Exploring Perceptions of Family Relationships by Individuals With Intellectual Disability and Psychiatric Disorders

Eric D. Widmer, Nadine L. Kempf-Constantin, & Giuliana Galli Carminati

ABSTRACT

Based on social network methods, this article explores the ways in which individuals with intellectual disability (ID) and psychiatric disorders perceive their family relationships compared with the perceptions of those relationships by family members. A sample of 17 individuals with mild ID and psychiatric disorders, compared with a sample of 17 nonclinical individuals, perceived their family as presenting less emotional support and fewer influential relationships, but the same number of conflict relationships. For the most part, interviews with family members confirmed these results; however, a significant difference exists in perceptions of size and density between patients and their family members. We discuss the importance of these findings for research on family relationships of individuals with ID.

Implications for Practice

- The present study reveals a lack of support in the family network of people with ID. It indicates that the caring of these people should give priority to the stimulation of positive exchanges between members of a family rather than focuses on negative possible interactions.

Family relationships are of prime importance for various kinds of support, whether emotional, domestic, or financial (Fehr & Perlman, 1985; Furstenberg & Hughes, 1995; Furstenberg & Kaplan, 2004; Hofer 1994; Widmer, 2004). At the same time, family relationships include many opportunities for conflict and ambivalence (Lüscher, 2002). Families facing mental impairment and psychiatric troubles on the part of one of their members have been found in previous research to experience a higher level of parenting stress and to develop fewer positive relationships and more conflict and tension than other families (Gupta, 2007; Dempsey, Keen, Pennel, O'Reilly, & Neilands, 2008; Hatton & Emerson, 2003; Widmer, Kempf-Constantin, Lanzi, Robert-Tissot, & Galli Carminati, 2008), while playing a greater role in the lives of impaired members (Krauss, Seltzer, & Goodman, 1992).

Interestingly, most research done on the subject is based on interviews of parents or siblings of individuals with ID, with little or no interest in the differences of perceptions existing between them. Are the views of family members confirmed by patients? This article aims to explore the extent to which perceptions of family relationships by individuals with ID are similar to perceptions by their family members, by comparing interviews of individuals with ID and psychiatric disorders with interviews of their family members and those of a comparison group. As we focus on perceptions of a large number of family relationships by individuals with ID rather than on their perceptions of specific family dyads, we use a social network approach (Wasserman & Faust, 1994), which has proven useful for assessing complex patterns of family relationships in clinical and nonclinical samples (Widmer, 1999, 2006; Widmer, Kempf-Constantin, et al., 2008; Widmer, Orita et al., 2008).

Social Networks and Perception Biases

Social network methods underscore that each individual's behaviors or attitudes are best understood as being embedded in complex webs of relationships among a large number of other individuals called *alters* (Scott, 2000). These methods relate respondents' (or *ego*) behaviors, attitudes, or resources to their position in networks of friends, colleagues, neighbors, and so on. Rather than assuming that individuals can be understood independently from each other, a social network approach emphasizes the interdependencies linking them, whether negative (conflict, competition) or positive (support, friendship, liking), and tries to uncover patterns of interactions among large numbers of actors (Wellman, 1988). As the number of relationships increases exponentially with increasing numbers of individuals belonging to a network, specialized methods are developed to uncover those patterns in relation to issues such as the centrality of individuals, the presence of subgroups, and the extent to which individuals are connected with each other (Wasserman & Faust, 1994). Despite a slow beginning in the 1960s and 1970s (Freeman, 2004), the social network approach has now gained prominence in various fields, including epidemiology and health-related research (e.g., Fowler & Christakis, 2008; Smith & Christakis, 2008).

In line with research results emphasizing the lack of relational resources available to individuals with ID (Robertson et al., 2001), a series of papers using social network methods showed that the structures of support relationships in family networks were strongly linked to the presence of psychiatric disorders (Widmer, Kempf-Constantin, et al, 2008; Widmer, Orita, et al., 2008). Individuals in clinical samples

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had fewer supportive family members linked by fewer significant relationships than individuals in nonclinical samples; they were less central in their family configuration compared with individuals from nonclinical samples. Although the size of each sample was small, consistencies in the results across samples confirmed that individuals with psychiatric disorders or ID benefited from a low number of supportive ties in their family configuration.

This set of results, however, raised some important issues about the validity of responses provided by individuals with ID or psychiatric disorders about their family relationships. Research on family relationships of individuals with ID emphasizes the cognitive processes limiting their ability to adequately perceive their relationships with others. First, the ability to understand social expectations and others' behaviors is said to be impaired in individuals with ID. The issue of perception biases of social relationships has received considerable attention in the literature on social networks. It has been found that individuals bias the evaluation of their networks toward greater reciprocity of relationships and a higher centrality for themselves in the network (Killworth & Bernard, 1976; Krackhardt, 1987; Kumbasar, Romney, & Batchelder, 1994). This bias may be different for individuals with ID than for others. A large body of research shows that people with ID may be at risk of greater biases in perceptions of social relationships; other individuals' feelings are often misunderstood, and interpersonal situations are perceived in a very subjective way (Lavin & Doka, 1999; Pescosolido & Wright, 2004). Studies of clinical samples also show that perceptions of relationships in groups are influenced by mental illness. For instance, paranoid adult patients perceive family relationships differently than their parents do (Rankin, Bentall, Hill, & Kinderman, 2005). Perceptions of schizophrenic patients concerning their position in family dynamics are described as frozen, with no link to the situation described by relatives (Nandrino & Doba, 2001). According to Kawachi and Berkman (2001), the ability to perceive one's own social situation leads to improvement in psychological well-being and is of greater importance for the patient's care. Furthermore, a shared perception of situation by family members reveals greater social abilities and greater availability of resources (Reiss & Oliveri, 1983).

Families of Individuals With ID and Psychiatric Disorders

Research on families of individuals with ID stresses the paucity of supportive relationships from which they benefit in family contexts. There are, however, contradicting interpretations of such a deficit. One interpretation states that family relationships may not be perceived by individuals with ID and psychiatric disorders in the same way as they are by other individuals because of perception biases associated with their diagnosis. In this perspective, individuals with ID and psychiatric disorders are believed not to perceive as many supportive or influential connections among significant family members, because cognitive impairment drives them to disregard some of these connections. An alternative hypothesis states that the deficit in supportive family relationships reported by individuals with psychiatric disorders in earlier studies is not the consequence of perception biases of patients and is confirmed by their family members. This article explores the ways in which perceptions of family relationships by individuals with ID relate to perceptions by a family member. It first examines whether individuals with ID and psychiatric disorders perceive their family relationships differently from a comparison sample of nonclinical individuals. It then assesses whether perceptions of family relationships by these individuals match the perceptions by their closest family member. Contrary to a large body of research in which family members were interviewed to assess support available to individuals with ID, we focus on the perceptions by individuals with ID and relate them to their family members' perceptions.

Method

Sample

The research was conducted in the Psychiatric Unit of Mental Development (UPDM) of the University Hospital of Geneva, Switzerland, a specialized entity adapted to patients presenting a double diagnosis of ID and psychiatric disorder. Note that people with ID have been found to present levels of psychopathology that are markedly higher than those of the general population. While Borthwick-Duffy (1994) reports a variation in prevalence rates of 10% to 80%, most authors agree that comorbidity of ID and mental health disorders is a major public health problem. The UPDM population confirms this result. A recent study of UPDM (Lehotkay, Varisco, Deriaz, Douibi, & Galli Carminati, 2009) shows that 48.2% of its patients with ID present psychiatric disorders, and the prevalence of psychiatric disorders is even more important when the ID is milder.

Part of this care structure, a day hospital, accommodates people with intellectual disability after crisis, during rehabilitation, before they are reintegrated into their usual environment (e.g., home, sheltered workshop, or residence). In this situation, the aim of intervention is to provide support outside the inner hospital. At the same time, professionals seek the social resources that might allow clients to leave the day hospital and reintegrate into their usual milieu (Galli Carminati, 2000). In the majority of cases, this reintegration consists of re-establishing a connection with their social background (i.e., families). In this context, practitioners very often face an unclear situation in which patients' perceptions of their families differ from those of family members and of professionals.

The clinical sample (ID group) comprised a total of 17 UPDM patients, with an average age of 31 ($SD = 12.51$), who participated in activities in the day hospital and presented a diagnosis of mild ID (F70, according to ICD-10 criteria; World Health Organization, 1993). All participants had received at least one other psychiatric diagnosis or presented a significant impairment in behavior requiring attention or treatment directly linked to the ID. A majority of UPDM patients fulfilled criteria for a diagnosis of schizophrenia or schizotypal and delusional disorders (F20-29: $n = 7$), adult personality and behavior disorder (F60-69: $n = 3$), or a mood disorder (F30-39: $n = 4$). For some, this diagnosis was associated with other diagnoses (e.g., affective disorders, eating disorders and organic disorders). The majority of participants were of Swiss nationality ($n = 12$), with 14 Eurasians, 2 Africans, and 1 Hispanic (from Latin America) also participating. Of 17 participants, 6 had divorced parents, and among these, 5 had a reconstituted family. In addition, 6 participants lived on their own in private apartments, 5 were still living with their parents, and 5 were accommodated in the Socio Educational Institution for Persons with Intellectual Disability. One participant was living in a hotel. All participants had a legal guardian, and, according to Swiss law, we excluded patients whose consent or the consent of parents or tutors was not given. Men represented 76.47% of the sample.

The ethics commission of the University Hospital of Geneva approved this study. An explanation and clear oral and written information were given to prospective participants in the clinical sample during individual sessions. The parents and legal tutor were informed, and written consent was obtained. Each participant with ID (clinical sample) was interviewed individually and completed the Family Network questionnaire under the supervision of the primary author and one UPDM staff member familiar to the participant who could facilitate the interview process by securing the participants and improving understanding of verbal exchanges by both the participant and the primary investigator. It is possible that these interactions influenced participants' responses, but the benefits of doing research on patients' perceptions rather than their family members' perceptions about them largely compensate, in our view, for this possible bias.

Interviews were conducted at the day hospital or at the consultation center with ID patients. The participants were also asked whether they consented to the first family member cited in their list being contacted for an interview. A total of 24 patients were originally interviewed; of these, 2 would not consent to our contacting a family member, and 5 family members who were contacted would not agree to participate. Therefore, the clinical sample is limited to the 17 patients for whom an interview was conducted with a family member. The average age of this sample was 30.70 (*SD* = 11.07), and 53% were men. It is worth noting that a majority of people we were not able to interview presented an emotionally unstable personality disorder characterized by difficulty in maintaining relationships (borderline or impulsive type, F60.3, *n* = 4, and unspecified disorder of adult personality, F69, *n* = 1). In our second sample (comprising family members), we interviewed mainly mothers (*n* = 11) but also fathers (*n* = 3). One adoptive father, one brother, and one former partner were also interviewed. Of family members interviewed, 71% were women, with an average age of 60.12 (*SD* = 13.88).

In order to estimate the effects of ID and psychiatric disorders on family relationships, we added a third, nonclinical sample, comprising 17 pre- or post-graduates of Swiss universities or professional schools. This sample was matched for age and sex with the clinical sample of individuals with intellectual disabilities and psychiatric problems. The average age of respondents was 30.5 (*SD* = 11.07; not statistically different from the clinical sample) and 59% were men. Estimates of the comparison group were used to broadly assess the extent to which family networks of individuals with ID differ from those of individuals in community samples.

Instruments

The Family Network Method (FNM; Widmer, 1999; Widmer & La Farga, 1999, 2000; Widmer, Chevalier, & Dumas, 2005) was used to evaluate the family relationships of patients. Respondents were first asked to provide a list of persons they considered significant family members at the time of the interview. Based on this list, we then asked several questions about emotional support, conflict, and influence. As in other cognitive network studies (Krackhardt, 1987), respondents evaluated not only their own relationships with family members, but also the relationships among all family members (Widmer, 1999; Widmer & La Farga, 2000; Widmer et al, 2005). The question of emotional support was introduced by asking, "From time to time most people discuss important personal matters with other people. During routine or minor troubles, who gives emotional support to X?" Conflict was measured by asking, "There is conflict and tension in every family. Who do you think can irritate X (make X angry)?" Influence was approached by asking, "Who do you think would be able to change X's mind (for example, about the clothes he wears, or his daily activities)?" In this process, all individuals included by the respondent in his or her list of family members were considered one by one.

In a second step, we interviewed family members of patients, following a similar procedure. We asked the first family member cited by the patient whether he or she agreed to be interviewed concerning family relationships of the patient. We started this new interview by asking the family member to provide the first names of all people he or she considered significant family members of the patient. The family member was then asked to provide his or her perceptions of the relationships among these individuals, answering the same questions about emotional support, conflict, and influence the patient had. Note that no information about the psychiatric record of family members was available, as the ethical committee of the host institution of patients prohibited asking any such questions. Individuals in the nonclinical sample were interviewed in the same manner as patients, but in their case, no family members were interviewed. The findings reported in this paper are based on evaluation of the three sets of interviews.

Measures

In order to estimate the extent to which perceptions of family relationships differ between patients and their family members and those of the comparison group, we applied four measures commonly used to assess connections in social networks (Wasserman & Faust, 1994; Widmer, 2006) to answers given by participants about emotional support, conflict, and influence in family configurations. These measures were computed for three different sets of family members, using UCINET 6™ (Borgatti, Everett, & Freeman, 2002). A first set, the respondent's *in-neighborhood*, concerned only family members perceived by the respondent as depending on him as a support provider, and being irritated or influenced by him. In Figure 1, arrows point from these family members to the respondent. (The figures used with the four measures are not displayed in this article.) A second set, the respondents' *out-neighborhood*, concerned only family members perceived by the respondent as providing him with support, getting him irritated, or able to make him change his mind. In this case, arrows originate from the respondent. The two sets of family members do not fully overlap. For instance, in Figure 1A, the respondent has no one in his family configuration to whom, in his view, he would give emotional support if needed (in-neighborhood set) and two persons in his family configuration from whom, in his view, he would receive support (out-neighborhood set). The third set, the *full family network*, extended over the respondent's neighborhood to include all individuals cited as family members, not just those with whom he or she was connected by a support, conflict, or influence relationship.

Size indicates the number of family members with whom the respondent is directly connected and that can be computed in each set.

Density is computed as the number of existing ties divided by the number of pairs of family members cited by the respondent (i.e., potential ties). It can be computed either for respondents' supported or supporting family members (in- and out-neighborhoods), or for the family configuration as a whole. For instance, the density of the family configuration presented in Figure 1A is 0.17, meaning that fewer than 20% of the support relationships possible in this case are perceived as existing. This is significantly more than in Figure 1C, where about 3% of possible relationships are perceived by the respondent as existing (density of 0.03).

An *index of components* constituting the respondents' neighborhoods was also computed as a percentage of the number of family members. A component is technically defined as a maximal connected subgraph (Wasserman & Faust, 1994). In a component, all actors can reach one another through one or more paths. The more components, the more central the respondent is within his or her circle of supportive or supported family members. The number of components (i.e., disconnected subgroups) was also computed for the family configuration as a whole.

Respondents' betweenness centrality captures the proportion of relationships in which the respondent is an intermediary; thus the respondent's neighborhood is said to be centralized if the respondent lies between all family members' relationships. In Figure 1C, for instance, the respondent has a higher betweenness centrality (both in terms of supportive and supported family members) than in Figure 1D, in which no two other people need him or her as an intermediary for connecting (see Widmer, 2006, for further details).

Results

We first compared the perceptions of relationships by patients, their family members, and the comparison group for emotional support. Table 1 presents average scores on the various network indices for emotional support according to group membership. Results of F-tests and Kruskall-Wallis tests (a nonparametric test not assuming normal distributions) are provided, with levels of significance.

ID group and comparison group were different on several accounts. First, size of the out-neighborhood was significantly smaller in the clinical sample; ID individuals perceived family members less often as resources of emotional support than did nonclinical individuals. The density of the out-neighborhood was twice as low in the ID group as in the comparison group (i.e., clinical individuals perceived about half of the connections existing among family members who supported them). Clinical individuals were also significantly less central in their set of supportive family members than nonclinical individuals, as reflected in betweenness centrality. Table 1 shows even stronger results for in-neighborhoods (i.e., family members for whom respondents were resources). Size of in-neighborhoods was much smaller for clinical individuals. Individuals with ID consider themselves much less often as resources of emotional support for their family members than do nonclinical individuals. The connections they perceived among family members they support were also significantly fewer, as the measure of density showed. The centrality of clinical individuals in their in-neighborhood was also much smaller. Evidence for the family network as a whole showed similar results for most indices. Density and centralization were much smaller in the clinical group than in the comparison group. The number of components was significantly related to group membership. Family networks of clinical individuals were significantly more disconnected than family networks in the comparison group.

Is this lack of supportive ties confirmed by family members? Responses of family members presented in Table 1 confirmed that patients had a very limited set of supportive relationships. Connections among providers were perceived as seldom existing (low density), and patients as peripheral to their own family configurations; however, some significant differences between patients' perceptions and their family members' perceptions were also found. Indices concerning the family configuration as a whole produced dissimilar results according to patients' and family members' perceptions. The density and number of components in the family configurations were significantly smaller in patients' perceptions than in family members' perceptions, similar to results with the comparison sample. In other words, family members perceived some additional relationships that patients did not perceive among family members. Those ties concerned individuals who were not part of the patients' directly supportive ties (i.e., their out-neighborhood).

The question about influence (Table 2) produced similar patterns of results, with even greater differences between the ID sample and the comparison sample. On average, patients were influenced by significantly fewer family members who were much less influenced by each other than in the comparison sample. Moreover, patients played

TABLE 1. *Indexes of Emotional Support: Mean by Subsamples, F-tests*

CHARACTERISTICS	PARTICIPANTS ($n = 17$)	FAMILY MEMBERS ($n = 17$)	COMPARISON GROUP ($n = 17$)	*F*-TEST	KRUSKAL-WALLIS
Respondent as support providers					
Size	2.29	1.06	6.88	19.70**	25.20**
Density	17.00	19.48	42.30	4.00*	9.90**
Proportion of components	50.69	12.65	24.41	6.40**	9.60**
Normalized respondents' betweenness	20.73	3.96	27.80	4.90**	14.30**
Respondent as support seekers					
Size	2.60	2.76	4.71	3.20	6.50*
Density	20.36	42.96	41.92	2.00	4.00
Proportion of components	52.47	59.17	42.26	0.90	1.90
Normalized respondents' betweenness	15.15	7.58	32.40	3.90*	7.30*
Full family networks					
Size	11.65	6.24	10.80	6.90**	16.30**
Density	0.18	0.38	0.37	6.00**	11.80**
Number of components	4.24	1.76	1.12	7.40**	16.30**
Betweenness centralization	0.09	0.11	0.26	7.50**	13.40**

* $p < .05$; ** $p < .01$.

TABLE 2. *Indexes of Influence: Means by Subsamples, F-tests*

CHARACTERISTICS	PARTICIPANTS ($n = 17$)	FAMILY MEMBERS ($n = 17$)	COMPARISON GROUP ($n = 17$)	*F*-TEST	KRUSKAL-WALLIS
Respondent as influence providers					
Size	0.94	0.35	5.12	23.08**	16.30**
Density	4.27	7.69	36.80	9.70**	24.60**
Proportion of components	23.37	26.47	29.90	0.13	6.40*
Normalized patients' betweenness	5.63	0.00	23.40	6.57**	17.80**
Respondent as influence seekers					
Size	1.41	1.88	3.76	6.70**	10.40**
Density	7.26	24.49	35.10	4.35*	10.10**
Proportion of components	43.63	44.71	47.90	0.05	0.40
Normalized patients' betweenness	9.05	0.00	30.30	10.60**	18.60**
Full family networks					
Density	0.07	0.20	0.25	8.82**	15.60**
Number of components	6.24	2.71	1.65	7.15**	8.20**
Betweenness centralization	0.05	0.05	0.19	10.21**	18.40**

* $p < .05$; ** $p < .01$.

a peripheral role as influence providers in their family networks. The number of people they perceived themselves as influencing was low compared with the comparison sample. On average, the centrality of patients in influence relationships was low in both in-neighborhood and out-neighborhood and in their family configuration as a whole. In other words, patients perceive themselves as peripheral in influence and they disregard influential relationships among family members. Interviews with family members for the most part confirmed the perceptions of patients. Family members reported even fewer alters influenced by the patient; among the 17 cases, in only five interviews did a family member report that the patient had an influence on at least one family member. Again, interviews with family members confirmed that the patients were not easily influenced and that they did not consider themselves able to change a family member's mind. As for emotional support, however, significant differences existed between patients and their family members when the full family configuration was considered rather than the neighborhoods of the patient. Again, the density of relationships was much higher and the number of components much smaller in responses of family members compared with those of patients. In this regard, responses of family members were no different from responses of the nonclinical sample.

Conflict relationships are considered in Table 3, which compares results for emotional support and influence. There was no significant difference between the three samples; in other words, patients, family members, and the comparison group reported the same number of individuals with whom they were in conflict, the same centrality in conflict relationships in family configurations, and the same density of conflict relationships overall. Only the density of relationships among conflict seekers (individuals who were bothered by the respondent) was significantly higher in the nonclinical sample.

Discussion

This research confirms previous research that has found that individuals with ID and psychiatric disorders have less emotional support and suggests that this is also the case with social influence: individuals with ID not only have fewer supportive ties but are also subjects and actors in fewer interactions in which values and norms are transmitted through communication. For the most part, the results of the present study show that family members support the views of patients. Family members also perceive the patients as relationally marginal in their family, with few supportive ties available to them, and even fewer relationships in which patients are support providers. Similarly, family members' responses showed that patients participate only marginally in flows of influence in their own families, either as influence seekers or as influence providers. Therefore, individuals with ID and psychiatric disorder face a severe risk of developing relatively small, sparse family configurations with few ties and a higher ratio of conflict to support than other individuals. Differences among clinical and nonclinical subsamples do not stem from a deficit in social cognitions of patients. In this study, family members confirm patients' perceptions that their family-based relational resources are significantly poorer, in terms of emotional support and influence, than the resources of individuals without a clinical record.

Some biases in perceptions may be significant as well, however. Results for emotional support and influence show a distinct pattern: relationships among individuals not directly connected to patients are not perceived by patients, whereas they are acknowledged by the interviewed family members. The acknowledgment of these relationships by family members accounts for the similarity between responses of family members and those of the comparison group in that regard. We are not yet sure how exactly to interpret this result. It may be linked to the difficulties of individuals with ID to perceive relationships that do not directly include them. If this interpretation were confirmed, it would indeed constitute a limitation of the patient's ability to function socially. Another explanation may be methodological rather than substantive and linked to the fact that family members cite fewer individuals and thus consider smaller networks, which are generally associated with greater density (Wasserman & Faust, 1994). It may also be that family members have a better knowledge of some of the borders of the patients' family configurations than the patient because of their own structural position within those borders.

Finally, the similarity of the three samples in conflict relationships may have far-reaching consequences; if confirmed by additional research, they may raise further issues and possible interpretations. Contrary to our hypothesis, no significant differences were found in conflict between families confronted with ID and other families. In other words, ID may not lead to a higher level of social negativity in interpersonal relationships but rather to estrangement from potentially important family members and from significant relationships. Of course, this might not be the case at every stage of family development, in particular when individuals with ID are children or adolescents. In those life stages, the strong proximity to and interdependencies of family life may trigger more conflicts in those families than in other families. But by early adulthood, many individuals with ID have to some extent distanced themselves from their parents and siblings, in particular, by moving out of the parental home for other living arrangements, including institutions where care professionals have a central role in their lives (Stoneman & Crapps, 1990).

Table 3. *Indexes of Conflict: Means by Subsamples, F-tests*

Characteristics	Participants ($n = 17$)	Family members ($n = 17$)	Comparison group ($n = 17$)	*F*-test	Kruskal-Wallis
Respondent as conflict providers					
Size	1.71	1.47	2.12	0.54	2.20
Density	8.23	18.94	32.81	2.10	3.30
Proportion of components	46.15	58.33	49.02	0.37	0.75
Normalized patients' betweenness	22.92	20.33	16.41	0.80	0.12
Respondent as conflict seekers					
Size	2.59	1.71	2.00	0.62	2.40
Density	10.97	13.80	55.48	9.10**	13.50**
Proportion of components	51.86	45.00	50.98	0.13	0.40
Normalized patients' betweenness	24.53	17.52	11.75	0.80	0.90
Full family networks					
Density	0.10	0.22	0.15	1.97	3.30
Number of components	6.71	2.94	4.45	3.80*	6.10*
Betweenness centralization	0.09	0.13	0.08	1.70	2.10

* $p < .05$; ** $p < .01$

On the other hand, Bigby (2008) observed a trend in which people with ID gradually lose contact with friends and family members in the process of moving from an institution to the community. This distancing may in turn reduce the occasions when negative interactions arise, and therefore the likelihood of conflict relationships within families of individuals with ID. In that regard, a striking result was that the ratio of conflict relationships to supportive or influential relationships was much higher in the clinical sample than in the comparison group, a result further supported by responses of family members. In other words, supportive or influential relationships are much more often associated with conflict in families of individuals with ID than in other families. Therefore, the decrease in supportive relationships in those family contexts may be interpreted as a means of reducing conflict and tension.

In any case, the finding of no difference in conflict relationships among subsamples, if confirmed by further research, emphasizes the occurrence of conflict and tensions as being the common ground among all families, with impaired individuals or otherwise. Using a social network approach of family ties may enable practitioners to focus more on strengthening nonconflict ties between impaired individuals and family members than on correcting conflict interactions, while taking into account the complex patterns of relationships characterizing contemporary families (Widmer, 2006).

Limitations and Directions for Research

Some crucial issues remain at this time, as this study is explorative rather than confirmative. A larger random sample of individuals with ID and psychiatric disorders from various institutional settings would considerably improve the research design by allowing us to test the validity of our findings in several other institutional settings. In order to generalize the results, one may wish to consider other populations with ID from socioeducational institutions. Working with a larger and more representative sample of individuals with ID and a less specific comparison group of individuals without a clinical background would also be a step toward confirmation of our findings. It is necessary to replicate the study on samples of individuals with ID but without psychiatric troubles, or with psychiatric troubles but without ID, in order to understand to what extent ID, psychiatric troubles, and the concomitant presence of ID and psychiatric troubles might change the ways in which family relationships are perceived by patients and their family members. This understanding will be possible only if a scientific and political interest develops in a more comprehensive understanding of the social integration of individuals with ID into their families. Another shortcoming of the study is the fact that we had only limited information about the psychiatric record, intellectual level, and private life events of interviewed family members. This kind of information would be important if one were to extend the study to larger samples.

References

Bigby, C. (2008). Known well by no-one: Trends in the informal social networks of middle-aged and older people with intellectual disability five years after moving to the community. *Journal of Intellectual and Developmental Disabilities, 33*(2), 148–157.

Borgatti, S., Everett, M. G., & Freeman L. C. (2002). UCINET 6 for Windows. Software for social network analysis. [Computer software]. Harvard: Analytic Technologies.

Borthwick-Duffy, S. A. (1994). Epidemiology and prevalence of psychopathology in people with mental retardation. *Journal of Consulting and Clinical Psychology, 62*, 17–27.

Dempsey, I., Keen D., Pennel D., O'Reilly J., & Neilands, J. (2009). Parent stress, parenting competence and family-centered support to young children with an intellectual or developmental disability. *Research in Developmental Disabilities, 30*, 558–566.

Fehr, B., & Perlman, D. (1985). The family as a social network and support system. In L. L'Abate (Ed.), *The handbook of family psychology and therapy* (pp. 323–356). Homewood, IL: Dorsey Press.

Fowler, J., & Christakis, N. (2008). Dynamic spread of happiness in a large social network: Longitudinal analysis over 20 years in the Framingham Heart Study. *British Medical Journal, 337*, a2338.

Freeman, L. C. (2004). *The development of social network analysis: A study in the sociology of science.* Vancouver, BC: Empirical Press.

Furstenberg, F. F., & Hughes, M. E. (1995). Social capital and successful development among at-risk youth. *Journal of Marriage and the Family, 57*(3), 580–592.

Furstenberg, F. F., & Kaplan, S. B. (2004). Social capital and the family. In M. Richards, J. Scott, & J. Treas (Eds.), *Blackwell companion to the sociology of families* (pp. 218–232). Blackwell.

Galli Carminati, G. (2000). *Retard mental, autisme et maladies psychiques [illegible]ez l'adulte* [Backwardness, psychic autism, and diseases in the adult]. Genève: Médecine et Hygiène.

Gupta, V. B. (2007). Comparison of parenting stress in different developmental disabilities. *Journal of Developmental and Physical Disabilities, 19*, 417–425.

Hatton, C., & Emerson, E. (2003). Families with a person with intellectual disabilities: Stress and impact. *Current Opinion in Psychiatry, 16*, 497–501.

Hofer, M. A. (1994). Early relationships as regulators of infant physiology and behavior. *Acta Paediatr, 83, suppl. 397*, 9–18.

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 78*, 459–467.

Killworth, P. D., & Bernard, H. R. (1976). Informant accuracy in social network data. *Human Organization, 35*, 269–286.

Krackhardt, D. (1987). Cognitive social structures. *Social Networks, 9*, 109–134.

Krauss, M. W., Seltzer, M. M., & Goodman, S. J. (1992). Social support networks of adults with mental retardation who live at home. *American Journal on Mental Retardation, 96*(4), 432–441.

Kumbasar, E., Romney, K., & Batchelder, W. H. (1994). Systematic biases in social perception. *American Journal of Sociology, 100*(2), 477–505.

Lavin, C., & Doka, K. J. (1999). *Older adults with developmental disabilities.* Amityville, NY: Baywood Publishing.

Lehotkay, R., Varisco, S., Deriaz, N., Douibi, A., & Galli Carminati, G. (2009). Intellectual disability and psychiatric disorders: More than a dual diagnosis. *Swiss Archives of Neurology and Psychiatry, 160*, 105–115.

Lüscher, K. (2002). Intergenerational ambivalence: Further steps in theory and research. *Journal of Marriage and the Family, 64*, 585–593.

Nandrino, J.-L., & Doba, K. (2001). La représentation de l'organisation familiale chez les patients schizophrènes institutionnalisés. Etude comparative du dessin de famille [The representation of the family organization among institutionalized schizophrenic patients. Comparative study of the drawing of family]. *Cahiers critiques de thérapie familiale et de pratiques de réseaux, 26*, 125–141.

Pescosolido, B. A., & Wright, E. R. (2004). The view from two worlds: The convergence of social network reports between mental health clients and their ties. *Social Science & Medicine, 58*, 1795–1806.

Rankin, P., Bentall, R., Hill, J., & Kinderman, P. (2005). Perceived relationships with parents and paranoid delusions: Comparisons of currently ill, remitted and normal participants. *Psychopathology, 38*, 16–25.

Reiss, D., & Oliveri, M. E. (1983). Sensory experience and family process: Perceptual styles tend to run in but not necessarily run families. *Family Process, 22*, 289–308.

Robertson, J., Emerson, E., Gregory, N., Hatton, C., Kessissoglou, S., & Hallam, et al. (2001). Social networks of people with mental retardation in residential settings. *Mental Retardation, 39*, 201–214.

Scott, J. (2000). *Social network analysis.* Newbury Park, CA: Sage.

Smith, K. P., & Christakis N. A. (2008). Social networks and health. *Annual Review of Sociology, 34*, 405–429.

Stoneman, Z., & Crapps, J.-M. (1990). Mentally retarded individuals in family care homes: Relationships with the family-of-origin. *American Journal on Mental Retardation, 94*(4), 420–430.

Wasserman, S., & Faust, K. (1994). *Social network analysis: Methods and applications.* Cambridge: Cambridge University Press.

Wellman B. (1988). Structural analysis: From method and metaphor to theory and substance. In B. Wellman & S. D. Berkowitz (Eds). *Social structures: A network approach.* Cambridge: Cambridge University Press.

Widmer, E. D. (1999). Family contexts as cognitive networks: A structural approach of family relationships. *Personal Relationship, 6*, 487–503.

Widmer, E. D. (2004). Couples and their networks. In M. Richards, J. Scott, & J. Treas (Eds.). *Blackwell companion to the sociology of families.* Blackwell, 356–373.

Widmer, E. D. (2006). Who are my family members? Bridging and binding social capital in family configurations. *Journal of Personal and Social Relationships, 47*(5), 131–156.

Widmer, E. D., Chevalier, M., & Dumas, P. (2005). Le "family network method" (FNM): Un outil d'investigation des configurations familiales à disposition des thérapeutes [The "family network method" (FNM): A tool for investigation of the family configurations at disposal of the therapists]. *Thérapie familiale, 26*(4), 423–441.

Widmer, E. D., Kempf-Constantin, N., Lanzi, F., Robert-Tissot, C., & Galli Carminati, G. (2008). How central and connected am I in my family? Family based social capital of individuals with intellectual disability. *Research in Developmental Disabilities, 29*, 176–187.

Widmer, E. D., & La Farga, L.-A. (1999). Boundedness and connectivity of contemporary families: A case study. *Connections, 22*(2), 30–36.

Widmer, E. D., & La Farga, L.-A. (2000). Family networks: A sociometric method to study relationships in families. *Field Methods, 12*(2), 108–128.

Widmer, E. D., Orita, A., Gauthier, J. A., Sénac, N., Cucchia, A. T., Stekel, K., et al. (2008). How central and connected am I in my family? Bridging and bonding social capital in family configurations of young adults with psychiatric disorders. *International Journal of Social Psychiatry, 54*(6), 550–561.

World Health Organization (1993). *The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research.* Geneva: Author.

Eric D. Widmer, PhD, is professor, University of Geneva, Department of Sociology. **Nadine L. Kempf-Constantin,** MS, is psychologist, University Hospital of Geneva, Psychiatric Unit of Mental Development. **Giuliana Galli Carminati,** PhD, is head psychiatrist of the Psychiatric Unit of Mental Development, University Hospital of Geneva. Correspondence regarding this article can be sent to the second author at Nadine.Kempf@hcuge.ch or University Hospital of Geneva, Psychiatric Unit of Mental Development, 2, chemin du Petit Bel-Air, 1224 Chêne-Bougeries, Geneva, Switzerland.

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