

## Solidarity and Reciprocity Between People With and Without Disabilities

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### ABSTRACT

Governments of contemporary welfare states call upon citizens to care for people with psychiatric or intellectual disabilities. This is deemed sensible and morally just. However, social–psychological theory suggests that stereotyping may stand in the way of engaging into contact. Sociological theory suggests that the giving of help is based on either balanced or generalized reciprocity. Balanced reciprocity depends on one’s ability to ‘pay back’, which people with disabilities may have trouble doing. Generalized reciprocity depends on close social bonds, while people with disabilities often have fewer social bonds than other citizens. The current study aimed to find out whether citizens—despite socio-psychological and sociological theories expecting otherwise—enter into supporting relationships with people with intellectual or psychiatric disabilities. Although we found socio-psychological and sociological theory to be largely correct, we also found people to be more creative than theory assumes. A smile can be experienced as a return gift, thus including people with intellectual disabilities in the web of balanced reciprocity. Some people create new social bonds to include people with disabilities: they feel close to them because they had a job in the healthcare sector or because they had a family member with a disability. In disadvantaged neighbourhoods, recognition of each other’s problems can create feelings of similarity and concomitant reciprocity. Copyright © 2016 John Wiley & Sons, Ltd.

*Key words:* reciprocity; people with disabilities; deinstitutionalization; active citizenship; social inclusion

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## INTRODUCTION: THE CARING SOCIETY

Over the past decades, most western welfare states have closed down residential institutions for people with intellectual and psychiatric disabilities (Tabatabainia, 2003). In order to avoid stigmatization and unnecessary medicalization people with disabilities are now supposed to be better off when cared for in their own living environments (De Freitas, 2011; Lamb & Bachrach, 2001; Novella, 2008). The provision of care within and by society—community care—has been widely embraced by governments. An inclusive, caring community seemed an attractive ideal for politicians of various persuasions (Trappenburg, 2009; 2013). Moreover, rising healthcare costs and criticism of professionals or government over-involvement have led to a rethinking of the welfare state (Clarke & Newman, 1997; Rose, 2000; Novella, 2008). In the remodelled welfare states of the twenty-first century politicians and policy makers expect people to take care of themselves and each other (Hurenkamp & Tonkens, 2011; Tonkens, 2009; Tonkens & De Wilde, 2013). People with psychiatric and intellectual disabilities should be taken care of by family and friends, but also by neighbours, colleagues and others who meet disabled people in their social lives (Bromley et al., 2013; Yanos, Stefancic, & Tsemberis, 2012). In this article we focus on the relationship between people with psychiatric and intellectual disabilities and other citizens not being professional carers or family members.

Research has shown convincingly that contacts between people with disabilities and family members do exist (e.g. Dusseljee, Rijken, Cardol, Curfs, & Groenewegen, 2011; Verdonschot, De Witte, Reichtrath, Buntinx, & Curfs, 2009). However, family members can be overburdened and other people may be needed to relieve their burden of care (Chan, 2011). Moreover social-psychological research has shown that family members can be overly protective toward people with learning disabilities (Jingree & Finlay, 2012) thus defeating one of the goals of deinstitutionalization which was to enable vulnerable groups to live as independently as possible. A similar tendency toward overprotection was found in a social-psychological study on professional carers (Jingree, 2015; Jingree & Finlay, 2013), although family carers tend to see professional carers as the bearers of an ill-advised ideology of empowerment which is too demanding for people with disabilities and puts them in harm's way (Jingree & Finlay, 2012). Hence fostering contacts between people with disabilities and third parties seems a promising strategy. Research indicates, however, that caring relationships between people with and without disabilities (family-members and social professionals excluded) are not self-evident. Van Alphen, Dijker, Van den Borne & Curfs (2010) and Van Alphen, Dijker, Bos, Van den Borne & Curfs (2012) investigated neighbouring contact between neighbours and people with an intellectual disability. Neighbours adapt their expectations and behaviour when neighbours with intellectual disabilities are involved as they are afraid to become more involved than intended (Van Alphen et al., 2010, p.359) and dependent on the group size and severity of the disability their attitude toward people with disabilities is more or less open (van Alphen et al., 2012). Van Asselt-Goverts, Embregts, Hendriks, & Frielink (2014) found that characteristics of the client for example not taking initiative, lack of social skills and difficulties with adaptation (Van Asselt-Goverts et al., 2014) complicate contacts between people with intellectual disability and society at large.

It is not easy to enlarge the social networks of people with disabilities. Social-psychological literature suggests that people have stereotyped ideas of people with intellectual disabilities or a psychiatric condition and that behaviour is moulded by people's

feelings with regard to stereotyped groups (Cuddy, Fiske, & Glick, 2007). Sociological research has shown that people prefer to fraternize with others who are similar to them and that inter-personal relations flourish when they are based on reciprocity (Flap, 1999; Lin, Woelfel, & Light, 1985; Linders, 2010, p. 125–126; McPherson, Smith-Lovin, & Cook, 2001; Volker, Flap, & Lindenberg, 2007). Both mechanisms may stand in the way of helping relations between people with and without disabilities; people without disabilities may feel different from people with disabilities and the latter may not always be capable of returning help. We assume that the first principle (people like to interact with similar others (McPherson et al., 2001)) cannot be rooted out whereas reciprocity might be engineered in one way or another. This makes the reciprocity principle more pertinent for policy makers. Reciprocity seems promising for people with disabilities as well, because it seems to ensure social inclusion, augments self-confidence and underlines people's value in society (Komter, 1996; Nelson, Hall, Squire, & Walsh-Bowers, 1992; Mogendorff, Tonkens, & Verplanke, 2012).

In this article we look at reciprocity (or the lack thereof) between people with and without disabilities in practice and zoom in on how sociological and social-psychological mechanisms influence initiation and continuation of these relations. The goal of this research is to find out whether reciprocity is generated between these groups and how this is related to sociological and socio-psychological mechanisms of initiation and continuation of contact. This is a relevant question not only for policymakers but also for social professionals because they need to know under what conditions people engage in reciprocal relations and look after each other in communities or whether they are hindered by stereotypes. Our research question is: to what extent and in which forms do we find patterns of reciprocity between people with intellectual or psychiatric disabilities and people without disabilities?

In the following section we first take a closer look at social-psychological literature on stereotypes and their impact on behaviour. Next we discuss what is known from sociological theory and empirical research on reciprocity; we will show how both bodies of literature are connected. After that, we introduce our research on social relations between people with and without disabilities in two Dutch neighbourhoods. We then present our findings. In the final section we relate our findings to the literature; we reflect on the conditions of reciprocity in relations between people with and without reciprocity and discuss what this implicates for policymakers and staff working at care organizations. Finally we discuss the strengths and limitations of our findings.

## GIVING AND RECEIVING IN SOCIAL RELATIONS

Social-psychological literature on stereotypes sheds light on reasons why people do or do not engage in contact with people with intellectual or psychiatric disabilities, and possible differences between these groups. Cuddy, Fiske & Glick (2008) found that people's attitudes toward groups other than their own are determined by two dimensions: warmth and competence. Groups perceived as both warm and competent were met with 'active and passive facilitation', that is they were tolerated and actively assisted if they needed help. Groups stereotyped as cold and incompetent were actively harmed, by verbal harassment, bullying or hate crimes. Groups falling in this category were the homeless as well as the welfare dependent. It seems likely that people with a psychiatric condition might fall in this

rubric as well because many people with a psychiatric condition cannot find or hold a job and some of them end up wandering the streets.

Angermeyer and Matschinger (2003) found that people with schizophrenia are stereotyped as dangerous; this perception evokes a desire for social distance. Angermeyer and Matschinger (2003) also found that people with schizophrenia react to these stereotypes by trying to keep their distance, in order to evade these stereotypical images (p. 308). Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) found that many people associate psychiatric disabilities with the likelihood of violence. To evade violence, they want to keep their distance from people with psychiatric disabilities. Concerning people with schizophrenia, for example, 63% of the (American) population expresses a desire for social distance (Link et al., 1999, p. 1332). Cuddy et al. (2008) also discuss the position of people perceived as warm but incompetent. The emotion that they tend to evoke is pity. Pitied groups sometimes elicit active facilitation (help) but they also score highly on passive harm ratings. That means they are excluded, ignored or neglected. People with intellectual disabilities will probably fall into this category along with e.g. the elderly.

The social-psychological studies discussed above provide us with insight in the precise emotions that stereotyped groups evoke in others and subsequently show how these emotions lead to behaviour (helping or harming, active or passive). However, emotions do not explain everything in this respect. For example: it is not clear when pity will lead to neglect and when it will elicit helping behaviour. Sociological theory can help us understand how behavioural patterns develop by looking closer at the circumstances in which contacts take place.

Since Marcel Mauss's pioneering work on gift exchange (1954, 1923), researchers have studied the many social aspects of giving and receiving. Sahlins (1972) focused on the relationship between people's emotional involvement and giving behaviour, introducing the term 'generalized reciprocity' for instances where expectations to receive something in return are less specific, with no demands set on the time, quantity or quality of the probable gifts given in return. As feelings of altruism and solidarity inform these types of exchanges, generalized reciprocity is characteristic of the inner circle of kindred and loved ones. Sahlins points out that when relationships are less personal, more direct and equal exchanges are expected without delay. In those cases he speaks of 'balanced' or 'symmetrical reciprocity'. Even more impersonal is what Sahlins terms 'negative reciprocity', or taking without giving back.

Several studies following Sahlins have shown that generosity is closely linked to the bond between giver and receiver (Ekeh, 1974; Komter, 2007; Newton, 2004; Uehara, 1990, 1995). As Komter (2007, p. 373) argues: 'Both biological and anthropological research about human generosity have unambiguously demonstrated that generosity is given more often and more generously to receivers who are genetically and/or emotionally related to their giver.' We may conclude that reciprocity is a common norm and pattern in relations between people. The weaker the emotional bond, the more important is the balance of reciprocity. Strong emotional bonds allow for generalized reciprocity, while weak emotional ties require balanced reciprocity.

Gouldner (1973 1960) argues that the norm of reciprocity weakens in relations with children, the elderly and people with intellectual and physical disabilities, as they are unable to live up to the norm. Reciprocity is then replaced or completed by the *norm of beneficence*

(Gouldner, 1973 1960, p.178), an idea endorsed by the American philosopher Lawrence Becker (2005, p. 27). According to Becker, people in relationships of reciprocity automatically take the social context of the giver and receiver into account and give according to their abilities so that the young, old, poor and physically disabled can participate in the network of reciprocal relations. However, the norm of beneficence does not quite solve the lack of proper reciprocity or similarity between unequal groups, as beneficence may lead to disrespect, humiliation or ungratefulness (Lichterman, 2005).

Numerous scholars have examined to what extent the norms of reciprocity and beneficence inform social relationships in real life. Linders's study (2010) of patterns of help in a disadvantaged neighbourhood in the Dutch city of Eindhoven revealed that people find it difficult to ask for help, regardless of how desperately they need it; there is a high degree of 'reluctance to ask'. When people must take this step, they seek reciprocity and would therefore rather ask people who are also in need of help than people in more fortunate circumstances. Linders concludes that often the 'paralyzed help the blind'. Other researchers described the same phenomenon (Nelson, 2000, 2005; Uehara, 1995, p. 490–492). Not being able to give back leads to feelings of guilt, which may explain why the vulnerable often turn to each other for help. Linders and others (Forrester-Jones & Barnes, 2008; Komter, 2007; Mogendorff et al., 2012, p. 55; Offer, 2012; Uehara, 1995) note that the giving of help by vulnerable people releases them from their position of dependence, increases their self-confidence and reduces social isolation.

In sum, social-psychological research suggests that stereotyped ideas of people with intellectual disabilities and people with a psychiatric disability portray them as respectively warm and incompetent and cold and incompetent. Both stereotypes can invoke negative behaviour referred to as active harm (verbal harassment, bullying) and passive harm (exclusion, neglect). People with intellectual disabilities tend to evoke pity which may lead to active facilitation (helping behaviour), but this type of benevolent stereotyping can also be insidious and damaging—sometimes more so than overt hostility. Sociological theory and research shed more light on the circumstances that might induce helping behaviour.

Sociologists suggest that reciprocity is the basis for inter-personal relationships as people tend to prefer reciprocity over beneficence. Beneficence is experienced as humiliating and degrading, while reciprocity ensures social inclusion, augments self-confidence and underlines people's value in society. However, reciprocity is difficult to establish between people who are or perceive each other as distant and different. Perceiving each other as similar and close seems to be a precondition for *generalized* reciprocity, while having enough to offer is a precondition for *balanced* reciprocity. If neither of these preconditions are met, only *negative* reciprocity and beneficence remain as unattractive alternatives. In our study we tried to find out whether and how helping patterns develop among different groups. Do patterns of balanced and/or generalized reciprocity arise between people with and without disabilities, and if so, under what conditions? And how are these relations experienced?

## METHODS

### *Study design and context*

Our research was carried out between January and December 2012 in two neighbourhoods in the medium-sized city of Zwolle in the Netherlands. One neighbourhood was socio-

economically underprivileged; the other was relatively affluent, with above-average household incomes. We came into contact with respondents with intellectual and psychiatric disabilities through care institutions in Zwolle. In the two neighbourhoods under study, 48 residents were registered as patients with a psychiatric disability; 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; respondents with psychiatric disabilities ranged from individuals requiring care 24 h a day to those who only required a visit once a week (see Table 1).

Our research consisted of surveys and in-depth interviews. The survey was meant to give insight into the extent of contact between neighbours who were disabled and those who were not, the types of exchange between them and the 'objective' balance in giving and receiving. We also investigated how patterns of reciprocity (or lack thereof) were experienced by those involved. An 'objective' imbalance in giving and receiving may not be perceived as imbalance, or the imbalance may not be perceived as a problem. In order to

Table 1. Overview of people with disabilities

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

\*Average age: 49.8 (19–83 years).

\*\*More answers possible.

find out how people experienced the contact—what they liked, what they struggled with, what made them decide to continue the contact or break it off—we performed in depth interviews. The interviews were analysed by way of a ‘directed contents analysis’. A directed contents analysis is used ‘to validate or extend a theoretical framework or theory’ (Hsieh & Shannon, 2005: 1281), in this case the framework of reciprocity explicated above. As opposed to a conventional or inductive content analysis (Elo & Kyngäs, 2008), a directed content analysis is helpful when the data are gathered on the basis of a theoretical framework, in which case the framework also structures the coding of the data.

*Survey.* We distributed a survey questionnaire to all 2949 households in the two neighbourhoods. Of these, 319 completed surveys were returned; the response rate was thus slightly over 10%. 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 (41% male, 59% female) in comparison with the Dutch population (51% male, 49% female). Younger (18–39-year-old) respondents were under-represented in our sample compared to both Zwolle and the Netherlands. For other background characteristics (see Table 2), our sample is broadly representative of the population of Zwolle and the Netherlands. The survey data were meant to provide a broad background picture of patterns of reciprocity that we scrutinized more closely during the interviews.

The same survey was sent to 143 people with intellectual and psychiatric disabilities and yielded 65 completed responses. It was distributed to professionals working in care centres, who answered the questions together with their clients (for some clients with an

Table 2. Overview of people without disabilities

<i>Overview: people without disabilities (N varies)</i>				
	<i>n</i>	%	%	%
	<i>Sample</i>		Netherlands	Zwolle
<b>Gender (N = 297)</b>				
Male	123	41	51	51
Female	174	59	49	49
Total:	297	100	100	100
<b>Age (N = 292)</b>				
18–39	57	20	35	41
40–64	176	60	45	41
65–89	59	20	20	18
Total:	292	100	100	100
<b>Neighbourhood (N = 292)</b>				
Disadvantaged neighbourhood	171	59		
Affluent neighbourhood	121	41		
Total:	291	100		
<b>Education (N = 291)</b>				
Low	55	20	27	16
Middle	95	33	41	38
Higher	135	47	32	46
Total:	291	100	100	100

Age varies between 18 and 89 years.

Average age = 52.8, SD = 14.4

intellectual disability filling out a written questionnaire without help is too complicated). The response rate was more than 40%. 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.

*Qualitative interviews.* In addition we conducted in-depth interviews with 22 individuals with a psychiatric disability, 25 individuals with an intellectual disability, 24 people without disabilities and 23 care-givers. Fifteen of the people without disabilities were recruited through the survey, where they had indicated their willingness to be interviewed; nine others were recruited during fieldwork.

In the interviews we aimed to obtain a more nuanced and in-depth insight into the answers we had obtained through the survey. The interviews relied on a topic list rather than a standardized questionnaire, used flexibly to adapt the interview to differences in respondents' communication skills. This also allowed respondents to exercise control over the direction of the interview and depth of discussion (cf. Jahoda & Markova, 2004). All respondents were guaranteed anonymity. The names in this article are pseudonyms.

While people with intellectual disabilities may feel more at ease in interview situations with their professional care worker present, this can lead to answers they think their care workers want to hear (cf. Douma & Kersten, 2001). We tried to avoid such situations as much as possible. Sometimes, however, the presence of a care worker was needed to put the respondent at ease. In such cases, the care worker was asked not to intervene unless the respondent did not understand the question (cf. Kersten, Schuurman, & Speet, 2000).

*Data analysis.* The surveys were analysed using SPSS. The qualitative interviews were taped and transcribed verbatim. The following steps were taken in the analysis process. (i) Various forms of reciprocity as mentioned in the sociological literature provided the starting themes (such as generalized reciprocity, balanced reciprocity, negative reciprocity, norm of beneficence). (ii) All three authors then read the transcripts to look for patterns as mentioned in the sociological literature. Additional themes emerged through reading the interview transcripts. (iii) The patterns that emerged were discussed between the three authors, which led to the identification of new themes such as new categories of proximity and new forms of balanced reciprocity. (iv) Then, labels describing a theme were used to code the interview transcripts. We conducted coding consistency checks by independent parallel coding and a check of this coding by the other researchers. The coding was done with the aid of the computer programme Atlas-ti.

In the next section we discuss our findings. The outcomes of the survey and the interviews are discussed in coherence.

## FINDINGS

We present our findings in three subsections. In the first section we discuss how much contact there is between neighbourhood residents with and without disabilities. In the second section we take a closer look at the people who do get in contact with neighbourhood residents with disabilities. In the third section we look at the types of contacts that are



established between the different groups. This third section is subdivided in categories derived from our theoretical framework: forms of reciprocity or lack thereof.

### **I How much contact?**

In our *survey* we first asked residents without disabilities whether they had any contact with people with psychiatric or intellectual disabilities. Two-thirds of the people without disabilities had no contact whatsoever with people with disabilities. The main reason mentioned in the questionnaire is that they do not meet people with disabilities.

We further found out during the *interviews* with people with and without disabilities and social professionals, that the disabilities prove to have an inhibiting effect on social participation. Because people with disabilities generally do not participate in the labour market, they have limited budgets and hence little resources for leisure activities or transport. Another important reason for difficulties in the initiation and continuation of contacts is the lack of social skills needed to undertake initiatives, whether or not related to the disorder. John, a man who is diagnosed with autism tells:

'Communication is very difficult. I find it hard to start a conversation with someone and to keep a conversation going. But as we do it like this; you are asking the questions and I am expected to give the answers, then it is clear and then I can do it.' (CR11)

Diffidence and a lack of self-esteem because of the disorder and the accompanying feelings of shame result in a reluctance to go out and isolation from others within society. Additionally, both groups hold stigmas and prejudices with respect to one another.

### **II Who gets in touch?**

As most people do not enter into contact with people with disabilities it is interesting to know those who do. We found that residents who initiate contact with people with disabilities seem to belong to four identifiable groups. The first consists of people who work, or have previously worked, in the healthcare sector. Seventy-five of the people without a disability who filled in the questionnaire worked in the health care sector and more than half of this group had contact with a person with a psychiatric or intellectual disability in their free time (not an occupational relation), while of the group of people without a disability working in other sectors, only a quarter do have contact with people with a disability.

The second group—we found out during interviews—seems to consist of people who want to help because helping is constitutive of their meaning in life. For some of them, this is connected to their religion. Steven explains:

'Normally you just keep to your own little corner and that is not what God wants from us. We must not stick to our own corner. We open the doors of our church. White, dark, sick, healthy: you meet every kind. (...) I didn't expect I would like this but you do meet really different people here and you have contact with them.' (WB3)

The third group consists of people with disabled family members. Respondents without a disability who filled in the survey were asked if they had a family member with an intellectual or psychiatric disability. A non-parametric test for two independent variables shows that citizens who have a family member with an intellectual disability ( $N=48$ ,  $p$ -value = .046,  $F=.117$ ) and local residents with a family member with a psychiatric disability ( $N=50$ ,  $p$ -value = .004,  $F=.168$ , weak link) have more frequent contact with people with a psychiatric disability, compared with respondents who do not have such a family member. We did not find this with respect to people with an intellectual disability. Nine of the

26 people without a disability who were interviewed told us they have a direct family-member with an intellectual or psychiatric disability. Like Jan en Annie, an elderly couple with four adult children. One of their sons, who has an intellectual disability, used to live at home but now lives in an institution. When he moved out of the house, the couple began volunteering at a neighbourhood care institution, driving on outings and helping in the centre's weekly activities.

The fourth group that seems to enter more often into contact with people with disabilities are people experiencing serious problems in their own lives: payment problems, poverty or difficult life-events. Els a social professional working with people with mild intellectual disabilities explains:

'My clients often have contact with people from the neighborhood who are experiencing problems themselves. They find each other and can support each other. Like single mothers who experience problems with their children or people who are isolated or have payment problems. It's easier for my clients to meet them, because they spend more time (...) in the neighbourhood than working people and they can make contact on the basis of equivalence.' (MW8)

Individuals who are experiencing serious problems in their own lives and people with psychiatric or intellectual disabilities seem to be able to create generalized reciprocity and to appreciate that, as it allows both parties to avoid beneficence and the humiliation that often accompanies it. Such relationships were found more often in the disadvantaged neighbourhood than in the more affluent one. Peter, who has a psychiatric disability, explains how he became friends with his next door neighbour:

'I think it began when her boyfriend ran off. She needed help or I needed help; I don't really remember. So we asked each other if we needed help and that's how we became friends. She doesn't have a psychiatric problem. She seems to have a serious problem with the Dutch language though.' (CR4)

Members of these four groups seem to be able to enter into relationships of generalized reciprocity because they empathize with their vulnerable neighbours. The basis of generalized reciprocity here is not—initially—familiarity or emotional closeness. Instead, familiarity and emotional ties are quickly created because of personal histories.

### III *Forms of contact and expectations of reciprocity*

*Light and superficial contact: greeting and small talk.* One-third of the neighbours had (occasional) contact. Figure 1 show what such contacts consist of.

Many people without disabilities (the group of 30–35% of the respondents in this study that *do* have some contact in the first place) have superficial contact in the street, during which they greet *each other* and chat with *each other*. For both people with and those without disabilities who completed the questionnaire, this proved to be the prevailing type of contact, which is in line with research of Van Alphen et al. (2010) published in this journal. These light and superficial contacts, as is evidenced by this study, often emerge spontaneously within the public domain: in dog walking areas, in the streets or in a store. The contact demands little from either party and can take place on the basis of equality. People do not have to struggle with imbalance in superficial contacts and do not get in trouble with complex social codes.

*More intensive contacts: socializing, giving advice, offering services.* While most people without disabilities and people with disabilities who are in contact are only having light

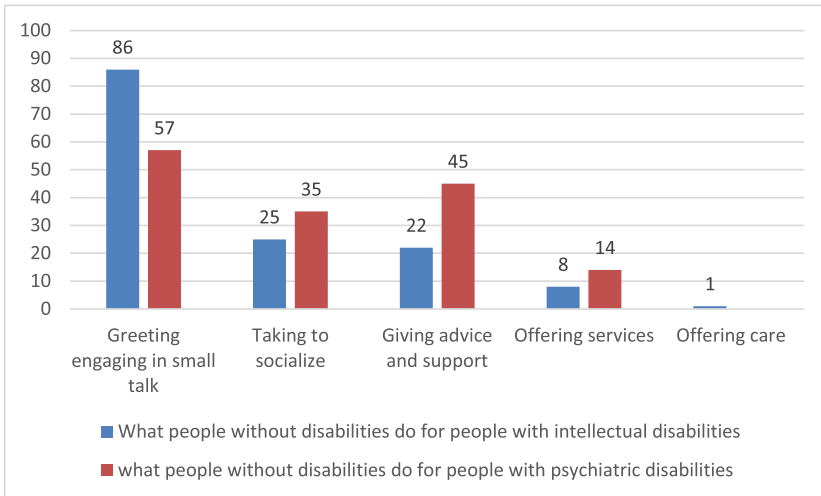


Figure 1. What people without disabilities do for or with people with intellectual and psychiatric in percentages. Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com).

and superficial contact, there is also a group who engages in more intense interaction. Some people socialize with people with disabilities (24% of the citizens socialize with people with an intellectual disability; 35% of the citizens socialize with people with a psychiatric disability) or give advice and support (21% of the citizens to people with an intellectual disability; 48% of the citizens to people with a psychiatric disability) and offer services to one another (8% of the citizens to people with an intellectual disability; 14% of the citizens to people with a psychiatric disability).

*More intensive contact: generalized reciprocity.* Among people with disabilities who have more intensive contact, we found only seven people who have access to relationships that can be characterized by ‘generalized reciprocity’. These seven interviewees were all people with a psychiatric disability, so none of the people with intellectual disabilities had reciprocal relationships. The reciprocal contacts of these seven concern contacts with old schoolmates, neighbours or colleagues who knew them before their psychiatric disorders were apparent. All seven people are largely able to independently shape their own lives. They get professional support for a few hours a week.

*More intensive contact: unproblematic balanced reciprocity.* While we found a small group of people with access to generalized reciprocity, most people do not have this type of relationship. When contacts intensify and people spend leisure time together, give advice and support or render a service for the other, reciprocity often becomes unbalanced. Both respondents with and without disabilities stated that the latter group gives more, more often asking how the other person is doing, more often taking initiative and more often offering help. We found, 14 of the 71 interviewed people who had a relationship characterized by ‘balanced reciprocity’. In some of these relationships the balance of reciprocity, as it takes shape in ‘regular’ relationships, was converted into the social norm of ‘beneficence’. Citizens without disabilities bear the disability in mind and therefore expect a smaller gift or act in return. As is the case in the contact between Bart and a neighbour with a psychiatric disability. He told us:

‘She lives here in the neighbourhood; she would always take the dog out and stop by, and then she would talk for a bit (...) You could not get rid of her quickly and one thing led to another. First a bike that needed to be repaired and then she would ask for all kinds of things in the house. (...) I hung boards on the wall, lighting, plinths, all kinds of things like that.’

*Interviewer:* ‘Does she also do something for you?’

‘Small talk and chatting and then giving a present to the children when it is their birthday, that is what she does and she really likes it.’ (WB1)

*No reciprocity, still contact.* The norm of reciprocity is present as both parties notice that there is an imbalance. However, we also found situations in which this imbalance was not experienced as a problem. Ellen, who has superficial street contact with a neighbour with a psychiatric disability, stated:

‘I think that I ask her more, how she is and such, but I don’t have a problem with that. I don’t expect that from her either. I understand that people with psychiatric problems are not focused on that.’ (WB2)

Some mechanisms may even out the seeming imbalance. First, there seems to be a phenomenon referred to as ‘resonating pleasure’: the pleasure one experiences when someone else derives pleasure from one’s help, care or support (Tonkens, Van den Broeke & Hoijtink, 2009). Patrick, took a mildly intellectually disabled neighbour along for an outing. He recalls:

‘When he was on the train, he leaned forward a little to look out of the window. At one point his head came up and I saw a really big smile on his face. I had never seen that on him. Then I thought: is he enjoying this within himself? Or is he laughing about something? And if you then ask him: what is it? Then he says: ‘Hmm...’ Then I thought: I am giving him joy with this.’ (WB18)

Second, we witnessed the ‘return gift’ of expanding one’s horizons. Some people with disabilities explicitly mentioned that they see people with disabilities as different—but in a positive way. Although for many people ‘being different’ impedes contact, those who do end up having contact with individuals with disabilities often find this difference appealing. They enjoy the experience of having their horizons expanded by being with people whom they do not normally meet. Marie, a person without disability said about her contact:

‘They have something that children also have. They simply are themselves, open. They do not hide anything out of self-defence. I like it when people are so open, it invites you to be more open yourself.’ (WB8)

In conclusion, in the group of people where contact goes a bit deeper than the many light and superficial contacts we found, some people are lucky to have access to relationships characterized by generalized reciprocity. In these relationships imbalance is not a problem. We also found a group of people in which the contact is characterized by a seeming imbalance that is compensated by other gift experiences that create unexpected forms of reciprocity. This can arise between relative strangers because people find immediate experiences of reciprocity in situations that sociological theory neglects or underestimates, such as ‘resonating pleasure’ or ‘expanded horizons’.

*More intensive contact: problematic balanced reciprocity.* But when this ‘norm of reciprocity’ is converted into the ‘norm of beneficence’ (Gouldner, 1973 1960) this also

evokes opposition. The equivalence in the contact diminishes and not all people with and without disabilities can deal with the imbalance. The opposition that arises when people are no longer expected to return a favour shows the importance of reciprocity.

Marie, who had contact with a neighbour with a psychiatric disability, stated:

'She claims me a bit more than I do her, and I can tell her less than she can tell me. (...) And that is a pity. (...) You start to feel a bit like a social worker, something you actually do not want. You just want it to be a normal relationship. The question is how to do that. (...) Maybe that is why these relationships do not develop properly.' (WB8)

Such imbalance can lead to the ending of relationships. Maud said about her neighbour with a psychiatric disability:

'I had contact with my neighbour, but I had to stop that relationship (...). She continuously asked for my attention. When I said that I had no time, she would get mad at me and would not understand why. (...) We do not greet each other anymore. She really claims my time and she is so self-absorbed that she forgets that I also have my issues and that I want to be there for my children.' (WB7)

The above passages reveal that people struggle with the norm of reciprocity. They start to feel that their generosity is being abused when unreciprocated relations continue for too long. The desire to get something in return then starts to itch.

Some of our respondents with an intellectual or psychiatric disability also felt uneasy about the lack of balance in their relationships. Tessa has a mild intellectual disability; an acquaintance of hers is willing to do everything for her. Tessa says:

'You want to do something in return but you don't get a chance. That makes us feel really guilty sometimes.' (CF12)

Linda, a woman with a psychiatric disability tells about the imbalance in her relationships with volunteers in the neighbourhood:

'They can visit you, but you are not allowed to call them or go to their house. They ask all kinds of things out of interest (...) but a certain distance has to be maintained, because they are healthy, and the patient is not.' (MW2)

People with disabilities told us during the interviews, they like it when they are able to give something in contact. This makes them feel needed. They are able to detach themselves from their role as 'patient'. Their competencies are being addressed and they may fulfil a 'role' in the relationship.

In conclusion, we found both people with and without disabilities reason on the basis of the norm of reciprocity. An imbalance in the relationship can arouse anxiety and/or anger among both parties. Therefore, mobilizing reciprocal relations is of great significance. It is a way of empowering people with disabilities and it is important for the continuation of relationships. When emotional commitment is weak people struggle with the imbalance and it sometimes ends the relationship.

## DISCUSSION

While policy-makers have high expectations for caring relationships developing between people with and without disabilities, socio-psychological theory suggests that stereotyping may stand in the way of engaging into contact. People perceived as cold

and incompetent (people with psychiatric disabilities among others) tend to evoke harming behaviour such as bullying or harassment. People perceived as warm but incompetent (people with intellectual disabilities among others) can face passive harm, as pity can create distance and lead to ignorance or neglect. Although they also sometimes evoke helping behaviour.

Sociological theory adds more insight into the specific circumstances under which helping behaviour may develop. This seems to occur under conditions of generalized or balanced reciprocity. Generalized reciprocity—where expectations to receive something in return are less specific, with no demands set on the time, quantity or quality of the probable gifts given in return—is supposed to require strong bonds and/or long-lasting relationships. These are generally not found in relationships among people who have a stereotyped vision of each other. Balanced reciprocity may occur between relative strangers, but is built on a condition that many persons with disabilities cannot fulfil: the ability to give back what one has received in the short run. Besides, between relative strangers stereotypes prevent people from getting in touch, especially with regard to people with psychiatric disabilities.

Our data suggest that sociological theory is partly correct. Most citizens do not engage in contact with people with disabilities. When they do interact, frustration often ensues when they cannot reach a balanced relationship. However, we also found that despite stereotypes about people with intellectual and psychiatric disabilities, some people do engage into contact. Interestingly, they invent other forms of reciprocity than those presaged by sociological theory. First, they create new forms of balanced reciprocity: a happy smile or the opening up of a new vista can be experienced as a return gift. Second, people experience generalized reciprocity through proximity: having (had) a job in the care sector, or having a family member with a disability makes them feel close enough to overcome the lack of similarity. Third, people create generalized reciprocity on the basis of identification with each other's problems: particularly people in the more deprived neighbourhood identified with and felt at ease with persons with disabilities, who they assumed did not have an easy life either.

The differences that we found between the two groups can be adequately explained by social psychological research on stereotyping. People with intellectual disabilities have more frequent and more positive contact than people with psychiatric disabilities. People with intellectual disabilities are seen as warm and incompetent whereas people with psychiatric disabilities tend to fall in the cold and incompetent stereotype. With regard to people with intellectual disabilities the sociological literature on reciprocity seems to be able to explain under what conditions they are helped rather than ignored or neglected. With regard to people with psychiatric disabilities even the conditions of reciprocity outlined above may not be enough to overcome reigning stereotypes.

The present study may have several implications for policymakers and social professionals. To overcome stereotypes it may be helpful to organize positive encounters between people with and without disabilities. For example let them meet at accessible places in the neighbourhood where people with disabilities play a positive role. To facilitate balanced reciprocity, they could engineer more ways for people with disabilities to return gifts: have them perform odd jobs, sweep the streets or mind the animals at a children's farm. Or, alternatively, policymakers and social professionals might show the attractions of the return gifts that we encountered in our study: the happy smiles and the new vistas. Finally, social professionals must be aware of the tensions that may occur

between people with and without disabilities when they struggle with the norm of reciprocity. Finding ways to deal with these tensions seems a challenge for the future.

## STUDY LIMITATIONS

While expanding the field's knowledge of mechanisms that can be helpful or may stand in the way of helping relations between citizens and people with disabilities who are not family members, this study is not without limitations. First, our study was based in one medium sized town in a one small Western country. Things may certainly be different in non-Western countries. Second, although we held almost 100 interviews, the sub-categories of people we discern are small in number. Further research would be needed before drawing any firm conclusions about the roles of each of these sub-categories in community care. Third the response rate to the survey of people without disabilities was low. There is no way of telling how non-respondents would have answered our questions although it seems unlikely that they would have reported more contacts with vulnerable groups than our respondents.

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