Do we (have to) Care, or just say 'Beware'?

Relational Ethics and Relational Research in Forensic Psychiatry: Two Birds with One Stone?

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"We have the word 'to be'
What I propose is the word 'to interbe'
Because it is not possible to be on your own, by yourself
You need other people in order to be
You need other beings in order to be
(...) so it is impossible to be on yourself, alone
You have to interbe with everything and anyone else"

Thich Nhat Hahn

There is practically no tolerance in society relating to errors made in TBS-treatment. Especially when those errors result in a repeated offence. Therefore, potential risks of a patient must be as well known as possible. The current standard in forensic hospitals is risk assessment based on group data (1). And indeed, group data is very useful. But do we do justice to the person in question? Should we not take a closer look, and consider other persons as individuals, with their own unique story and unique characteristics? And to do so, can we use a different approach?

In this paper, we argue that relational ethics will be helpful in forensic psychiatry.

Relational ethics, also known as ethics of care or care ethics, focuses on values that are important within (care) relationships (2-3). This corresponds with a method used in forensic psychiatry, Forensic Social Network Analysis (FSNA) (4). The idea that relational ethics and FSNA are mutually reinforcing is developed in this essay. Care ethics focuses on quality care for an individual. A person needs others to be as autonomous as possible and to do so, he creates his own network. Those two basic thoughts are what relational ethics and FSNA have in common. Often there is an asymmetric relation between patients, employees of a forensic clinic and the further social network members of a patient. Attention is needed for the social well-being of the patient when one wants to give 'good care'. At the same time, present risk factors of the patient must not be forgotten. The FSNA supports both factors. FSNA is developed in Forensic Psychiatric Centre Dr. S. van Mesdag and originated from collaboration between researchers and social workers. FSNA analyzes a social network with attention to two factors, risk factors and protective factors. After that, one determines which network members can play a more active role in a patient's

life concerning treatment, rehabilitation and beyond. Care ethics seems to seek 'the good' but seems a bit too woolly for forensic psychiatry. What is 'the good' and how can you achieve this? And FSNA is a way to analyze a social network, but by linking it to relational ethics it acquires a vision on care in forensic psychiatry.

This paper has been divided into six parts. The first section introduces a case study. This case study is the leading thread running through this essay. The second section focuses on autonomy in forensic psychiatry. How autonomous is someone with a TBS-status? The classical view on autonomy, that of a rational and reasonable individual who makes sensible choices, does not stand in forensic psychiatry. Therefore, we look for an ethical basis that is applicable in forensic psychiatry. Relational ethics is introduced in the third section. Relational ethics offers a view on autonomy that differs from the classic view on autonomy. It looks at man in dependency relations to others. It focuses on 'care' within these relationships. That sounds good but also woolly. Therefore, the fourth section introduces the FSNA approach. FSNA shakes off the woolliness of relational ethics. In the fifth section, the reinforcing cooperation between relational ethics and the FSNA is explained through an FSNA case study. Finally, the sixth section discusses the conclusions.

1 Introduction to the case study

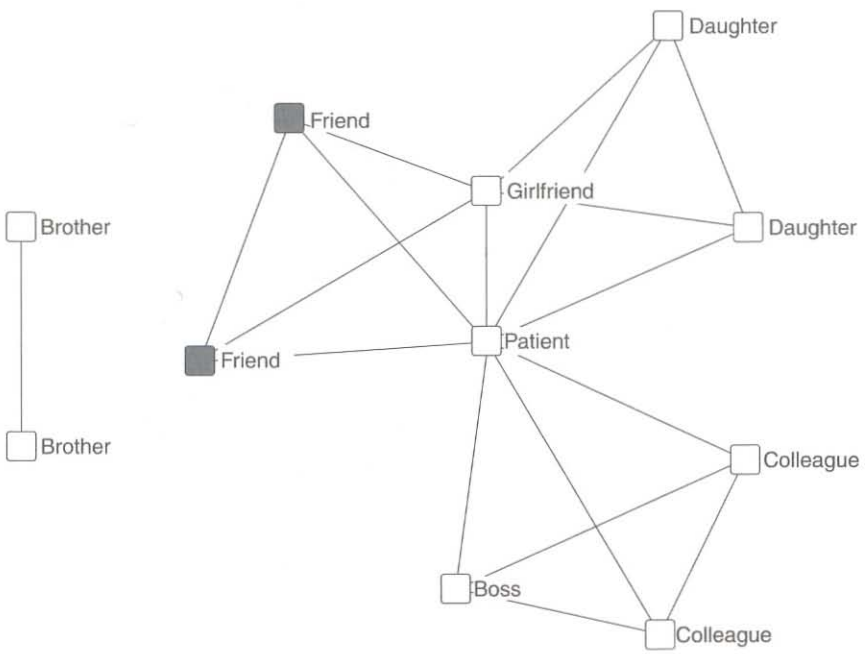
A case study about patient X is used to show the benefits of combining relational ethics with the forensic social network analysis approach. The case study is constructed from different cases, so traceability to persons or situations is not possible.

This first part describes the patient's (social) situation at the moment of crime.

Patient X – at the moment of crime

Patient X was diagnosed with a psychotic disorder (DSM IV Axis-I). Patient X did not use antipsychotic medication, but he used a lot of drugs and alcohol. Patient X has committed two murders. The first murder:*patient X was psychotic and he was convinced that criminals wanted to kill him. He thought that two persons were planning to murder him and he had to act quickly. So he killed the presumed murderer. X had no relationship with the victim; it was an unknown person who played a role in his psychotic perception. Patient X was not caught.* The second murder:*a few years later patient X was incarcerated as a result of committing a burglary together with two friends. Serving a prison sentence he was psychotic and based on hallucinations he thought his eldest daughter was sexually abused. Although his girlfriend did not share the suspicions and his daughter denied abuse, his suspicions grew. After his sentence, he*

*had a job and a colleague told him that another employee was a pedo-sexual. After that X started to see signs, which indicated that he in fact was ordered to kill this man. And so he did. X went home and continued with his usual activities. In the afternoon, he was arrested. At the trial he confessed also the first, never solved murder. At the moment of the crimes, patient X had a small personal social network. He was in an intimate relationship in which tension, partly by the psychosis, was running high. Patient X had two daughters with his girlfriend. Patient had two criminal friends. He was not in contact with his family members (his two brothers; both parents are deceased). Figure 1 shows the patient's social network. Patient was in contact with criminal friends, his girlfriend, his daughters and his boss and colleagues.*Figure 1: social network at the moment of crimes.



This case shows that patient X lost contact with reality at the time of his crimes, and that his social network was not able to serve as a buffer against committing an offense. X was psychotic, there was tension in the relationship with his girlfriend and concerning his eldest daughter there was also stress.

In the next sections, especially section 5, more information about patient X is given to discuss relational ethics and FSNA in relation to each other.

2 Autonomy in forensic psychiatry

It is not possible to reason from 'mainstream ethics' in forensic psychiatry. A care ethics approach of autonomy is appropriate. In this paragraph we first explain what TBS is. Second, we discuss what 'having TBS' implicates for the autonomy concept of an individual in forensic psychiatry.

In the Netherlands, mentally disturbed violent offenders can be sentenced to the so called TBS-order. The TBS-order (art 37 a, b of The Netherlands Criminal Code) is considered for offenders who suffer from a personality disorder and/or a severe mental illness and it is only intended for offenders who have committed an offence with a criminal threat of four years or more (5). The aim of TBS is to protect society and its citizens against mentally disturbed offenders and to provide effective treatments to prevent future recidivism (6). Most offenders go to prison first before they start treatment in forensic psychiatric hospitals (FPC's). As part of this treatment a number of fundamental rights are restricted. The nursing or the 'nursing-care' is forced treatment, and 'therapy' is voluntary. The aim of TBS is a gradual return to society, but only if the nursing care and treatment have decreased the risk of recidivism sufficiently (6).

If patients have been sent to forensic psychiatric centers, many dimensions of their life undergo significant changes that affect their autonomy. In literature, autonomy is understood as self-imposed laws, freedom and the opportunity to choose what to do (7). A distinction should be made between free will and freedom of action. Free will is the ability of rational individuals to control their own decisions and actions. (7) Freedom of action infers nothing about the will. Individuals with a TBS status are ultimately dependent on decisions of others. Not only are they separated from society, the duration of this separation is not certain; every two years, there is a re-evaluation whether or not extension of the measure for the individual patient is necessary. These aspects due to the TBS order have a negative impact on the patient's free will and freedom of action. A TBS-patient may have the will or desire to go for a jog in the park, but it is not possible to realize because he has no freedom of action. An example where both the will and freedom of action is limited is a psychotic TBS-patient who is refusing to take anti-psychotic medication. An autonomous choice must meet certain conditions. There must be an identifiable volition or choice, the person must have sufficient insight into his own situation and the choice made should be voluntary (8). Many patients are unable or do not have the opportunity to make such a choice. For an autonomous choice, one has to be in particular circumstances, but one also has to possess certain (mental and physical) capabilities. For example, the patient's freedom of action can be limited because the hospital decides to force medication. The TBS-patients are in a way dependent on the rules set by the clinic and the law. To guarantee high quality of care, every Dutch forensic psychiatric hospital has to define its own document about the vision on care. For example, the Dutch Forensic Psychiatric Center

(FPC) Dr. S. van Mesdag states that mutual respect is required between staff, between staff and patients and between patients (9). Respect is understood as mutual recognition of the other as an individual with his own responsibilities. There should be an attempt to achieve a meaningful life within the walls of an FPC. This implies that the clinic has to think about meaningfulness and values within 'the walls of a total institution'. It is also needed, based on the vision of care, to take the personality of the patient into account and the vulnerability of his existence. To generate more discussion about ethical dilemmas and to improve the quality of care, employees of the Dr. S van Mesdag have formed a discussion group[1] about ethical dilemmas. Patient and staff are confronted with different dilemmas. For example, employees (need to) consider what it means to give care and to 'have to' receive care. The patient is at the mercy of involuntary professional care. And especially in this ultimately dependent situation it is important that humanity is kept constantly in sight (10).

An important paradox in forensic psychiatry is internal versus external coercion / compulsion (11). Many forms of coercion and compulsion are not aimed at limiting patients' autonomy, but at mobilizing autonomy. In other words, external pressure is used to start the needed treatment. As a result, treatment reduces the internal coercion. It is a quest for a balance between the right to self-determination of the patient and the right to appropriate care. This means that autonomy is a central value, but that the assumption that everyone is or can be autonomous cannot be a central value within forensic psychiatry.

It is probably clear by now, that the classical description of autonomy cannot be applied to patients with a TBS status. Not only can it be questioned whether they had 'free will' at the time of the offence, TBS patients are also restricted in their freedom of action. All forms of ethics based on the classical notion of autonomy are not compatible within forensic psychiatry. The question arises as to whether it is possible to find a better suitable approach. In the next section, we argue that relational ethics will be helpful for a better understanding of the concept of autonomy in the forensic psychiatric context.

3 Relational ethics

Relational ethics, also known as ethics of care, seems to be particularly suitable for forensic psychiatry. It focuses on values that are important within (care) relationships (2-3). Autonomy in relational ethics is something very different from being independent. Autonomy can only be properly designed in relationships with others. This is why care or relational ethicists also speak of relational autonomy. Tronto specifies that within the ethics of care attention is drawn to the view that

1 The leader of this discussion group is Swanny Kremer.

human life only exists in a web of relationships that should constantly be maintained by our care (12).

Ethics of care focuses on *values* that are important within (care) relationships. Like ethics in general, care ethics asks very fundamental questions: 'What ought I to do?' and 'How will I live?' Care ethics has its own perspective. A basic principle is the concern of people for each other. Care ethics presupposes dependence, asymmetry within (care) relationships. Care is a primary and normative form of interaction between people. Care ethics is best known in health care but it is not (exclusively) designed for the care sector. In every situation within people care for each other, care ethics can be used. This can be also within a company or within a family.

For care ethicists, 'care' is an essential part of being human. The care relationship is always part of a network in which responsibilities play an important role. It covers the responsibilities of all persons engaged in the network of relationships and who are involved in care or a care-relationship. Thus, the 'care recipient', family, social workers and so on.

Held describes five characteristics of 'ethics of care' to define and qualify it as a better alternative to other 'dominant' theoretical approaches (2). The first is the scope of care ethics that is focused on meeting and fulfilling the needs of others for whom we take responsibility; 'Every person needs care for at least his early years' and 'most persons will become ill and dependent for some periods of their later lives(..)' (13). In relation to the case study of patient X one could say he needed care during his psychosis. He needed someone who would give him his medication. But he has not received this care. Second, care ethics tries to understand what the best morally thing to do would be within the actual interpersonal contexts from an epistemological perspective. 'Ethics of care values emotions rather than rejects it (...) moral emotions (...) need to be cultivated, not only to help in the implementation of the dictates of reason but also to better ascertain what morality recommends' (14). Third, ethics of care rejects the dominant conception of moral theories that suggest that the more abstract reasoning about a moral issue is the better it is to prevent prejudice and arbitrariness to achieve greater impartiality. Ethics of care focuses directly on certain others with whom we share real relationships. In the case of patient X for example, it is important to know who are the people in his social network. Then it is important to find out which contacts could be 'caring-relations', and which contacts should make us concerned. Fourth, care ethics is a new conceptualization of the distinction between 'the private' and 'the public' domain, and their respective importance. 'Dominant moral theories have seen 'public' life as relevant to morality, while missing the more significance of the 'private' domains of family and friendship' (15). Patient X was especially concerned about the violation of morality in the private domain. He feared that his daughter was abused. This resulted in the fact he also violated a moral and legal law in the private domain: 'thou shalt not kill'. Finally, care ethics has a relational conception of persons; this is in sharp contrast to liberal individualism. Ethics of care has a

'conception of persons as relational, rather than as the self-sufficient, independent individuals of the dominant moral theories' (16). In other words: 'it often calls on us to take responsibility, while liberal individualist morality focuses on how we should leave each other alone' (17). A relational vision on autonomy fits much better in patients with a TBS status.

A central notion of ethics of care is that it assumes all humans to be vulnerable and relational, as opposed to autonomous independent individuals. Autonomy is shaped in relationships; a person creates his own network. Therefore, autonomy consists of relationship to others; it is bound in relationship to the other. Jean Keller says care ethics takes 'the insight that the moral agent is an 'encumbered self,' who is always embedded in relations with flesh and blood to others and is partly constituted by these relations' (18).

In relational ethics, it is important to understand what the other feels and experiences, by putting yourself in that situation. Every person has his own sets of learnt dispositions, (social) skills and ways of responding to the other. It is important to 'put on the shoes of the other', to draw attention of the other ones *hexis* or *habitus* (19-20). Noddings uses the term 'engrossment', which refers to thinking about someone in order to understand him or her better (21). In other words, it is about 'real attention'. Engrossment is necessary for good care, because someone's personal and physical situation must be understood before proper care can be given. There must be reciprocity in communicating back and forth. Relational ethics is about a caring relationship between the person who gives, 'one-caring', and the one who receives, the one being 'cared for' (21). Reciprocity as a 'demand' in a care relationship does encourage dependence. The 'one-caring', and the 'cared-for' need each other to achieve quality care.

But what is actually good care? What is reciprocity? What is attention? And how can we achieve all this? Relational ethics is somewhat vague on these questions. However, relational ethics is concerned with questions different from those asked in traditional ethical theories. Relational ethics has the name to 'seek for good care', but is also seems a bit fuzzy and unclear. And how fuzzy can we be and do we dare to be when it comes to patients with severe criminal backgrounds and with risk of recidivism? The next section introduces a forensic social network analysis approach. Social network approaches are helpful in defining significant (care) relationships.

4 Forensic Social Network Analysis (FSNA)

The TBS-measure is aiming at rehabilitating the patient in society. Thereby, risks must be minimized. With the current generation of risk assessment instruments (eg HKT-30, HCR-20, SVR-20) it remains difficult to find the insights on group level and translate them to the individual situation of a patient (22). According to

the 'thinkgroup' Riskassessment Forensic Psychiatry (werkgroep Risicotaxatie Forensische Psychiatrie) it is possible that a particular feature does exist in a risk assessment tool, but that this characteristic might weigh relatively heavier than other items, while the instrument gives no opportunity for such differences in weighing in individual casuistic (23). It is also possible that a particular feature is important in a particular case, but that this feature is not included in the instrument (23).

To include characteristics of the individual (social) situation of a patient in risk assessment, the Forensic Social Network Analysis (FSNA) is developed as a tool for forensic social work (4). The FSNA is generally based on Social Network Analyses research (SNA) and has focused on the forensic aspect, the 'F'. FSNA has been developed within the TBS context, but it is also useful for forensic social work outside the TBS sector. The FSNA method is developed based on scientific findings and practical experiences of forensic social work. Researchers and social workers have worked together to ensure that FSNA is a scientifically method that can be used in practice. It is important to pay attention to contextual and environmental factors and underlying mechanisms. This in order to explore possibilities for treatment and for managing the risks specific to the *individual* patient when he might return to society. The FSNA method focuses at the specific social, cultural and relational circumstances of each individual patient at the time of the offence, comparing this with present time and then appoints potential positive as well as negative influences on future behaviour. The comparison of the 'crime network' with the 'return network' is the basis of an FSNA analysis. 'Crime network' means the collection of (meaningful) people (and their relationships) the patient knew at the time of the crime and the social contexts which the patient dealt with at this time. The 'return network' is defined as significant persons (and their relationships) with whom the patient has contact during the treatment phase and with whom he probably will have contact in the future. In addition, the return network consists of various social contexts in which the patient is likely to play a role. For example, a patient may meet some 'old friends' at the birthday party of his brother.

The three fundamental questions of FSNA (based on theories of Bem and Funder) are 1) Which network developments (relational and social dynamics) in combination with the crime context, were specific for the patient?, 2) What are the expected network developments (relational and social dynamics) in the current situation and the near future? and 3)What are the similarities and differences between these networks? (24)

The FSNA uses a structured method (methodologically sound) to collect information about the social network of the individual patient. Data processing is conducted by forensic social work. The FSNA method uses three different sources: file study, patient- and network interview.

File study: Relevant background information is collected, such as about the crime(s), life history, psychiatric diagnosis, social/relational, and offence history.

The file study focuses especially on the crime situation and the potential influence of people in the environment on the patient's criminal behaviour. Attention is also paid to how the patient during treatment behaves himself concerning people in the clinic and concerning his network members. It is investigated whether or not this observed behaviour is offence-related. Finally, reading the file, general information about the characteristics of the network members is collected.

Patient interview: a structured questionnaire is used during a patient interview in order to obtain patient information about the network at the time of the offence, the current network, and the network the patient will return to. For each period a systematically assessment of which people in what contexts maintain contact with the patient is executed. Patients are asked to list a maximum of 40 names of people who they considered as network members in their crime network, current network and return network. The FSNA uses a name generator: network members are identified in different domains. The questions are designed to identify network members with whom the patient is likely to have significant contacts, regardless of the frequency of interaction (25). After the names are inventoried, variables regarding the content of the contacts are gatherered on all indentified network members: personal variables of the network members (occupation, education, marital status, memberships), variables regarding the relationship (the duration, origin, context, frequency, initiatives of contact, etcetera.) and variables that show potential risks (criminal record, psychiatric problems, drug-usage, alcoholism, aggression or problematic way of life). A series of questions is asked about the social support system: the patient is asked to give the names of people from whom he has received social support: companionship support (spending time with), financial support (borrowing money), practical support (domestic help) and emotional support (seeking advice from, talking when troubled). The patient is also requested to nominate the network members with whom he had/have a tense relationship and whom he ask(ed) for help if he could get in trouble. Finally, the patient is requested for information about the relationships between the network members.

The network members interview: Unlike the new generation of dynamic risk management tools such as START or SORM, the FSNA not only weighs the opinion of the experts in the clinic, but also weighs the view of network members on the (risky) behaviour of the patient (26). The patient is asked whether his network members may be approached for a network interview. An important aspect is that the social worker, and not the patient, determines which people are visited. This approach is chosen because the network members of a patient do meet him in social situations and circumstances where the clinic does not. Thereby, one can more sufficiently assess whether the patient is applying learned skills in an uncontrolled environment. Another benefit of approaching patient's network members is that they may specify information given by patient in FSNA

research. Those people, who can supply the most essential information concerning the patient, are selected. Ideally, from every domain a network member is interviewed. For instance, a family member, a friend, a colleague, a neighbor, and so on. The disadvantage of potentially socially desirable answers given by the network members can be solved by approaching persons for an interview who have a close relationship with the patient, as well as network members who have a less close relationship with the client (27).

The FSNA-interview for network members includes a number of structured questions designed to measure clinical and future items of the HKT-30. Recent studies showed that the dynamic indicators of the HKT-30 have a reasonable to good predictive value, in terms of withdrawal of leave (28). Other research suggests that the clinical and future indicators of the HKT-30 predict the risk of recidivism after discharge of TBS reasonably well (29). The FSNA method uses the clinical items of the HKT-30 to assess whether the patient might end up in risky situations soon after discharge. Concerning the clinical item 'attitude towards treatment', for example network members are asked whether the patient spoke mainly positive or negative about his treatment in the last year. A patient can tell his network that he sees no further use of his treatment and can be supported in this by his network, while in the clinic he is known as a motivated patient. In contrast, the future/prospective (T) items of the HKT-30 are used to clarify if the patient will be able to achieve a stable and risk free environment in the future. The influence of the social network on the HKT-30 risk indicators will be described.

In summary, it is important to know who is involved in a patient's social network, and it is also important to know what we can expect from these people. It is important, from the forensic perspective, to discover the (im)possibilities of the social network members to stimulate the patient not to commit (new) crimes and in some cases to stop using alcohol or drugs. For instance, patient X used alcohol and drugs and didn't use any anti-psychotic medication. His girlfriend was not able to let him stay off booze and drugs (she did drink alcohol and used drugs in his presence) and she was also not able to give him his medication. When contact with network members reveals an increase of risk in a patient's behaviour, it is adequately identified by an FSNA and individual risk management may therefore been drawn up. And it is important to know as well whether there are 'protective network members'. Precisely these contacts should be attempted to be activated so that they can support the TBS patient during his treatment and rehabilitation. In other words, we need to know if social network members can be protective or posses potential risk factors. The next section shows that relational ethics and the FSNA have a lot in common. To clarify this, both concepts, relational ethics and relational research (FSNA) will be applied to the case of patient X.

5 Relational ethics and Forensic Social Network Analysis

Relational ethics and the FSNA have a lot in common and they reinforce each other.

Individual focus– Relational ethics and FSNA focus on the individual with his own individual (social) context and his own story as a theme running through his life

The individual context can only be understood by identifying the social context and vice versa - The view that human life only exists in a web of relationships (social context) that constantly should be maintained with 'care' is a vision that FSNA and care ethics share. Both concepts formulate significant questions related to the individual context.

People create their own social network - The thought that people create their own social network is supported by both positions.

The individual can only be understood by 'put on the shoes of that person' - Every person has his own sets of learnt dispositions, (social) skills and ways of responding to the other. It is important to 'put on the shoes of the other' in order to understand him or her better. This is necessary for good care and risk management, because someone's personal and physical situation must be understood before proper care can be given.

Reciprocity is a key element – Both concepts demonstrated that reciprocity is needed for stable long-lasting (care) relationships. To have true contact with each other, reciprocity is necessary. Although, professional contacts are not chosen voluntarily. The 'worker' must remember this is a joint process between care-provider and care-receiver. The care relationship is always part of a network in which responsibilities play an important role.

Relational autonomy - The care ethicists' description of autonomy matches that of FSNA. This concept of autonomy is a relational version, because autonomy can only be properly designed in relationships with others.

To show the common nature between relational ethics and FSNA, we discuss the last part of the case study.

Back to patient X...***Patient X- current treatment situation***

Patient X was imposed to the TBS order. He was not entirely 'responsible' for his acts, because he was psychotic during his committed crimes. The last years, patient X is stable and he seems to have made progress in his treatment. According to the TBS treatment, returning an offender to society can be achieved only by gradually granting the patient more liberties. Steps to more liberties are first supervised leave, then unsupervised leaves; after these steps, "transmural" leave may be granted (this involves the person's staying outside the clinic under the supervision and responsibility of the clinic). Finally, a probationary leave may

be granted. In the case of probationary leave, patients can return to society under certain conditions (6).

In the current situation, patient X has received treatment for five years and his status is "transmural". There is a lot of contact between X and TBS -practitioners. He is friendly and seems to be open and honest. But there is need for external control, structure and guidance. Concerning his psychotic vulnerability he is put on anti-psychotic medication. He has his medication in his own possession and takes it according to prescription. This is checked by monthly blood levels. These checks have always been positive. The prognosis is that X will probably need a certain degree of guidance and care for the rest of his life or at least for a very long while. A traject directing 'assisted living' is designed.

Last year, the treatment team, the task of the treatment team was to determine opportunities for risk assessment: How can the necessary care, structure and supervision adequately designed? They noticed that there were some significant issues related to the patient's social network at the time of the offence: patient was in contact with criminal friends, his girlfriend, his daughters and his boss and colleagues. Despite his psychotic symptoms he seemed relatively well to the outside world. For instance, his employer was very pleased with his attitude and commitment. But in a relatively short time, a few days, his psychotic perception grew. His boss never noticed. Also, patient's girlfriend was not aware of his psychotic symptoms. Even the day of the second murder she had seen nothing special, patient responded like he always did. He had no contact with family members at the moment of offences. To be specific, he had no contact with his two brothers. The treatment team recommended focusing on social network interventions motivated by the fact that in the current situation, the patient has no contact with his family.

Patient X- FSNA research

Patient X was invited to an FSNA interview. Patient X was asked to describe his network members of 1) his past network at the moment of the crime, 2) his current network, and 3) his return network. Patient X mentioned he has a small social return network. His social network consists his ex-girlfriend, their two daughters, his boss and one colleague.

About his relationship with his ex-girlfriend he said that they have children together and therefore they will always have a relationship.

Patient X told that his two brothers are very important to him. Patient X is feeling sad, because he has no contact with his brothers for a long time (the last contact was a year before his first committed crime). Patient X has always felt connected with his brothers even when they did not see each other. Figure 2 shows the current social network in patient's perception.

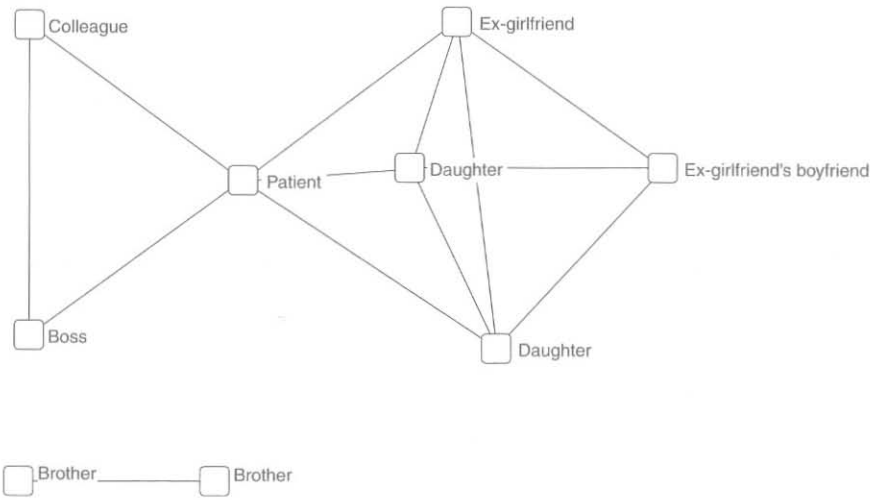


Figure 2

As a part of the FSNA method the ex-girlfriend, the two brothers and patient's boss were visited and interviewed.

The ex-girlfriend stated that when she met patient X she was 16 years old, patient X was 18. She was heavily in love and she was under the impression he loved her deeply. At 17 she was pregnant. At 19 again. She had a relationship for about 10 years with patient X. During these years the relationship was regularly broken by patient X. Sometimes because he had enough of her, sometimes because he was detained. He was jealous and suspicious and became more and more aggressive and violent in the relationship. In contact with their children he was brutal and harsh. Nowadays she still loves him even though the relationship is 'over': 'I feel as if we have become adults together, like we are family'. At the same time she is afraid of him. When patient X goes on leave the FPC informs her about this on her request. She wants only supervised visits to the children. Otherwise he could 'miss' the train. Then he must spend the night with her, she says. 'And you never know what happens'. Ex- girl-friend has a new relationship. She does not want her ex to meet her new partner because she is worried the two men will fight.

The brothers told the interviewer that they have not maintained contact with patient X because he was continuously in and out detention and that he also never listened to their advice. They tried to convince him to go to a psychiatric hospital voluntarily which had failed. They did not know what to do. And frankly, they were fed up with him. They were unaware of the psychiatric problems of patient X.

Patient X's boss told during the FSNA interview that he is satisfied with patient X; X is a highly valued employee. Patient X gets along with his boss and his immediate colleagues. He is friendly and is always willing to help others. The

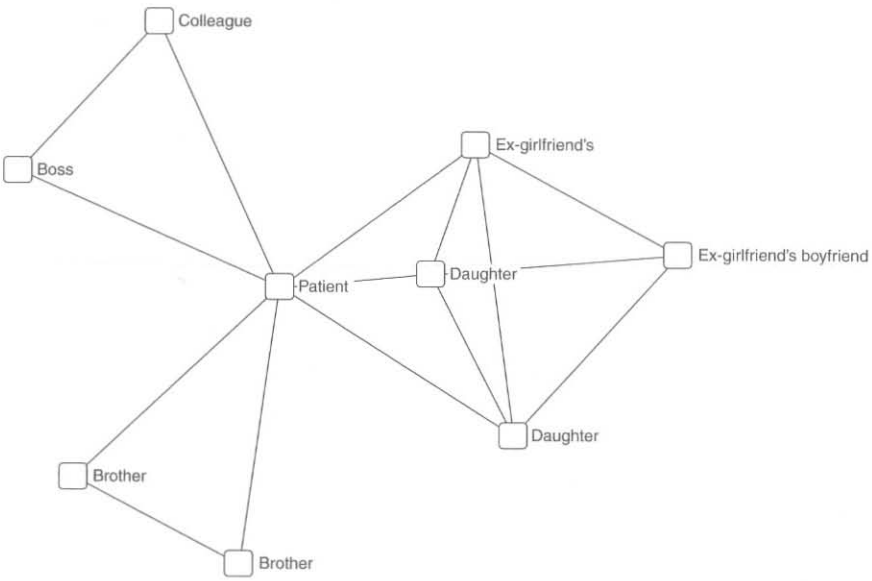
only concern is that patient X is sometimes a bit too assertive: 'When he gives his opinion, he ignores the feelings of others.'

Table 1 shows the answers of patient X about what he expects for support from his social network members. The answers of patient X are compared with the answers of his social network members.

Table 1: table of expected social support

Social Support	Practical support	Financial support	Emotional support
Patient Ex-girlfriend	Yes No	Yes No	Yes No
Patient Brother 1	Yes Yes	No Yes	No Yes
Patient Brother 2	Yes Yes	No Yes	No Yes
Patient Boss	Yes Yes	No No	No No

The interviews showed patient X has no good perception of the support he can expect in the future from his ex-girlfriend and his brothers. Patient underestimates the amount of social support given by his two brothers. He expects practical-, financial and emotional support from his ex-girlfriend, while she says 'no' to any form of support. Figure 3 shows the current social network after interviewing the network members. An assumption of the FSNA is that each existing misperception may lead to stress when the patient reenters society. Social support can be significant to care relationships, because it influences a person's mental health, and vice versa (30-31). Nel Noddings makes the distinction between 'caring-for' and 'caring-about' (32). Caring-for does culminate in caring relations. Caring-about is something more general. We can care about poor people in Africa and think we ought to give some money. One could say patient X' ex-girlfriend still cares-about patient X because she lets him visit the children, but she refuses tot care-for. Even though she still has warm feelings for him, somewhere. She is too scared. It is important to know if there is overestimation of expected social support. If clinicians are aware of this information during treatment, interventions become possible, such as telling the patient about his or her "real" social support system and helping her or him to build and expand a social support system.Figure 3: current social network after network interviews



Patient X - FSNA intervention

A positive finding is the willingness of the brothers to support patient X. Patient X did not expect this. Because the brothers are ready to 'care-for' patient X, they are approached for an intervention: psycho-education.

After the brothers have received psycho-education about patient X, as part of risk management suggestions from the FSNA research, they restored contact with patient X. They consider him now as a psychiatric patient who needs others for support and they understand better why their brother acts like he does. There are agreements made between patient, his brothers and the forensic clinic. For example, an appointment made is when brothers would see something special about the behaviour of their brother, they will inform the forensic hospital immediately.

Patient X visits his brothers regularly when he is on leave. On average, he is staying over two nights per month by one of his brothers. It seemed to go very well with patient X. At the transmural home of the FPC, an outside of the clinic placed residence, he is doing well. Monthly blood tests allow the treatment team to monitor patient's medicine use.

At work he is an appreciated colleague and his boss is satisfied with his work. His ex-girlfriend sees him when he visits her and their daughters. These visits are accompanied.

And then there is a phone call... The eldest brother of patient X calls the clinic. He and his brother are worried about patient X. Their brother seems to have lost grip on reality the last two days. X seems to be suspicious about the new boyfriend of his ex-girlfriend. Patient X is immediately picked up by his mentor

and brought back to the FPC. In a very short time, patient X had become psychotic again. And in his psychosis patient X found evidence that the current boyfriend of his ex-girlfriend would sexual abuse his daughters. A new, but very familiar, risk situation does his entry.

Thanks to the FSNA research contact between patient X and his brothers is restored. The brothers see patient outside the clinic, and were able to observe him outside the clinical setting. By means of the psycho education they recognised signals of a new psychosis. And because of their care relation with patient X they ensured that their brother could get the care that he needs. Fortunately, patient X was this time housed in a caring-situation before an offence has occurred.

Patient returned back to the FPC. He confessed that he did not take his medication in the last weeks. Because his ex-girlfriend had a new boy-friend he had felt unconfident. Patient X suffered from male erectile disorder most likely as a result of his medication use, and said; 'A real man does not use any medication.' The treatment team has to decide about the patient's future, his prospects are uncertain. The brothers will be involved in future treatment plans.

To conclude: good personal networks help you to meet other people, but *really* good personal care networks also help you to avoid people and situations which can bring you into trouble.

Discussion and future directions

This study has examined the extent to which relational ethics can play a significant role in forensic psychiatry, and how a forensic instrument, the forensic social network analysis (FSNA), can help to get rid of the fuzziness of relational ethics.

We stated that the classical view on autonomy, that of a rational and reasonable individual who makes sensible choices, does not stand in forensic psychiatry. We have to focus on the care ethicists' description of autonomy. This concept of autonomy is a relational version, because autonomy can only be properly designed in relationships with others. Relational ethics looks at individuals in dependency relations to others. It focuses on 'care' within these relationships. To not solely focus on care relationships but also to interpret this relationships in a forensic psychiatric context, the FSNA was introduced. FSNA activates the social network of a patient in the context of risk and protective factors. Also, FSNA provides additional information for risk assessment, as well as tools for possible intervention (risk management) purposes.

The case study about patient X was the the leading thread running through this essay and has shown us that relational ethics and FSNA together give us possibilities to give the patient the needed care within an individual oriented risk management approach. For example, patient's brothers were ready to 'care-for' their brother. Thanks to the psycho- education they recognised signals of patient's new psychosis.

The common nature of relational ethics and FSNA is motivated by some key elements; A shared focus on the individual with his own individual (social) context and his own story as a theme running through his life; The individual context can only be understood by identifying the social context and vice versa; Every person has his own sets of learnt dispositions, (social) skills and ways of responding to the other. It is important to 'put on the shoes of the other' in order to understand him or her better. This is necessary for good care and risk management, because someone's personal and physical situation must be understood before proper care can be given; To have true contact with each other, reciprocity is necessary. Although, professional contacts are not chosen voluntarily in forensic psychiatry, there will be only a therapeutic *relation*ship if there is reciprocity between patient and clinician. Thus, for the future, we would like to develop a care ethical autonomy concept for the forensic sector. An autonomy concept that includes *forced* contacts within the social network.

The care relationship is always part of the patient's network in which responsibilities play an important role.

FSNA disposes relational ethics in forensic psychiatry of 'fuzzyness', and FSNA becomes much more than a risk management tool: FSNA has become a method that does more justice to an individual, a method that has a vision on forensic psychiatric patients, a care ethical approach. We do catch two birds with one stone. To answer the question 'Do we (have to) care, or just say 'beware'?', with this care ethical social network approach, we can do both.

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