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HOW CENTRAL AND CONNECTED AM I IN MY FAMILY? BRIDGING AND BONDING SOCIAL CAPITAL IN FAMILY CONFIGURATIONS OF YOUNG ADULTS WITH PSYCHIATRIC DISORDERS

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ABSTRACT

Aims: This article explores the structures of relational resources that individuals with psychiatric disorders get from their family configurations using the concept of social capital.
Methods: The research is based on a sample of 54 individuals with psychiatric disorders and behavioural problems, and a comparison sample of 54 individuals without a clinical record matched to the clinical respondents for age and sex. Standard measures of social capital from social network methods are applied on family configurations of individuals from both samples. Differences are tested by variance analysis.
Results: Structures of family resources available to individuals with psychiatric disorders are distinct. Individuals with psychiatric disorders perceive themselves as less central in their family configurations and less connected to their family members. Their significant family members are perceived as less connected with each other. As a whole, their family configurations are smaller and do not include spouses or partners. Therefore bridging and bonding social capitals are not readily available for them.
Conclusion: As family configurations of individuals with psychiatric disorders provide fewer relational resources than other families, they are not able to deal with social integration of individuals with psychiatric disorders on their own.

Key words: young adults, psychiatric disorders, family configurations, social capital

INTRODUCTION

Do individuals with psychiatric disorders have access to relational resources from their families similar to those of other individuals? The interrelations existing between family relationships and psychiatric disorders have been a classical focus of social psychiatry. This article goes back to this issue, using an approach to family relationships that allows a detailed assessment of the structures of family resources (Widmer, 1999; Widmer, 2006). Based on previous research we hypothesize

that family resources available to individuals with psychiatric disorders are structurally distinct from family resources available to others, with likely consequences for their social integration beyond institutional settings.

Family relationships of individuals with psychiatric disorders

A body of research focused on the impact of positive family relationships on psychological well-being. It showed that those individuals who belong to families in which relationships are gratifying and which adequately support their members are less prone to depression and show higher self-esteem and self-efficacy (Hirsch, 1980; House *et al.*, 1988; Wilcox, 1981). Evert and colleagues (2003) were interested in the relationship between the patients' type of social network, either based on family or friends, and their functioning level, social competencies, professional activity and their living environment. They state that networks in which friends are predominant increase self-care and promote a higher self-esteem, while networks based essentially on family ties trigger inferior social competencies. Overall, this literature is mostly concerned with the valence of family relationships (negative or positive) and the amount of family support provided to individuals with psychiatric disorders. The focus on the amount of relational reinforcement provided to individuals with psychiatric disorders by their family members has relegated interest in the structural features of family resources to a marginal position in the field. Social network methods, with their emphasis on structural features of relationships (Wasserman & Faust, 1994), may provide a valuable contribution to the understanding of family resources of individuals with psychiatric disorders. A recent trend of papers has conceptualized family resources as social capital (Furstenberg & Hughes, 1995; Furstenberg & Kaplan, 2004; Widmer, 2007). Social capital has been defined in various ways – some very broad, assimilating it to social integration within local communities (Putnam, 1996). We take social capital in a narrower sense, closer to its original definition of 'resources stemming from the possession of a durable network of acquaintance or recognition' (Bourdieu, 1985). The concept focuses on the benefits accruing to individuals by virtue of their participation in groups. In this perspective, family ties are hypothesized to have various positive consequences for individuals, such as promoting physical and psychological health, increasing individual resilience against non-normative events of life, etc. (Furstenberg & Hughes, 1995; Furstenberg & Kaplan, 2004; Widmer, 2004).

Research on social capital has emphasized the beneficial impact of a high density of relationships within a group (Coleman, 1988). In dense networks, most, if not all, individuals are interconnected, a situation that enhances expectations, claims, obligations and trust among them because of the increase of the collective nature of normative control. If any network member fails to conform to the group's expectations at one point, he or she is likely to have several other network members jointly react against this situation. Dense networks also facilitate communication flows by multiplying the number of information channels and reducing the number of intermediaries between any two network members. Finally, in dense networks, support has a collective nature as several individuals are likely to coordinate their efforts when helping another. This 'bonding' structure of social capital is to be found in family configurations in which most individuals are interconnected.

A second perspective on social capital has recently been developed. It underlines the potential of some persons to connect otherwise unrelated individuals: the weaker connections between subgroups of a network create 'holes' in the structure, which provide brokers with opportunities to mediate the flow of information between group members and hence control the projects that bring them

together (Burt, 1995). Therefore, the intermediary position of brokers in relatively low-density networks provides autonomy to them, as they can benefit from resources from groups that they connect. This is called the 'bridging' structure of social capital (Burt, 1995; Widmer, 2006). Overall, bonding social capital reinforces the collective nature of support and social control, as several network members can coordinate each other when dealing with a problem concerning the individual. Bridging social capital helps individuals increase their autonomy as it is associated with intermediary positions and connections with otherwise unrelated relational contexts.

The structural dimension of relational resources can also be addressed by considering the composition of family configurations. The assumption that family configurations are always synonymous to the nuclear family (i.e. spouses and children living in a single household) is largely questionable as significant family ties extend well beyond it (Finch & Mason, 1993; Widmer, 1999; Widmer & La Farga, 2000; Widmer, 2006). People become part of family configurations through shared intimacy among same-sex partners or friends, post-divorce recomposition, adoption or reproduction technology (Carsten, 2004). In former publications based on non-clinical samples (Widmer, 1999, 2006, 2007) it was found that family configurations based on blood ties (grandparents, uncles and aunts, cousins) mostly provided bonding social capital. To the contrary, family configurations based on friends considered as family members mostly provided bridging social capital. Post-divorce family configurations, which included stepparents, half- or stepsiblings, were associated with neither type of social capital. These results suggest that the structures of family resources vary according to the composition of family configurations.

How may structures of family resources then vary depending on the psychological health of individuals? In this regard, two opposite hypotheses can be tested. First, one may hypothesize that individuals with psychiatric disorders have family resources structurally similar to those of individuals without psychiatric disorders. While individuals with psychiatric troubles may lack some important family ties, such as the conjugal tie, they are hypothesized to compensate these losses by developing alternative family relationships such as those stemming from their kinship network, or even family-like connections developed within the professional care support system. Thanks to those ties, individuals with psychiatric disorders may have bonding and bridging social capital similar to those of individuals without psychiatric disorders.

Alternatively, a second hypothesis states that individuals with psychiatric disorders perceive a smaller number of people as significant family members because they have a lower probability to experience parenthood or stable partnerships (Burnand *et al.*, 2004; Pescolido & Wright, 2004). The deficit hypothesis states that bonding social capital is less likely to be found for individuals with psychiatric disorders because of the negative effect that psychiatric disorders have on family cohesion (Olson *et al.*, 1989). As for bridging social capital, the deficit hypothesis states that it is lower in the clinical sample because of the difficulty for impaired individuals to maintain significant ties with others, and because of the feelings of dissatisfaction and incompetence of family members (especially parents and siblings), sometimes leading to their relational withdrawal from the individual with psychiatric disorders.

METHODS

The research took place in the rehabilitation unit of the Department of Adult Psychiatry (DUPA) of the University Hospital of Lausanne (Switzerland). This unit treats outpatients suffering from

enduring psychiatric disorders with potentially disabling effects. It aims at reintegrating patients into professional and social life. The clinical sample included a total of 54 patients from the rehabilitation unit, with an average age of 25 (*SD* = 3.35). They had all received a DSM-IV diagnosis of mood or personality disorder. They lived on their own or in residential establishments. Women represented 33% of the sample. The ethics commission of the University Hospital of Lausanne approved this study. An explanation and clear oral and written information were given to the prospective respondents of the clinical sample during individual sessions. The parents and legal tutor were informed, and written consent was obtained. Each participant with psychiatric disorders (clinical sample) was interviewed individually and completed the Family Network questionnaire under the supervision of one DUPA staff member (familiar to the participant) and the primary author. Interviews were conducted at the day hospital or at the consultation centre with patients.

The non-clinical sample comprised a total of 54 college students from Swiss universities in the French-speaking area of the country. This sample was matched for age and sex with the clinical sample. As in the clinical sample, the average age of respondents was 25 years old and 33% were women. The participants of the non-clinical sample filled out a self-administered questionnaire after individualized explanations.

Instruments

The Family Network Method (FNM) (Widmer, 1999; Widmer, 2006) is used to estimate the family ties of patients. Respondents are first asked to provide a list of persons whom they consider to be their significant family members. Based on the list of family members provided by each respondent, three questions about emotional support, conflict and influence are then asked, following the FNM. As in other cognitive network studies (Krackhardt, 1987), respondents not only had to estimate their own relationships with their family members, but also the relationships existing among all family members (Widmer, 1999; Widmer & La Farga, 2000). Emotional support was introduced as follows: 'From time to time, most people discuss important personal matters with other people. During routine or minor troubles, who would give emotional support to X?'. In this procedure all individuals included by the respondent in their list of family members are considered one by one. This question is based on the same model as other name generators used in social network research (Daugherty *et al.*, 1988; Fisher, 1982; Wade *et al.*, 1994).

Measures

We apply four measures commonly used to investigate the structures of social capital (Scott, 2000; Wasserman & Faust, 1994; Widmer, 2006) on answers given by participants about emotional support in their family configurations. These measures are computed for three different sets of family members using UCINET 6 (Borgatti *et al.*, 2002). A first set, the respondent's *in-neighbourhood*, concerns only family members perceived by the respondent as depending on them as a support provider. Those are family members whose arrows point to the respondent (see Figure 1 for an example). A second set, the respondent's *out-neighbourhood*, concerns only family members perceived by the respondent as providing them with support. In that 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 their in-neighbourhood (persons in their family configurations whom, in their view, they would give emotional support to if needed) and two persons in their out-neighbourhood (persons in their family configuration from whom, in their view, they would receive support). The third set, the *full family configuration*, extends over the respondent's neighbourhood

to include all individuals cited as family members, not only those with whom the respondent is connected by a support relationship.

Size indicates the number of family members with whom the respondent is directly connected (in- and out-neighbourhoods), or their full family network.

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 the respondent's supported or supporting networks (in- and out-neighbourhoods), or for the family configuration as a whole. For instance, the density of the family network presented in Figure 1a is 0.25, meaning that less than one fifth of the support relationships possible in this case are perceived as existing. This is significantly less than in Figure 1b, where about 33% of possible relationships are perceived by the respondent as existing (density of 0.03).

An *Index of Components* constituting the respondents' neighbourhoods 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 there are, the more central the respondent is within their circle of supportive or supported family members. The number of components (i.e. disconnected subgroups) is also computed for the family configuration as a whole.

Respondents' betweenness centrality captures the proportion of relationships for which the respondent is an intermediary: thus, the respondent's neighbourhood is said to be centralized if he/she lies between all family members' relationships. In Figure 1a, for instance, the respondent has a higher betweenness centrality (both in terms of supportive and supported family members) as in Figures 1c or 1d, in which no two other people need the respondent as an intermediary for connecting (Widmer, 2006). These indices are computed for emotional support and social influence.

The higher the density and the size of the neighbourhoods, the larger the bonding social capital is, as density and direct connections of individuals are classic indicators of connectedness within closely tied groupings. The higher the betweenness centrality and the number of components, the larger the bridging social capital is because these indices reveal the intermediary position of individuals within loosely tied networks.

RESULTS

We first considered the structures of resources available to individuals in their family configurations depending on their inclusion in the clinical or non-clinical samples. Then we turned to the composition of family configurations. Table 1 presents average scores on the various network indices according to group membership with ANOVA and Kruskal Wallis tests performed.

The structures of family resources of individuals with psychiatric disorders and those of individuals from the non-clinical sample are different on several accounts. First, individuals with psychiatric disorders perceive family members significantly less often as resources of emotional support in comparison to individuals without such disorders. On average, patients cite 1.1 family members as a support provider for them, compared with 4.3 in the non-clinical sample. The density of the out-neighbourhood is four times lower in the clinical sample than in the non-clinical sample – i.e. individuals with psychiatric disorders perceive much fewer connections existing among family members who support them than others. Individuals with psychiatric disorders are also significantly less central in their set of supportive family members than individuals of the non-clinical sample, as the betweenness centrality shows.

Table 1
Structural indices of family resources mean and standard deviation
by subsamples, F tests and Kruskall-Wallis tests

	Clinical sample (n = 54)	Non-clinical sample (n = 54)	F test	Kruskal-Wallis	R^2
Respondents as support seekers					
Size	1.1	4.3	95.4**	58.1**	0.47
Density	11	42.4	26.9**	31.1**	0.24
Proportion of components	50.2	46.4	0.27	0.14	0.0
Normalized respondents' betweenness	14.4	49.1	26.8**	30.7**	0.24
Respondents as support providers					
Size	1.9	5.5	67.4**	46.1**	0.39
Density	21.5	41.5	12.9**	10.7**	0.12
Proportion of components	50	38.6	3.1	1.1	0.03
Normalized respondents' betweenness	21.6	38.4	7.6**	13.4**	0.08
Full family configurations					
Size	6.2	9.7	36.9**	32.8**	0.26
Density	0.36	0.38	0.13	0.7	0
Number of components	1.6	1.3	0.18	0.01	0.02
Betweeness centralization	0.19	0.25	2.38	8.01**	0.02

** $p < 0.01$; * $p < 0.05$

Table 1 shows similar results for in-neighbourhoods – i.e. family members to whom respondents provide emotional support. Size of in-neighbourhoods is much smaller for individuals with psychiatric disorders (1.9 compared to 5.5 in the non-clinical sample). Individuals with psychiatric disorders consider themselves much less often as resources of emotional support for their family members. The connections that they perceive among the family members whom they support are also significantly fewer, as the measure of density shows. Their centrality in their in-neighbourhood is also much smaller. Quite differently from what happens in the neighbourhoods of the respondent, evidence for the family network as a whole shows non-significant differences between the clinical and non-clinical samples for most indices. Density, number of components and centralization are identical in the clinical and in non-clinical samples. However size of family configurations varies between the two samples. The average size of family configurations is 9.7 for the non-clinical sample and only 6.2 for the clinical group, with a statistically significant difference between the two groups ($p < 0.01$). In the clinical sample respondents cited a total of 50 family terms after standardization of minor terminological differences, among which 25 were cited by one respondent only. In the non-clinical sample respondents cited a total of 76 family terms, among which 36 were cited by one respondent only.

In order to capture the interrelationship between psychiatric disorders and composition of family configurations, we ran a variance analysis using *proc glm* in SAS (SAS Institute, 1995). We also applied the Kruskal-Wallis test, a non-parametric version of a one-way ANOVA designed for cases of non-normally distributed variables. Table 2 shows the average number of citations

Table 2
Family terms (average number of citations and standard deviation
for clinical sample and non-clinical subsample)

| Terms	Clinical sample ($n = 54$)	Non-clinical sample ($n = 54$)	F test	Kruskal-Wallis	R^2
Spouse or partner	0	0.54	61.5**	39.3**	0.37
Mother	0.94	0.96	0	0.2	0
Father	0.74	0.91	4*	5.1*	0.05
Siblings	1	1.35	4.2*	4.3*	0.04
Grandparents	0.54	0.78	1.9	3.5+	0.02
Uncles and aunts	0.61	1	2.7+	3.6*	0.03
Friends	0.19	0.41	3.3+	4.4*	0.03
Step-relatives	0.16	0.28	1.8	2.1	0.01
In-laws	0.04	0.46	16.6**	17.2**	0.14
Size	6.2	9.7	36.9**	32.8**	0.26

** $p < 0.01$ * $p < 0.05$ + $p < 0.10$

associated with various categories of family members, calculated within each sample, as well as the results of the F test and Kruskal-Wallis test, with levels of significance and the proportion of variance explained (R^2). Spouse or partner, mother, father, number of siblings, step-relatives, grand-parents, uncles and aunts, and friends considered as family members constitute the main categories of family terms cited in the two samples.

Table 2 shows that individuals of the clinical sample did not cite partners as family members. As a consequence, individuals with psychiatric disorders also cited in-laws much less often. Individuals of the clinical sample less often cited their father and siblings, although mother was identically cited by the two samples. Grandparents, uncles and aunts, and friends were also less cited as significant family members by individuals with psychiatric disorders than by individuals from the non-clinical sample, although the difference is not as important in that case as is spouse or partner and in-law. Do these results correspond to a lack of acknowledgement of existing family members by individuals with psychiatric disorders or to the absence of such family members? Only five of the 54 respondents had a partner at the time of the interview (9%). Therefore the lack of citation of partners closely matches an absence of partners. The difference for blood connections, however, was not due to demographic reasons. On average, respondents with psychiatric disorders had 1.7 siblings, 1.78 grandparents, 6.4 uncles and aunts and 0.5 step-relatives, which is similar to the findings in the non-clinical sample. Therefore the number of available kinship members is as large as in the non-clinical sample, although the number of significant kinship members is lower.

Visualization of family configurations

In order to give an overview of the family configurations associated with psychiatric disorders, social network softwares such as *Pajek* (Batagelj & Mrvar, 1998) make it possible to visualize respondents' perceptions of their family configurations in sociograms (Widmer, 1999; Widmer & La Farga, 2000). In Figures 1 and 2 arrows between individuals represent flows of emotional support in their family context as perceived by respondents. Arrows point to support providers, and the relationships are not necessarily reciprocal. Eight cases were drawn randomly from the two
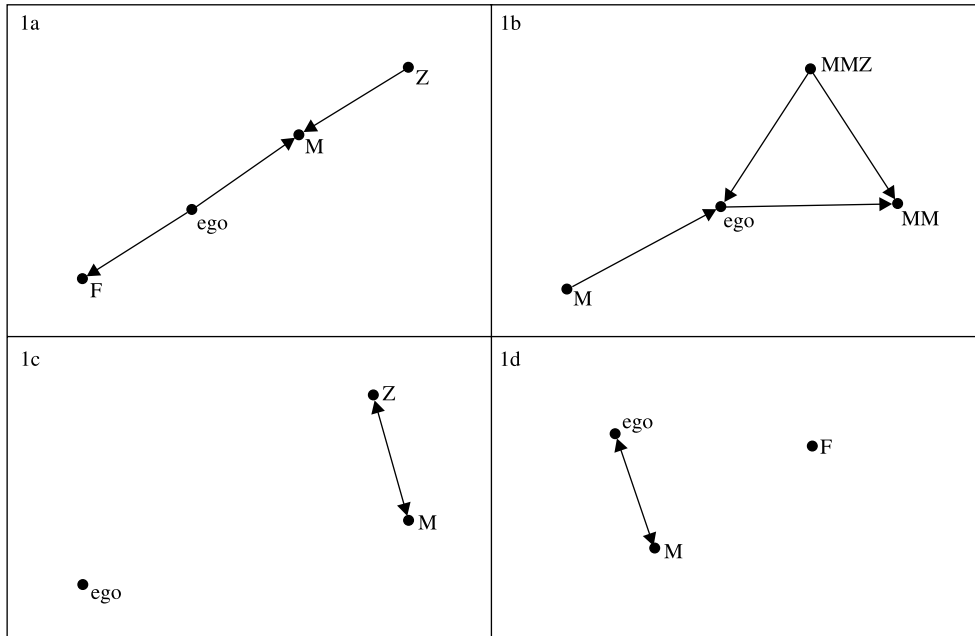
Figure 1. Family configurations of individuals from the clinical sample

sub-samples for the emotional support indicator. In Figure 1a the individual with psychiatric disorders estimates herself to be connected in a line with very few relationships. This is also the case in the three other family configurations in the clinical sample, which are small, sparse, with a low centrality of patients in them. It is of note that the patient is isolated in Figure 1c, which is not the case in Figure 1d. In graphs from the non-clinical sample (Figures 2a–2d) respondents are much more connected to family members, and much more central in their family configurations. The structures of family configurations of individuals with psychiatric disorders are distincts: social capital made available by them is in much shorter supply.

DISCUSSION

The structures of family-based social capital were strongly linked to the presence of psychiatric disorders. Individuals of the clinical sample had a smaller number of supportive family members, linked by fewer significant relationships. Therefore individuals with psychiatric disorders benefited from a low amount of bonding social capital within their family configuration. They could count on only one to two persons, on average, as support providers, which makes them dangerously de-pendent and may cause social isolation, for instance when they and their support providers grow old. They also seldom played the role of support provider for other family members, in their own perception, which raises some issues about the acknowledgement of their role in the family by other members. In addition they had a lower centrality both in their direct circle of supporters

Figure 2. Family configurations of individuals from the non-clinical sample (selection)

and in their family configuration as a whole, which makes their bridging social capital low as well. The deficit hypothesis is therefore confirmed by the data. Overall the family as a main support provider, as a place in which meaningful roles (such as helping others) can be experienced, as a social control agency or as a help to connect with external realities, was much less active for individuals with psychiatric disorders.

The difference is especially striking for the direct circles of supportive family members, which were much smaller and less dense than for other individuals. In other words, individuals with psychiatric disorders did acknowledge the existence of relatively dense sets of relationships in their family configurations, but, in their perception, they are not part of them. Individuals who take care of them were significantly more disconnected from each other than in the non-clinical sample. This may have been caused by the strong investment necessary to care for individuals with psychiatric problems. Because psychiatric disorders increase the level of family stress and reduce the quality of family life and well-being (Miklowitz, 2004), care providers are often physically and emotionally overwhelmed by the important and constant needs of helping a psychiatric family member (Seywert & Grasset, 1996). Parents in particular often describe themselves as exhausted, desperate and hopeless. For many of them the difficulty to understand the origin of the troubles leads to feelings of dissatisfaction, incompetence in the parental role and low self-esteem (Miklowitz *et al.*, 1995). These feelings may in turn lead to their withdrawal from other relationships. They are often the main reason for the decision of institutionalization (McIntyre *et al.*, 2002).

Similar results were found when the composition of family configurations was considered. Compared with individuals of the non-clinical sample, individuals with psychiatric disorders included fewer family members with a blood connection. They included much less often spouses or partners in their family configurations, with a statistically highly significant difference despite the small sample size. This difference was caused by the low rate of married or cohabiting individuals with psychiatric disorders. In addition there was no compensation of the relative lack of blood connections or partners by the inclusion of alternative ties in the family configuration, such as those associated with friends or professionals from the institutionalized care system considered as family members. Thus the deficit hypothesis is again confirmed by the data – i.e. individuals with psychiatric disorders have a smaller set of significant family members when compared to others, which is not compensated by other sources of support because daycare patients do not usually take professionals as confidants.

This lack of bonding and bridging social capital provided by family configurations may have important consequences for the social integration of individuals with psychiatric disorders. As the family remains a main agency of social support and social control in contemporary societies, the deficit of bridging and bonding social capital that it provides to individuals with psychiatric disorders casts doubt on the family's ability to cope with the social integration of psychologically fragile individuals alone. The results of this study suggest that family resources of individuals with psychiatric disorders are indeed rather scarce. Therefore the possibility for families to take care of their impaired members without significant institutional support is limited.

Some crucial issues remain open at this time. Most of all the comparison group comprised college students, which is a highly selected group. Although we do not expect major differences of family-based social capital according to educational level for young adults, we cannot exclude that a more heterogeneous control group would provide less clear-cut differences compared with the clinical sample. Also a larger and random sample of individuals with psychiatric disorders

from various institutional settings would considerably improve the research design in allowing us to generalize the results found on patients of a single psychiatric service. It should be noted, how-ever, that additional studies based on a sample of individuals with psychiatric disorders followed in psychotherapy in a private practice (Widmer & Sapin, 2008) and on a sample of individuals with psychiatric disorders and mental impairment in a daycare psychiatric unit (Widmer *et al.*, 2008) revealed the same results. In any case future research based on larger random samples would allow for estimating the interrelationship existing between types and severity of symptoms and family-based social capital. Working with a larger and more representative sample of patients with a less specific control group is only possible if an interest develops for a more comprehensive understanding of the relational resources available to individuals with psychiatric disorders within their families.

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