Denied Inclusion for Prejudiced Women

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Abstract

Women are subject of stereotypical discrimination that disables their agency for action. Women with intellectual disabilities are double discriminated compared to non-disabled women and live in a stage of denied relationships in community. This article argues that the situation of women with disabilities is worsened by the lack of social network that limits the access to relationship. The research has made use of qualitative methodology to analyse the characteristics of the social networks that facilitate the social integration and community participation for women with intellectual disabilities. The semi-structured interviews yielded information about the aspects of social networks that enhance effective participation and boost wellbeing for women with intellectual disabilities. The research revealed that women with intellectual disabilities lack the social relationship and social network support for independent living. Disabled women' opportunities for social inclusion and relationship are limited by environmental factors that decrease participation. Environmental agents influence social exclusion and deny women the basic structure for social relationships. Environmental aspects address behavioural adjustment which compensates for the shortcomings of intellectual functioning, by affecting the ability of women with intellectual disabilities to better cooperate with environment.

Keywords: Women, stereotypes, disability, exclusion, social network.

1. Introduction

universally society positions women at an eternal infancy by de-legitimizing their right to self-control. Devaluing their social status (De Beauvoir, 1949 [1972]; Martin, 2003; Ridgeway & Corell, 2004). Setting higher standards for men than for women, society shapes lower expectations and social responsibilities for women. Women with intellectual disabilities suffer a double discrimination of being both person with disabilities and female. For women with intellectual disabilities the social expectations are even lower compared to other women (French & Swan, 2004). Furthermore, the stereotype of females as passive, dependent emotionally and needing protection has much in common with the stereotype of a person with intellectual disabilities. Identified by their cognitive ability age rather than the natural one, women with intellectual disabilities live in a permanent childhood and have no adult roles (Black Well-Stratton, 1988). The *social disabilism* limits their access to qualitative life-long learning process and places barriers to their equitable social participation (Thomas, 2004). Because of the heightened discrimination based on intellectual disability, women with intellectual disabilities are more exposed to harmful forms of gender-based violence such as: home isolation, institutionalization, solitary confinement and rape (INWWD, 2010).

2. Literature Review

Historically disability has been surrounded by myths, prejudices, and fears. Consequently people with disabilities, including women with disabilities, were given the status of otherness and danger. Although considered a danger to normal people, women with disabilities were instead the victims of the systematic stigma of normal people. The families protected the disabled members from society stigma and harm. Not only were women stigmatized, but their human capital was devalued as well. They were considered unemployable and any investment on their education was money waste. Unjustly, they were congregated, segregated and isolated in institutions with low quality care and impoverished living conditions as a way to economise money. As Gallaher affirms, 'Most eugenic movements have had economic motivations' (Gallaher, 1990, cited in Smart, 2001, p.78). The 'protective' attitude of care policy produced walls, physically and metaphorically (Ericsson, 2001, p.3). The human services, which allied with the authorities, perpetuated the societal devaluation of people with disabilities (Wolfensberger, 1995). In former socialist countries, care system developed less

then paramedical service in residential, hospital-like institutions. Children with severe intellectual and multiple disabilities were left immobile, not sufficiently provided with stimulating, rehabilitative or recreational activity, under the supervision of untrained nursing staff. Exposed to a poor diet and wrapped up in plastic sheets, surrounded by few human contacts and living in emotional emptiness, just only few of them reached youth. After the collapse of the communist regime, most of the Eastern European countries were faced with a social-economical crisis. Massive unemployment followed the closure of state-owned industries. The economic crisis impacted all vital sectors of social organization, with the social, educational, and health care systems facing extremely difficult challenges. People with disabilities were the least protected and yet the most affected by these changes. Serious violations of human rights and extremely impoverished conditions of residential institutions alarmed humanitarian organizations and provoked an immediate intervention to stop a further deterioration of the situation (Granier, Axelsson & Adams, 2004). Nevertheless, this intervention had more than just a positive effect on the situation. By improving the physical conditions of residential institutions, unintentionally, humanitarian agencies reinforced the prevailing notion that residential institutions, with somewhat better conditions, are the designated living place for women with disabilities. However, former socialist countries have started the transition phase of moving from a model of residential services towards community based services (Siska, 2007). Along with existing residential institutions, there is a large legacy of very poor quality institutional care to address, including levels of material and social deprivation, as well as inhuman methods of care and treatment (Mensell, 2006). The transition between the two traditions of support requires an attitudinal shift which is difficult given the long history of social exclusion and long-time institutionalisation of intellectual disability. It is easy to change the services physical facilities, but it is more complicated to change attitudes (Ericsson, 2000). Based on the principle of normalisation, people with intellectual disabilities have been concealed from society and congregated in segregate special provision to be cured, rehabilitated and trained to conduct a normal life and to be brought back in society. Locating the problems arising from disability at the individual level, as stated by the medical model of disability, the society intervened to improve the person with intellectual disabilities adaptive behaviour to meet the societal expectations. Instead of changing the perception on the worth of human being and valorising persons with intellectual disabilities for what they are, the society tried to make them comply to prescribed societal norms and values and to 'fit them into existing structures' (Amado, 1988, quoted in Chappell, 1992, p. 43). By focusing on providing the pre-conditions for enabling an individual to cope with the demands of everyday living, the principle of normalisation overlooked the causes of devaluation making the notion of the `normative' a desirable goal and a measure of achievement (Myers, Ager, Kerr & Myles, 1998). Thus, the normalization attempt produced adverse outcomes: women with intellectual disabilities were devalued, as they could not fit into structured normative schemes. Subsequently, they were spaced-outside the mainstream (Armstrong, 2003). The segregation provision became the means of enacting societal policies of devaluation and oppression, though under the guise of care and benevolence (Wolfensberger, 1995). By giving them the status of otherness the society legitimized their alienation and social exclusion (Goffman, 1963). But in the following years, with the recognition that the intellectual disability cannot be cured, special provision program shifted from a training perspective to bring them near normality, to custodial care in institutions (Mandell & Fiscus, 1981; Kelly & Traustadottir, 2005). Even outside residential institutions, women with disabilities conduct a very difficult live. They live on the margins of society, deprived from basic human experiences, such as having their own home, family and social life (UN 2007, Disabilities). Compared to other disabled persons, women with intellectual disabilities face the extreme form of stigma and discrimination, social isolation and exclusion (Mental Health Europe, 2007). The exclusion ranges from provision with limited social and occupational skills to denial of access in paid labour market, community access, social participation and citizenship (Barnes & Mercer, 2005).

Although existing in practice, in principle the human rights violation of persons with intellectual disabilities is not tolerated. The evidence on residential care discredited the institutional isolation as an option for care. The segregation practice resulted in discriminatory practices of very poor quality care, social deprivation, and inhumane methods of treatment (Mensell, 2006). Therefore countries are taking steps towards community based services as an alternative to institutionalization. The social policies are targeting social inclusion as an ultimate goal to rescue people with disabilities from long-term damage effects of social exclusion and alienation. Social inclusion is introduced by the social model of disability, which calls for removal of all societal barriers towards participation of persons with disabilities in order to allow them full enjoyment of human rights and citizenship status (Barton, 1993). Framed within the disability social model paradigm, the normalisation principle is legitimizing the deinstitutionalization, contrary to what it did with the institutionalization based on disability medical model. Played out in inclusion policies, the social model urges society to provide people with intellectual disabilities living conditions which are as close as possible to the patterns of mainstream society. The normal living conditions include interaction with others, family, peers, neighbours, and friends (Wolfensberger, 1972). However, evidence has suggested that there exists a lack of awareness and preparedness to

engage with persons with intellectual disabilities as consumers, neighbours, or as possible friends (Myers et al., 1998). Understandably, the long absence of people with intellectual disabilities in community has increased the wariness of neighbourhoods on the presence of them and sometime has nourished hostile behaviour towards them. Meanwhile, social relations and networking as determinants of quality of life have received little attention (Walsh et al, 2007). Nonetheless, the contemporary human rights-based approach places a strong emphasis on social inclusion and wellbeing as indicators for the quality of life. Conceived in terms of human rights, social inclusion policies try to provide women with intellectual disabilities opportunities for social participation 'as an affirmation of the value of personal choice, independent living and self-control' (Barton, 1993, pp.253). As a quality indicator, social relationships and participation are used to monitor social exclusion and to contribute to reduction of inequalities and injustice (Felce, 2000; Slee, 2001; Walsh et al., 2007). Social relationships develop in presence of family, friends and neighbours, in daily activities.

3. Methodology

The information was gathered through mothers and sisters interviews that served as proxy participants for women with intellectual disabilities. The research analysed the characteristics of social networks that enhance social relationship and wellbeing for women with intellectual disabilities. The study used the ecological perspective on intellectual disability according to which: the interaction of individuals with intellectual disabilities with environment and systematic application of individualised support can enhance human functioning (Schalock et al., 2007; WHO, 2008; AAIDD, 2008). Consequently, lack of support from social actors, as the most prominent environmental factors, can hinder the process of inclusion. Therefore, women with intellectual disabilities need family, friends and community support to be empowered to perform better in creating and maintaining a relationship and to be able to function effectively in the daily lives. Aimed at examining the quality of life for women with intellectual disabilities, the data provide information on two life domains: social inclusion in community and personal wellbeing. The social relationship is an indicator for inclusion, while life satisfaction is an indicator for wellbeing. The social network and community atmosphere influence the inclusion process of women with disabilities.

Table 1: Quality of Life Core Domains and Indicators

Independence	Civic Engagement & Social Inclusion	Well-being
Personal skills	Social networks and friendship	Mental health
Material wellbeing	Community activities	Physical health
Self-determination	Education/Employment	Personal life satisfaction
Other	Other	Other

Source (adapted version): Supported Accommodation Services for People with Intellectual Disabilities: A Review of Models and Instruments used to measure the Quality of Life in different various settings, by Walsh et al., 2007

The sample is composed of caring mothers and sisters of fourteen women with intellectual disabilities, aged 15-40 years old. The research involved an interpretive, naturalistic approach to the world, by exploring things in their natural environment and attempting to make sense of phenomena in terms of meanings people bring to them (Denzin & Lincoln, 2005). To this end, the study has extensively interpreted the social relationships of women with intellectual disabilities seen through the eyes of their mothers and sisters with the aim to render their lived experiences visible. The reality of life for women with intellectual disabilities is not conditioned only by themselves, as environment plays a major role as well. Inclusion and wellbeing depend on readiness of community to cooperate with them as neighbours and friends. This entails that the community have the resources for relationships and can use them in favour of inclusion and wellbeing. By considering women with intellectual disabilities as valuable persons, the community actors can construct a better reality for women and for themselves. Furthermore, by adopting a constructivist stance and making use of gender theory and disability studies, the research considers that concepts of gender and disability are socially constructed, and therefore can be dismantled (Rapley, 2004; Ridgway & Correll, 2004; Risman, 2004; Thomas, 2004; McClimens, 2007). The reality of women with disabilities in this research is known through answering the questions on: How social networks impact community inclusion and wellbeing of women with intellectual disabilities and what characteristics of social networks contribute to the social relationship. Aiming at analysing the social interaction of women with intellectual disabilities from the sociological perspective, this research is oriented by the model of *symbolic interactionism*. The study has employed the theoretical concept of social relationship as used in theory of social psychology and makes use of qualitative

methodology because this approach is extensively used in studying social interaction (Silverman, 2000). By using the interactionist model of relationship construction, the study tries to explain how the social capacity of women with intellectual disabilities to socialize with others develops through interaction. As theory confirms, social transactions are constructed in daily interaction with others (Karp et al., 2004). Furthermore, the feminist epistemological stance encourages the unpacking of taken-for-granted ideas about women with disabilities that place them in eternal infantile and de-gendered position (Fine & Asch, 1998; Blackwell-Stratton et al., 1998; Martin, 2003). Aiming at social justice for women, the research has problematised the adverse situation of women with intellectual disabilities by making their alienation visible (Olesen, 2005).

Having an exploratory nature, the research has employed the use of interview as the main research strategy to find out what is the situation of women with intellectual disabilities with regard to social inclusion. The research has made use of qualitative method because the research is concerned with the understanding of subjects' 'inner experiences' and the 'forms of social interactions' between them and society, viewed through the eyes of proxy participants and based on the 'cultural meaning' they attach to those experiences (Silverman, 2000: 89). Collected data are analysed and interpreted in order to suggest relationships between patterns or variables and to infer generalisation and theory (Gray, 2004). The collected data provide information in four areas: relationship, community participation, family support and life satisfaction. Data were obtained from active members of parents' organisations in Czech Republic. The sample is composed of fourteen women with intellectual disabilities, of age 15-40 years old, living in the city of Prague. The research investigates the social relationships of women with disabilities. The interview model was adapted by the interview protocol, based on the model of quality of life (QOL), developed by Walsh (Walsh & LeRoy, 2004; Walsh et al., 2007). Quality of life is a concept described by attributes called social indicators such as social equity, social relationship, friendship, employment, education, and so on (Brown & Brown, 2003). The indicator for social inclusion is social relationships and for social wellbeing it is life satisfaction. Each indicator is reduced into operational concepts. The operational concepts related to social relationships are family, friends, and neighbours that constitute the social network. The focus in this inquiry is the family support, while the other social agents such as friends and neighbours are seen as related factors close to family. The operational concepts for the domain of social wellbeing are the activities that make life purposeful and stimulate positive feelings such as happiness and usefulness and boost capacity for decision making.

The data analysis proceeded through a systematic series of content analysis of interviews (Cohen et al, 2007). The strategy for data analysis was based on the editing approach which is flexible and uses no *apriori* pre-definite codes. The initial set of materials obtained from interviews was codified based on the researcher's interpretation of the meaning of the patterns in the text (Robson, 2002). A summary of interview data reflects the salient features of emerging issues such as the role of friends, neighbours and family support for social relationships of women with intellectual disabilities. Following the main outlines of the phenomena of study as defined in the research question, the data have been grouped under each block per thematic, and put together to make a coherent story (Vengraf, 2001; Cohen et al, 2007).

4. Results

The analysed data explore the nature of relationship within family and the support that family provides to women with intellectual disabilities to develop relationships outside family with other social network actors such as friends and neighbours. Proxy participants informed that except for three adult women living in group-homes, the eleven others were living with their families. Women living in their family home are reported to depend on parental and sibling support for relationships within and outside family, while women living in group-homes depend more on flat-mates and assistants rather than on family for social relationships. Mothers are reported by proxy-participants to be the most important persons in family for women with intellectual disabilities, whatever the woman's age. The reasons for rating the relationship with mother as the most significant other are: the long time mothers have been caring and the trust of women with intellectual disabilities for mothers due to the care and dependency. Women with disabilities love their mothers, as is nicely expressed in Jana's mother words: "My daughter calls me: you are my ever-beloved mother". Half of mothers are reported to care as single mothers for their daughters, in absence of fathers. Even when women with disabilities have fathers, the parental care for women with intellectual disabilities is reported to come mostly from mothers. Mothers are reported to be more supportive in creating opportunities for women with intellectual disabilities for social relationships outside family, through the socialisation with mothers' friends or by accompanying women in leisure activities.

Contrary to the relationship with mothers, the relationship with fathers was reported to be negative for the majority of women with intellectual disabilities. Almost half of women with intellectual disabilities are raised by mothers only, as their fathers left them at an early age, the first day they knew of having a daughter with disabilities, which is reported by

Marta's mother in a very significant way, saying that, "Her father did not recognise her to be his daughter, as he couldn't believe to have a child with disability". For half of fathers, staying with the family after having a daughter with intellectual disabilities the comment was different, providing a dichotomist description: caring fathers and rejecting fathers. The rejecting fathers are reported in two cases. They refused to have a daughter with disability by showing constant dissatisfaction and refusing to care for them, as expressed in Barbora's mother words: "Her father was unhappy with her; she was a burden to him". They showed more affection towards healthy children, considering the daughter with disability as harm to fatherhood pride referred in Kristyna's mother story: "He never liked her; he was proud of the healthy daughter". Out of fourteen women with intellectual disabilities, five are reported to have caring fathers. Those having supportive fathers are the adolescents and young women with intellectual disabilities. The fathers of adolescent girls were reported to have a good relationship with their daughters and to spend time with them upon returning back home from work. Both adolescents' and young women's fathers were sharing part of the caring responsibility for their daughters and participating in domestic work. Fathers were sometimes privileged in the family relationship by the daughters with intellectual disabilities, as they were more permissive to them than mothers were. Proxy participants informed that this preference for fathers is related to the fact that fathers are more involved in home leisure activities with daughters, such as playing with adolescents. According to Petra's mother: "He is very good at her, that little time he is at home; he only plays with", while mothers are strict due to their instructive role. Fathers were reported to be more engaged in interacting with daughters with intellectual disabilities when at home and less involved with daughter's activities outside the home, like mothers did. Participants reported that for mothers, who were living in a partnership, daughters with intellectual disabilities had very good relationships with the mother's partner.

Siblings' relationships were reported to be most of the time positive, with very few exceptions, only two cases out of fourteen were reported as an absent relationship. The relationship with sisters was rated as more positive than the one with brothers. Elderly sisters were more caring and authoritarian, while younger sisters of women with intellectual disabilities were more permissive, less critical, expressed affection openly and were more engaged in playing with and sharing things, probably because of similarity in cognition ability, as expressed by Pavlina's mother: "Although she is thirteen years older than her little sister, she used to play with her; they do understand each other very well, because their cognitive age is the same". Elder sisters sometimes shape the self-identity of younger sisters with intellectual disabilities who wish to identify with the elder, as expressed in the Radka's mother statement, "The elder sister is a role model to her". Elder brothers were more responsible towards care duty for younger sisters with intellectual disabilities, while younger brothers were less involved with caring. Sisters were more willing to include the sisters with intellectual disabilities in their friends' networks especially when inviting friends home.

Brothers were reported to socialise more with sisters with intellectual disabilities when they were children, such as playing more together; but they became distant when they grew up and after adolescence they refused to spend time with sisters. As Stipanska's mother reported: "They have been going along better before; they used to play when they were children, but now he has his friends, he doesn't care about her". Elder siblings were reported as more promising to care for their sisters with intellectual disabilities in the future, substituting for parental care, as Vera's mother noted: "He has promised to care for her when I will not…".

5. Discussion

Natural social ties are developed within family first which is the main source of love, care and protection. Parental and sibling roles are crucial in creating opportunities for relationships in the community for women with intellectual disabilities, either by supporting them to create acquaintances with neighbours or by including them in their existing friendship networks. The most direct way for women with intellectual disabilities to learn how to build social capital however, is through the relationship bonds developed within family with parents and siblings. In this study, mothers are quoted as the closest person to women with intellectual disabilities because of trust and dependency on mothers as the main source of love, care and support. Whatever the age, women in this study count on mothers for help and advice. Despite having good qualifications and wanting to be economically active, mothers were not free to work as the responsibility of care overweighed the need for a job. The majority of women have been raised by mothers only, as fathers left them in their first days. Fugitive fathers could not reconcile the self as a father of a child with disabilities, while some questioned the fatherhood. A remorseful sentiment leads few of them to come into rare contacts with daughters. Negative fatherhood is reported for some fathers who remained with the family, after the presence of the disabled daughter. Those did not interact and clearly expressed no satisfaction for having a child with disabilities. The preferential attitude for the healthy children has contributed to an unpleasant relationship tension between family members by creating factions within it.

There is an interesting difference regarding fatherhood between two generations. Contrary to fathers of older women who left, the younger fathers are more likely to stay. Those fathers have good relationships and are supportive to their daughters. Younger fathers have interiorised the cultural changes occurring to gender stereotypes, in the post-modern society, related to the domestic labour division and share of care for children. As role models they inspire daughters to participate in the housework. Despite positive cultural changes, the traditional family model of *man- bread-winner* and *wife-care-giver* continues to prevail. When fathers are present at home, they engage more in leisure activities rather than providing substantial care.

Siblings are another source of support. Elder siblings are authoritarian, but they show responsibility of caring and are influential for the role modelling for younger girls with intellectual disabilities. Seemingly promising carers, elder siblings are a big relief to parents' worries about future care for women with intellectual disabilities. Younger siblings share more time and things with sisters with intellectual disabilities because of closer cognitive age. When younger, siblings use to play a lot, as the gender differentiation is not yet internalised as a central social value. Growing up, the siblings of opposite gender cope with differentiated social roles as adults. Sisters continue to be close, while younger brothers create distance.

Families, especially mothers are the main support for relationship by exposing women with intellectual disabilities to community acquaintance or family friends' networks. The family support is a crucial factor for social inclusion. Although the level of mothers' support is high, women with intellectual disabilities are only physically present rather than socially included in the community. All women with intellectual disabilities were living in community, but as outsiders. They had no purposeful relationships and friends in the community. The only ties were family friendship. The recognition of the physical presence of women with intellectual disabilities in the community is translated as community acceptance and tolerance by familiars. Usually neighbours behave politely to women with intellectual disabilities because they want to please the family and not because they genuinely accept them as neighbours and friends.

With regard to the obstacles to relationship and friendship in community, the personal characteristics of women with intellectual disabilities are highlighted as the main obstacle, especially cognitive ability. Additionally, several environmental characteristics present barriers to inclusion as well. Amongst those the most influent are the superficiality of neighbours' communication, lack of understanding, communication difficulties associated with intellectual disability and mistrust of neighbours on women capacity for socialisation and relationship. Finally, *infantilisation* and *asexualisation* of intellectual disability were the major barriers to relationship, such as intimacy, love and friendship. In relation to social wellbeing, women with disabilities are reported to be happier with family and flatmates rather than in institutions.

Clearly the community tolerates physical presence but does not involve women with intellectual disabilities in purposeful cooperation or genuine friendship. Accepting is important, but creating meaningful interaction is the core of social relationships. Despite being physically integrated women with intellectual disabilities remain socially excluded. Therefore the opportunities for social relationship and friendship, beyond family ties, are restricted. Presence in community is a necessary but not sufficient for social participation. Physical exposure creates adverse results such as the sense of alienation and otherness, when not followed by social inclusion. This result is clearly indicated in the research findings suggesting that it is social not physical integration that has a reliable positive influence on wellbeing and participation (Young et al., 1998; Hundert et al., 2002; Spreat & Conroy, 2002; Emerson & Mc Villy, 2004)

6. Conclusion

In conclusion, family support was reported to be very important to the social relationships of women with intellectual disabilities with family members. Although the main source of parental care and love comes from mothers, the relationship with fathers was reported to be important in stabilising the self-security in parental love, care and protection. Besides parents, siblings are reported to be decisive actors in creating opportunities for socialisation of women with intellectual disabilities by sharing toys and playing, especially for adolescent girls with intellectual disabilities, and by caring and supporting them in doing things good, especially elder siblings. The relationship with sisters was reported to be steadier over time, while brothers' interaction was reduced over time. Elder siblings are the hope of parents for the future care of the women with intellectual disabilities. Mothers and sisters are reported to be more supportive than fathers and brothers. Mothers are the main agents of the socialisation of women with intellectual disabilities outside family, by creating social relationships with other people in neighbourhood or including them in their own friends networks.

Concerning characteristics of social networks that improve community inclusion and social wellbeing of women with intellectual disabilities, changes should occur in environmental level with the due support to improvement of personal characteristics for relationship. Participants have considered the social network support to be important and therefore

women with disabilities are more included in social network of at least parents, siblings and peers more, through family, school/job and leisure activities. Research has evidenced that social networks can be effective in increasing participation of women with intellectual disabilities in community life, by having more relationships and doing purposeful activities. Mothers see the physical integration as the initial stage of the long-term process of *deisntitutionalisation*, and to this end, they as parents 'organisations are working to prepare the conditions in community for a safe inclusion in a network of friendly neighbours in community. Being part of social network themselves, mothers believe that social networks can create the social capital that will hold women with intellectual disabilities tied to the community social structure.

Although girls and women with intellectual disabilities are more present in the community, they have no meaningful relationships and friendship within the neighbourhood. Previous literature has presented similar findings suggesting that people with intellectual disabilities exposed to community have found effective social integration extremely difficult to achieve (Whitehouse et al., 2001; Hundert et al., 2002; Cummins & Law, 2003). Contrary to what community offers them, women with intellectual disabilities want to be socially accepted, welcomed and considered valuable persons. To address the absence of social networking for women with intellectual disabilities, the study identified that some changes at different levels such as personal, environmental, policy and civic activism are necessary.

Firstly, changes at the personal level include personal characteristics such as social skills, self-dependency, self-confidence and ability for communicating in order to maximise behavioural adjustment. While improving communication ability and social skills, changes at the personal level only are insufficient prerequisites to address the absence of social relationships. Therefore the second set of changes occurs at the environmental level that implies increase of community cooperation and decrease of familial protectionist control. Additionally, the increase of knowledge on intellectual disability informs attitudinal changes. The openness of community towards people with disabilities is crucial for friendship establishment. This is highly recommended by previous literature suggesting that success of inclusion into community is determined by the characteristics of the environment that support improvement of personal characteristics for adaptation (Emerson, 1985; Young et al., 1998; Dangan et al., 1998; Felce, 2000; Whitehouse et al., 2001; Hundert at al., 2002; Baker, 2007). A third change targets policy, implying that social policy is more inclusive when provides opportunities for social relationship. Social policy has extensively articulated community-based services, but not yet tackled the necessary issue of development of more meaningful friendships for people with intellectual disabilities (Gregory et al., 2001).

Mothers and sisters are very active human advocates, but they lack the collective political action to promote the right of social inclusion. Cooped with mothers' activism, women with intellectual disabilities self-advocacy, enables their participation in the decision-making process and allows them greater control over their lives. Social networks are beneficial to both personal wellbeing and collective political action to achieve improvement for social inclusion of women with intellectual disabilities.

Lastly, the community living of people with intellectual disabilities is being forwarded by the social policies dealing with inclusion given the impact it has on the quality of life. However, the good intentions of inclusive policies are not attained as long as the presence of women with intellectual disabilities in community is merely physical rather than true inclusion. Although the personal characteristics of women with intellectual disabilities are held responsible in creating and maintaining relationship with others, they should not be overemphasized. Personal communication skills and ability to perform in the areas of social responsibility and self-sufficiency are only to some extent prerequisites for social relationship and participation, for it is the combination with environmental factors that reduces the individual opportunities to perform well in daily self-responding tasks and interact with environment. Inside a person with intellectual disabilities limitations coexist with strengths and with appropriate environmental support functional capacity can improve over time so women with intellectual disabilities may be able to assume adult roles and responsibilities in maintaining good relationship and contributing to community life. The role of social networks is crucial in assisting women with intellectual disabilities to overcome personal limitations and successfully function within community conducting quality lives among normal population.

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