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Urban encounters limited: The importance of built-in boundaries in contacts between people with intellectual or psychiatric disabilities and their neighbours

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Abstract

People with intellectual disabilities or psychiatric disorders who live in ordinary neighbourhoods often have little contact with fellow residents without disabilities. Recent research suggests that we should not strive for warm contacts based on familiarity and shared values between utterly different groups in urban areas. Daily life between people with and without disabilities is described as a process in which boundaries are negotiated. This study builds on that observation. It was based in a middle sized town in the Netherlands and consists of a survey among people with intellectual or psychiatric disabilities and neighbourhood residents (not being support staff or relatives of people with disabilities); semi structured interviews and participant observation. We found that fruitful encounters between different groups depend on built-in boundaries in contacts. Positive encounters occur when roles are clear and boundaries do not have to be negotiated because they are given. Both parties benefit from boundaries and fixed roles: people with disabilities do not need social reflexivity or intricate social skills to find their way in the situation; people without disabilities can end the contact without being rude. In line with previous research we also found that positive neighbourhood contacts are usually light and superficial and result in conviviality rather than long term relationships.

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Introduction

From the 1970s onwards, many people with intellectual and/or psychiatric disabilities were relocated from large scale facilities in the countryside to ordinary neighbourhoods, in urban areas, in independent apartments or group homes (Lamb and Bachrach, 2001; Novella, 2008; Tabatabainia, 2003; Tonkens and Weijers, 1999). Many people with disabilities who came of age in the era of deinstitutionalisation were never in large institutions at all. After nearly 50 years of deinstitutionalisation policy, there is an abundance of research showing that people with disabilities have a larger social network when they live in community settings (Chow and Priebe, 2013: 10; Emerson, 2004; Kozma et al., 2009: 195; McConkey, 2007; Young and Ashman, 2004a: 22), that their quality of live improves (Dusseljee et al., 2011; Kozma et al., 2009; Young and Ashman, 2004a) and that many of them enjoy better living conditions, which includes having a place of their own with privacy (Chow and Priebe, 2013; Verplanke and Duyvendak, 2010; Young and Ashman, 2004b). However, one disadvantage that research shows is that many people with intellectual or psychiatric disabilities do not fully participate in mainstream society. Many are unable to find regular employment (Beyer, 2012; Gray et al., 2014; Harris et al., 2014). Some become homeless and wander the streets until they are finally institutionalised in the criminal justice system (Abramowitz et al., 2008; Kramp and Gabrielsen, 2009; Wallace et al., 2004). These individuals' social networks are small and usually consist of family, other people with disabilities and support staff (Bigby, 2008; Bromley et al., 2013; Duggan and Linehan, 2013; Hall and Hewson, 2006).

Policy makers, which include city planners and health care authorities, are reluctant to accept this harsh reality. Policy makers attempt to devise ways to further the participation of people with disabilities, as we can read, for example, in the policy report of one of the local care institutions in Zwolle:

> Participation in society is an important prerequisite for the well-being of people with disabilities. It increases self-reliance, strengthens social relationships and offers space for self-development. Unfortunately, participation is not obvious. On the contrary. For people with long term mental health problems and other disabilities, it is often not easy to participate in society. We want to create conditions to make them fully participate. (Project community work RIBW, 2012: 4)

On the one hand, this policy should benefit the target group at issue by making them feel more at home, empowered or accepted in society. On the other hand, this policy may reduce costs if people with disabilities could be helped and supervised by residents in their neighbourhoods and volunteers rather than professional staff. In the Netherlands, both policy motives play an important role in a widely acclaimed transition from a traditional welfare state to a 'participation society'. In the participation society in the making, people should rely as minimally as possible on professional care and should preferably not be institutionalised. Instead, vulnerable citizens should take care of themselves as much as possible and rely on their social network if they cannot take care of themselves. This suggestion applies to all sorts of vulnerable citizens: the chronically ill, the physically disabled, the fragile elderly, as well as people with intellectual or psychiatric disabilities. Because family members of vulnerable citizens are often overburdened already (Chan, 2011), the government hopes that volunteers and neighbourhood residents will assist and help. Intimate personal care (helping people take a shower or go to the bathroom) is

considered a service that should be rendered by paid professionals but many other forms of help could be provided by neighbourhood residents, friends and acquaintances. These individuals may buy groceries, tend gardens, complete forms and take those needing assistance to the doctor or the dentist. The participation society in the making should be an actively caring society.

The Dutch government is not alone in this; Fincher and Iveson (2008: 73–74) observe in the Australian context that the advocates of deinstitutionalisation often hoped that this policy would save money: 'if people lived in community settings, there was a possibility of their support being provided in part by volunteers in these local communities'. Thus, it appears pertinent for policy makers and city planners, but evidently also for citizens with disabilities themselves and for those who care about their fate, to know whether and how contacts between people with intellectual or psychiatric disabilities and neighbourhood residents originate and whether and how they may be engineered. In the next section, we will discuss the sociological research regarding contacts between neighbourhood residents in general and regarding contacts between neighbourhood residents and people with intellectual or psychiatric disabilities in particular. We will observe that recent research focuses on the specific role of negotiated boundaries in those contacts. Developing that research, we want to determine how contacts between people with and without disabilities occur and what role boundaries play in these encounters. After the theory section, we introduce our research. The findings will show the importance of built-in rather than negotiated boundaries in contacts between neighbourhood residents and people with intellectual or psychiatric disabilities. We will end our article with reflections on the implications and limitations of our findings.

Sociological theory and research on neighbourhood behaviour

In an intriguing 1969 article, Eugene Litwak and Ivan Szelenyi reflect on the similarities and differences between primary groups: the nuclear family, extended kin, friends and neighbours. What sort of help is provided by each of these groups? Characteristic for neighbourhood residents (next door neighbours but also residents living in the same block, in close proximity) is that they are often willing to provide short-term immediate help; many people will ask their next door neighbour for a cup of sugar that they need immediately. However, this is not all that neighbours do for each other. In the wider circle of neighbourhood residents, people find fellow citizens who share the same public goods: police protection, water, the sewage system, neighbourhood schools. Hence, neighbours can join forces when services fail them. Additionally, neighbours can benefit from each other with regard to 'activities that require everyday observation'; e.g. they can cooperate to observe whether the neighbourhood teenagers do not become juvenile delinquents.

People with intellectual disabilities or psychiatric disorders living in the neighbourhood could benefit from the first and the third kind of help: immediate assistance and everyday observation. It is important to note that Litwak and Szelenyi did not believe that neighbours would be those to turn to in case of long-term or chronic illnesses; that type of help is usually provided by family members or professionals.

Later research has investigated the question of what it means to be a good next door neighbour. Sociologists who studied urban neighbourhoods found that certain general neighbouring principles apply to modern Western urban neighbourhoods (Alphen et al., 2010; Blokland, 2005; Forrest and Kearns, 2001; Linders, 2010; Paquin and

Gambrill, 1994; Unger and Wandersma 1982, 1985). As indicated by Litwak and Szelenyi, neighbours tend to view each other as potential sources of support that can be relied on when needed (Alphen et al., 2010: 349). Neighbourly contacts are based on reciprocity ('could you please look after my children this evening; I'll mind yours next week'), and they appear to be the most logical option when professional support is not available (Jager-Vreugdenhil, 2012: 214). Neighbours avoid assistance in daily care because they do not want to interfere in each other's private domains. Neighbours want to maintain their distance to prevent inconvenience and neighbourly disputes (Blokland, 2005; Bulmer, 1986, 1987; Jacobs, 1960; Linders, 2010). Most neighbours meet in their garden, on the street or on the pavement; they do not visit each other at home. Particularly in urban neighbourhoods, where people live close to each other, it is difficult to maintain one's distance. Paquin and Gambrill (1994) studied neighbourly disputes in urban life. The researchers conclude that hassles are part of the urban ecology but are particularly found in urban neighbourhoods where people live close to each other in flats or apartments (p. 30).

Fulfilling the role of next door neighbour is difficult because it is surrounded by unwritten rules. Because of these unwritten rules, it can be particularly difficult for people with intellectual or psychiatric disabilities because they may not be able to adhere to the implicit norm of reciprocity and may find it difficult to maintain the appropriate distance. However, our research showed that quarrels between neighbours occur as often with neighbours without disabilities, as we will describe in the findings section. Research into the neighbourhood participation of people with intellectual disabilities or psychiatric disorders usually does not distinguish between their roles as next door neighbour and neighbourhood resident. However,

the research does show that neighbourhood participation is a daunting goal. Various reasons have been proffered to explain the difficult integration into neighbourhoods of people with disabilities. Researchers blame the competencies of people with disabilities (notably a lack of social skills) and/or those of neighbourhood residents (Alphen et al., 2010); they refer to feelings of insecurity in people with disabilities due to negative experiences in the past such as name-calling and abuse (Alphen et al., 2009; Robertson et al., 2005). Researchers point at prejudice and negative community attitudes (Dijker et al., 2011; Hudson-Allez and Barret, 1996; Pittock and Potts, 1988). Researchers blame the lack of professional support (Alphen et al., 2010) or seek explanations in the developed environment, such as the manner in which people with disabilities are housed (non-congregate settings versus congregate settings) (Bostock and Gleeson, 2004), housing in weaker neighbourhoods with small apartments where proximity is a problem (Trappenburg, 2015), lack of community spirit in urban areas (Nicholson and Cooper, 2013) or a lack of common space (such as bordering gardens or a shared driveway) (Alphen et al., 2009, 2010; Pittock and Potts, 1988). When asked for their opinions and attitudes, respondents without disabilities indicate that they would accept people with intellectual disabilities or psychiatric disorders as a neighbour provided that people with disabilities do not bother them and that they can rely on a qualified social professional if they are bothered or have problems (Alphen et al., 2010; Leegwater and Lubbinge, 2005; Robertson et al., 2005; Veldheer et al., 2012).

Recently, Australian researchers Wiesel, Bigby and Carling-Jenkins (2013) advocated a new direction for investigating neighbourhood contacts between people with and without disabilities. In these researchers' view, much previous research was inspired

by a nostalgic vision of community with shared values, familiarity and long lasting relationships. In modern urban life, it is much more feasible, perhaps preferable, to strive for *conviviality*, as described by Fincher and Iveson (2008): 'encounters which provide people with an opportunity to step outside a fixed identity and explore more transient shared identifications with those they meet' (Wiesel et al., 2013: 11). Wiesel, Bigby and Carling-Jenkins observed interactions between five people with disabilities and others. The researchers found three positive types of encounters in which elements of conviviality could be traced: 1. *fleeting exchanges*: small moments of interaction between people living in the same city in which they briefly acknowledge each other's existence; 2. *service transactions*: between a shopkeeper or service provider and a client with disabilities; and 3. *Encounters within a distinct social space*: where people with disabilities meet each other, usually supervised by support staff. Two sorts of negative encounters were found: *exclusionary encounters*: moments when the otherness of people with disabilities was emphasised in a negative manner, and *unfulfilled encounters*: people with and without disabilities hesitating to accost one another and, ultimately, failing to do so.

In a later article, Wiesel and Bigby (2014) describe the attitudes and reactions of residents without disabilities towards people with intellectual disabilities. The researchers found that most people do not have any contact with people with disabilities who live in their neighbourhood. Whereas some of them related negative community attitudes towards people with disabilities, others simply did not want to interfere in other people's business, did not want to be patronising or did not know how to relate to people with disabilities because they were always moving about in a group that was supervised by support staff (on the attitudes of staff see also

Bigby and Wiesel, 2015). Many people chose to avoid contact with people with disabilities because they were afraid of over commitment; they sensed that people with disabilities would not know when it was time to move on. Brief moments of conviviality were also described in this article: moments when people without disability displayed gestures of help or showed patience in public places because certain people with disabilities have difficulty maintaining pace in modern life. Wiesel and Bigby describe the interactions between neighbourhood residents with and without disabilities as a process in which 'boundaries of inclusion and exclusion are negotiated daily'.

Our study develops these Australian studies. Although we acknowledge that boundaries of inclusion are indeed occasionally negotiated on a daily basis, we argue that at other times boundaries do not have to be negotiated because they are a given. We will introduce the notion of built-in boundaries in contacts between people with and without disabilities and psychiatric disorders. Following Goffman (1963, 1983) social life may be characterised as an interaction order. Certain encounters are heavily structured in terms of rules and roles. When you visit a general practitioner you are supposed to tell her what is bothering you whereas she will not trouble you with her complaints in return. She will examine you, prescribe one or another medication and then you are done. Other encounters are much less structured. When you visit a friend at his house you may overstay your welcome but it is also quite possible that the two of you enjoy the visit till the early hours of the morning. Encounters in public space are sometimes almost as structured as the visit to the doctor. The communication traffic order (Goffman, 1963), the rules and roles in those situations are clear, or, as we put it in this article: the situation has built-in boundaries. The rules and roles allow for a natural form

of closure. One example of a contact with built-in boundaries is the service transaction between shopkeeper and the client with disabilities that Wiesel, Bigby and Carling Jenkins (2013) described. Our research will show that there are other examples and that these contacts may also lead to moments of conviviality. However, many types of contacts do not have such built-in boundaries. These contacts call for boundary negotiations; because that is a difficult process, many residents without disabilities attempt to completely avoid them.

Researching the neighbourhood

Our research was carried out between January and December 2012 in two neighbourhoods in the medium sized city of Zwolle. Zwolle is a town with 121,525 inhabitants, situated in the North-East of the Netherlands. Both neighbourhoods are situated in the suburb, Zwolle-South, located approximately three kilometres from Zwolle's inner city. Table 1 indicates certain general background characteristics of these two neighbourhoods. Ittersummerlanden ranks low in various socio-economic aspects compared with the average of Zwolle and the Dutch average. The average income level in Ittersummerlanden is low (about €16,800 disposable annual income per year) compared with the national average (€18,600 disposable income per year). In Ittersummerlanden, social housing predominates (84 percent), with many flats and apartments, whereas in Schellerlanden most houses are privately owned. In Ittersummerlanden, many residents are jobless and on welfare (54 per 1000 habitants, compared with 29 per 1000 habitants in Schellerlanden and compared with 41 per 1000 habitants nationally). Schellerlanden, in contrast, is a well-established residential area with an average socioeconomic status. The average income in Schellerlanden (€19,100) is approximately equal to the Dutch average, and the percentage of residents with a high income is approximately equal to the national rate (24% compared to 20% nationally). Schellerlanden includes a small number of

Table 1. Background characteristics of the neighbourhoods.

Background characteristics of Ittersumerlanden and Schellerlanden*

	Ittersummerlanden		Schellerlanden		Zwolle		Netherlands	
	n	%	N	%	n	%	n	%
Residents*	3885		2983		120,403		16,730,348	
18 years <	3124	80	2343	79	94,042	78		
Households*	1775		1174					
Household one person**		44		26		33		36
Benefits per 1000 inhabitants**	54		29		33		41	
Rental house****		84		37		48		44
Non-Western background***		9		4.4		9.1		11.9
Social minima**		6		6		8.1		7.7

Notes: *CBS 1 January 2011.
**No significant difference with the Dutch population.
***A significant difference between Schellerlanden and the Dutch population.
****A significant difference between Ittersummerlanden and the Dutch population.

Table 2. Overview of people without disabilities.

Overview: people without disabilities (N varies)				
	n Sample	%	% Netherlands	% Zwolle
Gender (N = 297)				
Male	123	41	51	51
Female	174	59	49	49
Age (N = 292)				
18–39	57		35	41
40–64	176		45	41
65–89	59		20	18
Neighbourhood (N = 292)				
Disadvantaged neighbourhood	171	59		
Affluent neighbourhood	121	41		
Education (N = 291)				
Low	55	20	27	16
Middle	95	33	41	38
Higher	135	47	33	46

Note: Age varies between 18 and 89 years. Average age = 52.8, SD = 14.4.

migrants (people with an ethnic background other than Dutch). Both neighbourhoods house a sizeable minority of people with intellectual and/or psychiatric disabilities; however, their percentage is larger in Ittersummerlanden. Schellerlanden houses approximately 40 people with a disability, and Ittersummerlanden houses approximately 100 (counting solely those people who are registered as having an intellectual disability or a psychiatric condition by the local care institutions).

We found our respondents with intellectual and psychiatric disabilities through local care institutions in Zwolle. In the two neighbourhoods under study, 48 residents were registered as patients with a psychiatric condition; 95 were registered as having an intellectual disability. The severity of their disabilities varied: respondents with intellectual disabilities included individuals with mild, moderate and severe disabilities; and respondents with psychiatric problems ranged from individuals requiring care 24 hours a day to those who simply required a weekly visit.

Our research employed a mixed-methods design that encompassed surveys, in-depth interviews and (participant) observations to arrive at a detailed picture of community care in action.

Survey

We distributed a survey questionnaire to all 2949 households in the two neighbourhoods. Of these, 319 completed surveys were returned; thus, the response rate was slightly over 10 percent. Both neighbourhoods are equally represented in the sample. Demographic data were requested to determine whether our sample reflected the population of Zwolle and the Netherlands. We found that female respondents were over-represented in our sample, whereas ethnic minority and younger (18–39-year-old) respondents were under-represented. For other background characteristics (education and living situation), our sample is broadly representative of the population of Zwolle and the Netherlands.

The same survey was sent to 143 individuals with a psychiatric condition or intellectual disability and yielded 65 completed responses. Because of the small number of respondents, this is not sufficiently high enough to generalise to all people with disabilities in Zwolle or the Netherlands. Nevertheless, the surveys provided us with an approximate estimate of the number of contacts in the investigated neighbourhoods between people with and without disabilities and what these contacts appear to be.

We found that the sample reflected the types and degrees of disability in the two neighbourhoods (see Table 3). The questionnaires for people with a psychiatric background were distributed to all the mentors of people with a psychiatric background working in the care centres in the two neighbourhoods. The clients completed the questionnaire alone or together with their mentor. The surveys for people with an intellectual disability were conducted face to face by a care worker.

Qualitative interviews

We conducted in-depth interviews with 22 individuals with a psychiatric condition, 25 individuals with an intellectual disability, 24 neighbourhood residents without disabilities and 23 care-givers. Fifteen of the neighbourhood residents without disabilities were recruited through the survey because they had indicated on the survey that they were willing to be interviewed. During the participant observation (see below) we met neighbours and recruited nine other neighbours. In selecting our respondents, our objective was to interview individuals who reported experiences with different forms of contact.

Respondents with various degrees of disability were recruited via the city's care institutions. In the interviews, our objective was to obtain more nuanced and in-depth insights into the answers we had obtained

Table 3. Overview of people with disabilities.

Overview: people with disabilities (N varies)

	n	%
Disability (N = 65)		
Psychiatric disability	21	33
Intellectual disability	44	67
Gender (N = 65)		
Male	37	57
Female	28	43
Age (N = 65)		
18–30	6	9
31–40	17	26
41–50	13	20
51–60	12	19
61–70	7	11
71 <	10	15
Neighbourhood (N = 65)		
Disadvantaged neighbourhood	47	72
Affluent neighbourhood	13	20
Other neighbourhood	5	8
Living situation (N = 64)		
With parents, extramural care	1	2
Single house, extramural care	28	44
Group home, 16 hours of care per day	21	33
Institutions in the neighbourhood, 24 hours of care per day	13	20
Other	1	2
Day time occupation (N = 65)		
Paid employment	5	8
Activities for people with disabilities	54	68
Volunteer	9	14
Other	14	22

Note: Average age: 49.8 (19–83 years).

through the survey. The interviews relied on a topic list, which was used flexibly to adapt the interview to differences in respondents' communication skills. This method also allowed respondents to exercise control over the direction of the interview and the depth of discussion (cf. Jahoda and Markova, 2004).

Although people with intellectual disabilities may feel more at ease in interview situations with support staff present, this can lead to answers they believe their care workers want to hear (cf. Douma and Kersten, 2001).

We attempted to avoid such situations as much as possible. However, occasionally the presence of a care worker was needed to put the respondent at ease. In such cases, the care worker was requested not to intervene unless the respondent did not understand the question (cf. Kersten et al., 2000).

Participant observation

Between September and November 2012, the first author participated in four projects organised by local care institutions to encourage contact between people with intellectual disabilities and neighbourhood residents: a public garden, a restaurant, a children's farm and an odd jobs project. The public garden and the restaurant were accessible to people with and without disabilities. Both groups could tend the garden and pick flowers and dine in the restaurant, preferably in each other's company. The animals in the children's farm were minded by people with a psychiatric background. In the odd jobs project, people with intellectual disabilities or a psychiatric condition provided services such as bike repair. People without disabilities were usually customers. The researcher adopted the role of observer as partial participant (Patton, 2002), at times purely observing and shadowing practice and at other times assisting in the different projects, for instance cooking and performing odd jobs. The research again focused on whether social contact actually develops between neighbours with and without disabilities and what specifically characterises such contact.

Data analysis

The interviews were transcribed verbatim by students, whereas the observations were reported in detailed log books by the first author. All three authors then analysed the transcripts and logbooks. This analysis led to a coding scheme partly based on our literature study (neighbourhood rules), partly found inductively. The coding was performed with the aid of the computer program Atlas-ti; the surveys were analysed using SPSS. Below, we do not use respondents' real names but use pseudonyms to ensure anonymity.

Findings

No contact and negative contact

Our survey shows that two thirds of the people without disabilities do not enter into any contact with people with disabilities. The main reason noted in the questionnaire by people without disabilities is that they do not meet people with disabilities.

In the group who are in contact (31 to 35 percent of the people without disabilities), we unfortunately found many negative contacts. We found two types of negative contacts, one explicitly abusive and the other more the consequence of good intentions that did not work out well.

Bad intentions: Harassment and exploitation

People with disabilities, particularly people with an intellectual disability, are easy victims for malevolent people. We found financial, intellectual and/or sexual exploitation among half of the 25 interviewed people with intellectual disabilities and one third of the 22 people with psychiatric disorders. Mr and Mrs Zuidhof, for example, are both intellectually disabled. A social worker visits them every week. This couple narrates to the researcher that they must address conflicts and harassment by their direct and indirect neighbours:

> In Zwolle, neighbours spread ketchup and mayonnaise on the windows and threw eggs at the window. They also glued sex pictures on the windows with our names on them.

When his neighbours threw garbage over the fence, Mr Zuidhof was tired of it and made a phone call to the neighbours to complain. However, the situation worsened and became uncontrollable:

> Well, he laughed at me. So I said: 'My fingers itch, and if I could, I would let you have it!' … I should not have said that. … Then, the son came and pushed me to the ground. I broke my hand, and then he also wanted to kick me but he failed because I just turned my head away. Then, I left and called the police.

Some of the harassment cannot be understood as a reaction to what people with disabilities did themselves, but is simply exploitative and mean. For example, neighbours, but also distant friends, acquaintances and salespersons, come to the disabled people's doors and sell products and subscriptions to them that are excessively expensive for them. These exploiters talk the disabled into selling precious objects such as a newly received bicycle or a computer for a small price. Although salespersons attempt to sell their goods to all people, they find people with disabilities to be very easy victims, and they were often viewed around the institutions and houses of people with disabilities.

There are 'friends' who use disabled people's houses as a place to hang out at night, depriving them of privacy and sleep. These friends steal the disabled person's money and possessions, or issue registration certificates for cars and mopeds in their name, and relentlessly drive excessively fast, knowing that the person with disabilities is saddled with the fines. A social worker reported on a man with an intellectual disorder who is financially exploited by a neighbour:

> There was a neighbour who was helping my client with his finances, but in the end, this neighbour was paying his own groceries with my client's money.

Most neighbours who are willing to engage with people with disabilities begin with good intentions, but this positive attitude can easily turn around. Conflicts happen when people with disabilities do not appear to be able to recognise, let alone acknowledge, the tacit expectation to respect each other's privacy. Certain people with disabilities do not maintain the implicitly expected distance and do not recognise the signals of boundary setting by their neighbours. Without knowing, these individuals interfere with the privacy of other people. These disabled people do not understand the implicit rules of an encounter that is limited in time, if we follow the definition of Goffman of an encounter as an event 'where people effectively agree to sustain for a time a single focus of cognitive and visual attention' (Goffman, 1961: 298 cited by Wiesel et al., 2013: 3). People with disabilities sometimes do not effectively agree because they do not understand. This misunderstanding is, in turn, not understood by their neighbours, and this double misunderstanding stirs up conflict. Mrs Roesink is feeling uncomfortable because of the claiming behaviour of her neighbour with an intellectual disorder:

> For example: she was looking after the dog of some of our friends and sometimes she just dropped by. And then she didn't know when it was time to go. She stayed put. She has difficulty keeping a balance in the relationship, and she lacks sensibility to notice the appropriateness of her visit. So she came at untimely hours and was staying for hours. And it is also difficult to refuse her. If somebody doesn't sense, you can tell her again and again, but she doesn't understand, and then the positive contact can turn into something negative. That is not what we hoped for.

Certain people with an autistic disorder may not grasp implicit rules regarding noise, and therefore may irritate their neighbours. A social worker:

> If somebody is autistic, they are also a bit narcissistic, and then they don't understand that they cause inconvenience. If they have a tantrum, they can't control it. They have to smash and scream.

One social worker tells about a couple who both have an intellectual disability with an IQ of approximately 48. They moved four times in one year, after they had been harassed by their neighbours:

> Els acts like a small child. She starts kicking and screaming if she does not get her way. But she is an adult woman!

We conclude that conflicts arise easily, particularly with next door neighbours.

Our data confirm earlier findings that limited intelligence and limited social skills can be important sources of conflict in urban areas. In particular, people with intellectual disabilities are not always socially reflective, as various research has shown (Greenspan et al., 2001; Lichterman, 2005; Nettleback et al., 2000; Teeuwen, 2012; Wilson et al., 1996). In turn, their neighbours do not understand what they experience as demanding behaviour of people with disabilities. Neighbourhood contacts, particularly in poorer urban neighbourhoods, are difficult to avoid. Next door neighbours may benefit from each other; however, they can also be bothered by loud noises, inappropriate behaviour or different lifestyles. Neighbouring contacts are riddled by soft, implicit norms. There are no supporting external boundaries that encourage a person to keep contact light and superficial, to instruct a person to go when it is time to leave. Below, we will discuss our findings on positive contacts and show that positive interaction is supported by the presence of such external boundaries.

Positive contact

We found four types of positive encounters between neighbours with and without disabilities. First, similar to Wiesel, Bigby and Carling Jenkins (2013), we found *fleeting exchanges*. Neighbours with and without disabilities meet each other on the street and greet each other, wave and occasionally engage in small talk. Mr Schuitemaker is such a neighbour. Mr Schuitemaker explains why he likes to engage in small talk with people with disabilities:

> You say goodbye to them and you chat about the weather. I think this kind of contact is valuable. It's like: 'I know who you are and where you live'.

Mr Kroon, a man with a psychiatric background, regarding such contacts:

> These are people who know me only superficially. We only meet at the street or in the neighbourhood. Yesterday, I was drinking a cup of coffee in a café in my neighbourhood, and I saw a woman I have seen before. And she waved at me when she left. These little things are important; they can make my day.

People similar to Mr Kroon and Mr Schuitemaker enjoy these contacts with 'familiar foreigners' (Blokland, 2005; Jacobs, 1960). Expressions of contact such as a nod or a wave hover between anonymous and intimate and make a foreign environment more familiar. These expressions contribute to a sense of recognition and of 'feeling at home' in a neighbourhood, as was previously stated by Alphen et al. (2009, 2010). This feeling is very important because people with disabilities remain within their neighbourhoods most of their time (Verplanke and Duyvendak, 2010).

We also found positive *encounters around dogs*: walking with a dog instigates contact between neighbours with and without disabilities (as well as likely between other neighbours). People with a psychiatric disability particularly, who were included in our study and not in the study by Wiesel,

Bigby and Carling-Jenkins (2013), meet other people when they walk their dogs. Mrs Tromp, a neighbour without a disability, relates the contact she has with people with disabilities at the dog walking areas:

> When you both have a dog, you easily engage in small talk, just like when you are both gardening or chatting with your neighbour. It's funny, sometimes you don't know the name of the people, you only know the name of the dog. But we do not intensify the contact. We only have contact in the park. On a certain moment, I just say I have to move on or interrupt the contact.

Third, as with Wiesel, Bigby and Carling-Jenkins (2013), we found local stores to be conducive places for contact between people with and without disabilities. Some people with disabilities point out that shopkeepers are very important in their social network. Mr Klaverman, a man with an intellectual disorder, is very proud that the fishmonger knows him so well that he does not need to place an order to be served:

> The fishmonger does not have to take my order anymore. He just knows that I eat fried fish and drink cola light, and without questioning, he serves it!

The relationships with shopkeepers are of vital importance to people with disabilities such as Mr Klaverman because they provide recognition ('The shopkeeper knows my name and he knows what I like!') and a listening ear.

Fourth, we found positive contacts in the four community projects: the restaurant, the public garden, the children's farm and the odd-jobs project. In contrast to the 'distinct social places' described by Wiesel, Bigby and Carling-Jenkins (2013), those we studied were designed to enable encounters between people with and without disabilities. The four projects showed us the importance of boundaries in contacts. The least successful project was the restaurant. Although people with disabilities had a pleasant time here eating healthy food in the company of other people, not as many people without disabilities visit the restaurant because the setting is very intimate. People cannot freely move around because running away during dinner is very rude. Dining at a restaurant usually takes more than an hour, which is a long time to spend in the presence of occasionally awkward appearing strangers whose behaviours are unpredictable. Various visitors without disabilities tended to maintain distance, by grouping together:

> I [first author] am dining at the restaurant. At an adjacent table, two women are having dinner with a ten year old. They share their table with an unfamiliar couple with disabilities. While we are eating our spaghetti, suddenly the woman at the adjacent table starts to speak very loudly to her companion. Her face turns red and she is repeating things like 'I really want to make up with you' and she grasps the hand of the woman and shakes it with wild movements, time and again. The mother of the child bows to me and whispers softly: this is why I said to my friend, let's take our own table! (PO 7, 12 November 2012, restaurant The Kitchen of South).

The restaurant does provide a built-in boundary (you can leave once you have finished your meal) but apparently the boundary is too far away. Since restaurants for people with and without disabilities are not a rare phenomenon it might be interesting to see whether restaurants serving lunch or fast food lead to more positive contacts than those serving dinner. The public garden and the children's farm accomplished more contact between residents with and without disabilities. Residents visit there to perform a certain activity: pick flowers or fruit or have a brief outing with their children. People can move around and away whenever they want,

which makes for a safe, non-demanding situation.

> While Martin (a client with a psychiatric background) and I are painting the chairs, a woman comes in with a bike. The front tire is flat. She asks: 'I heard from one of my neighbours that you can help me fix my bike? Is that true?' Martin walks quickly to the woman and shakes her hand. 'Yes you are right. I can help you. Fixing bikes is my specialty'. … Martin starts repairing the bike. The woman looks at Martin repairing her bike. Meanwhile, Martin tells the woman that he has been working at the shed for three months now and that, before he became ill, he was working in the construction sector and how much he likes working at the shed and meeting other people. The woman is interested and asks him questions like 'Why do you like it?', 'Are you working every day?' When Martin is finished after about fifteen minutes, the woman thanks him extensively, hands him five euros and cycles away. (PO 11 October 2012, Little Shed of the South)

The children's farm and the odd jobs project have the additional advantage of providing strictly circumscribed roles. At the children's farm, residents with a psychiatric disability maintain the farm; visitors enjoy a well-maintained environment. The odd jobs project provides a more clearly defined quid pro quo (I hand you the money and you repair my bike, although somewhere in the background government subsidies have enabled you to land this job type activity). Contacts through defined roles appear to reduce the social stigma associated with disability. A resident who allowed someone to perform a job at home through the 'Little Shed in the South' project in Zwolle said:

> These people also need to have meaning in their lives, right? I have nothing negative to say about it. Having nothing to do does not make you happy either. I find it really nice that they can mean something to society in this way.

Projects such as the Little Shed in the South and the children's farm do not lead to friendships or longer lasting relationships between neighbourhood residents with and without disabilities; however, they can be understood as a bridge between community presence and community participation. Here one finds convivial encounters, which are valued social interactions in themselves and essential pillars of social inclusion.

Interestingly, the community projects seem to confirm the contact theory of Allport (1954) who suggests that contact between dominant and marginalised groups can lead to favourable outcomes when: 1. There is a common interest; 2. Conditions of contact foster cooperation; 3. Contact is supported by the authorities; and 4. There is personal interaction in ways that could facilitate meaningful relationships. In the community project all conditions are realised, which would suggest that these projects could foster mutual understanding in people with and without disabilities. (cf. also Craig and Bigby, 2015)

Nevertheless, the projects do not require enormous efforts; roles are well-defined and contacts are restricted by external boundaries; thus, they can remain superficial. In situations without built-in boundaries, people must set them themselves. Certain respondents were indeed able to do so. Mr De Jager lives close to a group home for people with intellectual disabilities. Mr De Jager found a means to address his neighbours with disabilities; he would talk in public but never invite people to his home or enter a conversation while he was in the garden:

> Of course I talk to them, but I wouldn't invite them to drink a cup of coffee or something. … I am always afraid that they won't maintain a proper distance. That they will cross the lines. … The same applies when I am in the garden. Sometimes I see my neighbours with

disabilities on the balcony watching me. But then I don't start waving or shouting like 'the weather is nice, isn't it?' I am afraid we would end up shouting the whole day.

However, many others did not find a suitable means to negotiate boundaries themselves.

Summarising, we found positive contact in four situations: on the street in general, on the streets around dogs, in the local shops and in specially designed social spaces. All appear to have built-in boundaries in contrast to the situations described earlier in which negative contacts occurred.

Conclusion and discussion

In urban areas positive contacts between people with and without disabilities do not always arise spontaneously once both groups are housed alongside each other. However, this contact is important for people with disabilities and for people without disabilities; this is not because people without disabilities will suddenly engage in long-term caring relationships with vulnerable fellow citizens. As Litwak and Szelenyi showed in 1969, such is not the nature of neighbourhood contact. Moreover, such is not life in a modern urban environment, as Fincher and Iveson (2008) argued. Contacts between different groups in an urban environment can lead to moments of conviviality, where people briefly acknowledge each other's existence and feel recognised, as Wiesel, Bigby and Carling-Jenkins (2013) have shown.

In addition, our study has shown that positive contacts between residents with and without disabilities are often characterised by built-in boundaries. It is relatively easy for people to engage in contact with people who are different when the rules of the situation are clear and when they do not need to negotiate boundaries because boundaries are provided. Such is the case in dog walking areas and shops. Boundaries can also be engineered in places specifically created for people with and without disabilities where both parties have a fixed role, for example one party minding the animals and the other party visiting the children's farm with children or grandchildren. Fixed roles and structures do not demand the social reflexivity that people with disabilities often do not have. Problems tend to arise much more rapidly when boundaries are missing, become blurred or are easily transgressed. When contact is unrestricted and those involved are not able to set boundaries themselves, negative contacts may easily arise.

There are obvious limitations to our study. Our study was based in two neighbourhoods in one medium sized town in one small Western country. Things may certainly be different in non-Western countries. We found more negative contacts in the less affluent neighbourhood where a lot of people with disabilities were housed in flats or apartments. Houses in this neighbourhood are smaller and people live closer to each other, so disputes arise more easily. Our quantitative study was too small to draw firm conclusions from these findings though.

However, our general findings, notably the lack of contact between groups with and without disabilities, concur with previous sociological research in the Netherlands and other Western countries. Certain more specific findings, such as the importance of light, superficial contact, and moments of conviviality, tie in with Australian research, which was based in a Victorian country town and in Melbourne (over 4 million inhabitants), a much more metropolitan context. This similarity makes us fairly optimistic regarding the validity of our main finding: the importance of built-in boundaries. Dutch policy makers and other urban planners who aim for conviviality between people with and without disabilities could internalise these findings and attempt to engineer light, superficial contacts between

neighbourhood residents. Our findings in the community projects warrant a certain confidence that contacts can indeed be engineered. However, governments should not be overly optimistic about the chances that these projects will nurture long lasting caring relationships. In fact, emphasising this as a hidden agenda might scare away people who visit community projects precisely because of their built-in boundaries, who do not want to end up being a designated carer for people with disabilities. In other words, aiming for wider effects might destroy the built-in boundaries that made the projects successful in the first place.

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