybody about what had happened because they felt ashamed. A sister stated: *"You cannot explain it to other people,*

> *because they do not understand how terrible the situation is."* Most of the participants only told it to family members or good friends from whom they received support. Only a few feel supported by professionals.

After the break, the therapists summarized the session and concluded that the family members sometimes needed to take care of themselves and to start thinking about their own life and future. This reflection led to a homework assignment about 'self-care'.

> The therapist explained the homework assignment: *"We would like you to do something in the next two weeks. It should be something you would not usually do, and you will indulge yourself with it. Something that makes you happy, something that can help you take a leave from care for a moment. It should not cost you any money. You should only do something you normally do not make time for, but that can make you happy."* After hearing this homework assignment, participants reacted very differently. A father stated: *"And if you find you do not need that?"* A mother reacted: *"Taking care of my child is my choice, it is sometimes not pleasant but…"* She was very reluctant to do something: *"And what if you do not have the time in the coming two weeks?"* The therapist reacted: *"You have to make time. It should be something you can enjoy."* At the end, many participants were of the opinion that they already enjoyed life and did things they liked. They found it hard to think about something they could do for themselves.

4.4.2. Session 2: Balance between caregiving and self-care

During the go-round of session 2, the participants discussed the homework assignment about 'self-care'.

> Some participants had done something small to fulfil the homework assignment. A mother reported: *"I went to yoga lessons with a friend. I went three times last week, and it was very relaxing."* Other family members went to the cinema, had a facial treatment, bought flowers or tickets for a concert, visited a city for one day, or had breakfast with friends. Some did not do anything − a father said: *"In my life, I do what I want, so I do not know what else I can do"* − or, due to a difficult situation they were confronted with at the moment of the FSG, it was impossible to do something for themselves.

During the session, the balance between taking care of a relative and self-care were discussed. Attention was given to how family members could keep on surviving, how to set boundaries, how to protect oneself, and who would take care of their child/sibling in the future.

> The therapists not only acknowledged the caring and the striving of the family members, but also the worries they had for the future of their relative. However, some family members disclosed that they could have a future perspective again when experiencing hope when it was going better with their relative. One father explained: *"When it is going better, I put forth strength for the future."* A sister explains that she sometimes has to take a break from taking care of her brother to protect herself and to live a comfortable life: *"I had a burn-out because of my brother's situation. So, a psychologist told me that I should take a leave from care. […] And now I have a very comfortable situation, as I only visit my*

> *brother once or twice a month. Before, I went one or two times a week − and that was too much."* Parents, in particular, found it hard to think about the question: *"What will happen when I am not around anymore?"* Some reported not knowing what would happen, and others were convinced one of their other children would continue the caretaking. However, some participants indicated that giving the responsibilities of caring to one of their other children would not be a good solution − as one father said: *"I think the task will be too heavy for the brother or the sister. We are thinking about who will take care, but we have not found a solution yet."* Some stressed the importance of professional care (e.g., in psychiatric facilities).

After the break, a homework assignment, which stimulated family members to think about what would happen to their relative if they were not around anymore, was given to reflect on different ways caregiving could be outsourced.

> The reflection of the therapist raised a lot of different reactions. In the first FSG, family members responded that making yourself redundant is impossible, and they believed that giving the mentally ill relative financial support or a good place to live was important. In the second FSG, more attention was given to the course of the relative's mental illness. A father asked: *"Do people recover from schizophrenia?"* Which started a discussion about psychosis and its rehabilitation process.

4.4.3. Session 3: Strengths and capabilities of family members

During the go-round, the therapist opened the discussion of the homework assignment by saying: *"This is not a theme that's easy to talk about. But we know that it's an important theme, although no easy solutions can be found for it".*

> One mother said: "*My other children have the right to live their own lives."* Others reacted by saying: *"We cannot know what the future of our child will be or how we can anticipate it."* A mother said: *"I do not want to worry about what is going to happen in the future. I hope he will be admitted to a residential psychiatric hospital with good care. Then our problem will be solved."* Others also believed that society (psychiatric hospitals or out-patient services) had to take care of their relatives in the future. A father wondered: *"What are his possibilities outside the psychiatric hospital when we are no longer around?"*

The group discussion of this session contained psycho-education about several themes (e.g., extended minority[1], financial administration, changes in the law and contact with lawyers) and let the participants think about the limitations (of the mental health care system and their relative) they are confronted with.

> The therapist explained: *"You are in conflict not only with the limitations of the mental health care system, but also with the limitations of the mental illness of your relative who will sometimes say no to you or to the help offered. So, you might not only get a 'no' from the mental health services but from your relative as well. As family members, this is difficult because you have every good intention to help*

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[1] Extended minority is a legal status in Belgian Law, meaning that a person aged 18 or older can still be viewed as a child.

> *your relative."* A mother reacted: *"Yes, we cannot get on one line with our son."* Another mother explained: *"They are allowed to say 'no', if they are happy. But his [mentally ill offender] 'no' should not be a burden for other people."*

Furthermore, the therapists asked the participants reflective questions to focus on being able to stop thinking about the situation ('action-stops-thinking' methods), and on the well-being of the family members and on how they (can) use their strengths and capabilities to cope with the feelings they experience (anger, sadness, grief).

> Many of the family members stated that the situation is for them *"never really out of my mind"*. One mother explained: *"Sometimes it is possible, but it keeps on slumbering… You are never 100% relaxed. That doesn't happen."* A brother responded that this depends on the situation their relative is in: *"If everything is going well, it's easier to clear your head."* When asked about their strength to proceed, a father explained: "*Out of love, you get strength out of love. If you lose that for your child, then your life is also over."* Another father reported: *"My strength is that I would do anything just to be able to say he is recovered!"* However, he knew that was an illusion. He mentioned that the support he got from his wife was important for him: *"We support each other*." Others mentioned their job or doing voluntary work as providing strength to keep on going or to stop thinking for a moment about their situation.

Discussing the strengths and competences made many participants think about their own roles as a father, mother, brother, sister or daughter and the feelings they have towards the situation and their relative.

> One father said: *"If I have to tell my son that we are going to a session [FSG] about psychosis, I do not know how he will respond, because he has no insight into his illness. […] and I have to admit that I did not think so much as you [his partner] about it, because the past weeks these sessions focused on how we cope with the situation. […] Now I started to think about this and maybe it would be helpful to tell my son that we feel like a victim ourselves because of everything that has happened. And that is the reason we come to these sessions [FSG]."*

After the break, the therapists summarized the session and described the different boundaries and situations family members face by making use of the metaphor: "*It is like sitting on a little boat on a stormy sea".* With this metaphor, they illustrated that − in addition to caring for their mentally ill relative − the participants also cared for their other family members and were battling the judicial order and the mental health care system. For this reason, the therapists found it important to look at the strengths and competences of each participant. While the therapist stood next to a group member, all of the other group members listed some of the person's strengths. At least 3 or 4 qualities were written down on post-it notes and were passed around. This exercise enabled the participants to reflect on their own strengths, which is often difficult, especially in periods of crisis and distress. Over the following two weeks, the participants had to think about these strengths and how they are present in their daily lives.

> The therapist explained: *"I would like you to give each other two qualities, talents. One person will write it down on a post-it, and afterwards you can take the post-it home."* The therapist started with the first

> person in the circle and asked the other participants to name the person's talents. The participants all spoke up at the same time: *"Combative, a strong person, powerful, considerate of other family members, quiet and tender."* After the go-round, a father said: *"Hearing all these words just made our day!*"

4.4.4. Session 4: Reflection on the previous sessions and future

During the go-round, the therapist asked the participants about the strengths they had received at the end of session 3 and if they had recognized these strengths in the past month during their daily pursuits.

> Every participant explained the strengths they received. A mother said: *"The strengths I received are power, being critical and having a good understanding. I think this is correct. The first one, power, concerns all of us. Because we are all fighters."* Another person was described as being patient and combative. Those were strengths he recognized, and they had helped him through the difficult situation. When a father mentioned the quality he received about being a 'helmsman of a ship', he was of the opinion that he had to remain at the helm for a long time. When looking at this strength and linking it to his situation, he said: *"I am my son's confidential advisor, we say everything to each other."* The therapist asked: *"And what does a confidential advisor do?*" The father answered: *"I always understand him and I am never negative, even if it is difficult. I say comforting words and that we have to be strong together to survive this."*

During the group discussion, attention was also given to the participants' questions about the mental illness of their relative and the judicial order, which referred to the previous 3 sessions. Furthermore, the therapists focused on facing limitations of the person's illness, of the judicial system, and of the psychiatric support and mental healthcare system. These proved to be a difficult issue to cope with for many family members.

> Participants answered that it is important to realize that their relatives live in another world and, for many, this is the hardest thing to accept. As a mother stated*: "Do you know what your son or your brother sees or hears? I do not know that. Do you know what they are going through if they have a psychosis?"* When the therapist advised that they should 'choose their own battles', many family members found that difficult. A father reported: *"It is hard when he says: 'it's your fault'. Then you say we have tried everything to give you a better life, and still he keeps saying: 'it's your fault!' That is hard to live with."*

After the break, the therapists reflected on the 4 sessions and encouraged the participants to hold on to their strengths and to keep using them in daily life. During the second FSG, the participants were asked to make use of their own strengths and capabilities to give the other group members advice on their situation by writing a Christmas card. It was important for the participants to imagine 'sitting in the therapist's chair' while writing these cards.

4.5. Some reflections on the Family Support Group

We have developed a systemic FSG for family members of mentally ill offenders on which some reflections can be made. First, from a literature study and previous research, we know that little research has yet focused on the experiences of family members and how they can be supported (Rowaert et al., 2016; Rowaert et al., 2017). By means of an FSG, we have tried to give more attention to the burdens and experiences of family members by supporting them in how they deal with the situation, as there is often no care for family members despite the burdens they experience (Absalom-Hornby et al., 2011; Rowaert et al., 2016; Rowaert et al., 2017). In this way, an FSG differs from family therapy for other psychiatric disorders, as our focus is primarily on the well-being of family members instead of on the rehabilitation of the client. One reason is that mentally ill offenders are often living in secured environments and are not easily accessible (Davies et al., 2014; Fadden, 2006; Rowaert et al., 2017); and secondly, it would divert the focus from the well-being of the family member and place it on the problems of the client. In comparison to McFarlane (2002), family members in an FSG can express emotions and disclose their experiences, and, in return, receive support from other participants. Moreover, family members can have fewer difficulties disclosing their story, as the FSG is detached from a (forensic) psychiatric setting and from the client. Previous research has shown that many family members are afraid to express their complaints about their relative and his/her situation in a mental health setting, because they think it can affect their relative's treatment (Fadden, 2006). By prescribing the aforementioned in a treatment protocol, it has coloured our group, as more focus is placed on the family members' coping strategies and self-care.

Second, family members are still living in dominant 'stigmatized' stories (Nordström et al., 2006; Pearson & Tsang, 2004; Rowaert et al., 2017). Therefore, during a group discussion, it is important to – first of all – let family members ventilate about the impact of the psychiatric illness and the criminal offence on their lives before giving attention to self-care. Some family members could make this switch easily, others needed more time. This can be influenced by the fact that some family members had longer histories with mental health care systems and judicial systems, and could already cope with the situation more adequately. Consequently, a group of family members in the initial phase of the judicial process could differ from the FSGs with family members with a long forensic psychiatric history.

A third reflection is that, although no formal psycho-education about judicial services was given because these family members benefit more from informal questions and information, a psychiatrist with forensic knowledge is preferable in addition to a therapist experienced with MFG processes. However, forensic psychiatrists can often be too expensive, for which also therapists can be involved on condition that they follow a training to develop forensic knowledge. Within an FSG it is important to have a forensic psychiatrist or therapist as they can provide concise information about the judicial system and services, without leading to an interminable discussion about these judicial processes. By doing so, the group discussion can quickly refocus on the experiences of the family members, without losing themselves in a downward spiral linked to difficulties families experience with the psychiatric and judicial services.

Fourth, it was difficult to find family members willing to participate, which probably can be linked to the double stigma and the shame family members are confronted with, especially in the early phase of the process. Family members are confronted with judicial processes with no, or limited, possibility for reflection (Rowaert et al., 2016; Rowaert et al., 2017). Furthermore, only two couples participated in the sessions. Other participants came alone to the groups, which is different from MFG research, in which more family members of one relative are involved. The reason for this small number of persons can be that family members of mentally ill offenders become socially isolated, without family or friends left to support them (Nordström et al., 2006; Rowaert et al., 2016; Rowaert et al., 2017). Looking at the participating family members, fathers were especially absent. Compared to other research studies with family members of mentally ill offenders, it is noticeable that, in most research, more women − and especially mothers − are involved (Absalom-Hornby et al., 2011; MacInnes & Watson, 2002; Nordström et al., 2006; Ridley et al., 2014). In addition, there was less drop-out in the groups, which indicates that participating in an FSG is meaningful for the participants despite the long travel distances they sometimes have to undertake.

Fifth, within the group, more attention was given to the mental illness, treatment and prison than to the criminal offence. This can be due to the fact that family members see the mental illness as the primary problem, and the criminal offence more as an 'incident', as it is often something trivial. They are of the opinion that their relative first had to commit an offence before he could get the treatment he needed (Rowaert et al., 2017).

Finally, the homework assignment family members received at the end of each session was of great value, as it let them reflect on the previous session. This was a way to have family members focus more on themselves, rather than on their relative, when they are at home. Letting them proceed with reflecting at home about a particular subject also raised the intensity of the group, as there were only 4 sessions. Furthermore, 4 sessions can be too short for family members, as they perhaps only provide elements for basic reflection, without deeper discussion on some themes. Therefore, more research is needed to investigate whether an FSG is effective in supporting family members of mentally ill offenders and which therapeutic processes are perceived as helpful.

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5

Family Support Groups for family members of mentally ill offenders: A pilot study

This chapter is based on:

Rowaert, S., Vandevelde, S., Audenaert, K., & Lemmens, G. (submitted). Family Support Groups for family members of mentally ill offenders: A pilot study.

Abstract

To date, there is a lack of family interventions for family members of mentally ill offenders. With the aim of addressing this issue, a Family Support Group (FSG) has been developed. The current pilot study investigated the impact of two pilot FSGs for family members of mentally ill offenders in relation to quality of life, burden, coping strategies, and resilience. Family members completed several questionnaires (i.e., WHOQOL-BREF, ZBI-22, CERQ, RS-nl) both before and after the group intervention. A total of 20 family members participated in both FSGs. The results indicated that participants experienced less self-blame, a decrease in loss of control over their lives, and improved emotional well-being. The findings showed that attending an FSG can be empowering for family members as it offers support in the management of emotional experiences and coping strategies.

Keywords
Family Support Group, Family members, Mentally ill offenders

5.1. Introduction

Family members of mentally ill offenders often play an important role in their relatives' lives, which may seriously impact upon their own well-being (Rowaert et al., 2016). Research has shown that family members struggle with feelings of anxiety, powerlessness, and grief. As society tends to doubly stigmatise mentally ill offenders through the application of constructs including that of 'psychiatric patient' and 'criminal', mentally ill offenders frequently experience guilt and shame, and feel socially isolated (Absalom-Hornby, Gooding, & Tarrier, 2011; Pearson & Tsang, 2004; Rowaert et al., 2016; Rowaert, Vandevelde, Lemmens, & Audenaert, 2017; Tsang, Pearson, & Yuen, 2002). Family members reportedly struggle with feelings of (self-)blame which often exacerbates their perceived burdens and diminishes their sense of hopefulness (Moses, 2010). Furthermore, family members may feel both inadequate and intimidated in their role as caregiver, which is associated with poorer psychological well-being and which may affect their life-course and identity (Moses, 2010; Ridley et al., 2014). In general, family members of mentally ill offenders report a poorer quality of life, increased stress as well as emotional, financial, and psychosocial burdens compared to families of mentally ill individuals (Ferriter & Huband, 2003; Marsh & Johnson, 1997; McCann, McKeown, & Porter, 1996; Nordström, Kullgren, & Dahlgren, 2006; Tsang et al., 2002). Family members often receive little support from friends, family, and professionals, although research has shown that family support plays a critical role in alleviating feelings of self-blame (McCann et al., 1996; Moses, 2010; Nordström et al., 2006; Ridley et al., 2014).

Mechanisms that are intended to improve social contact and to reduce stigma and shame are already included in family interventions for family members of mentally ill relatives (Wasserman, Weisman de Mamani, & Suro, 2012). Such family interventions can assist family members in helping them to explore their fears and in allowing them to develop new and hopeful narratives with regard to their situation (Moses, 2010). Despite the fact that family interventions for psychiatric disorders are common practice and recommended by most guidelines, such as National Institute for Clinical Excellence (NICE) guidelines, only a minority of reported family interventions have thus far focused specifically on the needs and experiences of family members of mentally ill offenders (Absalom, McGovern, Gooding, & Tarrier, 2010; Absalom-Hornby et al., 2011; Geelan & Nickford, 1999). Consequently, the researchers of the present study developed a Family Support Group (FSG) intervention to support family members of mentally ill offenders (Rowaert, Hanssens, Vandevelde, Audenaert, & Lemmens, submitted). The aim of this pilot study was to investigate the effects of the FSG on quality of life, experience of burdens, coping strategies, and resilience of family members of mentally ill offenders.

5.2. Methodology

5.2.1. Sample selection

Participants were recruited through the distribution of an information leaflet in several locations in Flanders (e.g., [forensic] psychiatric facilities, prisons, non-profit organizations for family members of persons with a mental illness, and outpatient mental health services). The inclusion criteria required that participants in the FSG were: (1) being a family member of a mentally ill offender who has been mandated to care under a current or past internment measure[1] and who has received a diagnosis of schizophrenia, psychotic or bipolar disorder; and (2) being of age 18 or older. A group cycle commenced after six family members provided their informed written consent to participate in the study.

The pilot study was approved by the Ethics Committee of Ghent University Hospital (EC decision: B670201526897); and participants gave informed consent before the start of the FSG.

5.2.2. Participants

A total of 20 family members participated in two FSGs. The mean age of the participants was 59.5 years (SD = 12.66, range: 28–75). Participant characteristics of each group cycle are described in Table 5.1. Three participants withdrew from the FSG. Within the first group cycle, one participant did not attend any session. Two participants withdrew from the second group cycle, following the first and second sessions, respectively. On average, participants took part in 3.2 sessions (SD = 1.6, range 1–4).

Table 5.1. *Participants in the different Family Support Groups*

Group cycle	Families (n = 16)	Composition of the group (n = 20)	Mean age of family members (range)	Current stay of their relative at the time of the Family Support Group	Still under the internment measure
1	9	1 daughter, 1 sister, 1 brother, 3 fathers, 5 mothers (n = 11)[a]	57 (28-70)	Living independent with outpatient mental health care (n = 4); residential (forensic) psychiatric care (n = 3); community-based inpatient setting (n = 2)	n = 5
2	7	1 sister, 2 fathers, 6 mothers (n = 9)[a]	63 (32-75)	Living independent with outpatient mental health care (n = 2); residential (forensic) psychiatric care (n = 3); prison (n = 2)	n = 7

Note. [a] Couples participated.

5.2.3. Organization of the Family Support Groups

The treatment protocol of the FSG is described extensively in another article (Rowaert et al., submitted). The aim of the FSG was to support the family members of mentally ill offenders in managing the implications of both psychiatric problems and the internment measure of a relative. An FSG cycle consisted of four group sessions. The first three sessions were held fortnightly, with the fourth session being held one month following the third session. The sessions were approximately 120 minutes in duration. A coffee break was permitted after 90

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[1] In Belgium the internment measure is defined as: *"a safety measure to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires in view of his/her reintegration into society"* (Heimans, Vander Beken, & Schipaanboord, 2015, p. 1051, translation by the authors).

minutes. Each session was audio- and video-recorded, and was similarly structured with a go-round, group discussion, break, and therapeutic reflection. The first session commenced with an introduction outlining the organization of the FSG and its rules. Furthermore, the first session focused on the impact of mental illness and the internment measure on the family members' lives. The following sessions focused on self-care rather than on care for the relative (session 2), and addressed the strengths and capabilities required to cope with the situation (session 3). The final session (session 4) consisted in a reflection on previous sessions as well as on the future. The group sessions were directed by 2 psychiatrists, namely, a forensic psychiatrist and an experienced Multi-Family Group therapist. The therapists stimulated the exchange of experiences, and pointed to similarities and differences in the stories of the family members. Following session 2, 3, and 4, homework assignments were given (e.g., family members were asked to do something for themselves during the following two weeks that they usually did not do, and which constituted an indulgence).

An observation team followed the groups after a one-way screen. The first group cycle included the first author of this paper (i.e., the main researcher of the study) and two master-level students in Special Needs Education from Ghent University. The second group cycle included the researcher and a medical assistant in Psychiatry from the Department of Psychiatry and Medical Psychology at Ghent University Hospital.

5.2.4. Data collection

The participants were asked to complete a battery of questionnaires a week before the commencement of the FSG (T0) and one week following the final session (T1) (see Fig. 5.1.). The questionnaires assessed quality of life (WHOQOL-BREF), experienced burden (Zarit Burden Interview; ZBI-22), cognitive coping strategies (Cognitive Emotion Regulation Questionnaire; CERQ) and resilience (Resilience Scale Dutch Version; RS-nl 25) of the participants.

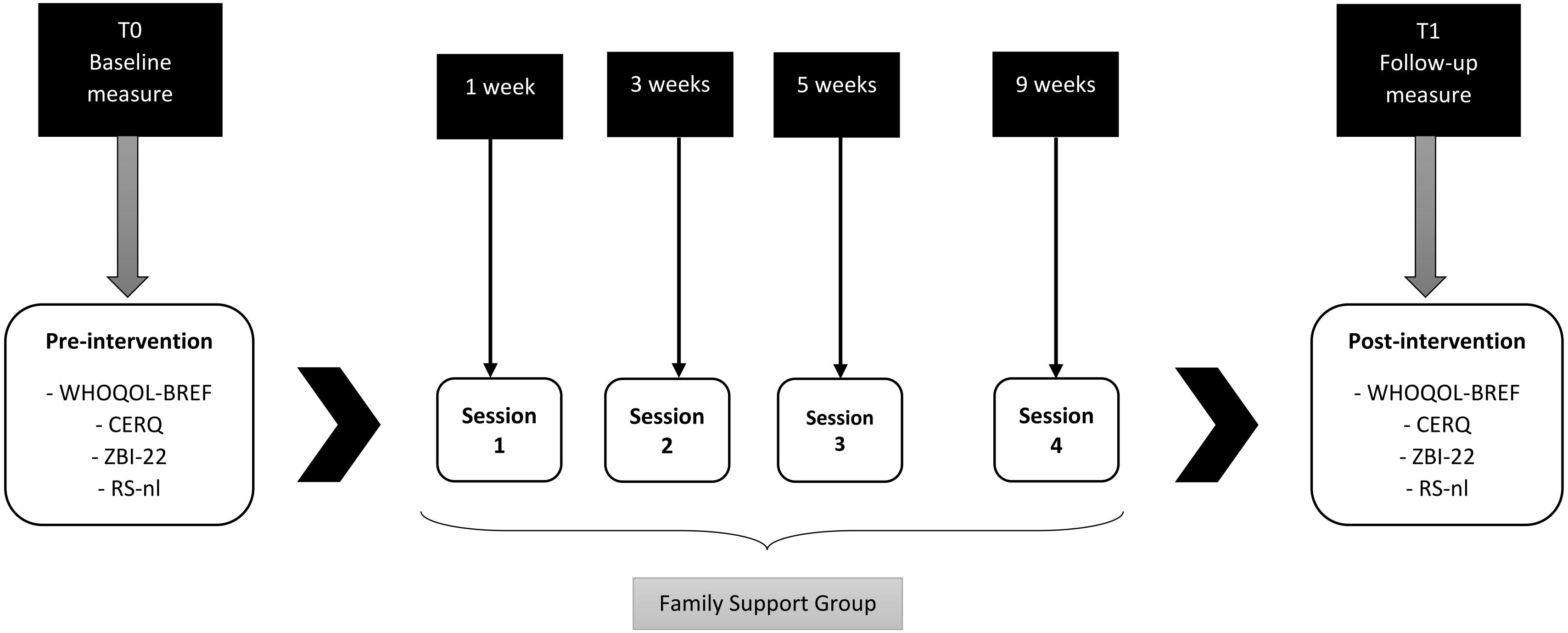

Figure 5.1. *Study flow-chart*

5.2.4.1. Quality of Life

The World Health Organization Quality of Life Instrument (WHOQOL-BREF), Dutch version (De Vries & Van Heck, 1996), is a 26-item questionnaire that measures Quality of Life (QoL). Two items are scored separately and are used to indicate a participant's overall perception of QoL and health: (1) *"How would you rate your QoL?"* (range: 1 ['very poor'] to 5 ['very good']; and (2) *"How satisfied are you with your health?"* (range: 1 ['very dissatisfied'] to 5 ['very satisfied']. Furthermore, the WHOQOL-BREF contains four different domains ranging from 1 ['very poor'] to 5 ['very good']: (1) Physical health (seven items; Cronbach alpha in this study: α_pre = .87, α_post = .86); (2) Psychological health (six items; α_pre = .81, α_post = .90); (3) Social relationships (three items; α_pre = .74, α_post = .43); and (4) Environment (eight items; α_pre = .90, α_post = .80). Domain scores range from 0–100 with higher scores indicating a better QoL (THE WHOQOL GROUP, 1995, 1998). Given the poor internal consistency (α_post < .50) of 'social relationships', this domain was omitted from the analysis.

5.2.4.2. Experienced burdens

The Zarit Burden Interview (ZBI-22) (Mapi Research Trust, 2014; Zarit, Reever, & Bach-Peterson, 1980; Zarit, Todd, & Zarit, 1986) is a subjective measure of the caregiver's burden, and consists of 22 items. Twenty-one items are summed to produce a total burden score, measured on a scale ranging from 0 ['never'] to 4 ['nearly always'] (Cronbach alpha in this study: α _pre = .90, α_post = .93). Item 22 represents an overall burden, and is scored from 0 ['not at all'] to 4 ['extremely']. It reflects five different domains (Rankin, Haut, Keefover, & Franzen, 1994): (1) Burden in the relationship (six items; α_pre = .65, α_post = .0.77); (2) Emotional well-being (seven items; α_pre = 0.84, α_post = 0.86); (3) Social and family life (four items; α_pre = 0.79, α_post = 0.80); (4) Finances (one item); and (5) Loss of control over one's life (four items; α_pre = 0.68, α_post = 0.81). Higher scores indicate that caregivers experience a greater burden (Mapi Research Trust, 2014).

5.2.4.3. Coping strategies

The Cognitive Emotion Regulation Questionnaire (CERQ) is a Dutch self-report instrument consisting of 36 items measured on a scale ranging from 1 ['almost never'] to 5 ['almost always']. The CERQ refers to nine cognitive coping strategies commonly utilised following a confrontation with a threatening or stressful event. Each coping strategy is measured with reference to 4 items: (1) Self-blame (Cronbach alpha in this study: α_pre = .72, α_post = .60); (2) Other-blame (α_pre = .51, α_post = .71); (3) Rumination or focus on thought (α_pre = .61, α_post = .90); (4) Catastrophising (α_pre = .78, α_post = .78); (5) Putting into perspective (α_pre = .81, α_post = .88); (6) Positive refocusing (α_pre = .74, α_post = .74); (7) Positive reappraisal (α_pre = .78, α_post = .76); (8) Acceptance (α_pre = .86, α_post = .82); and (9) Refocusing on planning (α_pre = .65, α_post = .54). Higher scores suggest an increased likelihood that the associated coping strategy will be utilised (Garnefski & Kraaij, 2007; Garnefski, Kraaij, & Spinhoven, 2006). Given the poor internal consistency (α < .55) of 'other blame' and 'refocusing on planning', these domains were omitted from the analysis.

5.2.4.4. Resilience

The Resilience Scale Dutch Version (RS-nl 25) (Portzky, Wagnild, De Bacquer, & Audenaert, 2010) is a self-report instrument consisting of 25 items (Cronbach alpha in this study: α_pre = .86, α_post = .77) with scores ranging from 1 ['strongly disagree'] to 4 ['strongly agree'] to produce a total resilience score. The scale is subdivided into two subscales: (1) Personal Competence (17 items; α_pre = .86 , α_post = .78); and (2) Acceptance of Life and

Self (eight items; α_pre = .51, α_post = .17). Given the poor internal consistency (α < .50) of the latter scale with regard to both pre- and post-intervention, only the total score and the scores on the 'Personal Competence' scale have been analysed. Higher scores indicate greater levels of resilience (Portzky et al., 2010).

5.2.5. Data analysis

Statistical analysis was performed using SPSS 23, with p < .05 as the standard determining statistical significance. To verify a normal distribution of the data, the Shapiro-Wilk test was utilised. Questionnaire data was analysed using Linear Mixed Model analysis (LMM). All 20 participants were studied for baseline measures (T0) and were thus included in the Linear Mixed Model analysis. The independent variable time was entered into the model as a fixed effect. Intercepts were considered to be fixed effects. Post hoc pairwise comparisons were computed using Bonferroni correction for multiple comparisons. Residual analysis was performed to assess model adequacy.

5.3. Results

With regard to the ZBI-22, family members showed improved emotional well-being, F(1,165) = 7.643, p < .05, with a mean difference of −1.19, 95% CI[1] [−2.09 to −0.28], as well as a decrease in loss of control over one's life, F(1,163) = 4616, p < .05, with a mean difference of −0.86, 95% CI [−1.0 to −0.01]. Furthermore, results from the CERQ showed that family members experienced a decrease in self-blame, F(1,169) = 5.493, p < .05, with a mean difference of −1.41, 95 % CI [−2.68 to −0.14]. When compared to the norm scores, a similar result can be found, suggesting that family members engage in more self-blame than the norm during pre-intervention whereas they engage in less self-blame than the norm post-intervention (see Table 5.2.).

The alternative scales did not produce any significant results. However, comparing the norm scores of the CERQ with the results of this study, the results suggested that family members are more likely to utilise the following coping strategies: acceptance, rumination or focus on thoughts, positive refocusing, putting into perspective, and catastrophising. Only positive reappraisal is lower than the norm, decreasing progressively post-intervention. Evaluating the norm scores of the RS-nl with the results of the current study, family members score considerably lower. With reference to the personal competence scale, the scores indicated in the present study are almost equal to the norm.

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[1] CI = Confidence Interval

Table 5.2. *Main effect of time*

	Norm scores[a]	Pre-intervention Mean (95% CI)	Post-intervention Mean (95% CI)	Post – Pre Mean (95% CI)	*P*
WHOQOL-BREF[b]					
General QoL	-	56.87 (46.57 – 67.18)	61.65 (49.90 – 73.41)	4.78 (-3.69 – 13.25)	*.249*
Physical health	-	63.21 (53.90 – 72.53)	62.50 (53.63 – 71.38)	-0.71 (-7.32 – 5.90)	*.824*
Psychological	-	59.58 (51.88 – 67.28)	60.13 (51.71 – 68.55)	0.55 (-3.72 – 4.82)	*.788*
Environment	-	69.53 (60.31 – 78.75)	70.66 (64.05 – 77.27)	1.13 (-4.08 – 6.33)	*.654*
ZBI-22[c]					
Total score	-	43.30 (36.97 – 49.63)	40.64 (33.81 – 47.46)	-2.66 (-6.66 – 1.34)	*.177*
Burden in the relationship	-	12.15 (10.34 – 13.96)	11.56 (9.47 – 13.66)	-.58 (-2.23 – 1.06)	*.463*
Emotional well-being	-	13.15 (10.70 – 15.95)	11.96 (9.67 – 14.25)	-1.19 (-2.09 – -.28)	*.014**
Social and family life	-	7.90 (6.40 – 9.40)	7.91 (6.41 – 9.42)	.01 (-.90 – -.92)	*.978*
Finances	-	1.30 (.67 – 1.93)	1.32 (.66 – 1.98)	.02 (-.69 – .73)	*.951*
Loss of control over one’s life	-	8.80 (7.49 – 10.11)	7.94 (6.55 -9.34)	-0.86 (-1.0 – -0.01)	*.047**
CERQ					
Self-blame	8.29	9 (7.62 – 10.38)	7.59 (6.31 – 8.86)	-1.41 (-2.68 – -.14)	*.032**
Acceptance	10.66	12.10 (10.73 -13.47)	11.42 (9.97 – 12.87)	-.68 (-1.96 – .59)	*.274*
Rumination or focus on thoughts	10.14	12.10 (10.73 -13.47)	11.63 (9.81 – 13.46)	-.47 (-1.93 – .10)	*.509*
Positive refocusing	9.75	10.80 (9.47 – 12.13)	10.96 (9.08 – 12.84)	.16 (-.99 – 1.31)	*.769*
Positive reappraisal	12.15	11.80 (9.93 – 13.67)	10.98 (9.48 – 12.48)	-.81 (-1.93 – .30)	*.144*
Putting into perspective	11.45	12.18 (10.66 – 13.70)	11.78 (10.21 – 13.36)	-.40 (-1.50 – .70)	*.452*
Catastrophizing	6.14	8.20 (6.64 – 9.76)	8.23 (6.78 – 9.68)	0.03 (-1.11 – 1.18)	*.955*
RS-nl					
Total Score	86	79.65 (75.30 – 84)	79.03 (75.62 – 82.44)	-.62 (-3.02 – 1.78)	*.593*
Personal competence	55.5	54.90 (51.58 – 58.22)	54.48 (51.71 – 57.25)	-.42 (-2.26 – 1.42)	*.636*

Note. CI = Confidence Interval.

[a] Norm scores is a column with the norm scores of the subscales mentioned in the manuals. These scores are the mean scores for men and woman. A higher score on the CERQ suggests an increased likelihood that the associated coping strategy will be utilised. Higher scores on the RS-nl indicate greater levels of resilience. [b,c] No norm scores exist for the WHOQOL-BREF and the ZBI.

*p < .05.

5.4. Discussion

This study investigated the effect of an FSG for family members of mentally ill offenders on the families' QoL, experienced burdens, coping strategies, and resilience. First, the main findings of this study suggest that FSGs help to (further) reduce the self-blame of family members of mentally ill offenders. However, in examining the norm scores, participants in the current study showed both in pre- and post-intervention mean scores that were close to the norm. A possible explanation for this finding may be that the participants in this study already had a long history of coping with the situation they were confronted with, and were able to overcome self-blame over the course of time (Moses, 2010). Moreover, some studies highlight the fact that family support may help to reduce feelings of self-blame (Moses, 2010; Nordström et al., 2006; Ridley et al., 2014). Second, family members showed improved emotional well-being following attendance of the sessions. This finding may be due to the particular model of the FSG (i.e., in terms of its format and content) which was designed to foster a context that enabled family members to disclose their emotions. This feature is important as many family members of mentally ill offenders are confronted with a diverse range of emotions, a double stigma, and poorer well-being, which warrants particular attention during the intervention (Moses, 2010; Ridley et al., 2014; Rowaert et al., 2017; Tsang et al., 2002). Moreover, many participants were listened to by others (i.e., therapists and family members) for the first time, which may also have positively influenced their emotional well-being. As shown by other researchers, many family members frequently receive little support from friends, family members or professionals for their experienced burdens (Absalom-Hornby et al., 2011; Nordström et al., 2006; Pearson & Tsang, 2004). Third, participants experienced less loss of control over their lives. This finding may be partly explained by the fact that peer support within the FSG may provide families with a novel understanding of their situation. Peer support is reported to promote changes in family members' lives, as participants are viewed as consultants which instigates feelings of support and recognition for their situation (Asen, 2002; McFarlane, 2002). Attendance increases the social support network as participants encourage each other, reinforce strengths, and develop coping strategies through the sharing of their stories (McFarlane, 2002).

In addition, the researchers anticipated improvements in the scores from the RS-nl as the sessions specifically focused on participants' strengths. However, participants in this study showed a lower resilience than the norm both during, pre- and post-intervention, and no improvement was found. In contrast, the total burden score decreased. This finding suggests that four sessions may be sufficient to experience less burden and improve emotional well-being, but that additional sessions or a longer support period are required to influence resilience. As described by other studies, family interventions are important to empower families, to explore family members' fears, and to assist them in developing new and hopeful narratives (Absalom-Hornby et al., 2011; Moses, 2010; Nordström et al., 2006; Saleeby, 1996).

Finally, it is important to acknowledge some limitations of this study, particularly given the small number of participants who were willing to take part. Reluctance to participate may be understood in terms of the double stigma that families may experience. Second, there is also a selection bias, as most family members were recruited from non-profit organizations for family members of persons with a mental illness. Only a minority of participants from other organizations contacted the research team. Moreover, the participants had to take contact with the researcher themselves, which perhaps caused difficulties. The latter could for many family members be a big step to achieve, as they have become during time mistrustful in contacting professionals.

Therefore, it may be suggested that family members who already had a long history of taking care of a mentally ill offender were able to speak more candidly about the situation they were confronted with. Furthermore, this study did not devise a control condition. Therefore, it cannot be decisively concluded that the results obtained were due to an effect of the intervention and/or different variables. Notwithstanding these limitations, the results seem to support the hypothesis that an FSG can support and empower family members in terms of managing their emotional experiences and developing coping strategies. However, it is necessary that future research utilises more rigorous designs and control groups in order to examine the generalisability of our findings.

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6

Family Support Groups for family members of mentally ill offenders: Therapeutic factors

This chapter is based on:

Rowaert, S., Vandevelde, S., Audenaert, K., & Lemmens, G. (submitted). Family Support Groups for family members of mentally ill offenders: Therapeutic factors.

Abstract

This study investigated therapeutic factors of a Family Support Group (FSG) intervention for family members of mentally ill offenders. 17 family members completed the ‘Group Therapeutic Factors-Client Questionnaire’ (GTF-CQ-28) during 4 sessions of 2 FSGs. Results indicated that families have experienced the relational climate, interactional confirmation, expressing and experiencing mutual positive feelings, forgetting own problems, hope from seeing progress in others, guidance from therapists, and getting interpersonal feedback as helpful over the course of the intervention. The therapeutic factors learning by observation, support from the group, and universality of problems correlated with a decrease in self-blame, improved emotional well-being, and experiencing less loss of control over one’s life, respectively. Further, family members were satisfied with what the FSG has provided for them personally and for the relation with their relative. Finally, clinical implications of the FSG are discussed. The study sheds light on valuable therapeutic factors within an FSG and the important role of the therapists.

Keywords

Family Support Group, Family members, Mentally ill offenders, Therapeutic process

6.1. Introduction

Family members of mentally ill offenders experience specific issues as they are confronted with a range of emotional, financial, and psychological burdens, social isolation, and a double stigmatisation (mentally ill person and criminal) of their relative (MacInnes & Watson, 2002; Rowaert et al., 2016; Rowaert, Vandevelde, Lemmens, & Audenaert, 2017; Tsang, Pearson, & Yuen, 2002). Yet, there is a dearth of family interventions to support family members of mentally ill offenders (Absalom, McGovern, Gooding, & Tarrier, 2010; Absalom-Hornby, Gooding, & Tarrier, 2011; Geelan & Nickford, 1999). In order to address this lack, a Family Support Group (FSG) intervention has recently been developed to support family members in dealing with both the mental illness and the judicial situation of a relative (Rowaert, Hanssens, Audenaert, Vandevelde, & Lemmens, submitted[a]). Preliminary results indicate that family members experience less self-blame, improved emotional well-being, and less loss of control over their lives after participating in the FSG (Rowaert, Vandevelde, Audenaert, & Lemmens, submitted[b]). However, it is important to understand the therapeutic factors underlying these benefits so that they can be further emphasized in therapy. The major aim of this study is to enhance our understanding of these crucial therapeutic factors.

Research concerning therapeutic factors of family interventions, especially Multi-Family Groups (MFGs), is lacking in forensic psychiatric research. However, several therapeutic factors of MFGs have been identified in various psychiatric and somatic, non-forensic patient groups (Gelin, Cook-Darzens, & Hendrick, 2017). These factors include: the exchange of experiences through peer support, therapeutic alliance, group cohesion and support, empathy, feeling understood, learning by observation and identification with other families, experiencing communality, gaining insight and hope, and self-disclosure (Gelin, Cook-Darzens, & Hendrick, 2017; Hellemans et al., 2011; Lemmens, Eisler, Dierick, Lietaer, & Demyttenaere, 2009; Lemmens et al., 2003). Moreover, the occurrence of these therapeutic factors tends to increase over the course of the intervention (Lemmens et al., 2009). Finally, MFG – which, by its unique structure and non-stigmatizing atmosphere, facilitates communication and social interactions (McFarlane, 2002) − is generally well accepted by its participants. Most studies show an explicitly high treatment satisfaction, in different populations, which is also reflected in low drop-out figures (Brunaux, & Cook-Darzens, 2008; Salaminiou, Campbell, Simic, Kuipers, & Eisler, 2015).

The present study specifically focuses on the therapeutic factors of an FSG for relatives of mentally ill offenders. The study has 3 primary aims:

- First, to investigate the therapeutic factors underlying the FSG.
- Second, to investigate the evolution over time and the association between the therapeutic factors and the outcomes of the FSG.
- Finally, to assess the participants’ treatment satisfaction.

6.2. Methodology

6.2.1. Sample selection

To recruit participants for the FSGs in this study, an information leaflet was disseminated in different settings. These settings were assumed to provide contact with family members of mentally ill offenders in Flanders, such as (forensic) psychiatric facilities, prisons, non-profit organizations for family members of persons with a mental illness, and outpatient mental health services. Family members of mentally ill offenders were selected to participate based on the following inclusion criteria: (1) having a relative with a current or past internment measure[1] who has a diagnosis of schizophrenia, psychotic or bipolar disorder, and (2) being 18 or older. An FSG cycle was initiated once a minimum number of 6 family members agreed to participate.

The Ethics Committee of the Ghent University Hospital approved the study (EC decision: B670201526897); and participants gave informed consent before the start of the FSG.

6.2.2. Participants

In total, 20 family members (mean age of 59.5 years; SD = 12.66, range: 28-75 years) were selected to participate in two Family Support Groups. However, only 19 started the intervention, as one father dropped out before the start of the first session. During the intervention, a second person dropped out after session 1 and a third person dropped out after session 2 (both were mothers). The results of the remaining 17 family members were analysed since they participated in more than one session. Twelve of them were female, with most of them being a mother of a mentally ill offender (n = 9). Others were sisters (n = 2) and a daughter. Four fathers and one brother participated. Within the first group cycle, 10 persons from 9 different families participated. The second group cycle consisted of 7 persons from 6 different families. In both groups, one couple participated. On average, family members participated in 3.2 out of 4 sessions (SD = 1.6, range 1-4).

6.2.3. Organization of the Family Support Groups

Conceptually, the FSG is based on a systemic MFG therapy that has been adjusted to the forensic context (Lemmens, Eisler, Migerode, Heireman, & Demyttenaere, 2007; Rowaert et al., submitted[a]). The main treatment goal of the FSG is to support family members in dealing with the psychiatric problems and the judicial procedure of their relative. A group cycle consisted of 4 sessions, with 3 sessions held every two weeks and one session after one month. The content of the sessions focused on some prescribed themes: self-care (session 1), caring in the future (session 2), and strengths of family members (session 3). Session 4 reflected on the strengths discussed in session 3 and contained questions to the family members about the themes of the previous sessions. Homework assignments were given to the participants after each session. Each session lasted about 120 minutes with a coffee break after 90 minutes. After the break, the therapists summarized the session and explained the homework assignment. For more information on the protocol of the study, see Rowaert et al., submitted[a].

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[1] In Belgium, 'internment measure' is defined as: 'a safety measure to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires in view of his/her reintegration into society' (Heimans, Vander Beken, & Schipaanboord, 2015, p. 1051, translation by the authors).

6.2.4. Data collection

6.2.4.1. Therapeutic factors

Participants were asked to complete the 'Group Therapeutic Factors − Client Questionnaire' (GTF-CQ-28) after each session. The 'GTF-CQ-28' is a 28-item questionnaire that asks about helpful experiences during the group sessions (Dierick & Lietaer, 2008; Lemmens et al., 2009). Each of the 28 items represents a Basic therapeutic factor ('Bf 1-28') (see Table 6.1.). These therapeutic factors are hierarchically structured into 7 Main factors (Mf): (1) Group cohesion, (2) Interactional confirmation, (3) Self-revelation, (4) Self-insight and progress, (5) Observational experiences, (6) Getting directives, and (7) Interactional confrontation; and 2 dimensions of therapeutic factors: (1) Relational Climate of the group (RC), and (2) Psychological Work (PW) (Dierick & Lietaer, 2008). More specifically, RC and PW each contain 10 scales (see Table 6.1.). Cronbach Alphas in this study for both domains and Main therapeutic factors over all 4 sessions range from .70 to .89, except for the Main therapeutic factor 'Interactional confrontation' (Mf 7), because no Cronbach Alpha could be calculated as 'Bf 25' had the same score (namely, '1') over the course of the intervention (Table 6.1.). Therefore, Mf 7 is not used in the analysis and the underlying subscales of this factor − 'getting interpersonal feedback' (Bf 24) and 'expressing negative feelings' (Bf 25) − are classified into separate scales (Table 6.1.). The occurrence of the experiences or events was rated on a 4-point Likert scale: not applicable (1), slightly applicable (2), clearly applicable (3), highly applicable (4). Mean scores of both domains and therapeutic factors were calculated.

6.2.4.2. Treatment outcome

Outcome was measured by the scores on the *Zarit Burden Interview (ZBI-22)* (Zarit, Reever, & Bach-Peterson, 1980; Zarit, Todd, & Zarit, 1986; Mapi Research Trust, 2014) and the *Cognitive Emotion Regulation Questionnaire* (*CERQ)* (Garnefski, & Kraaij, 2007; Garnefski, Kraaij, & Spinhoven, 2006). These questionnaires measure perceived burdens and cognitive coping strategies of family members, respectively. The questionnaires were filled out by the family members one week before the start of the group (T0) and one week after the last session (T1). Improvement from T0 to T1 was described as a significant mean difference of the scores on the ZBI-22 and the CERQ (for further details on the outcome of the study, see Rowaert et al., submitted[b]).

6.2.4.3. Treatment satisfaction

After the group intervention, the participants completed a Post-evaluation Family Support Group Questionnaire (Post-evaluation FSGQ) to measure treatment satisfaction during the course of the intervention (from session 1 to session 4). The questions asked to what extent they perceived the treatment to have been helpful personally and for their relationship with their family member. Satisfaction was rated on a 6-point Likert scale ('1 = very unsatisfied', '2 = unsatisfied', '3 = slightly unsatisfied', '4 = slightly satisfied', '5 = satisfied', '6 = very satisfied').

6.2.5. Data analysis

A Linear Mixed Model (LMM) analysis was performed to compare the means of the therapeutic factors and the two domains − Relational Climate (RC) and Psychological Work (PW) − over the 4 sessions. The independent variable 'Time' (sessions 1, 2, 3 and 4) was entered in the model as a fixed effect. Intercepts were considered as fixed effects. Post-hoc pairwise comparisons were computed using Bonferonni correction. To assess model adequacy, residual analysis was performed.

To investigate which therapeutic factors were associated with symptom improvement on both the ZBI-22 and the CERQ, two-tailed Pearson Correlation coefficients were computed. Differences between sessions 1 and 4 were calculated and associated with the mean differences pre- and post-intervention on the ZBI-22 and the CERQ. A descriptive analysis was performed based on the results of the Post-evaluation Family Support Group Questionnaire.

The above-mentioned statistical analysis was performed using SPSS 23 with $p < .05$ as standard for statistical significance.

6.3. Results

6.3.1. Therapeutic factors perceived by the participants over the 4 sessions

Family members experienced different therapeutic factors as helpful (score ≥ 3) over the 4 group sessions. Particularly *group cohesion (Mf 1), acceptance (Bf 1), cohesive working group (Bf 2), support from the group (Bf 3), confidence in therapists (Bf 10), similarity with others (Bf 18),* and *universality of problems (Bf 20)* are therapeutic factors that the participants rated as clearly applicable. Most of these basic therapeutic factors are within the domain of relational climate of the group (RC). When comparing the mean value (2.78) of RC with the mean value (1.98) of psychological work of the group member (PW), RC scores clearly higher within FSGs. Two factors were also rated as not strongly applicable (score ≤ 1.5): *insight into connections between current behaviour and feelings and childhood experiences (Bf 15),* and *recognizing one's own transference reactions (Bf 27).* Moreover, all of the participants always rated *expressing negative feelings (Bf 25)* as '1' during the different group sessions − meaning that family members did not express negative feelings during the group interventions (see Table 6.1.).

Table 6.1. *Differences in the mean applicability of main and basic therapeutic factors of FSG 1 and FSG 2*

Group therapeutic factors	**Session 1 Mean [95% CI]**	**Session 2 Mean [95% CI]**	**Session 3 Mean [95% CI]**	**Session 4 Mean [95% CI]**	**Session 1 to 4 Mean**	***P***
A. Relational climate (RC)[a]	**2.67 [2.36, 2.98]**	**2.64 [2.36, 2.92]**	**2.95 [2.65, 3.24]**	**2.86 [2.50, 3.23]**	**2.78**	***.032****
Mf 1 – Group Cohesion	**3.19 [2.85, 3.52]**	**3.12 [2.83, 3.41]**	**3.36 [3.10, 3.61]**	**3.36 [3.10, 3.61]**	**3.26**	***.300***
Acceptance (Bf 1)	3.17 [2.78, 3.56]	3.18 [2.85, 3.50]	3.34 [2.93, 3.75]	3.38 [3.04, 3.73]	3.27	*.791*
Cohesive working group (Bf 2)	3.34 [2.97, 3.71]	3.18 [2.85, 3.50]	3.65 [3.37, 3.92]	3.42 [3.10, 3.75]	3.40	*.100*
Support from the group (Bf 3)	3.02 [2.63, 3.41]	3 [2.59, 3.41]	3.08 [2.68, 3.48]	3.17 [2.87, 3.48]	3.07	*.613*
Mf 2 – Interactional confirmation	**2.04 [1.70, 2.37]**	**2.08 [1.77, 2.39]**	**2.84 [2.48, 3.21]**	**2.68 [2.24, 3.13]**	**2.41**	***.000*****
Expressing mutual positive feelings (Bf 4)	1.17 [0.89, 1.45]	1.18 [0.90, 1.45]	3.16 [2.68, 3.64]	2.55 [1.98, 3.12]	2.01	*.000****
Experiencing positive feelings (Bf 5)	2.51 [2.02, 2.99]	2.65 [2.20, 3.09]	2.78 [2.29, 3.26]	2.93 [2.53, 3.32]	2.72	*.042**
Self-confidence in helping others (Bf 6)	2.42 [1.86, 2.97]	2.41 [1.93, 2.89]	2.50 [2.03, 2.97]	2.54 [1.97, 3.11]	2.47	*.844*
Mf 3 – Self-revelation	**2.52 [2.13, 2.90]**	**2.53 [2.21, 2.85]**	**2.42 [1.94, 2.89]**	**2.55 [2.01, 3.09]**	**2.50**	***.837***
Authentic self-expression (Bf 7)	2.70 [2.28, 3.12]	2.71 [2.31, 3.10]	2.67 [2.13, 3.20]	2.70 [2.11, 3.29]	2.69	*.998*
Self-disclosure (Bf 8)	2.51 [1.97, 3.06]	2.47 [1.99, 2.96]	2.12 [1.57, 2.67]	2.61 [2.06, 3.17]	2.43	*.334*
Getting things off one's chest (Bf 9)	2.36 [1.94, 2.78]	2.41 [1.93, 2.89]	2.48 [1.89, 3.06]	2.53 [1.95, 3.12]	2.44	*.959*
Separate scales						
Confidence in therapists (Bf 10)	3.31 [2.93, 3.70]	3.12 [2.81, 3.43]	3.12 [2.73, 3.52]	3.11 [2.68, 3.55]	3.16	*.755*
Understanding others (Bf 11)	2.56 [2.12, 3]	2.53 [2.08, 2.98]	2.69 [2.06, 3.32]	2.47 [1.90, 3.03]	2.56	*.688*
Forgetting own problems through helping others (Bf 12)	1.95 [1.54, 2.36]	1.76 [1.38, 2.15]	2.32 [1.74, 2.91]	2.33 [1.81, 2.85]	2.09	*.031**
B. Psychological work (PW)[b]	**1.85 [1.61, 2.09]**	**1.87 [1.64, 2.10]**	**2.10 [1.84, 2.36]**	**2.10 [1.75, 2.46]**	**1.98**	***.125***
Mf 4 – Self-insight and progress	**1.67 [1.40, 1.94]**	**1.78 [1.53, 2.03]**	**1.77 [1.55, 1.99]**	**1.92 [1.56, 2.28]**	**1.78**	***.209***
Making progress in trying out new behaviour (Bf 13)	1.31 [1.06, 1.56]	1.35 [0.95, 1.76]	1.41 [1.09, 1.73]	1.80 [1.23, 2.37]	1.47	*.062*

Insight into patient's problem (Bf 14)	2.14 [1.55, 2.73]	2 [1.49, 2.51]	2.03 [1.56, 2.50]	2.11 [1.51, 2.72]	2.07	*.829*
Insight into connections between current behaviour and feelings and childhood experiences (Bf 15)	1.20 [0.99, 1.41]	1.23 [1.01, 1.46]	1.09 [0.96, 1.22]	1.18 [0.91, 1.44]	1.17	*.139*
Becoming conscious of existential responsibility (Bf 16)	2 [1.62, 2.38]	2.53 [2.12, 2.94]	2.47 [1.97, 2.96]	2.54 [2.04, 3.03]	2.38	*.181*
Mf 5 – Observational experiences	**2.87** **[2.53, 3.21]**	**2.75** **[2.43, 3.06]**	**2.96** **[2.62, 3.30]**	**3.01** **[2.60, 3.43]**	**2.90**	***.093***
Learning by observation (Bf 17)	2.68 [2.22, 3.13]	2.88 [2.48, 3.28]	2.80 [2.27, 3.34]	2.96 [2.45, 3.46]	2.83	*.701*
Similarity with others (Bf 18)	3.24 [2.77, 3.71]	3.18 [2.76, 3.59]	3.13 [2.69, 3.56]	3.18 [2.67, 3.68]	3.18	*.929*
Hope from seeing progress in others (Bf 19)	2.15 [1.72, 2.57]	1.94 [1.56, 2.33]	2.58 [2.01, 3.14]	2.67 [2.16, 3.18]	2.33	*.045**
Universality of problems (Bf 20)	3.40 [2.98, 3.83]	3 [2.55, 3.44]	3.34 [2.88, 3.80]	3.13 [2.58, 3.68]	3.22	*.226*
Mf 6 – Getting directives	**1.90** **[1.56, 2.25]**	**2.23** **[1.99, 2.48]**	**2.25** **[1.88, 2.62]**	**2.34** **[1.92, 2.76]**	**2.18**	***.050***
Suggestions from members (Bf 21)	1.64 [1.26, 2.02]	1.71 [1.46, 1.95]	2.07 [1.51, 2.63]	2.12 [1.66, 2.77]	1.88	*.232*
Learning a method to master a problem (Bf 22)	1.64 [1.22, 2.06]	1.94 [1.56, 2.33]	1.68 [1.24, 2.12]	1.81 [1.34, 2.27]	1.77	*.384*
Guidance from therapist (Bf 23)	2.42 [1.99, 2.85]	3.06 [2.67, 3.44]	3.04 [2.63, 3.44]	3.02 [2.56, 3.47]	2.88	*.017**
Separate scales						
Getting interpersonal feedback (Bf 24)	1.45 [1.12, 1.78]	1.47 [1.15, 1.79]	2.50 [1.91, 3.10]	2.26 [1.77, 2.75]	1.92	*.009***
Expressing negative feelings (Bf 25)	1 [1, 1]	1 [1, 1]	1 [1, 1]	1 [1, 1]	1	-
Modelling (Bf 26)	2.18 [1.60, 2.75]	2.06 [1.63, 2.48]	2.48 [1.86, 3.08]	2.55 [1.95, 3.16]	2.32	*.153*
Recognizing own transference reactions (Bf 27)	1.62 [1.13, 2.10]	1.41 [1.09, 1.73]	1.71 [1.12, 2.30]	1.42 [0.99, 1.84]	1.54	*.378*
Open expression of feelings towards therapist (Bf 28)	1.82 [1.30, 2.33]	1.53 [1.16, 1.90]	1.68 [1.07, 2.28]	1.70 [1.15, 2.25]	1.68	*.507*

Note. Mf = Main Therapeutic Factor. Bf = Basic Therapeutic Factor. CI = Confidence Interval. P = significance based on F-test. Likert scale of the GTF-CQ-28: '1 = not applicable', '2 = slightly applicable', '3 = clearly applicable', '4 = extremely applicable'

[a]Relational Climate consists of the following ten Basic Therapeutic Factors: Bf 1, 2, 3, 4, 5, 6, 7, 8, 10, 11. [b]Psychological Work consists of the following ten Basic Therapeutic Factors: Bf 13, 14, 15, 16, 20, 21, 22, 24, 26, 27

*p < .05. **p < .01. ***p < .001.

6.3.2. Changes in the perception of therapeutic factors over time

Over the course of the intervention, there was an increase on the dimension 'Relational Climate', F(3,14.731) = 3.872, p < .05, (see Table 6.1.). Considering the main therapeutic factors, an increase over the 4 sessions was found on 'interactional confirmation' (Mf 2), F(3,14.319) = 17.601, p < .01, (Table 6.1.). Looking at the basic therapeutic factors, consistent increases were found for 'expressing mutual positive feelings' (Bf 4), F(3,13.586) = 32.961, p < .01, 'experiencing positive feelings' (Bf 5), F(3,14.834) = 3.505, p < .05, 'forgetting own problems through helping others' (Bf 12), F(3,15.039) = 3.868, p < .05, 'hope from seeing progress in others' (Bf 19), F(3,14.460) = 3.441, p < .05, 'guidance from therapists' (Bf 23), F(3,14.781) = 4.717, p < 0.5, and 'getting interpersonal feedback' (Bf 24), F(3,14.886) = 5.530, p < .01, (Table 6.1.).

6.3.3. Association between therapeutic factors and symptom improvement on the ZBI-22 and the CERQ

Based on the scores of the CERQ, a decrease in self-blame was found after the intervention (respectively M = 8.88; SD = 2.87 versus M = 7.53; SD = 2.53), F(1,169) = 5.493, p < .05, indicating that people made less use of this maladaptive coping strategy. This result was correlated with different therapeutic factors over the course of the intervention (session 1 to session 4). Significant correlations were found with 'learning by observation' (Bf 17), r = 0.537, p < .05, 'insight into patient's problem' (Bf 14), r = 0.529, p < .05, and 'modelling' (Bf 26), r = 0.645, p < .01. The scores on the ZBI-22 showed an improvement of emotional well-being after the intervention (respectively M = 13.53; SD = 5.18 versus M = 12.29; SD = 4.80), F(1,165) = 7.643, p < .05, indicating that people experienced less burden, which increases their emotional well-being. Over the time of the intervention (session 1 to session 4), a negative correlation with 'support from the group' (Bf 3), r = -0.590, p < .05, was found. A decrease on the scale 'loss of control over one's life' was found after the intervention (respectively M = 9; SD = 2.98 versus M = 8.12; SD = 3.04), F(1,163) = 4616, p < .05, indicating that people experienced less burden on this scale, which increases the sense of control they have over their lives. From session 1 to session 4, negative correlations were found with 'similarity with others' (Bf 18), r = -0.563, p < .05, and with 'universality of problems' (Bf 20), r = -0.533, p < .05.

6.3.4. Treatment satisfaction

Based on the descriptive analysis of the results of the Post-evaluation FSGQ, family members reported to be satisfied over the course of the FSG with what the intervention provided for them personally (M = 5.56; SD = 0.51). Furthermore, they were also satisfied with what the intervention has provided for the relationship they have with their mentally ill relative (M = 5; SD = 0.63).

6.4. Discussion

The above-mentioned results show that family members participating in an FSG experience a variety of therapeutic factors as helpful. Within the Relational Climate (RC) of the group, '*group cohesion*', '*acceptance*', *'cohesive working group'*, *'support from the group'* and *'confidence in therapists'* were frequently mentioned as important therapeutic factors. Further, *'similarity with others'* and *'universality of problems'* were the most reported factors within the domain of Psychological Work (PW). These results are in line with several other studies of MFG in psychiatric patient populations, indicating that group cohesion and support, similarity with others and universality of problems are important therapeutic factors in family groups (Asen, & Schuff, 2006;

Lemmens et al., 2003; Lemmens et al., 2009; McFarlane, 2002). This means that family members can experience an FSG as destigmatizing, because they come into contact with others confronted with similar situations, which can promote feelings of solidarity. On the other hand, family members also reported therapeutic factors that were less applicable for the FSG, such as *'expressing negative feelings'*. This may partly reflect the use of the FSG format, which focuses on people's capabilities and strengths rather than on negative feelings (Lemmens et al., 2009).

Furthermore, most applicable therapeutic factors − such as *'group cohesion', 'acceptance', 'cohesive working group', 'support from the group', 'similarity with others'* and *'universality of problems'* − are continuously reported as very important right from the start (session 1) and in all successive sessions. This may reflect the participating population of family members, who were strongly isolated, often chronically burdened and stigmatised by the mental illness and criminal offence, and often lacked professional and social support (Nordström, Kullgren, & Dahlgren, 2006; Rowaert et al., 2017; Tsang, Pearson, & Yuen, 2002). This may explain their focus on and need of therapeutic factors i.e., group cohesion and support, universality of problems, and similarity with others right from the start. The latter may also explain why factors of the RC are more frequently mentioned than factors of PW in FSGs, which contrasts with the study of Lemmens and colleagues (2003) of family groups with depressed inpatients. This also explains why these factors don't increase over time. Yet, other therapeutic factors − such as *'interactional confirmation', 'expressing mutual positive feelings', 'experiencing positive feelings', 'forgetting own problems through helping others', 'hope from seeing progress in others', 'guidance from therapists'* and *'getting interpersonal feedback'* − are gradually more frequently reported over the course of the intervention. In contrast with the 'continuously reported' therapeutic factors, these evolving therapeutic factors are mostly situated within an interactional domain, as most reported factors are about helping others and expressing positive feelings, getting feedback and making progress in seeing and trying out new behaviour. This might reflect the fact that interactional patterns, which are often stimulated in MFG (Gelin, Cook-Darzens, & Hendrick, 2017), need some time to develop in an FSG. This may also partly be explained by the protocol that was used − with a different treatment focus for each session − and the absence of the mentally ill offender in the sessions of the FSG (Rowaert et al., submitted[a]).

Apparently, the participants' self-blame decreased when they learned new behaviour (e.g., *'learning by observation' and 'modelling'*) or gained new insights *('insight into patient's problem'*) in the FSG. Having insight into the family process is mentioned as a helpful factor in different family group studies, yet the therapeutic strategies creating these insights are different from ours (*'observation and modelling'*) as they focus on psycho-education, or shared experiences, or a combination of both (Hellemans et al., 2011; Lemmens et al., 2003). In other studies, *'learning by observation'* and *'modelling'* are mentioned as strategies to have family members cope with their problems (Lemmens et al., 2009). For this reason, MFG is seen as a method offering opportunities to family members, as they can indirectly learn from each other and experiment with new behaviours (Eisler, 2005; McFarlane, 2002). Based on the family group discussion, family members can develop cognitive coping strategies, such as self-reflection, for which they are able to rebuild self-confidence (Lemmens et al., 2003). Although other studies also mention getting support as a factor helpful in reducing feelings of self-blame, this was not observed in our study (Moses, 2010; Nordström et al., 2006; Ridley et al., 2014). Perhaps due to the small number of sessions, a correlation between self-blame and experiencing support did not have time to develop. Interestingly, therapeutic factors such as *'group support', 'similarity with others'* and *'universality of problems'* − which are most frequently mentioned in MFG literature (Lemmens et al., 2003; Lemmens et al., 2009) − are associated with less burden in this study. The presence of other family members in the group generates a supportive climate, enabling family members to recognize similarities and differences in stories (Hellemans et al., 2011). Moreover, within a study of depressive patients, therapeutic factors such as '*feeling accepted as family members'* and '*getting support'* have proven to have a positive impact on the patient's improvement (Lemmens et al., 2009). Experiencing communality by feeling supported and similar to others makes family members feel less isolated and stigmatised (Asen, & Schuff, 2006; Lemmens et al., 2003; McFarlane, 2002).

The findings of this study may further indicate that different therapeutic factors are associated with different outcomes in MFGs. Both therapists and family members can experience different therapeutic factors as helpful in a family discussion group, because a variety of learning levels is available: specifically, individual, family and group levels (Lemmens et al., 2003). Furthermore, starting from session 2, therapeutic guidance is rated as clearly applicable by the participants. In research with depressive patients, therapeutic guidance is seen as an essential helpful aspect in MFGs for both patients and their families (Hellemans et al., 2011). The role therapists play in MFG interventions is seen as that of a catalyst, enabling families to share experiences and make contact (Asen, 2002). Therefore, therapists also need to be aware of the therapeutic process family members go through and the meaning they attach to their experiences, as their role primarily facilitates this process (Lemmens et al., 2003). In addition to focusing on similarities within FSGs, therapists should also give attention to differences between family stories.

The primary results of an FSG show that family members were satisfied, which is also reflected in the low dropout rates (Salaminiou et al., 2015). Furthermore, an FSG can be seen as effective, because therapeutic factors considering interactional processes evolve through treatment and families are able to gain insight into their situation. Family members can come into contact with others in similar situations, which heightens feelings of support and solidarity. As many family members feel socially isolated and doubly stigmatised, an FSG can help to rebuild social networks (McFarlane, 2002). Although we have seen that some therapeutic factors become more helpful through treatment, 4 sessions may be too short − and for this reason, long-term FSGs should be developed and studied in the future. Furthermore, the important role therapists play should not be neglected, and more attention should be given to a strengths-based framework within FSGs.

The results of this study should be interpreted in the context of some limitations. The study sample is small, which can be due to a reluctance of family members to participate because of the double stigma they experience. Furthermore, the sample may be biased as most family members were recruited from a non-profit organization for family members of mentally ill persons. Moreover, participants needed to contact the researcher, which may have been perceived as a 'big step' by family members who have often become mistrustful in contacting professionals. Most of the participating family members already had a long history of taking care of the mentally ill offender and have learned how to cope with it. In the study, no control condition was initated, so it cannot be decisively concluded that the changes in therapeutic factors are due to an effect of the intervention and/or other variables. Despite these limitations, this study sheds light on potential important and helpful therapeutic factors for family members of mentally ill offenders when attending an FSG. Future (randomized and controlled) studies should further elaborate on FSGs and therapeutic processes, with attention to family and therapist perceptions.

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7

Family Support Groups for family members of mentally ill offenders: Family expectations and experiences

This chapter is based on:

Rowaert, S., Audenaert, K., Lemmens, G., & Vandevelde, S. (submitted). Family Support Groups for family members of mentally ill offenders: Family expectations and experiences.

Abstract

Family Support Groups (FSGs) are developed for family members of mentally ill offenders. This study investigates family treatment expectations and experiences of an FSG. Family members were interviewed before (n = 20) and after (n = 17) attending an FSG. Results show that family members hesitated or were curious about the FSG, expected to receive peer support and to experience universality of problems, to receive information and advice and thought about the safety and respect of the group. Family members experience the FSG intervention as helpful because it is supportive, they gain new insights and they feel relieved and satisfied. Many family members perceive the guidance of the therapists and the differences in family and gender roles as an added value of attending an FSG. However, considering the limitations of the study, future studies should gain insight in and stress the importance of the meaning of therapeutic processes for family members confronted with different psychiatric disorders and/or situations.

Key words

Family Support Group, Family members, Mentally ill offenders, Qualitative research, Forensic psychiatry

7.1. Introduction

In Belgium, mentally ill offenders are simultaneously considered as a potential danger to society ('offenders') and as a person who needs treatment and care ('patients'), for which they are placed under an 'internment measure' (Vandevelde et al., 2011). Since 1 October 2016 The Law on Internment of Mentally Ill Offenders (5 May 2014, amended by the Potpourri III-law of 4 May 2016) came into force, describing the measure of 'internment' as *"a safety measure to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires in view of his/her reintegration into society"* (Casselman, De Rycke, Heimans, & Verpoorten, 2017, p. 103; Heimans, Vander Beken, & Schipaanboord, 2015, p. 1051). This Law states that persons can be subjected to an internment measure: (1) if their criminal offence harms the psychical and psychological integrity of a third party, (2) if they have a mental illness at the time of the offence, and (3) if there is a danger of committing new offences. The internment measure can be enforced for an unlimited period of time (Casselman et al., 2017; Vander Beken, Heimans, & Schipaanboord, 2016).

However, not only the mentally ill offenders themselves, but also their family members are confronted with both the mental illness and criminal offence, causing different emotional, social and psychological burdens (Rowaert et al., 2016; Rowaert, Vandevelde, Lemmens, & Audenaert, 2017; Tsang, Pearson, & Yuen, 2002). Therefore, many of them − the majority of whom are parents − take on an ongoing caregiving role for which they often feel unprepared (Corsentino, Molinari, Gum, Roscoe, & Mills, 2008; Marsh & Johnson, 1997; Wynaden, 2007). Yet, many often lack support from friends, family members or professionals, and thus they do not talk about their concerns like who will take care of their relative in the future (Corsentino et al., 2008; MacInnes & Watson, 2002; Nordström, Kullgren, & Dahlgren, 2006). Recently, Family Support Groups (FSGs) have been developed for family members of mentally ill offenders based on a Multi-Family Group (MFG) format. FSGs aim to support family members of mentally ill offenders in dealing with both the relative's mental illness and the internment measure (Rowaert, Hanssens, Audenaert, Vandevelde, & Lemmens, submitted[a]).

A process-pilot study investigating the outcomes of FSGs has shown that families experience less self-blame as they could learn from and observe others, have greater emotional well-being because they received support from the group, and experience less loss of control over their lives by feeling similar to others and seeing the universality of the problems (Rowaert, Vandevelde, Audenaert, & Lemmens, submitted[b]; Rowaert, Vandevelde, Audenaert, & Lemmens, submitted[c]). Furthermore, therapeutic factors regarding the relational climate (e.g., group cohesion, support from group, confidence in therapists) were considered to be particularly helpful from the start of the sessions; whereas therapeutic factors such as expressing and experiencing positive feelings, forgetting one's own problems through helping others, hope from seeing progress in others, guidance from therapists, and getting interpersonal feedback gradually increased over the various sessions (Rowaert et al., submitted[c]).

Whilst the quantitative studies examined specific helpful therapeutic factors, less is known about the expectations and experiences of family members before and after attending family group interventions. Nonetheless, it is important to 'give voice' to family members through qualitative interviews, because there is a need for more profound research on treatment expectations and experiences before and after attending family group intervention (Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012). To our knowledge, this has only been studied within Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) research. MST is a family and community-based treatment that empowers family members to obtain resources to cope with adolescents' antisocial behaviour such as substance abuse and criminal offences (Henggeler & Schaeffer, 2016; Kaur, Pote, Fox, & Paradisopoulos, 2017; Sheridan, Peterson, & Rosen, 2010). FFT is an evidence-based family therapy treatment for adolescents with behavioural problems and their families − it focuses on understanding familial relationships and developing adaptive behaviours that can change maladaptive ones (Hartnett, Carr, Hamilton, & Sexton, 2017; Robbins, Alexander, Turner, & Hollimon, 2016). Although these results are not generalizable as such − because some aspects are specifically linked to the MST or FFT context − they are important to mention because no other research is available (Hartnett et al., 2017; Kaur et al., 2017). Researchers report that families were reluctant at the beginning, as they were tired, stressed and felt that they had already tried everything (Tighe et al., 2012). When asked about expectations, they mainly inquired about what was going to happen (Sheridan et al., 2010). When taking part in the family group intervention, many family members appreciated the new ideas and the concrete advice they were given, their increase in reflection, the changes in their beliefs, and the improvements in their family functioning (e.g., parenting and communication skills) (Hartnett et al., 2017; Kaur et al., 2017; Tighe et al., 2012). Family members felt heard and supported by the therapists and liked their guidance, as they were empathic, understanding and sincere. The non-blaming, sincere and encouraging approach used by the therapists led to feelings of being respected and accepted, which created stronger self-confidence, improved mental well-being, and reintroduced hope into the lives of the participants. Through the family intervention, participants become more resilient and unburdened, as it provides a safe place to ask questions and exchange experiences (Asen & Schuff, 2006; Hartnett et al., 2017; Kaur et al., 2017; Sheridan et al., 2010; Tighe et al., 2012).

Family members' treatment expectations and experiences are important to identify potential problems or limitations of an intervention, and they can provide insight into possible improvements in the future (Tighe et al., 2012). The present study focused on treatment expectations and experiences of family members before and after attending an FSG. The study considers the views of family members with regard to the changes the FSG brought into their lives.

7.2. Methodology

7.2.1. Sample

An information leaflet was disseminated in several settings in Flanders − e.g., (forensic) psychiatric facilities, prisons, non-profit organizations for family members of persons with a mental illness, and ambulatory mental health services − to recruit participants for 2 FSGs. These setting were assumed to provide contact with family members of mentally ill offenders. Participants were selected based on the following inclusion criteria: (1) having a relative with a current or past internment measure who has a diagnosis of schizophrenia, psychotic or bipolar disorder, and (2) being 18 or older.

The Ethics Committee of the Ghent University Hospital approved the study (EC decision: B670201526897) and participants gave informed consent before the start of the FSG.

7.2.2. Family Support Groups

An FSG aims to support family members in dealing with the psychiatric problems and the internment measure of a relative. It is sub-divided into 4 sessions, each consisting of a particular prescribed theme:

- Session 1 focuses on self-care of the family members,
- Session 2 on who is going to take care of their relative in the future,
- Session 3 on their strengths and capabilities for coping with the situation, and
- Session 4 is a reflection of the previous sessions.

Furthermore, homework assignments are given after each session to have the participants reflect upon the topic of the session and the effect on their own lives (Rowaert et al., submitted[a]).

FSGs are conceptually based on a systemic MFG format, which is adapted to a forensic context (Rowaert et al., submitted[a]). MFGs aim to bring families together to reduce stigma and enable participants to expand their social network, as they have become socially isolated because of the situation (Asen, 2002; Asen, Dawson, & McHugh, 2001; McFarlane, 2002). The therapists take on the role of catalyst to help family members connect with each other. In this respect, peer support is very powerful and can promote change, as family members are seen as advisors to one another (Asen, 2002; Asen & Schuff, 2006; McFarlane, 2002). Family members can indirectly learn from each other by being provided psycho-education and mutual support and feedback (Asen et al., 2001; McFarlane, 2002). See for more information Rowaert et al., submitted[a].

7.2.3. Participants

In total, 20 persons with a mean age of 59.5 years (SD = 12.66, range: 28-75 years) gave informed consent to participate in the study. Before the start of the first session, every participant (n = 20) was interviewed about their expectations, which were then analysed. Still, during the intervention, 3 persons dropped out: 1 father did not attend any session, and 2 mothers attended only one session. Therefore, after the intervention, only 17 interviews were conducted and analysed concerning the participants' treatment experiences. Most of the family members were female: 11 mothers, 2 sisters and 1 daughter. In addition, 5 fathers and 1 brother participated.

7.2.4. Data collection

A qualitative research method was chosen to represent the richness and the complexity of the family members' lived experiences (Elliott, 2010; Pistrang & Barker, 2010). One week before the start of the first session (pre-intervention) of the FSG, in-depth interviews were conducted about the expectations family members had about participating in an FSG. Post-intervention in-depth interviews were conducted one week after the last session. These interviews aimed to map the treatment experiences family members had when attending an FSG. Topic lists were used with questions about the current situation of their relative and their expectations towards the FSG (pre-intervention) and about the impact that the FSG had on their lives and how they experienced the treatment (post-intervention).

7.2.5. Data analysis

In this study, it was considered important to 'give voice' to the treatment expectations and experiences of family members who attended an FSG. The pre- and post-intervention in-depth interviews were transcribed verbatim and analysed using Nvivo 11 (QSR International Pty Ltd, 2015). Thematic analysis was used, because it is *"a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in rich detail"* (Braun & Clarke, 2006, p. 6; Pistrang & Barker, 2010). An inductive approach was used to derive themes closely linked to the data (Braun & Clarke, 2006, 2012; Mortelmans, 2011), which was important as this study aimed at capturing the expectations and experiences of family members who participated in an FSG. The first author of this research paper analysed the data of both pre- and post-intervention separately, by using an open coding process closely linked to what the family members said. Afterwards, these codes were generated to (1) pre-intervention themes (e.g., emotions, support, general prospects) and (2) post-intervention themes (e.g., quality of the treatment, emotions, experiences, lessons learned from the sessions, roles in the group, and homework assignments) to form 2 separate tree structures which were discussed with the co-authors of this study. The analysis was sub-divided into 2 domains − (1) expectations and (2) experiences − which respectively generated 4 themes (curiosity or hesitation about taking part in the FSG, peer support and universality, receiving advice and information, and group-specific hopes) and 5 themes (feelings of satisfaction and relief, communality and support, gaining new insights, differences in family and gender roles, and group-specific characteristics) (see Table 7.1.).

Table 7.1. *Expectations and experiences of family members participating in an FSG*

EXPECTATIONS before the start		**EXPERIENCES after the intervention**
Curiosity or hesitation about taking part in the FSG	→	Feelings of satisfaction and relief
Peer support and experiencing universality of problems	→	Communality and support
Receiving and giving advice and information	→	Gaining new insights
Safety and respect	→	Group-specific characteristics • *Group guidance* • *Group organization* • *Homework assignment* • *Heterogeneity of the group*

7.3. Results

7.3.1. Treatment expectations

When family members were asked about their expectations of the FSG, they described various topics: (1) curiosity or hesitation about taking part in the FSG, (2) peer support and experiencing universality of problems, (3) receiving and giving advice and information, and (4) safety and respect. Some did not have any expectation and went with an open mind.

> *"I do not have any expectation, but I think it will give me in a way a satisfied feeling."* (mother)

7.3.1.1. Curiosity or hesitation about taking part in the FSG

Some family members said they hesitated to participate in the FSG because of some practical concerns (e.g., combination with working hours) or because they did not know what they had to do in an FSG or what they should expect from it. Yet, the majority did not hesitate and were curious about what the FSG was about.

> *"The first time I received the information about the FSG, I did not react, because I thought what can I say or do there? […] But I always have the idea that, by telling my story, I can make other people understand about communicating with professionals or about the confrontation with the internment measure."* (mother)

7.3.1.2. Peer support and experiencing universality of problems

Peer support and coming into contact with others in the same situation is mentioned by many family members. However, this expectation gives some family members an ambivalent feeling: on the one hand, they find peer support very positive; but on the other hand, they are afraid about possible differences in coping among the participants.

> *"On the one hand, peer support can give you a pleasant feeling, because nobody really can understand what the situation [having a mentally ill offender as a relative] is about, unless you have to deal with it yourself. On the other hand, they are all people who are coping with their situation in a different way. Many are at a different stage in getting over it. Perhaps anger can dominate the group and demands energy from the others."* (daughter)

Some family members expect to learn from other participants by hearing other stories and getting to know how others cope with the situation. They hope to recognize their own situation in other stories and to receive recognition from other family members in how they cope with the situation. Furthermore, many also want to help others from their own (positive) experiences.

> *"To hear the experiences of other families and to share my experience, which is now more or less positive. To know I am not alone in my situation, because before I always blamed myself for what happened to my son."* (mother)

> *"I want to learn from others and hear which course they have followed, which I think, in many cases, will not be very positive. […] Not only how they have dealt with it emotionally, but also practically."* (sister)

Meeting others is important for many family members as they have a need to feel they are not alone in their situation.

> *"Alone is still alone, but with more you are stronger."* (mother)

One participant also has the feeling that attending an FSG will not only help herself, but also her relative. Besides, many family members hope that some things will change in the future. Moreover, they argue that other family members should not be confronted with the same problems they have had to deal with.

> *"I think that contact between families will not only help ourselves, but will also be positive for the patient. As we will know more about how we can cope with the situation."* (mother)

7.3.1.3. Receiving and giving advice and information

Some participants hope that they can receive information that will help their relative's situation. Others also express the hope of receiving tools, not only from other participants, but also from the therapists leading the group. Furthermore, some want to get advice about what they can do for their relative in the future, because many – especially parent – are very worried about what will happen to their child if they are no longer around.

> *"I hope the other family members will give me answers to my questions, especially about what will happen in the future and how they think about it."* (mother)

7.3.1.4. Safety and respect

The majority express the desire to actively participate in the FSG − however, a few family members prefer to listen to others instead of speaking themselves. Others say that they hope there will be attention to safety in the group and respect for the integrity of the participants.

> *"I think participating actively is important. […] I hope that, besides telling our stories, attention is also given to safety, respect and the tempo of the participants."* (brother)

7.3.2. Experiences and feelings after attending the FSG

When family members were asked about their treatment experiences, some of their answers showed their expectations were fulfilled. They mentioned more helpful (therapeutic) experiences than before attending the FSG. Family members experienced (1) feelings of satisfaction and relief, (2) communality and support, (3) gaining new insights, and (4) group-specific characteristics.

7.3.2.1. Feelings of satisfaction and relief

When asked about their emotions after the sessions, family members reported that they were relieved and satisfied − one mother even described it as a *"satisfied tiredness"*. The sessions also energized many of the participants. But because the sessions were also experienced as very intense, 'tired' and 'energized' often went hand-in-hand.

> *"Usually I was very tired, but in a strange way the sessions also gave me energy. It is tiring to sit there for two hours, to listen and to tell your story. But when I drove home, I thought about the session and the things other participants had said, and how I could move on in my own situation."* (sister)

Notwithstanding the intensity of the sessions, many family members had a good feeling about the FSG, as they picked things up from other participants' situations by observing and learning about how others cope with their situation.

> *“The fact that people come to these sessions − even if they won’t help their relative’s situation − shows how important it is for people to relieve their feelings.”* (mother)

7.3.2.2. Communality and support

Participants report that experiencing feelings of communality is helpful, because in the FSG they get the opportunity to discuss their situation with others in the same (or similar) situation. This is experienced as useful, as many family members often do not have the possibility to talk about their situation with friends or family members. Within this group, they are confronted with people who are dealing with a similar situation and understand what they are going through. This helps them to tell their story easily, as they are aware that the others know how it feels. A daughter described the FSG as *“a mirror for my own feelings and coping strategies”*.

> *“You all went through similar situations, which you cannot discuss with outsiders. In this group, you meet people who understand the situation you are dealing with.”* (father)

> *“People who attend this group all know how it feels. The recognition is very supportive.”* (sister)

Many family members had the feeling, often for the first time, that they are not alone in having to deal with both a relative’s mental illness and internment measure. By meeting others, family members feel supported and are able to experience solidarity and universality with the problems and situation.

> *“We always thought we were the only ones who were confronted with a mentally ill offender. And attending this group made me aware that we are not alone. You start thinking of the fact that everyone has to deal with the same issues.”* (mother)

> *“Meeting others who are confronted with the same misery, that is somehow supportive. Especially seeing people who were very combative and had already tried everything to make sure their child would receive the treatment he needed.”* (mother)

7.3.2.3. Gaining new insights

Family members found the content of the sessions of the intervention interesting and helpful as they gained insight into their challenges and problems. The treatment within an FSG helped them reflect upon their own lives and the lives of their relatives. Especially because the discussion included the fact that they are stuck between the reality of the law and the reality of the patient’s needs.

> *“This group [FSG] is made of people who are involved and who are living in the situation. While usually everything is kept superficial, the content of these sessions was always very thoroughly discussed. You are sitting there between people you do not know and you commit yourself. Something I basically never do.”* (mother)

Some family members also put their own situation into perspective by hearing others tell their story. This helped many of them reflect on their situation by telling themselves: *“It can get a great deal worse than the situation* *we are in now"*. Many family members compared situations of others with their own and found that, in general, the problems others were confronted with were more severe.

> *"I found others had to deal with a much more severe situation than mine. But then I thought 'we are companions in misfortune'. I have realized that other family members also keep on fighting. […] So, the interaction between my situation and the situation of others induced something like confidence. I got the feeling that you do not have to think it is all lost with those children and with those problems. It is still liveable, even as difficult as it is − and that is something I have learned from the other participants."* (father)

7.3.2.4. Group-specific characteristics

Many family members also point to the significance of an FSG and are convinced this format can be useful for other family members. Some also feel that an FSG should be something permanent for family members to go to because, for some, 4 sessions were too short. The sessions merely started some reflections that the participants should take further and work on themselves.

> *"Four sessions are definitely too short. You have planted a seed and we need to let it germinate now."* (mother)

In this regard, almost all of the participants conveyed their thoughts about some specific group characteristics, such as group guidance, group organization and homework assignments, which are discussed below.

A. Group guidance

The guidance from the therapists was deemed necessary by every family member. In particular, the therapists' way of focusing on specific subjects and guiding the group towards prescribed themes, focusing on the strengths and capabilities of family members, was considered especially important.

> *"I think the guidance from the therapists is essential − otherwise, the FSG would become a lamentation, with everyone recounting his misery. Then, it would no longer have been a supportive group."* (daughter)

Family members described the therapists as respectful and understanding, as good listeners, and as persons who were able to bring in a positive note and also acted firmly to give each participant an equal chance to tell their story.

> *"They were very good listeners. […] Now and then, it was humorous with smiles and laughs. People should be able to laugh, despite the difficult situation."* (father)

Many family members experienced the therapists as added value for the group, because they gave feedback and could respond on each other. Some family members were of the opinion that they would not have told each other so many details if no therapists were involved.

> *"Getting feedback from the two psychiatrists was interesting, because you are so emotionally involved in your own situation that it's often hard to see the reality. They can communicate things in a simple way, so that you can get another image of certain situations."* (sister)

> *"For us, this was new [attending an FSG], because in all those years we never searched for help for ourselves. Maybe we should have done it sooner."* (father)

B. Group organization

Most of the family members felt that 10 participants was a maximum number, because more participants would make the session too short for everyone to be able to ventilate about their situation. Family members have the feeling that more participants would undo the profundity of the FSG and would not lead to the reflection they have now experienced. However, a small number of participants would also be a problem, because then people can go into greater detail, which can be too confronting and too heavy to bear. On the other hand, fewer participants can also be an advantage, as that would make it easier to remember each participant's situation.

> *"The size of the group was perfect. I think there should not be more people, because then it would take more time and would weaken the connection between the participants."* (mother)

> *"Being with a small group can be confronting. For example, if you are a group of only four persons, the FSG can be emotionally charged."* (mother)

Many family members liked the break between the first and the last parts of the session. It helped them have more spontaneous contacts with others, to catch their breath, and to let the first part 'sink in'.

> *"Especially when there are severe stories being told, it is important to have a break. So that you can drink a coffee, and people can talk one-on-one with each other."* (daughter)

When family members were asked if they would also want their relative to be involved in the FSG, different reactions were given. Some are of the opinion that they would restrain themselves to say particular things about their relative, so that he/she would not feel offended. Others feel that their relatives could be present, but they do not know if this would bring added value, especially because the content of the sessions would then perhaps focus more on the patients than on the family members. Most family members do not express a need to involve their relative, and they also do not know if their relative would be willing to come.

> *"I do not know if it would have added value, because the conversations would be guided in a different way when the person with a mental illness is also involved. The questions that would then be asked could be confronting for the person and even burden him or her. Perhaps it would also give us a sense of guilt when talking about certain aspects of the situation. So, personally, I do not have a need to have my relative involved in an FSG."* (mother)

C. Homework assignment

Family members liked the homework assignments, as they helped them reflect upon self-care, caring in the future, and using their own strengths to cope with the situation. For some, it was a tool used in the sessions to let you know what the subject during the next session would be. At first, many family members found the homework assignments very simple. Yet afterwards, they were surprised to find that they made them reflect and take action.

> *"When I first heard the assignment, I thought it was childish. But when you start thinking about it and searching for something you can do, then it means more than you thought it did."* (mother)

> *"A homework assignment gives you the opportunity to prepare something for the next session and to reflect upon it. It was not explicitly said that this would be the next subject − we were only told that we should think about it. […] A difficult exercise for me was about who will take care of my son in the future? Who will have that responsibility? I do not want to burden my children with it. Therefore, these sessions taught me that I must search for a solution for the future. As long as I live, I will search for a permanent solution for my son − and that is an understanding I have received by following these sessions."* (mother)

Especially the task of the third session − in which family members had to recognize other participants' strengths and capabilities, which were afterwards written down on a Post-it note − has stayed in many family members' memory. Some of them even kept the Post-it.

> *"There was a lot of truth in that task, we have not yet thrown the Post-it away. […] We have talked about it with each other, and we've found a lot of truth in it. I even reflected upon myself, because I need to deal with some things in a different way. And I will work on it."* (father)

D. Heterogeneity of the group

During the interview, more than half of the family members said something about how they experienced the different family and gender roles in the FSG. Especially the presence of mothers and fathers was discussed. The majority of the participants were mothers, but a few fathers also attended the group, which made many participants happy. One participant said that a mother is seen as someone who never gives up, and a father as someone who is more powerful in his opinion and distances himself more often from the situation.

> *"The fact that a man will also come to such a group to tell his story and show his vulnerability is very important! I mean the fathers in this group do not hide the problems. My son was no longer welcome with his father."* (mother)

Participants describe the difference in family and gender roles as a 'healthy mix' within the FSG. They value the heterogeneity of family roles: not only parents, but also sisters, a brother and a daughter participated in the FSG. Various family members specifically pointed out that an FSG should not be unilateral.

> *"There were a lot of mothers, but that is because they feel more involved with the problems of their child. […] But eventually I became aware that my family role as daughter is not very different from the role of parents, because of the parentification."* (daughter)

> *"A mixed group is important, because it should not be too unilateral. The 'main themes' of the stories are all the same. If, in the beginning, suitable treatment is not immediately available, you all are confronted with the same situations [prison and (forensic) psychiatric care]."* (mother)

There were only a few couples attending the FSG. One couple was struck by the fact that they were the only husband and wife in the group. The couples who attended the group together found it very interesting, as they could discuss the session with their partner. They also found participating together supportive.

> *"I think attending the group as a couple is very interesting, because when we drove home, we discussed what was said. […] We could share it together."* (mother)

7.4. Discussion

This study investigated the treatment expectations and experiences of family members of mentally ill offenders attending an FSG. Many family members were curious about what the FSG was about before it started. Only a few mentioned that they hesitated a while, due to practical or emotional reasons. This differs from the study of Tighe and colleagues (2012), because they report that family members were at first reluctant to participate in a family intervention because they were stressed, tired and had the feeling that they had already tried everything. The engagement of the family members in our study can be due to the fact that they already had a long history of coping with their relative's mental illness and the internment measure. Moreover, for the greater part, family members were selected from non-profit organizations that organize activities for family members, which could have made it easier for these family members to participate in the FSG. Another explanation could be that an FSG aims to support and empower family members without the mentally ill persons being involved. This differs from an MFG, which aims to help the patient in his/her recovery process by engaging family members in the treatment and rehabilitation (McFarlane, 2002).

The results show that, at the end of the 4 sessions, family members had a satisfied feeling, as their (limited) expectations were fulfilled (see Table 7.1.). Yet, it is noteworthy that most of their expectations (experiencing universality of problems, peer support, and receiving advice and information) were in line with the difficulties (double stigma, social isolation, and no or incorrect information) they had experienced in the years before (Nordström et al., 2006; Rowaert et al., 2017; Tsang et al., 2002). Looking at the experiences, the same trend can be observed, as family members valued the communality, the support from the group, and gaining new insights. The latter helped them to reflect upon their lives and the lives of their relatives, which was developed further in the homework assignments. The homework assignment about taking care of their relative in the future was considered especially important, because many family members had never planned for what will happen to their relative when they are no longer around (Corsentino et al., 2008).

In the interviews, family members mainly mention therapeutic factors considering the relational climate of the FSG, as they talk about support from the group, communality, and the confidence they have in the therapists. This is in line with previous quantitative research reporting that group cohesion, universality of problems, and similarity with others are important from the start of the FSG (Rowaert et al., submitted[c]). Experiencing communality is regarded as important by many family members – not only confronted with a relative's mental illness – because they want to meet persons dealing with similar situations, as that is destigmatizing and helps build up a social network (Asen, 2002; Asen & Schuff, 2006; McFarlane, 2002). Family members of mentally ill offenders are often socially, emotionally and psychologically burdened due to the situation they are confronted with − and attending an FSG creates for them the opportunity to talk to other family members in a safe and supportive environment, which can improve their emotional well-being (Asen & Schuff, 2006; McFarlane, 2002; Tsang et al., 2002). Family members can observe others and indirectly learn from their behaviour and coping strategies, which in a way is also supportive, as this helps reduce their self-blame and rebuilds self-confidence (Lemmens et al., 2003; McFarlane, 2002; Rowaert et al., submitted[c]). Furthermore, family members develop feelings of solidarity and experience less loss of control over their lives, because participants inspire each other by informal psycho-education and sharing experiences (Asen, 2002; Asen & Schuff, 2006; Rowaert et al., submitted[c]).

Furthermore, this study highlights the important role of the therapists within an FSG. Their respectfulness and understanding are especially highly valued. Many family members often experienced these values with professionals for the first time, as previously they had been confronted with mental health care workers or psychiatrists who did not want to listen to their story or involve them in the treatment of their relative (MacInnes & Watson, 2002; Nordström et al., 2006, Rowaert et al., 2017). Also, in other MFG research studies, the non-blaming and encouraging approach of therapists is considered to be very important (Sheridan et al., 2010; Tighe et al., 2012). Thanks to this, a family group intervention can become a safe place for family members to exchange experiences, observe others and change their beliefs (Sheridan et al., 2010).

As this is a pilot study, the results are not generalizable, and some limitations of the study need to be mentioned. First of all, the study consists of 2 FSG cycles, with only 17 participants engaged in the complete duration of the FSG. Based on the inclusion criteria, many participants are selected from non-profit organizations for family members of mentally ill persons, which could have biased the results. The small sample size can also be explained by the fact that some family members do not express a need to participate in an FSG because they have enough support or have the feeling they can cope with the situation they face. Although the FSG is created as a supportive and empowering treatment for family members, the format can also generate a barrier to participation by family members, because they do not want to be regarded by therapists as 'second patients' who are in need of treatment. Second, the experiences of family members can be biased, as most of them had a long-standing history with mental health care and had already developed some coping strategies. Third, by only focusing on empowering and supporting family members, the study did not (yet) investigate if attending an FSG may have an influence on the situation and rehabilitation of the mentally ill offenders.

To conclude, this study shows that family members are in need for information and collaboration with professionals. They look for advice and new pathways to improve the situation of their relative. Therefore this study is important in understanding family treatment expectations and experiences towards an FSG. Future family groups should focus on communality, peer support, and differences in family and gender roles, as the latter was important for many family members to experience solidarity through a heterogeneity of family roles. Therapists will play an important role, guiding the group towards gaining new insights and experiencing positive feelings, like satisfaction and energy. Moreover, homework assignments can help by having family members further reflect upon certain themes being discussed within the group. Future research about FSG should pay attention to different psychiatric disorders, as the hypothesis is raised as to whether other family members experience the same therapeutic factors as helpful. Furthermore, future research should also try to include family members who do not have a long-standing history of taking care of their relative, by trying to contact family members who have only recently been confronted with the mental illness and/or the criminal offence of their relative.

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8 General discussion

Abstract

The general discussion of this dissertation starts with a summary of the findings in relation to the research questions. Second, the strengths, limitations and future research recommendations are discussed. Third, implications for practice and policy are presented.

8.1. Main findings and conclusions

The aims of the doctoral dissertation were twofold. First, we aimed to investigate the 'lived experiences' of family members of mentally ill offenders, considering the internment measure, (forensic) psychiatric treatment, and mental illness of their relative. Second, we aimed to explore if, and to what degree, an intervention based on Multi-Family Groups (MFGs) could support and empower family members of mentally ill offenders. Within these two broad aims, 6 specific research questions were addressed:

- How are the experiences, needs and burdens of families of mentally ill offenders described in scientific literature? (*Chapter 2*)
- How do family members experience the mental illness, the interment measure, and the (forensic) psychiatric treatment of their relative? (*Chapter 3*)
- How can family members be supported in dealing with both the mental illness and the judicial order of a relative? (*Chapter 4*)
- What are the effects of a Family Support Group on quality of life, burdens, coping strategies, and resilience of family members of mentally ill offenders? (*Chapter 5*)
- Which therapeutic factors underpin a Family Support Group? (*Chapter 6*)
- What are the treatment expectations and experiences of family members before and after attending a Family Support Group? (*Chapter 7*)

These research questions will be reviewed briefly in the following paragraphs, in accordance to the three main work packages the PhD thesis was subdivided.

8.1.1. Work package 1: systematic review (Chapter 2)

The results of a systematic review showed that only 8 studies about the experiences of family members of mentally ill offenders were available. The studies focused on the roles of families in the rehabilitation process of the mentally ill offender, on their needs and burdens, and on their family strengths. Several needs and burdens were emphasized that heighten the stress of family members confronted with a mentally ill offender, such as the confrontation with violent behaviour, double stigmatisation, disintegration of the family, diminishing social contacts, and feelings of guilt, anxiety and grief (e.g., MacInnes & Watson, 2002; Pearson & Tsang, 2004; Tsang, Pearson, & Yuen, 2002). Only one study pointed to the importance of family strengths (Nordström, Kullgren, & Dahlgren, 2006). The review showed that family members often feel abandoned by friends, family and professionals and that they lack support (McCann, McKeown, & Porter, 1996). In addition, the review indicates that family members express a need for clear communication with healthcare professionals (Absalom-Hornby, Gooding, & Tarrier, 2011; Ferriter & Huband, 2003; James, 1996; MacInnes & Watson, 2002; Nordström et al., 2006; Pearson & Tsang, 2004; Ridley et al., 2014).

8.1.2. Work package 2: semi-structured interviews (Chapter 3)

In a second step, a qualitative study was developed to investigate family members' experiences with the mental illness, the internment measure and the (forensic) psychiatric treatment of their relative. Semi-structured interviews (24 in total) were conducted with 27 family members of mentally ill offenders. The analysis led to 6 themes:

(1) the criminal offence and the internment measure as an additional stigma,
(2) ambivalent feelings towards the judicial system,
(3) prison is not the right place to be,
(4) mental health support as an answer to problems,
(5) fight a losing battle, and
(6) while there is life there is hope.

The results indicated that family members experience a double stigma because their relative is being labelled as a patient and a criminal. Family members also see these labels as an important source of stress, as they hinder the search for appropriate mental health treatment. As a result, they become socially isolated and experience discrimination leading to feelings of guilt and shame. Other studies also described the double stigma leading to emotional and social burdens, which has a negative impact on the family members' quality of life (Nordström et al., 2006; Tsang et al., 2002; van der Sanden, Stutterheim, Pryor, Kok, & Bos, 2014). Family members have ambivalent feelings towards the Commission of the Protection of Society, as they feel they have no influence on the decision process. Furthermore they find that (legal aid) counsellors lack sufficient knowledge about mental illness and the needs of their relative. In line with previous studies, family members experience additional stress and frustration in dealing with police, the court and the judicial system (MacInnes & Watson, 2002; McCann et al., 1996; Tsang et al., 2002). Visits to prison – where mentally ill offenders are often referred to – are reported as burdensome by the family members, because of the lack of treatment and care in these correctional facilities. Therefore most family members used every possible means to get their relative out of prison into more appropriate mental health care facilities. Some participants in this study acknowledged that the internment measure was the starting point of change for their relative, leading to appropriate treatment. Many family members also have reported sorrow and anger, because they felt that the mental health care system had failed in preventing the crime. Family members pointed towards the possible preventive value of mandatory treatment, earlier in the life course of their mentally ill relative. They think that, by applying mandatory treatment, criminal involvement may be prevented, admission to (forensic) psychiatric hospitals rather than incarceration in prison could be facilitated, and mutual collaboration among family members and professionals and peer support could be organized. Furthermore, many of the participating family members reported to fight a losing battle and perceive the internment measure as burdensome because of its unlimited duration. In line with previous research (Nordström et al., 2006), the participants mentioned that professionals could take more initiative to inform, educate, and support family members.

8.1.3. Work package 3: mixed methods research

In the third work package, a study of the development and evaluation of a family intervention (Family Support Group, FSG) was carried out.

An FSG was developed, based on an MFG format, that integrates systemic and narrative approaches and is adapted to the forensic context. An FSG specifically focuses on the well-being of the family members instead of on the rehabilitation of the patient (McFarlane, 2002). The FSG protocol (described in Chapter 4) consisted of 4 sessions. Session 1 focused on the impact of mental illness and the judicial order on the lives of family members. During the first session, the participants introduced themselves and were encouraged to express their experiences considering their situation. Session 2 focused on the balance between caregiving and self-care, with attention to how family members keep on surviving, how they set boundaries, how they protect themselves, and who would take care of their relative in the future. In the third session, the strengths and capabilities of family members were discussed and informal psycho-education on several themes (e.g., financial administration) was provided. In the last and fourth session, the participants reflected on the previous sessions and the future. After each session, homework assignments were given for the participants to reflect on the topic of the session.

Family members completed several questionnaires before (n = 20) and after (n = 17) the group intervention (i.e., WHOQOL-BREF, Zarit Burden Interview [ZBI], Cognitive Emotion Regulation Questionnaire [CERQ] and Resilience Scale [RS-nl]) to investigate quality of life, burdens, coping strategies and resilience (Chapter 5). Furthermore, they also completed the Group Therapeutic Factors-Client Questionnaire (GTF-CQ-28) after each session (Chapter 6). Results on the CERQ indicated that family members experienced less self-blame after the group intervention, but that the mean scores were close to the norm (Chapter 5). This can be linked to the fact that the participants learned to cope with their situation and perhaps were able to overcome self-blame over time (Moses, 2010). The decrease in self-blame is correlated with several therapeutic factors of the group process such as learning by observation, insight into the patient's problems, and modelling (Chapter 6). The focus on gaining insight into the situation by observation and modelling differs from other studies that focus more on psycho-education and sharing experiences to acquire this insight (Hellemans, De Mol, Buysse, Eisler, Demyttenaere, & Lemmens, 2011; Lemmens et al., 2003). The results of family members after the group intervention also showed an improvement in their emotional well-being on the ZBI (Chapter 5). Further, the ZBI results indicated that family members experience less loss of control over their lives after the group intervention (Chapter 5). Moreover, the experiences of less burden were also correlated with some therapeutic factors such as group support, similarity with others, and universality of the problems – which are most frequently mentioned in MFG literature (Lemmens et al., 2003; Lemmens, Eisler, Dierick, Lietaer, & Demyttenaere, 2009) (Chapter 6). Meaning that the presence of other family members in the group created a supportive climate, because family members come into contact with others dealing with a similar situation. This implies that family members can recognise similarities and differences in the stories of others (Hellemans et al., 2011). Furthermore, experiencing communality by feeling supported and similar to others makes family members feel less isolated and stigmatised and shows that an FSG can be supportive and empowering for family members of mentally ill offenders (Asen & Schuff, 2006; Lemmens et al., 2003; McFarlane, 2002).

The results showed that the following therapeutic factors were helpful: group cohesion, acceptance, cohesive working group, support from the group and confidence in therapist (linked to the Relational Climate [RC]), and similarity with others and universality of problems (linked to Psychological Work [PW]). This is in line with other studies and indicates that therapeutic factors such as group cohesion and support, similarity with others and universality of problems are important in intervention groups organized for family members (Asen & Schuff, 2006; Lemmens et al., 2003; Lemmens et al., 2009; McFarlane, 2002). Factors linked to RC are mentioned more frequently from the start than factors linked to PW, which contrasts with MFG studies in general mental health (Lemmens et al., 2003). Yet, some factors that are situated within the interactional domain are more gradually reported over the course of the intervention, which might reflect the fact that these factors need some time to develop in an FSG, which differs from MFG research (Gelin, Cook-Darzens, & Hendrick, 2017). Finally, from the second session onwards, the participants valued the therapists' role and therapeutic guidance (Chapter 6). Moreover, during the interviews, participants reported they highly value the therapists' respectfulness and understanding within the FSG (Chapter 7). Other studies point to similar results, as therapists are seen as catalysts enabling families to share experiences, for which their non-blaming and encouraging approach is considered to be very important (Asen, 2002; Sheridan, Peterson, & Rosen, 2010; Tighe, Pistrang, Casdagli, Baruch, & Butler, 2010).

Regarding the importance of giving voice to family members in line with family resilience and strengths-based approaches (Anuradha, 2004; Mokgothu, Du Plessis, & Koen; Walsh, 2012), semi-structured interviews were conducted about expectations and experiences, before and after the intervention respectively (Chapter 7). Family members' expectations about the intervention involved: (1) curiosity or hesitation about taking part in the FSG, (2) peer support and experiencing universality of problems, (3) receiving and giving advice and information, and (4) safety and respect. Many family members reported not having hesitated to participate in the FSG, and they especially valued the prospect of coming into contact with others in the same situation. Receiving and giving information was therefore important, as it could be done in a safe and respectful environment. When family members were asked about their experiences after the intervention, most of the aforementioned expectations had been fulfilled. They felt satisfied and relieved and they valued the communality, the support from the group, and gaining new insights, which are in line with the helpful therapeutic factors mentioned in Chapter 6. Furthermore, the participants discussed some group-specific characteristics (e.g., group organization and heterogeneity of the group) that can be important in an FSG (Chapter 7).

8.2. Strengths, limitations and future research recommendations

8.2.1. Family members' lived experiences

The dissertation focused exclusively on the experiences of family members of mentally ill offenders, as research about the needs, burdens and experiences of this target group is very limited (Chapters 2 and 3). The FSG focused on the well-being of the family members and how they can be supported and empowered in their coping strategies (Chapters 4-7). Therefore the FSG makes this study different from MFG studies, that usually aim to support the rehabilitation of the patient (hence often involving patients as well) (McFarlane, 2002). Yet the development of an FSG may possibly have led to the feeling that family members are to blame for what happened. In a more general sense, this has been reflected on by Roose and colleagues (2014), who stated that: *"strengths-oriented social work risks reinforcing a process of individualization […] and those who cannot fit the strengths-oriented approach might be labelled as more problematic"* (Roose, Roets, & Schiettecat, 2014, p. 13-14). Therefore, it is important to take individual, societal as well as cultural aspects into account when applying strengths-based approaches.

We have chosen to focus this dissertation on family members still maintaining some sort of contact with their relative, as mentioned in the introduction (Chapter 1). Based on the results of the systematic review, family members are often confronted with caregiver burdens (Chapter 2). Furthermore, they frequently indicate that they are socially isolated and tend to withdraw from social activities (Nordström et al., 2006; Tsang et al., 2002). These issues also appear in the results of this dissertation, as many participants already had a long-standing history with mental health services and the judicial processes. Lived experiences of family members recently confronted with the internment measure of a relative were not documented. This can be due to the double stigma family members are dealing with, which can inhibit them from participating in research. Other explanations include the fact that family members are not seeking support and are only looking for information and mental health care services for their relative. The perspectives of these family members are not represented in this dissertation and, therefore, they need further investigation. Moreover, in the general introduction (Chapter 1), it is also mentioned that some family members have no or a troubled relationship with their relative, due to the mental health issues and the legal proceedings they are confronted with (Absalom, McGovern, Gooding, & Tarrier, 2010; Canning, O'Reilly, Wressell, Cannon, & Walker, 2009; Lamb, Weinberger, & Gross, 2004). When addressing family members of mentally ill offenders, it is important to take the heterogeneity of family members into account.

In addition, the dissertation did not explicitly focus on the role of family members in the rehabilitation of the mentally ill offender. Therefore an important avenue for future research could be to involve mentally ill offenders − whether or not in contact with their family members − in order to fully grasp the complexity of family relationships. With the purpose of examining the generalisability of the findings, we recommend to investigate the lived experiences of family members and mentally ill offenders whose internment measure has been completed and to expand the study to other 'target groups', such as family members of parolees and convicted offenders with mental health problems. Furthermore, the perceptions of mental health professionals concerning the involvement of family members of mentally ill offenders are also not investigated. In particular, the difficulties mental health professionals are confronted with − such as professional confidentiality vis-à-vis the mentally ill person, and how they can involve family members − are important to explore. Investigating the foregoing perspectives of family members, mental health professionals and mentally ill offenders may lead to greater insight into how mutual collaboration and support can be further developed.

8.2.2. Sample

In this dissertation, 'giving voice' to family members by means of qualitative interviews was considered essential, because this represents the richness and the complexity of family members' lived experiences (Elliott, 2010; Pistrang & Barker, 2010). Besides, we have chosen to use a mixed methods methodology in order to fully grasp the experiences of family members as well as the facilitating factors and outcomes of an FSG-intervention. This broad view is a particular strength of the study, just like the fact that this intervention was organized for the first time in Flanders.

Moreover and in line with other studies about family members of mentally ill offenders (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; McCann et al., 1996; Nordström et al., 2006; Pearson & Tsang, 2004), the current study sample is small, with 27 family members being interviewed about their experiences with the internment measure and the mental illness of their relative (Chapter 3) and 17 family members who participated in the FSGs (Chapters 4-7). Furthermore, the sample consisted (for the most part) of parents, many of whom were mothers, which is in line with other studies (e.g., Ferriter & Huband, 2003; MacInnes & Watson, 2002; McCann et al., 1996; Nordström et al., 2006; Vermeulen et al., 2015). One of the explanations given in international research is that mothers are often most responsible for the daily care of the patient (Gutiérrez-Maldonado, Caqueo-Urízar, &

Kavanagh, 2005; Ochoa et al., 2008). For this reason, other family roles are underrepresented in the dissertation − which compromises the generalisability of the results. Besides, the FSG study did not include a control group, so it cannot be decisively concluded that the results obtained were due to an effect of the intervention. This warrants further study, using randomised controlled trials.

Different reasons may explain the small sample in this dissertation. First, the participants were selected by approaching services known to maintain contact with family members of mentally ill offenders. Professionals were asked to distribute flyers to family members. This could have biased the sample, as the professionals might have decided whether or not the family members would be suitable to participate. Many of the family members are affiliated with a non-profit organization of family members for mentally ill persons, many of whom suffer from schizophrenia or psychosis. Consequently, family members of offenders with other mental illnesses (e.g., personality disorder, intellectual disability, etc.) are underrepresented. Moreover, the participants had to contact the researcher themselves − which could have been a big step for some, as they might have become distrustful of contacting professionals, based on previous (negative) experiences.

8.2.3. Family Support Group

In this dissertation, the FSG took place at one location (Ghent University Hospital), which is different from other studies about family interventions in forensic settings, which are usually implemented in forensic psychiatric settings (e.g., Absalom et al., 2010; Davies, Mallows, Easton, Morrey, & Wood, 2014; Geelan & Nickford, 1999). The results in this study showed that family members highly appreciate the safe place that was created, and that they have fewer difficulties in disclosing their story to others when the FSG is held at a location that is neutral for the participants (Chapter 7). Previous research showed that many family members are afraid to express their worries about their relative and his/her situation in a mental health setting, because they think it will affect their relative’s treatment process (Fadden, 2006).

Although the study showed that an FSG may be supportive and empowering (Chapters 5, 6 and 7), several questions remain in relation to some practical aspects − e.g., the number of sessions (should there be more or fewer than the 4 applied here?) or the choice of location − but also with regard to more fundamental issues. One of these includes the question as to whether or not FSGs are the most suitable intervention for all family members. We may assume that hard-to-reach families might profit from other activities, such as outreaching or low-threshold services. In this regard, similar projects already exist for adolescents, like ‘De Vuurvogel’ (http://www.cidar.be/vuurvogel; De Vos, 2015), which is a form of intensive context support, starting from the questions about, and perspectives on, the client’s problematic situation and his/her social network.

Finally, some inclusion criteria were applied to the FSG, which could have led to a bias in our study, as only family members of mentally ill offenders suffering from psychosis, schizophrenia or bipolar disorder could participate. Therefore, in the future, it is important to reflect on organizing FSGs with family members of persons suffering from other mental illnesses. It is also important to further investigate if, and how, an FSG can be integrated in regular or forensic community treatment services or penitentiary facilities, taking into account some of the difficulties mentioned above.

8.3. Implications for practice and policy

8.3.1. Need for changes in the treatment of the mentally ill offender

The participating family members referred to some problems they experienced with the mental health care system failing to prevent their family member from committing a crime (Chapters 2 and 3). They regret that something 'bad' had to happen before their relative received adequate treatment. The results indicate that family members point towards the possible crime preventive value of mandatory treatment and support earlier in the life course of their mentally ill relative (Chapter 3). This is in line with the "*bonus for delict"*-mechanism developed by De Bock, which posits that adequate treatment is often initiated only after a confrontation with legal proceedings, which underlines the need for prevention (as cited in Verhellen, 1998). Yet, it goes without saying that mandatory treatment (even without a crime being committed) also raises tensions: for example, in relation to respecting the autonomy of the patient and the family members.

The results further show that family members express a need to revise the educational programmes of professionals to pay more attention to how family members can be involved and supported in mental health care (Chapter 3).

8.3.2. Limited involvement of family members in the mental health treatment of their relative

Participants in this dissertation reported on the limited involvement they have in the treatment of their relative (Chapter 3). Previous studies have also described how many family members are often not involved in the treatment of their relative, nor listened to by professionals, when their relative is admitted to a (forensic) psychiatric hospital (Absalom-Hornby et al., 2011; Nordström et al., 2006; Pearson & Tsang, 2004). However, research in Northwest England has shown that more than 56% of the family members are involved in the discharge planning of their relative (Absalom et al., 2010). A study conducted in Singapore with family members of mentally ill persons admitted to a psychiatric hospital, described that 58% of the family members actively seek contact with mental health professionals. These family members wish that professionals would take their input on the situation seriously and that professionals make themselves more available to family members (Quah, 2017). Participants in this dissertation reported that, at the moment information was given to them, it was often regarded as incomprehensible 'physician talk'. Furthermore, they mentioned that the mental health professionals' medical confidentiality is problematic. The latter causes the family members having limited involvement in the treatment of their relative and also hinders a mutual collaboration (Chapter 3).

Considering the above-mentioned, recent research has shown that working with families based on a strengths-based approach relates to re-examining and redefining the problem by making use of a shared partnership (Roose et al., 2014). A shared partnership can be defined as:

> *"a cooperation between the family caregiver and the medical team, involving the participation of the family caregiver in clinic visits, regular feedback, and contact on the patient's progress and condition and other relevant aspects of care"* (Quah, 2017, p. 533).

A shared partnership focuses on the strengths, resources, and expert knowledge of all parties involved, for which it is essential that professionals *"understand potential conflicts regarding confidentiality and the ways in which* *these conflicts can be resolved"* (Marsh & Johnson, 1997, p. 235; Roose et al., 2014). Shared partnerships are challenged by barriers in the health care system (e.g., patient confidentiality regulations) and family barriers (e.g., disruptiveness, poor contact and over-involvement) (Quah, 2017). Taking these barriers into account, it is relevant for researchers and practitioners to explore ways on how to involve family members as 'partners in care' in the treatment of their relative, rather than as caregivers who can take over when the treatment is finished or is considered to be ineffective (Kim & Salyers, 2008). Based on the findings in this dissertation, professionals could be encouraged to (re)think and reflect on the policy and vision of their setting with regard to the involvement of, and mutual collaboration with, family members, without seeing them as 'second patients' (Riebschleger, 2005). However, several questions remain, e.g., about broken family bonds and how mental health professionals can work towards 'new' relationships or a recuperation of contact between family members and their relatives. This accords well with concepts as shared care and shared responsibility, pointing at the current 'care pressure' family members are dealing with. This warrants balancing between giving more care responsibilities to family members (with the caveat that this could also be underpinned by economical motives in times of financial cutbacks) and – simultaneously – providing family members with adequate support. (Vermeulen et al., 2015).

8.3.3. Fight for personal recognition and support

The dissertation has shown that FSGs can help family members experience less self-stigma, less loss of control over their lives, and more emotional well-being (Chapter 5). Furthermore, the presence of therapists was highly appreciated by the participants and considered to be important in gaining new insights into the situation (Chapters 6 and 7). More specifically, adding a therapist with forensic knowledge along with a therapist experienced in MFG processes was considered to be valuable (Chapters 4, 6 and 7). In MFG studies, therapists are seen to adopt the role of catalyst to help family members connect with each other (Asen & Schuff, 2006; McFarlane, 2002). Moreover, not only is the role of the therapists regarded as important, but the sharing of information and experiences is equally essential, as family members are seen as consultants for one another (Asen, 2002).

In addition to the FSG, described in this dissertation, there are other interventions that need further study. On the individual level, interventions such as Family WRAP® (see Chapter 1) and psycho-education programmes or activities can support family members in coping with the situation or provide them with information about the mental illness (Copeland, 2013; Lobban et al., 2013; Sin, Jordan, Barley, Henderson, & Norman, 2015). On the societal level, (preventive) measures are being taken (e.g., volunteer aid strategy and Mental Health First Aid) to make the public and mental health practice aware of how mentally ill persons and their caregivers (most often, family members) could be supported (Vandeurzen, 2016, 2017).

8.3.4. The importance of the relational climate in an FSG

Considering the therapeutic factors of the FSG, group cohesion, peer support, acceptance and confidence in therapists are important for family members of mentally ill offenders (Chapter 6). The relational climate (e.g., group cohesion, interactional confirmation) of the group is considered to be more important than psychological work (e.g., [self-]insight, observational experiences), which is in contrast with other research (Lemmens et al., 2003). These results may reflect the needs of the participating family members, as they are often socially isolated and lack support (Nordström et al., 2006; Tsang et al., 2002). However, it might seem paradoxical that, in order to realise this informal support, a formal FSG was developed (Chapter 4). The 'formal' sessions of the FSG proved to be the starting point for informal contacts and meetings between the participants afterwards. One mother explains this with a metaphor: *"You [therapists] have planted a seed and we need to let it germinate now."* (Chapter 7).

8.3.5. Reflections about the results from a macro-perspective

The results of the dissertation show that many family members do not feel supported by mental health and judicial services, they are confronted with a double stigma and they have the feeling of 'fighting a losing battle' (Chapter 2 and 3; Pryor, Reeder, & Monroe, 2012). Within the movement of de-institutionalisation and socialisation of care (see Chapter 1, 1.1.3.), it is important to positively influence the perception of mental illness in society (e.g., campaigns like 'Rode neuzendag' or 'Te Gek?!') (Liégois & Van Audenhove, 2001).

In regard to mental health care, society has been shifting from a traditional medical culture towards a culture of partnership and empowerment, in which the '*Trialogue'* movement can be seen as an example (Amering, Mikus, & Steffen, 2012). Trialogue is a form of communication between patients, their social network members and the mental health professionals, and provides the opportunity to work together on an equal basis (Amering et al., 2012; Javed & Amering, 2016). The Trialogue movement emphasises the importance of reflecting on the idea of 'relational recovery'. Meaning that we need to move beyond 'individual journeys' and give attention to the development of interpersonal acts that *"only have meaning within the context of relationships that undermine the autonomy or transgress the interpersonal boundaries people with a lived experience wish to establish"* (Price-Robertson, Obradovic, & Morgan, 2017, p. 116). 'Relational recovery' accepts the complexity of people's lives and of our society, in which concepts like social integration, inclusive citizenship and socialisation are impossible to neglect (Dewaele et al., 2015). Taking this a step further, mental health professionals, policy makers and society at large need to assume responsibilities in caring for and supporting mentally ill persons/offenders and their relatives. In a video advertising an annual conference − entitled 'A powerful mental health care system together with families: policies, visions and good practices' − a mother of a mentally ill person speaks about the need for a structural safety net:

> "*[In our society] appreciation, support, self-care or just a little encouragement is often missing. A structural safety net is needed, on which you − as a mother, or partner, or family member of a person in need of special attention − can rely. A safety net that ensures that you keep on going every single day.*" (HomeMade Productions, 2017).

8.4. References

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Appendix 1

Nederlandstalige samenvatting

1. Context, probleemstelling en doelstellingen van het onderzoek

Aan de Universiteit Gent loopt sinds 2014 een project in het kader van de Geconcerteerde Onderzoeksacties (GOA) met als titel: 'Naar multidisciplinaire op sterkte gebaseerde strategieën voor wetsovertreders met een psychiatrische problematiek'. Het project is een samenwerking tussen de Faculteit Rechtsgeleerdheid (hoofdpromotor: prof. dr. Tom Vander Beken), de Faculteit Geneeskunde en Gezondheidswetenschappen (promotor: prof. dr. Kurt Audenaert) en de Faculteit Psychologie en Pedagogische Wetenschappen (promotor: wijlen prof. dr. Eric Broekaert). Het project is gegrond in een sterktegerichte benadering als alternatief voor de hedendaagse overwegend risicogerichte aanpak van personen met een psychiatrische problematiek die strafbare feiten hebben gepleegd. Binnen de Belgische context spreekt men hierbij van de interneringsmaatregel, waarvoor er sinds oktober 2016 een nieuwe Wet betreffende de internering van personen (wet van 5 mei 2014, gewijzigd door de Potpourri III-wet van 4 mei 2016) in werking is getreden. Deze wet definieert in Art. 2 een internering van personen met een psychiatrische problematiek als volgt: *"Het is een veiligheidsmaatregel die er tegelijkertijd toe strekt de maatschappij te beschermen en ervoor te zorgen dat aan de geïnterneerde persoon de zorg wordt verstrekt die zijn toestand vereist met het oog op zijn re-integratie in de maatschappij"* (Casselman, De Rycke, Heimans, & Verpoorten, 2017, p. 103; Heimans, Vander Beken, & Schipaanboord, 2015, p. 1051). Personen kunnen een interneringsmaatregel opgelegd krijgen als ze (1) de fysieke of psychische integriteit van derden aantasten, (2) op het ogenblik van de feiten aan een geestesstoornis leiden en (3) er een gevaar is voor het plegen van nieuwe feiten (Casselman et al., 2017; Heimans et al., 2015; Vander Beken, Heimans, & Schipaanboord, 2016).

Het GOA-project is opgebouwd uit vijf doctoraatsonderzoeken met volgende onderwerpen: (1) rechten en bekwaamheden, (2) procedurele rechtvaardigheid, (3) desistance, (4) herstel en (5) familieleden van personen die geïnterneerd zijn (geweest). Voorliggende dissertatie heeft betrekking op de laatste studie.

Internationaal is er tot op heden weinig onderzoek verricht naar de ondersteuning van familieleden van geïnterneerde personen, waardoor ook het perspectief van deze familieleden ten aanzien van de problematiek en de gevolgen ervan, nog onderbelicht zijn. De inleiding van dit proefschrift (Hoofdstuk 1) start daarom met een uiteenzetting van de interneringscontext in België, waarna wordt ingegaan op de ervaringen en perspectieven van familieleden van personen die geïnterneerd zijn. Vervolgens wordt er ook aandacht besteed aan de huidige benaderingen in het ondersteunen van familieleden met aandacht voor een sterktegericht perspectief.

In een eerste deel van de inleiding (Hoofdstuk 1) wordt ingegaan op de Belgische wetgeving betreffende de internering van personen. Er wordt aangegeven dat vandaag de dag nog steeds een groot aantal geïnterneerde personen in de gevangenis terechtkomt zonder adequate hulp of behandeling (Lamb, Weinberger, & Gross, 2004; The Sentencing Project, 2002). Door het stigma waar geïnterneerde personen mee geconfronteerd worden, ervaren zij vaak moeilijkheden om een gepaste behandeling te krijgen in psychiatrische voorzieningen (Mezey, Youngman, Kreztschamr, & White, 2016). De laatste tijd is binnen de hulpverlening een shift merkbaar, waarbij meer sterktegerichte benaderingen als complementair aan de risicogerichte benadering worden gezien en ingezet (Barnao & Ward, 2015). In een tweede deel van de inleiding worden de perspectieven van familieleden van geïnterneerde personen belicht. Internationale studies hebben aangetoond dat deze familieleden vaak te maken krijgen met toegenomen stress door de gevolgen die het plegen van een strafbaar feit door een naaste met zich meebrengt (McCann, McKeown, & Porter, 1996; Nordström, Kullgren, & Dahlgren, 2006; Pearson & Tsang, 2004). Zo komen familieleden in contact met justitiële diensten en krijgen ze te maken met een interneringsmaatregel die geen einddatum kent, wat kan leiden tot gevoelens van frustratie, machteloosheid, verdriet, angst en woede (Tsang, Pearson, & Yuen, 2002). In een derde deel van de inleiding wordt de sterktegerichte benadering waarvan het proefschrift uitgaat, verdiept. Onderzoek heeft immers aangetoond dat familieleden ondersteund kunnen worden door 'protectieve' factoren (bijvoorbeeld positief denken, religie, steun en psychoeducatieve programma's) die hen helpen om reacties op negatieve situaties te verminderen, waardoor hun veerkracht versterkt wordt (Zauszniewski, Bekhet, & Suresky, 2015). Daarnaast is het ervaren van sociale steun erg belangrijk omdat het bepaalde 'burdens' ('lasten') (emotioneel, sociaal, psychisch) kan verminderen en hierdoor ook de draagkracht van familieleden kan verhogen. Omdat crisissituaties waarin een naaste zich kan bevinden een impact kan hebben op alle familieleden, is het opbouwen van familiale veerkracht essentieel. Hoe meer familieleden zich kunnen 'wapenen' tegen stressvolle gebeurtenissen, hoe beter ze zijn toegerust om met crisissen om te gaan (Bishop & Greeff, 2015). Tot op heden heeft onderzoek over familieleden van personen die geïnterneerd zijn zich slechts in beperkte mate gefocust op krachten van familieleden, waarbij vooral hoop wordt aangehaald als een belangrijke krachtbron (Nordström et al., 2006; Walsh, 2012).

Daarnaast is er ook aangetoond dat familie-interventies tegemoet kunnen komen aan de stress en lasten waar familieleden mee geconfronteerd worden. Dergelijke interventies binnen een forensische sector zijn echter beperkt beschikbaar (Absalom-Hornby, Hare, Gooding, & Tarrier, 2012; Geelan & Nickford, 1999). Hierbij worden verschillende barrières aangehaald, zoals de vaak lange afstanden die familieleden moeten afleggen om hun naaste te bezoeken, het feit dat familieleden en patiënt enkel op bepaalde (vastgelegde) momenten bij elkaar kunnen zijn en het tekort aan goed opgeleide therapeuten om deze interventies te kunnen begeleiden (Absalom, McGovern, Gooding, & Tarrier, 2010; Geelan & Nickford, 1999; Davies, Mallows, Easton, Morrey, & Wood, 2014). Gebaseerd op deze onderzoeksbevindingen, is er voor gekozen om in dit doctoraatsonderzoek aandacht te besteden aan Multi-Family Groups en Family Support Groups voor familieleden van personen met psychische problemen. Bij deze interventies wordt er in groepen aandacht besteed aan copingstrategieën, solidariteit, lotgenotencontact en emotioneel welzijn (Asen, Dawson, & McHugh, 2001; Asen, & Schuff, 2006; Chien & Norman, 2009; Chou, Liu, & Chu, 2002; Jewell, Downing, & McFarlane, 2009; McFarlane, 2002).

Samengevat is dit doctoraatsonderzoek erop gericht om meer kennis te verwerven betreffende bovengenoemde tekorten in internationaal onderzoek. Daarom focussen de verschillende deelstudies op de ervaringen van familieleden die geconfronteerd worden met een naaste die geïnterneerd is (geweest) en op hoe deze familieleden ondersteund kunnen worden door het organiseren van Familieondersteunende Groepen (FOG). Hiervoor zijn volgende onderzoeksvragen opgesteld:

1. Hoe worden de ervaringen, noden en draaglasten van familieleden van geïnterneerde personen beschreven in wetenschappelijke literatuur? (*Hoofdstuk 2)*
2. Hoe ervaren familieleden de psychische problematiek, de interneringsmaatregel en de (forensisch) psychiatrische behandeling van hun naaste? *(Hoofdstuk 3)*

3. Hoe kunnen familieleden ondersteund worden in het omgaan met zowel de psychische problematiek als de interneringsmaatregel van een naaste? *(Hoofdstuk 4)*
4. Wat zijn de effecten van een Familieondersteunende Groep op de kwaliteit van leven (Quality of Life, QoL), de ervaren draaglasten, copingstrategieën en veerkracht van familieleden van geïnterneerde personen? *(Hoofdstuk 5)*
5. Welke therapeutische factoren liggen aan de basis van een Familieondersteunende Groep? *(Hoofdstuk 6)*
6. Wat zijn de verwachtingen en ervaringen van familieleden voor en na deelname aan een Familieondersteunende Groep? *(Hoofdstuk 7)*

Om een antwoord te formuleren op deze onderzoeksvragen is er gebruik gemaakt van verschillende onderzoeksmethoden, waaronder een literatuurstudie, semigestructureerde interviews en *'mixed methods'* onderzoek (Johnson & Onwuegbuzie, 2004). Bij dit laatste zijn zowel kwalitatieve (semigestructureerde interviews en therapie) als kwantitatieve onderzoeksmethoden (premeting, postmeting en procesevaluatie op basis van gestandaardiseerde vragenlijsten) gebruikt om de laatste 4 onderzoeksvragen te kunnen bestuderen.

2. Onderzoeksbevindingen per hoofdstuk

De doctoraatsstudie werd opgedeeld in 3 werkpakketten

2.1. Werkpakket 1: systematische literatuurstudie

Een eerste werkpakket omvat een systematische literatuurstudie, waarbij in verschillende databanken, volgens de PRISMA-richtlijnen, is gezocht naar internationale literatuur over perspectieven van familieleden van personen die geïnterneerd zijn (Hoofdstuk 2). Dit heeft geresulteerd in 8 studies die voornamelijk de rol beschrijven die familieleden opnemen in de rehabilitatie van de patiënt en de noden en lasten waarmee men geconfronteerd wordt (gewelddadig gedrag, dubbel stigma, verminderde sociale contacten, beperkte communicatie met professionelen en gevoelens waarmee men te maken krijgt). In deze studies gaat slechts beperkte aandacht naar de krachten of mogelijkheden van familieleden om met de situatie om te gaan.

2.2. Werkpakket 2: semigestructureerde interviews

Het tweede werkpakket bevat een empirische studie, waar de ervaringen van familieleden (n = 24 families die zijn bevraagd) betreffende de psychiatrische problematiek en de interneringsmaatregel van hun naaste en de (forensisch) psychiatrische behandeling via interviews is nagegaan (Hoofdstuk 3). De resultaten zijn geclusterd in zes thema's, waarbij familieleden het delict en de interneringsmaatregel ervaren als een bijkomend stigma (thema 1), ze ambivalente gevoelens benadrukken die ze hebben ten opzichte van het justitiële systeem en haar procedures (thema 2) en voornamelijk de gevangenis omschrijven als een ongeschikte omgeving voor hun naaste (thema 3). Daarnaast zijn de familieleden in de interviews ingegaan op de ervaren tekortkomingen in de hulpverlening of op de positieve wendingen die men er heeft gekend (thema 4). Men heeft vooral het 'eindeloze gevecht' en de ermee gepaard gaande 'rollercoaster van emoties' omschreven (thema 5). Tot slot is ook aangegeven dat ze hoop ervaren wanneer het opnieuw beter gaat met hun naaste (thema 6).

2.3. Werkpakket 3: mixed methods onderzoek

In een laatste en derde werkpakket is onderzoek verricht naar de ontwikkeling van een interventie voor familieleden van personen die geïnterneerd zijn (zie Figuur 1).

2.3.1. Therapeutisch protocol (zie Figuur 1: Familieondersteunende Groep)

In de eerste studie van dit werkpakket is het protocol van deze interventie (Familieondersteunende Groep) uitgeschreven (Hoofdstuk 4). De therapeutische concepten (systemische en narratieve benadering, Multi-Family Groups en de aanpassing aan de forensische context) waarop de interventie is gebaseerd zijn besproken. Er is dieper ingegaan op de organisatie van twee verschillende FOG's en het verloop van het therapeutisch proces. Beide interventies bestaan uit 4 sessies, waarbij drie sessies om de twee weken plaatsvinden en waarbij de laatste sessie een maand na de derde wordt georganiseerd. In de eerste sessie is er vooral gefocust op het ventileren van emoties door familieleden en op de impact van de psychiatrische problematiek en de interneringsmaatregel op hun leven. De tweede sessie gaat in op het evenwicht dat familieleden moeten proberen te vinden tussen het zorgen voor hun naaste en het zorgen voor zichzelf. Een derde sessie focust op de krachten en de mogelijkheden van de familieleden in het omgaan met de situatie. In de laatste sessie reflecteren de deelnemers over de voorbije thema's en over de toekomst. Na sessie één, twee en drie bij groep 1 en na de vierde sessie bij groep 2, zijn er huiswerkopdrachten meegegeven[1]. In het algemeen hebben de huiswerkopdrachten tot doel de deelnemers thuis verder te laten nadenken over zelfzorg, over zorgen voor hun naaste in de toekomst en over hoe ze hun sterktes kunnen benutten in het omgaan met de situatie. Deze groepen onderscheiden zich van andere (Multi-)familiegroepen, gezien ze vooral focussen op familieleden en de patiënt zelf er niet bij betrokken wordt.

2.3.2. Pilootstudie met pre- en postmetingen (zie Figuur 1: Vragenlijsten)

Een pilootstudie over het effect van de interventie op QoL (Hoofdstuk 5) bracht de ervaren lasten, de copingstrategieën en de veerkracht van de participanten (n = 20) in kaart. Hiervoor zijn een week voor de eerste sessie en een week na afloop van de vierde sessie verschillende vragenlijsten afgenomen. Kwaliteit van leven is gemeten met behulp van de WHOQOL-bref, de ervaren draaglast aan de hand van het Zarit Burden Interview (ZBI-22), de copingstrategieën met behulp van de Cognitive Emotion Regulation Questionnaire (CERQ) en veerkracht door middel van de Resilience Scale (RS-nl). De resultaten hebben aangetoond dat familieleden significant minder zelfschuld ervaren na afloop en dat hun emotioneel welzijn verbetert alsook dat men minder het gevoel heeft de controle over het eigen leven te verliezen.

2.3.3. Therapeutische factoren (zie figuur 1: GTF-CQ-28 en post-evaluatie)

De derde studie van dit werkpakket (Hoofdstuk 6) focust op de onderliggende therapeutische factoren van de FOG. Na iedere sessie is gebruik gemaakt van de 'Group Therapeutic Factors − Client Questionnaire' (GTF-CQ-28) om ondersteunende therapeutische factoren in kaart te brengen. Verder zijn de correlaties tussen de resultaten van de pilootstudie (Hoofdstuk 5) en helpende therapeutische factoren onderzocht. Tot slot is met behulp van de Post-evaluation Family Support Group Questionnaire (Post-evaluation FSGQ) gepeild naar de mate van

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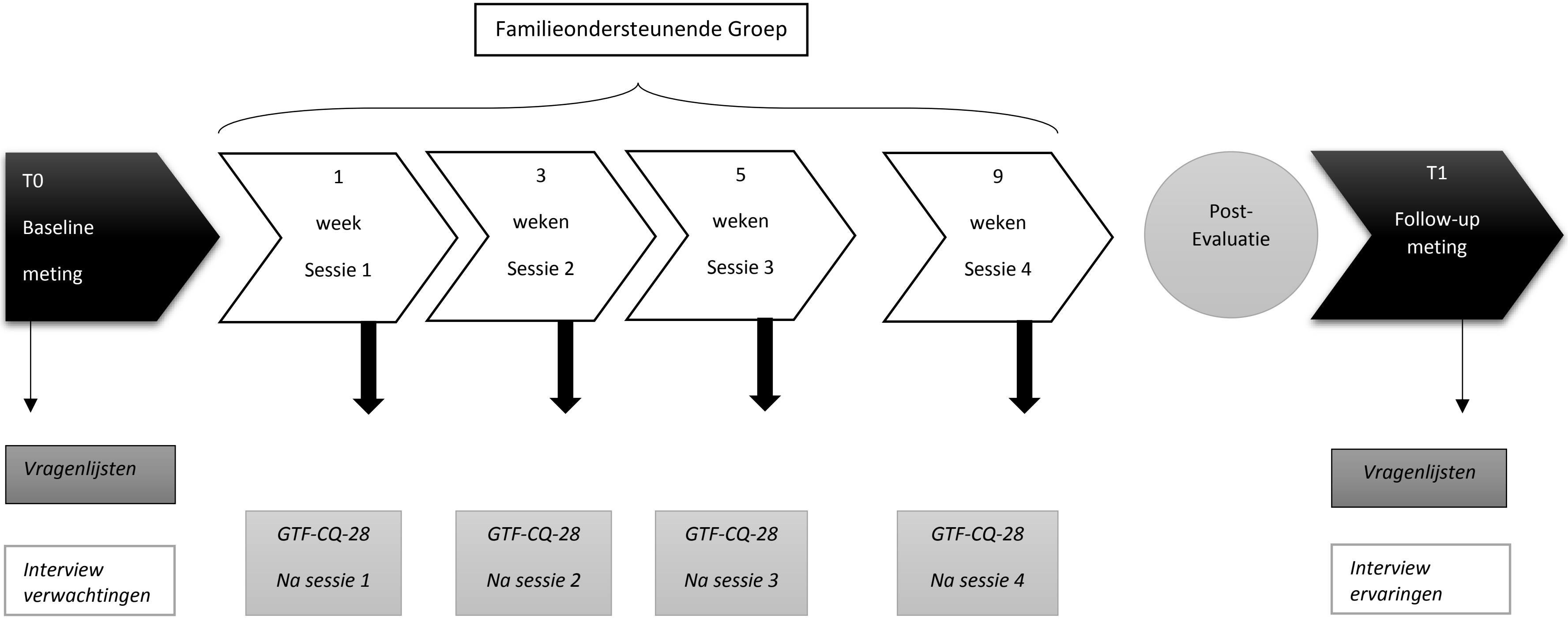
[1] De huiswerkopdrachten verschillen in aantal, gezien er aan de familieleden van de tweede groep is gevraagd om elkaar een kerstkaart te schrijven met een sterktegerichte boodschap. Deze kaarten zijn verzameld door de onderzoeker en nadien opgestuurd naar de betrokken personen.

tevredenheid van de deelnemers betreffende de familiegroep. De resultaten tonen aan dat verschillende factoren zoals groepscohesie, solidariteit en universaliteit van de problemen, reeds hoog scoren bij aanvang van de eerste sessie. Andere factoren (bijvoorbeeld uiten van negatieve gevoelens naar anderen toe) scoren eerder laag en veranderden niet doorheen de sessies. Er is een significante verbetering merkbaar van sessie 1 tot 4 op de dimensie relationeel klimaat en op de factoren interactionele bevestiging, uitdrukken en ervaren van positieve gevoelens, eigen problemen vergeten door anderen te helpen, ervaren van hoop door vooruitgang te zien bij anderen, begeleiding van de therapeuten en krijgen van feedback. Het observeren van andere groepsleden en het krijgen van inzicht in de problemen van hun naaste, zorgt ervoor dat familieleden minder zelfschuld ervaren. Daarnaast is er door het ervaren van steun in de groep een verbetering merkbaar in het emotioneel welzijn van de deelnemers. Familieleden herkennen zich ook in anderen en er is aandacht voor de universaliteit van de problemen. Hierdoor hebben de aanwezige familieleden het gevoel minder de controle te verliezen over hun eigen leven. Tot slot kan er worden vastgesteld dat familieleden tevreden zijn met wat de groep heeft betekend voor hen persoonlijk en voor de relatie met hun naaste.

2.3.4. Empirische studie (zie Figuur 1: interview verwachtingen en interview ervaringen)

In een vierde empirische studie (Hoofdstuk 7) zijn familieleden bevraagd over hun verwachtingen vooraf (n = 20) en hun ervaringen nadien (n = 17) met betrekking tot hun deelname aan de FOG. Aandacht voor het ‘stem geven’ aan familieleden staat hierbij voorop, gezien de vorige studies (Hoofdstuk 5 en 6) vooral via kwantitatieve methodes een aantal therapeutische factoren in kaart hebben gebracht. Op basis van de resultaten blijkt dat familieleden vooraf nieuwsgierig zijn en dat slechts enkelen hebben getwijfeld om deel te nemen.

Verder bestaan hun verwachtingen vooral uit het ontmoeten van lotgenoten en inzicht krijgen in de universaliteit van de problemen, uit het krijgen en geven van informatie en advies en uit het gevoel deel te kunnen nemen in een veilige en respectvolle omgeving. De concrete ervaringen hebben verder te maken met het feit dat ze in contact kwamen met lotgenoten en hierbij een gevoel van solidariteit ervaren, dat ze door de verhalen van anderen nieuwe inzichten verwerven in hun eigen situatie en dat ze zich opgelucht en tevreden voelen na afloop van de sessies. Verder halen ze ook nog een aantal punten aan die voor hen belangrijk zijn en vooral te maken hebben met de groep, waarbij de begeleiding van de therapeuten, de grootte en heterogeniteit van de groep en de huiswerkopdrachten besproken worden. Achteraf blijkt dat de interventie aan de verwachtingen tegemoet komt en dat vele participanten de groep als heel diepgaand ervaren.



Figuur 1 *Schematische voorstelling werkpakket 3: Familieondersteunende Groep.*

GTF-CQ-28 = Group Therapeutic Factors-Client Questionnaire. Vragenlijsten = WHOQOL-bref, ZBI-22, CERQ, RS-nl.

3. Discussie

Het proefschrift wordt afgesloten met een algemene discussie (Hoofdstuk 8), waar wordt ingegaan op de algemene onderzoeksbevindingen, de sterktes, beperkingen en aanbevelingen voor verder onderzoek en de implicaties voor praktijk en beleid.

3.1. Sterktes, beperkingen en aanbevelingen voor toekomstig onderzoek

Ten eerste staan de ervaringen van familieleden van personen die geïnterneerd zijn centraal in het doctoraat, omdat onderzoek over de noden en draaglasten van deze doelgroep beperkt is. Hierdoor wordt er minder aandacht besteed aan de invloed van het onderzoek op de relatie met het geïnterneerd familielid. Verder wordt er aangegeven dat er geen onderzoek verricht werd naar de ervaringen van familieleden van veroordeelden (die ook psychiatrische problemen kunnen hebben) of naar andere 'stakeholders' zoals hulpverleners. De perspectieven van deze laatste personen zijn belangrijk om in de toekomst verder te onderzoeken om de complexiteit van familiale relaties in kaart te brengen. Ten tweede wordt ook de kleine steekproef vermeld, zoals ook in andere studies vaak het geval is (Absalom-Hornby et al., 2011; Ferriter & Huband, 2003; Nordström et al., 2006). Door de rekruteringsmethodiek (zelfselectie), selectiecriteria en rekening houdend met de situatie en de verschillen in levensgeschiedenis van familieleden, is de steekproef mogelijks '*gebiased'*, waarbij een homogene groep participanten werd bereikt. Tot slot, hoewel de studie heeft aangetoond dat de FOG (emotioneel) ondersteunend werkt en zelfstigma vermindert van familieleden, blijven er toch nog enkele vragen bestaan in relatie tot praktische aspecten (bvb. een belangrijke vraag is of en hoe deze ondersteuning ook onder een andere vorm verleend kan worden dan deze die in dit proefschrift werd ontwikkeld). Outreach initiatieven of laagdrempelige diensten zouden hierbij mogelijks kunnen worden ingezet om andere 'doelgroepen' van familieleden te bereiken. Daarnaast werden er ook inclusiecriteria toegepast op de organisatie van de groep, waardoor familieleden van personen met andere psychiatrische problemen dan psychosen, ondervertegenwoordigd zijn.

3.2. Implicaties voor praktijk en beleid

De implicaties worden weergegeven door te focussen op vijf overkoepelende resultaten en reflecties van het doctoraat. In eerste instantie wordt er aangehaald dat familieleden een nood uitten voor veranderingen in de behandeling van hun naaste. Familieleden halen vooral aan dat ze het gevoel hebben dat de geestelijke gezondheidszorg gefaald heeft in het voorkomen van het delict. Ze wijzen erop dat er eerst een crimineel feit moet plaatsvinden alvorens gepaste behandeling wordt geboden. Deze resultaten zijn in het licht van het *"premie voor delict"*-mechanisme (Verhellen, 1998) en delictpreventie bekeken, waarbij er aandacht is besteed aan vormen van 'preventieve gedwongen behandeling'. Echter kan deze laatste een mogelijk gevaar inhouden voor de autonomie van zowel de geïnterneerde persoon als zijn familie, wat verder onderzoek noodzakelijk maakt. Ten tweede wordt de beperkte betrokkenheid van familieleden in de zorg van de naaste als een belangrijk reflectiepunt gezien. Hierbij wordt vooral de nadruk gelegd op een gedeeld partnerschap tussen familieleden en de hulpverleners. Ten derde hebben de resultaten van dit doctoraatsonderzoek aangetoond dat familieleden vechten voor persoonlijke herkenning en ondersteuning, waarbij vooral de ondersteunende functie van de FOG belangrijk is. Desalniettemin wordt ook aangetoond dat er naast therapeutische interventies andere interventies zijn, die familieleden kunnen informeren en ondersteunen in het leren omgaan met de situatie. Ten vierde wordt het belang van het relationeel klimaat binnen de FOG aangehaald, wat aantoont dat familieleden van personen die geïnterneerd zijn, in eerste instantie meer behoefte lijken te hebben aan goepsondersteuning, aanvaarding en vertrouwen in therapeuten. Hierdoor komen aspecten van psychologisch werk later op gang in een FOG. Tot slot worden er ook enkele reflecties gemaakt betreffende het macro-perspectief. Hierbij wordt aangehaald dat het van belang is om de publieke opinie en het maatschappijbeeld positief te beïnvloeden in het kader van het verminderen van stigma in de samenleving. Verder worden ook ‘Trialogue’ en ‘relational recovery’ vermeld als belangrijke concepten, waarbij de nood aan een structureel vangnet in de maatschappij voor familieleden wordt aangehaald.

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Appendix 2

English summary

1. Context, problem definition and methodology

The dissertation is part of a more comprehensive project (concerted research action - ‘GOA’-project) of Ghent University, entitled: ‘Developing multidisciplinary strengths-based strategies for mentally ill offenders.’ The project is carried out by the Faculty of Law (main supervisor: prof. dr. Tom Vander Beken), Faculty of Psychology and Educational Sciences (supervisor: the late prof. dr. Eric Broekaert) and the Faculty of Medicine and Health Sciences (supervisor: prof. dr. Kurt Audenaert). It aims at developing multidisciplinary (legal, criminological, psycho-social and medical-psychiatric) strengths-based strategies to overcome the predominance of a risk-oriented approach towards mentally ill offenders. The project consists of 5 different research tracks (each leading to a doctoral dissertation) about (1) legal capacitation, (2) procedural justice, (3) desistance, (4) recovery and (5) family members of mentally ill offenders.

The present dissertation focuses on the fifth theme and aims to gain insight in the experiences and perspectives of family members and how they can be supported in coping with both the mental illness and the criminal offence of a relative.

Within international studies, less attention has been paid to supporting family members of mentally ill offenders, for which these family members’ perspective has not yet been thoroughly investigated. Therefore the introduction of this dissertation (Chapter 1) starts by describing the context of dealing with mentally ill offenders in Belgium. In the second section, the particular situation of family members confronted with a mentally ill offender, focusing on their lived experiences, is described. The third section reviews the current approaches to supporting family members of mentally ill offenders, with particular attention to strengths-based interventions.

In the first part of the introduction, the situation of mentally ill offenders in Belgium and the new Law are presented. Many mentally ill offenders (although the figures are decreasing) are still locked up in prison, often without appropriate treatment and care (The Sentencing Project, 2002; Lamb, Weinberger, & Gross, 2004). Recently, strengths-based approaches have gained importance and represent a shift from a risk-management approach to a more holistic view of the person, including his/her strengths, capacities, possibilities and hopes (Barnao & Ward, 2015). In a second part of the introduction, attention is focused on family members of mentally ill offenders. They are confronted with police and judicial procedures and with mental health services, which often do not provide help or information to family members (Ferriter & Huband, 2003; McCann et al., 1996; MacInnes & Watson, 2002; Pearson & Tsang, 2004; Absalom-Hornby et al., 2011). A third part focuses on the strengths-based approach of this dissertation. Strengths and resilience are discussed and attention is given to family interventions, because various guidelines (e.g., National Institute for Clinical Excellence [NICE] or National Institute for Health and Care Excellence) indicate that family interventions are essential in providing mental health care. However, within forensic psychiatric settings there is a dearth of family interventions (Absalom-Hornby, Hare, Gooding, & Tarrier, 2012). Therefore this dissertation specifically focusses on a therapeutic family intervention based on Multi-Family Groups and Family Support Groups.

In summary, this dissertation aims to enhance scientific knowledge on the influence of the internment measure in relation to the experiences and perceptions of family members of mentally ill offenders and how they can be supported. The aims of the present study were twofold:

- First, we investigated the lived experiences of family members considering the internment measure, (forensic) psychiatric treatment, and the mental illness of their relative;
- Second, we examined if and to what degree an intervention based on Multi-Family Groups could support and empower family members of mentally ill offenders.

The following research questions were put forward:

1. How are the experiences, needs and burdens of families of mentally ill offenders described in scientific literature? *(Chapter 2)*
2. How do family members experience the mental illness, the interment measure, and the (forensic) psychiatric treatment of their relative? *(Chapter 3)*
3. How can family members be supported in dealing with both the mental illness and the internment measure of a relative? *(Chapter 4)*
4. What are the effects of a Family Support Group on quality of life, burdens, coping strategies, and resilience of family members of mentally ill offenders? *(Chapter 5)*
5. Which therapeutic factors underpin a Family Support group? *(Chapter 6)*
6. Which are the treatment expectations and experiences of family members before and after attending a Family Support Group? *(Chapter 7)*

Data were collected by making use of three different research methods: (1) a systematic review; (2) semi-structured interviews; and (3) mixed methods research consisting of qualitative (semi-structured interviews) and quantitative (standardized questionnaires) research methods (Denscombe, 2008; Johnson & Onwuegbuzie, 2004).

2. Research results for each chapter

The study was subdivided into three work packages.

2.1. Work package 1: systematic review

A systematic review (Chapter 2) on the perspectives and experiences of family members of mentally ill offenders was carried out, in line with the PRISMA guidelines for systematic reviews (Moher, Liberati, Teztzlaff, & Altman [PRISMA Group], 2010). The ISI Web of Science, PubMed, ProQuest and Elsevier databases were examined in relation to studies about family roles, needs, burdens and the strengths of family members of mentally ill offenders. The results showed that only eight studies about the experiences of family members of mentally ill offenders were available. Most of these studies focus on burdens and needs (e.g., MacInnes & Watson, 2002; Pearson & Tsang, 2004; Tsang et al., 2002), with only one study pointing to the importance of strengths (Nordström et al., 2006).

2.2. Work Package 2: semi-structured interviews

The *second work package* entailed a qualitative study aimed at investigating family members' experiences with the mental illness, the internment measure, and the (forensic) psychiatric treatment of their relative. Semi-structured interviews with family members were conducted with 27 different family members of 24 families (Chapter 3). Analysis of the results led to six themes: (1) the criminal offence and the internment measure as an additional stigma, (2) ambivalent feelings towards the judicial system, (3) prison is not the right place to be, (4) mental health support as an answer to problems, (5) fight a losing battle, and (6) while there is life there is hope. The results indicated that family members wished for compulsory interventions earlier in the life course of their mentally ill relative, in order to prevent criminal involvement, to facilitate admission in (forensic) psychiatric hospitals rather than in prison, and to promote mutual collaboration of family members and professional and peer support.

2.3. Work package 3: mixed methods research

The third work package consisted of 4 studies of Family Support Groups (FSGs) that were organized for family members of mentally ill offenders (cf. Figure 1). Chapters 4 to 7 discuss the development of the protocol (Figure 1: white with black; Chapter 4), the outcomes (Figure 1: dark grey; Chapter 5), the therapeutic processes (Figure 1: light grey; Chapter 6), and the expectations and experiences (Figure 1: white with grey; Chapter 7) of family members who participated in different Family Support Groups (FSGs). In total, two FSG cycles were organized: from February 2016 until May 2016, and from October 2016 until December 2016, respectively. Twenty family members agreed to participate in the FSG and were interviewed one week before the start (T0). However, before the start of the first session, one father dropped out and, during treatment, another two mothers dropped out after the first or second session. Therefore, 17 persons were interviewed one week after the last session (T1).
Chapter 4 specified the intervention protocol. An FSG was developed, based on a Multi-Family Group format that integrates systemic and narrative approaches and is adapted to the forensic context. The FSG consisted of four sessions, with session one looking at the impact of mental illness and the judicial order on the lives of family members. Session two focused on the balance between caregiving and self-care. The third session looked at the strengths and capabilities of family members. During the fourth session, reflections on the previous sessions and the future were made.

A pilot study investigated the effects of an FSG on the quality of life, burdens, coping strategies, and resilience of family members of mentally ill offenders (Chapter 5). Family members completed several questionnaires (i.e., WHOQOL-BREF, Zarit Burden Interview [ZBI], Cognitive Emotion Regulation Questionnaire [CERQ] and Resilience Scale [RS-nl]) both before ($n = 20$) and after ($n = 17$) the group intervention. Results indicated that family members experienced less self-blame and less loss of control over their lives one week after the intervention. Furthermore, their emotional well-being improved over time, showing that an FSG can be supportive and empowering for family members afterwards.

In order to investigate the therapeutic factors that underpin an FSG*,* the Group Therapeutic Factors-Client Questionnaire (GTF-CQ-278) was completed by 17 family members after each session. The results indicated that family members valued the following therapeutic factors: relational climate, interactional confirmation, expressing and experiencing mutual positive feelings, such as hope by seeing progress in other participants, forgetting own problems, guidance from therapists, and getting interpersonal feedback. Moreover, the therapeutic factors learning by observation, group support, and universality of problems correlated with a decrease in self-blame, improved emotional well-being and a decrease in loss of control over one’s life, respectively (Chapter 6).

Finally, Chapter 7 addresses the treatment expectations and experiences of family members before and after attending a Family Support Group. Family members’ treatment expectations involved (1) curiosity or hesitation about taking part in the FSG, (2) peer support and experiencing universality of problems, (3) receiving and giving advice and information, and (4) safety and respect. When family members were asked about their treatment experiences, most of their expectations, such as peer support and experiencing universality of problems, receiving and giving advice and information and safety and respect, were fulfilled. They also mentioned helpful experiences as (1) communality and support, (2) gaining new insights, (3) feelings of satisfaction and relief, and (4) group-specific characteristics.

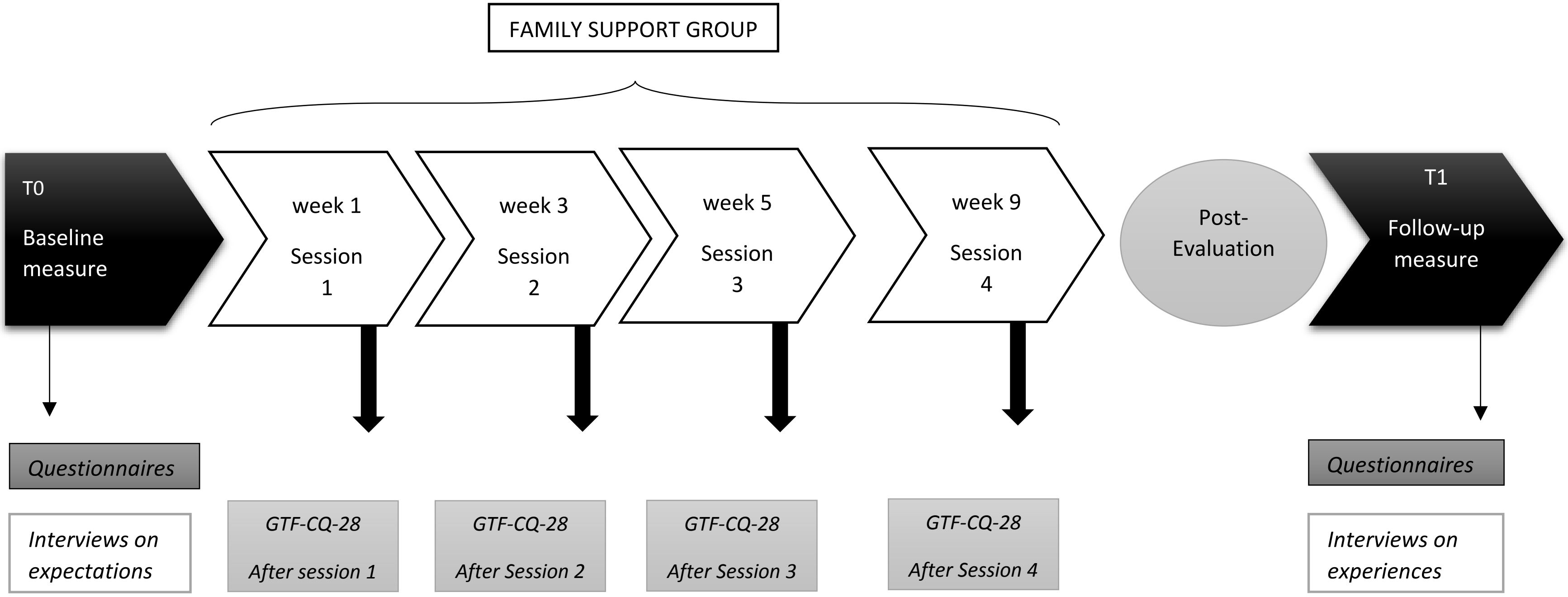

Figure 1 *Study flow chart of the Family Support Group.*

GTF-CQ-28 = Group Therapeutic Factors-Client Questionnaire. Questionnaires = WHOQOL-bref, ZBI-22, CERQ and RS-nl.

3. Discussion

The dissertation concludes with a general discussion (Chapter 8). It starts with a summary of the main findings in relation to the research questions. Second, the strengths, limitations and future research recommendations are discussed. Third, implications for practice and policy are presented.

3.1. Strengths, limitations and recommendations for future research

First, the dissertation focused exclusively on the experiences of family members of mentally ill offenders, as research about the needs, burdens and experiences of this target group is very limited. Furthermore, the dissertation did not explicitly focus on the role of family members in the rehabilitation of the mentally ill offender. It would also be interesting to expand our study to other 'target groups', such as family members of parolees and convicted offenders with mental health problems. Besides, perspectives of other stakeholders such as mental health professionals are not investigated. However, these perspectives can be interesting to investigate in order to fully grasp the complexity of family relations. Second, in line with other studies about family members of mentally ill offenders (Absalom-Hornby, Gooding, & Tarrier, 2011; Ferriter & Huband, 2003; McCann, McKeown, & Porter, 1996; Nordström et al., 2006; Pearson & Tsang, 2004), the study sample is small. Furthermore, the sample consisted for the greater part out of parents, of whom many were mothers. Therefore other family roles are underrepresented in the dissertation, which compromises the generalizability of the results. Finally, although the study showed that an FSG may be empowering and destigmatizing, several questions remain in relation to some practical aspects. Inclusion criteria were applied to the FSG, which could have led to a bias in our study as only family members of mentally ill offenders suffering from psychosis, schizophrenia or bipolar disorder could participate. Therefore it is important to reflect on organizing FSGs with family members of persons suffering from other mental illnesses in the future. It is also important to further investigate if and how an FSG can be integrated in regular or forensic community treatment services or penitentiary facilities, taking into account some of the difficulties mentioned above.

3.2. Implications for practice and policy

First, the need for changes in the treatment for the mentally ill offender is mentioned. Family members regret that a criminal act had to happen before their relative was supported. this relates to ideas on crime prevention by means of mandatory treatment and the "*bonus for delict*"-mechanism (as cited in Verhellen, 1998). Second, the limited involvement of family members in the mental health treatment of their relative is described. A shared partnership between family members and mental health services is discussed, which challenges different aspects (e.g., confidentiality of care). Third, family member indicated to 'fight' for personal recognition and support. The Family Support Group may add to this as it could support family members to experiencing less self-stigma, less loss of control over their lives and better emotional well-being. Besides, other interventions (therapeutic or non-therapeutic) are discussed. Fourth, the importance of the relational climate (RC) in the FSG is mentioned, because group cohesion, peer support, acceptance and confidence in therapists seem to be important for family members of mentally ill offenders. This differs from other studies, where psychological work (PW) is more valued from the beginning of the intervention. Within an FSG, the therapeutic factors of PW need to develop more through the session. Finally, some reflections on the dissertation are made considering a macro-perspective. It is mentioned that positively influencing the conceptualisation of mental illness in society is important (e.g., campaigns like

‘Rode neuzendag’ or ‘Te Gek?!’) (Liégois & Van Audenhove, 2001). Furthermore, regarding the shift towards a culture of partnership and empowerment, Trialogue, relational recovery and a structural safety net are concepts that need further consideration by mental health professional and policy makers.

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Appendix 3

Data Storage Fact Sheets

Data Storage Fact Sheet 1

Systematic review (Chapter 2)

Author: Sara Rowaert

Date: 06/09/2017

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1. Contact details

1a. Main researcher
- Name: Sara Rowaert
- Address: Ghent University, Department of Special Needs Education, H. Dunantlaan 2, 9000 Ghent
- E-mail: Sara.Rowaert@UGent.be

1b. Responsible Staff Member (ZAP)
- Name: Stijn Vandevelde
- Address: Ghent University, Department of Special Needs Education, H. Dunantlaan 2, 9000 Ghent
- E-mail: Stijn.Vandevelde@UGent.be

If a response is not received when using the above contact details, please send an email to data.pp@ugent.be or contact Data Management, Faculty of Psychology and Educational Sciences, Henri Dunantlaan 2, 9000 Ghent, Belgium.

2. Information about the datasets to which this sheet applies

* Reference of the publication in which the datasets are reported:

Rowaert, S., Vandevelde, S., Lemmens, G., Vanderplasschen, W., Vander Beken, T., Vander Laenen, F., & Audenaert, K. (2016). The role and experiences of family members during the rehabilitation of mentally ill offenders. *International Journal of Rehabilitation Research, 39*(1), 11-19. doi: 10.1097/MRR.0000000000000152

* Which datasets in that publication does this sheet apply to?:

All data used in the corresponding article and chapter.

3. Information about the files that have been stored

3a. Raw data

* Have the raw data been stored by the main researcher? ☑ YES / ☐ NO

If NO, please justify:

* On which platform are the raw data stored?
- ☑ researcher PC
- ☐ research group file server
- ☑ other (specify):

This article relates to a systematic review. Sources, papers, books … that have been used are stored, partly on paper and partly in digital format. The digital files are also stored on a UGent share managed by DICT and accessible by the main researcher.

* Who has direct access to the raw data (i.e., without intervention of another person)?
- ☑ main researcher
- ☐ responsible ZAP

- ☐ all members of the research group
- ☐ all members of UGent
- ☐ other (specify): ...

<u>3b. Other files</u>

* Which other files have been stored?

- ☐ file(s) describing the transition from raw data to reported results. Specify:
- ☐ file(s) containing processed data. Specify:
- ☐ file(s) containing analyses. Specify:
- ☐ files(s) containing information about informed consent
- ☐ a file specifying legal and ethical provisions
- ☐ file(s) that describe the content of the stored files and how this content should be interpreted. Specify:
- ☑ other files. Specify:

  Folders containing a self-made reference system for all the references used in this publication, to easily get access to the scientific articles on paper and in a digital format.

* On which platform are these other files stored?

- ☑ individual PC
- ☐ research group file server
- ☑ other: UGent share managed by DICT, accessible by the main researcher.

* Who has direct access to these other files (i.e., without intervention of another person)?

- ☑ main researcher
- ☐ responsible ZAP
- ☐ all members of the research group
- ☐ all members of UGent
- ☐ other (specify): ...

4. Reproduction

* Have the results been reproduced independently?: ☐ YES / ☑ NO

* If yes, by whom (add if multiple):

- name:
- address:
- affiliation:
- e-mail:

Data Storage Fact Sheet 2

Qualitative interviews with family members of mentally ill offenders (Chapter 3)

Author: Sara Rowaert

Date: 06/09/2017

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1. Contact details

1a. Main researcher
- Name: Sara Rowaert
- Address: Ghent University, Department of Special Needs Education, H. Dunantlaan 2, 9000 Ghent
- E-mail: Sara.Rowaert@UGent.be

1b. Responsible Staff Member (ZAP)
- Name: Stijn Vandevelde
- Address: Ghent University, Department of Special Needs Education, H. Dunantlaan 2, 9000 Ghent
- E-mail: Stijn.Vandevelde@UGent.be

If a response is not received when using the above contact details, please send an email to data.pp@ugent.be or contact Data Management, Faculty of Psychology and Educational Sciences, Henri Dunantlaan 2, 9000 Ghent, Belgium.

2. Information about the datasets to which this sheet applies

* Reference of the publication in which the datasets are reported:

> Rowaert, S., Vandevelde, S., Lemmens, G., & Audenaert, K. (2017). How family members of mentally ill offenders experience the internment measure and (forensic) psychiatric treatment in Belgium: A qualitative study. *Journal of Law and Psychiatry, 54*, 76-82. doi: 10.1016/j.ijlp.2017.05.003

* Which datasets in that publication does this sheet apply to?:

> All data used in the corresponding article and chapter.

3. Information about the files that have been stored

3a. Raw data

* Have the raw data been stored by the main researcher? ☑ YES / ☐ NO
If NO, please justify:

* On which platform are the raw data stored?
- ☑ researcher PC
- ☐ research group file server
- ☐ other (specify): ...

* Who has direct access to the raw data (i.e., without intervention of another person)?
- ☑ main researcher
- ☐ responsible ZAP
- ☐ all members of the research group
- ☐ all members of UGent
- ☐ other (specify): ...

3b. Other files

* Which other files have been stored?

- ☑ file(s) describing the transition from raw data to reported results. Specify: Different topic and coding schemes and tree structures of the nodes being produced.
- ☑ file(s) containing processed data. Specify: transcripts from audio files.
- ☑ file(s) containing analyses. Specify: Nvivo files (.nvp files) to analyse the raw data.
- ☑ files(s) containing information about informed consent
- ☑ a file specifying legal and ethical provisions
- ☑ file(s) that describe the content of the stored files and how this content should be interpreted. Specify:
  Paper files containing basic information for each case stored in the office of the researcher at the Department of Special Needs Education (Begijnhoflaan 464, 9000 Ghent).
- ☐ other files. Specify: ...

* On which platform are these other files stored?

- ☑ individual PC
- ☐ research group file server
- ☑ other:
  Informed consents, paper files, paper transcripts of the interviews and the analysis in the office of the researcher at the Department of Special Needs Education (Begijnhoflaan 464, 9000 Ghent). The anonymized transcripts and the Nvivo-files are also stored on a UGent share managed by DICT.

* Who has direct access to these other files (i.e., without intervention of another person)?

- ☑ main researcher
- ☑ responsible ZAP
- ☐ all members of the research group
- ☐ all members of UGent
- ☐ other (specify): ...

4. Reproduction

* Have the results been reproduced independently?: ☐ YES / ☑ NO

* If yes, by whom (add if multiple):

- name:
- address:
- affiliation:
- e-mail:

Data Storage Fact Sheet 3

Family Support Groups (Chapters 4 - 7)

Author: Sara Rowaert

Date: 06/09/2017

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1. Contact details

1a. Main researcher

- Name: Sara Rowaert
- Address: Ghent University, Department of Special Needs Education, H. Dunantlaan 2, 9000 Ghent
- E-mail: Sara.Rowaert@UGent.be

1b. Responsible Staff Member (ZAP)

- Name: Stijn Vandevelde
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- E-mail: Stijn.Vandevelde@UGent.be

If a response is not received when using the above contact details, please send an email to data.pp@ugent.be or contact Data Management, Faculty of Psychology and Educational Sciences, Henri Dunantlaan 2, 9000 Ghent, Belgium.

2. Information about the datasets to which this sheet applies

* Reference of the publication in which the datasets are reported:

- Rowaert, S., Hanssens, F., Audenaert, K., Vandevelde, S. & Lemmens, G. (submitted). A Family Support Group for family members of mentally ill offenders: concepts and therapeutic processes. *(Chapter 4)*
- Rowaert, S., Vandevelde, S., Audenaert, K., & Lemmens, G. (submitted). Family Support Groups for family members of mentally ill offenders: A pilot study. *(Chapter 5)*
- Rowaert, S., Vandevelde, S., Audenaert, K., & Lemmens, G. (submitted). Family Support Groups for family members of mentally ill offenders: Therapeutic factors. *(Chapter 6)*
- Rowaert, S., Audenaert, K., Lemmens, G., & Vandevelde, S. (submitted). Family Support Groups for family members of mentally ill offenders: Family expectations and experiences. *(Chapter 7)*

* Which datasets in that publication does this sheet apply to?:

All data used in the corresponding articles and chapters.

3. Information about the files that have been stored

3a. Raw data

* Have the raw data been stored by the main researcher? ☑ YES / ☐ NO

If NO, please justify:

* On which platform are the raw data stored?

- ☑ researcher PC
- ☐ research group file server
- ☑ other (specify):

Shared file (S:) named: familiegroepen_s_rowaert and paper files and paper and pencil questionnaires are stored in the office of the researcher at the Department of Special Needs Education (Begijnhoflaan 464, 9000 Ghent).

* Who has direct access to the raw data (i.e., without intervention of another person)?
- ☑ main researcher
- ☑ responsible ZAP
- ☐ all members of the research group
- ☐ all members of UGent
- ☐ other (specify): ...

3b. Other files

* Which other files have been stored?
- ☑ file(s) describing the transition from raw data to reported results. Specify:
  Topic and coding schemes of the pre- and post-treatment interviews, coding schemes of the different sessions of the Family Support Group (FSG) and SPSS syntax files (.sps) of the different questionnaires (WHOQOL-bref, ZBI, CERQ, PHQ-9, GAD-7, AUDIT, SCORE-15, RS-nl and GTF-CQ-28)
- ☑ file(s) containing processed data. Specify:
  Transcripts from the interviews pre- and post-treatment, transcripts from audio files for each session of the two FSGs, SPSS dataset (.sav) containing raw and transformed data.
- ☑ file(s) containing analyses. Specify:
  WORD-file containing a table analysing the different group sessions and SPSS output files (.spv).
- ☑ files(s) containing information about informed consent
- ☑ a file specifying legal and ethical provisions
- ☑ file(s) that describe the content of the stored files and how this content should be interpreted. Specify:
  Paper files containing basic information for each case stored in the office of the researcher at the Department of Special Needs Education (Begijnhoflaan 464, 9000 Ghent).
- ☐ other files. Specify: ...

* On which platform are these other files stored?
- ☑ individual PC
- ☐ research group file server
- ☑ other:
  Informed consents, paper files, paper transcripts and coding shemes in the office of the researcher at the Department of Special Needs Education (Begijnhoflaan 464, 9000 Ghent). The anonymized transcripts and the SPSS- and Nvivo-files are also stored on a UGent share managed by DICT.

* Who has direct access to these other files (i.e., without intervention of another person)?
- ☑ main researcher
- ☑ responsible ZAP
- ☐ all members of the research group
- ☐ all members of UGent
- ☐ other (specify): ...

4. Reproduction

* Have the results been reproduced independently?: ☐ YES / ☑ NO

* If yes, by whom (add if multiple):
- name:
- address:
- affiliation:
- e-mail:

Appendix 4

List of publications

Publications in journals

1. Published

Rowaert, S., Vandevelde, S., Lemmens, G., & Audenaert, K. (2017). How family members of mentally ill offenders experience the internment measure and (forensic) psychiatric treatment in Belgium: a qualitative study. *International Journal of Law and Psychiatry*, *54*, 76-82. doi: 10.1016/j.ijlp.2017.05.003

Rowaert, S., Vandevelde, S., Lemmens, G., Vanderplasschen, W., Vander Beken, T., Vander Laenen, F., & Audenaert, K. (2016). The role and experiences of family members during the rehabilition of mentally ill offenders. *International Journal of Rehabilitation Research, 39*(1), 11-19. doi:10.1097/MRR.0000000000000152

2. Submitted

Rowaert, S., Audenaert, K., Lemmens, G., & Vandevelde, S. (submitted). Family Support Groups for family members of mentally ill offenders: Family expectations and experiences.

Rowaert, S., Hanssens, F., Audenaert, K., Vandevelde, S., & Lemmens, G., (submitted). A Family Support Group for family members of mentally ill offenders: concepts and therapeutic processes.

Rowaert, S., Vandevelde, S., Audenaert, K., & Lemmens, G. (submitted). Family Support Groups for family members of mentally ill offenders: A pilot study.

Rowaert, S., Vandevelde, S., Audenaert, K., & Lemmens, G. (submitted). Family Support Groups for family members of mentally ill offenders: Therapeutic factors.

Publications in books

Aga, N., Rowaert, S., Wuyts, Y., & Vanderplasschen, W. (2017). Historiek en organisatie van de Geestelijke Gezondheidszorg in Vlaanderen. In: Vanderplasschen, W., Vandevelde, S., Van Damme, L., Claes, C., & De Pauw, S. (Red.). *Orthopedagogische werkvelden in beweging – Recente evoluties en veranderingen in Vlaanderen* (6de herziene en uitgebreide druk), (pp. 269-330). Antwerpen-Apeldoorn: Garant.

Rowaert, S., & Vandevelde, S. (2016). De ervaringen, noden en behoeften van familieleden tijdens het herstelproces van een delictpleger met een psychiatrische problematiek, met aandacht voor een sterktegericht perspectief. In: Vander Beken, T., Broekaert, E., Audenaert, K., Vander Laenen, F., Vandevelde, S., & Vanderplasschen, W. (red.). *Sterktes van mensen: sterktegerichte strategieën voor het ondersteunen van mensen met een psychiatrische problematiek die strafbare feiten pleegden*, (pp. 169-189). Antwerpen: Maklu.

Rowaert, S., & Vandevelde, S. (2016). Sociale processen: de persoon in zijn omgeving. In: Decoene, S. (red.). *Over stoute dingen doen*, (pp. 83-94). Leuven: Acco.

Rowaert, S., & Vandevelde, S. (2017). De ervaringen van het sociaal netwerk met betrekking tot het herstelproces van een naaste. In: Vanderplasschen, W., & Vander Laenen, F. (red.). *Naar een herstelondersteunende verslavingszorg*, (pp. 189-200). Leuven: Acco