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Laura Jacinto
Stuck in the Sibling
Relationship: Growing Up
with a Sibling with a Serious
Mental Illness and How
Intimate Relationships Later
in Life May Be Affected

ABSTRACT

This theoretical study examines the experience of growing up with a sibling with a serious mental illness and how this phenomenon may then affect intimate relationships later in life. Theoretical perspectives of both trauma theory and object relations theory are applied to this phenomenon and how it affects the well siblings. Findings of the current study suggest that individuals internalize aspects of this early relationship and also internalize aspects of the relationship with their parents who are focusing so much care and attention on the mentally ill sibling. Patterns of maladaptive relationships may then continue to occur in the future. The findings highlight that it is important for clinicians to pay attention to the needs of the well siblings and work from a family systems framework while treating someone with a serious mental illness. When treating individuals in adulthood, it is also important to pay attention to early needs that may not have been met in childhood which may be contributing to unhealthy relationship patterns.

STUCK IN THE SIBLING RELATIONSHIP: GROWING UP WITH A SIBLING
WITH A SERIOUS MENTAL ILLNESS AND HOW INTIMATE RELATIONSHIPS
LATER IN LIFE MAY BE AFFECTED

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

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CHAPER I

INTRODUCTION

Serious mental illness (SMI) impacts approximately 6% of the population in the United States. These include major depression, schizophrenia, and bipolar disorder (National Institute of Mental Health, 2008). The impact of these illnesses on the individual is well known at this point. The individual may be kept from pursuing regular employment, establishing regular social relationships, and leading a life free of debilitating symptoms. Those additionally impacted directly are the family members of those with the diagnosed SMI. The family system as a whole has been examined in previous research, determining how roles in the system are influenced by mental illness and how the family might objectively respond in this event (Marsh & Johnson, 1997; Muhlbauer, 2002). Several researchers have also documented the impact mental illness has had on specific members of the family, other than the affected member, whether it is parents, siblings, or children (Sivec, Masterson, Katz, & Russ, 2008; Maybery, Ling, Szakacs, & Reupert, 2005; Lukens, Thorning, & Lohrer, 2004). Subjective experiences can generally be found with ease in articles, books, and other publications. The question in the present study, however, is how an individual who has a sibling with an SMI is emotionally affected by this relationship while growing up, and how future intimate relationships are approached and influenced later in the developmental cycle.

While documentation has been included in studies regarding one's experience of what it is like to be in a relationship with a sibling who has a diagnosed SMI, adult

sibling relationships are often focused on because often times, individuals are not diagnosed with a SMI until adulthood. It is important to pay more attention to this phenomenon as it occurs in childhood/adolescent sibling relationships as this may reflect development into adulthood. Once in adulthood and the establishment of adult intimate relationships occur, it is important to understand how the sibling relationship may have or have had an impact on an intimate relationship. Also missing from existing knowledge is how different factors within the sibling relationship might play a role in the emotional effects of the unaffected sibling. For example, same sex siblings vs. brother and sister relationships, if the siblings come from a family that is of a low socioeconomic background, or how race might influence the emotional experience of the unaffected sibling (Lukens, Thorning, & Lohrer, 2004).

The importance of this knowledge to the field of social work has several implications. While the individual with the SMI may demonstrate direct need for services based on symptoms, their siblings may be forgotten since providers of mental health services may be so focused on helping the individual displaying symptomology. This study will emphasize the importance of the need for social work clinical services to be family systems based, ecological, and person-in-the-environment based, so that siblings of those with mental health issues are not forgotten (Dia & Harrington, 2006). These “forgotten” siblings may then demonstrate difficulty later in life, when they are in an intimate partner relationship, which may then hinder the health and growth of the relationship. This has implications for clinicians because so often people seek services due to difficulty in intimate relationships. Social workers must be aware that growing up with a sibling with an SMI may be a factor which is affecting clients’ relationships.

Of course, those who have grown up with a sibling with a SMI may not always be “forgotten” siblings. The experience of being in a family in which a member has a mental illness is not always one filled with burden. Numerous variables influence the impact of mental illness on individuals and families, including their particular strengths and limitations, their roles and responsibilities, and other prior or current problems. As with any catastrophic stressor, the illness may offer families an opportunity to change in constructive ways. Researchers have suggested that there is evidence of the development of stronger family bonds and commitments, expanded knowledge and skills, and family members’ positive role in their relative’s recovery (Marsh, 1998). In addition, previous research participants have affirmed their potential for personal resilience, noting that they had become better, stronger, and more compassionate people (Marsh & Dickens, 1997). In weighing these research findings in balance with the compelling evidence for family burden, however, this paper does focus more so on aspects of emotional burden rather than strength and resilience. Bruce (1996) conducted a study specifically designed to elicit positive responses from family members in this situation. Two-fifths of participants still offered negative comments, such as the following: “I thought that my son’s tragedy would completely ruin our lives because it broke our hearts. But we’ve learned—finally, painfully—not to let this tragedy totally dominate our lives”. However, resilience is part of the family experience and should not go unrecognized. List (1996) conducted a study in which three fourths of the participants reported that they had undergone a process of adaptation as they acquired the competencies needed for successful coping. Commenting on the strengths of his family, one adult offspring reminds us, “Just because there is

mental illness in a family doesn't mean the family has to stop growing as a unit of that the person cannot lead a constructive life.”

In the following chapters, conceptualization and methodology will provide a basis for the reader to understand why this topic is important and why it was chosen, as well as theoretical applications towards understanding the phenomenon of the sibling's emotional experience. The phenomenon will be deeply described in more specific terms and will include some background of the construction of a family and its dynamics and what happens when mental illness is a part of those dynamics. Following this, more detail on each theory will be provided as well as the history of each theory and its contribution to the question proposed.

Two theories will be used in this study to explore the phenomenon of the emotional impact of the unaffected sibling and how these individuals' intimate relationships later in life are connected to their early experiences are object relations theory and trauma theory. Trauma theory can be used to conceptualize a sibling's experience when he or she has a brother or sister with a SMI because they may witness firsthand self destructive behaviors, symptoms of psychosis, and/or the hospitalization of their brother or sister. Also traumatic can be the neglect experienced by parents who are focusing so much on the sibling with the SMI. Trauma theory posits that trauma is an assault on the self; and self development emphasizes separation, autonomy, self-definition, individuality and achievement. Also, coping with trauma invariably will have a strong impact on attachment relationships, no matter what the source of the trauma. Furthermore, trauma can interfere with the capacity to make use of attachment relationships (Allen, 2005).

Object Relations Theory is a psychodynamic theory based on the belief that all people have within them an internal, often unconscious world of relationships. The theory focuses on the interactions individuals have with other people, on the processes through which individuals internalize those interactions, and on the role these internalized object relations play in psychological development (Flanagan, 2008). This theory may help to explain why siblings experience some of the feelings they have based on a relationship with a sibling with a SMI. It may also help to explain the influence this earlier relationship has on later partner relationships in life.

The goal of this study is for the reader to gain a better understanding of an individual's experience when he/she has grown up with a sibling with a SMI. Through the theoretical perspectives of object relations theory and trauma theory, the reader will hopefully be able to see the connection between this phenomenon and how it may affect later relationships in life.

CHAPTER II

CONCEPTUALIZATION AND METHODOLOGY

In this chapter, I lay out a theoretical framework for the chapters that follow. As already discussed, this paper explores the experience of growing up with a sibling who has a SMI and how later intimate relationships are approached/affected through the lens of both trauma and object relations theory. The phenomenon chapter lays out what it may be like to experience growing up with a sibling with a SMI through direct accounts of people who have experienced this derived from literature, also offering an interpretation of the affects of having faced this situation. The family life cycle and development is looked at and how interruptions within can create great stress and catastrophe. With keeping the experience in mind and what may be direct results of the situation, the study then looks towards how the phenomenon may affect relationships later in life.

The phenomenon can be conceptualized as a traumatic event. Although it may not be seen as a true traumatic event, growing up with a sibling with a SMI is a struggle. Accounts in literature illustrate that these siblings experience a host of feelings and emotions which mimic that of being traumatized, which is why trauma theory was chosen as a framework of understanding. The definition of trauma is an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience that shatters a sense of invulnerability to harm. This person is then rendered acutely vulnerable to stressors, overwhelming an ordinary system of care that gives

people a sense of control, connection, and meaning in the world. With this definition in mind, of course growing up with a sibling with a SMI can constitute trauma (Herman, 1992). The chapter goes into history of trauma theory and its influence on what is regarded as trauma today, especially in terms of PTSD and how this can sometimes be limiting in recognizing the trauma people face. It then goes into how trauma affects later relationships.

The basis of object relations theory is that aspects of early relationships are internalized and incorporated into later relationships. This is why object relations theory was chosen to conceptualize the phenomenon; because residual effects of the early relationships between parents and well siblings, and between well siblings and siblings with SMI were speculated to have been transferred into later relationships. The chapter talks about influences on the birth of object relations theory and a conceptual framework for understanding it in this context.

The study then draws key points from both theories as applied to the phenomenon and compares and contrasts them in the discussion chapter. Key points drawn from trauma theory are 1) trauma is an assault on the self in which all structures of the self (the image of the body, the internalized images of others, and values and ideals that lend a sense of coherence and purpose) are broken down; 2) the individual's perception of themselves reflects how the individual is seen by others and how he/she feels in relation to them; and 3) the trauma of growing up with a sibling with a SMI influences a tendency to maintain emotional distance in the future, creating an individual who may later strive for those attachment needs while at the same time being weary of trusting their partner. Key points drawn from object relations theory are 1) object relations looks at how needs

are either met or not met in relationships; 2) growing up with a sibling with a SMI may compromise both the sibling relationship and the parent relationship; and 3) the components of those compromised relationships are internalized and individuals carry with them an internal meaning and preface for other future relationships. These key points were selected because they seemed the most salient and also support one another. They will help the reader conceptualize both theories and see the connection to how growing up with a sibling with a SMI may influence later intimate relationships. Strengths and limitations of the current study are offered in the discussion, as well as how the information provided is important for the field of Social Work.

CHAPTER III

PHENOMENON

In this chapter, I will provide a summary of the literature regarding the family and its dynamics, the impact SMI may have on family dynamics, and the emotional impact a sibling with a SMI may have on an unaffected sibling as well as what is known about how this may influence partner relationships later in life. Also included are personal accounts of what the experience is like. I will refer to the unaffected sibling as a “well sibling”, while the sibling with the SMI will be referred to as an “individual/sibling with a SMI”.

Family Structure and Family Life Cycle

Traditional definitions of family suggest that “family” denotes a group of people affiliated by consanguinity, affinity or co-residence. Family can be recognized as a group of people living together, particularly from the perspective of children, the family of orientation; which services to locate children socially, playing a role in their enculturation and socialization. For the purpose of this particular study, family can be seen in this way. However, this is not to say that this is how all families truly are, for “the ecology of the family is first and foremost the family’s domain” (Carpenter, 2002). Winton (1990) captures the essence of the family:

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a

family by birth, adoption, marriage, or from a desire for mutual support. A family is a culture unto itself, with different values and unique ways of realizing its dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Our families create neighborhoods, communities, states and nations. (p. 94)

It is important to keep this in mind and recognize that families are not so “traditional” these days.

Disruptions of the family life cycle can occur in response to a number of stressful events. Some of these include family patterns, myths, secrets, expectations, and attitudes that are transmitted from generation to generation. Other stressful events include predictable developmental events, such as the changes associated with parenthood, and unpredictable events, such as untimely death or chronic illness. For both individuals and families it is assumed that transition points are associated with increased stress, which may interact with other stressful events life events such as mental illness. Transition points have an inherent quality of upheaval and disruption that may be heightened by—and exacerbate—the disarray that accompanies mental illness. Thus, we might expect adolescent or middle-aged family members to be particularly vulnerable to the adverse consequences of a relative’s mental illness (Marsh, 1998).

The Family Experience

Researchers have indicated that families with SMI members experience such things as initial confusion as awareness of the mental illness occurs, crisis, instability, and growth and advocacy (Muhlbauer, 2002). For example, a family member may first

encounter a feeling of crisis brought on by erratic or unusual behavior exhibited before diagnosis occurs. The members of the family may not know how to respond or what to do in these situations. Problem behaviors may have increased slowly or happened within hours, days or even months, but the family typically acknowledges that something is wrong followed by trying to manage these sudden increasing difficulties usually unsuccessfully. This is usually followed by crisis episodes exhibited by erratic, violent, or even aggressive behavior, often times out of the family's control. Unpleasant confrontation with the mental health care system, emotional distress, and financial concerns may also occur and be sources of burden on the already stressed family. Crisis may then become recurrent, with the family thrown into constant distress. Finally, families hopefully begin to move towards stability when the mental illness is under some kind of management.

Some researchers propose that throughout this process, family members may experience feelings of intense emotions such as shock, disbelief, anger, despair, guilt, anxiety, and shame, experiencing psychological "costs" produced by the illness (Karp & Tanaurugsachock, 2000; Lukens, Thonrning, & Lohrer, 2004; Marsh & Johnson, 1997; Muhlbauer, 2002). In addition, a sense of symbolic loss, chronic sorrow, a feeling of being on an emotional roller coaster, and empathic pain may occur (Marsh & Johnson, 1997).

The Sibling Specific Experience—Impact on Childhood and Adolescence

Goetting (1986) describes the developmental tasks of siblingship throughout the life cycle, reporting that the exchange patterns of companionship, emotional support, and caretaking in childhood and adolescence creates a precedent for the sibling bond as well

as the exchange of these things in relationships later in life. Young siblings are especially vulnerable to any disruptive or traumatic event, such as mental illness. When one sibling develops a mental illness, it has a profound impact on the sibling bond. For example, siblings may feel they have experienced the dual losses of their brother or sister and of their parents, whose energy may be consumed by the mental illness. Achievement of the developmental tasks of early childhood may be undermined, including the attainment of basic trust and of self-esteem. During middle childhood, as children shift from the family to the larger social world, the school environment and peer relationships become increasingly important. Young family members may experience difficulty in school as a result of their preoccupation with problems at home and may feel alienated from the “normal” world of their peers. Adolescents are likely to be profoundly influenced by the mental illness in their family. They may worry about developing mental illness themselves as they deal with identity issues, may find that their losses and vulnerability affect their emerging sexuality, and may be influenced by their family circumstances as they formulate educational and career plans. They may also feel that their needs are neglected or may try to compensate their anguished parents:

I became the perfect child to spare my parents more grief. I was forced to become responsible. In many ways it forced me to accomplish things in my life I might not have otherwise done. But I have spent my life trying to run away from this problem. Feeling guilty and helpless, the unending sorrow for not being able to help. I have not felt entitled to be happy most of my adult life. (Dickens, 1996, p. 48)

Many of the same themes previously discussed for families came up in research when applied to siblings recalling events later in adulthood. In addition to the above described feelings, siblings also had strong memories of watching their parents struggle with the care of their siblings. Feelings of abandonment and a sense of resentment are often common, as well as the sense of fear particularly associated with the unpredictability of the illness and how this might play out (Lukens et al., 2004). Riebschleger (1991) compares sibling emotional responses to the emotional continuum of denial, anger, bargaining, depression and acceptance devised by Elizabeth Kubler-Ross as response stages of individuals facing death, with the addition of a phase of relief/respice as siblings attempted to cope with the mental illness of a brother or sister. Although not completely comparable, learning that a sibling has a SMI can be like experiencing the death of a sibling due to the similar emotional response that Kubler-Ross devised as a response to death. Other researchers have agreed and have come up with other theories and ways to conceptualize this phenomenon. Marsh (1998) describes several sibling-specific themes experienced by the unaffected sibling. These include a sense of being a forgotten family member, the experience of survivor's guilt, and the experience of replacement child syndrome. Much information regarding this phenomenon is provided by Diane Marsh in several books and studies, which is why her viewpoint is used throughout this paper.

Siblings as Forgotten Family Members

The sense of being a forgotten family member often comes up throughout personal accounts of siblings. Outside the family, siblings may feel alienated from the world of their peers and ignored by a mental health system that seems unreceptive to their

distress and concerns. Siblings are often doubly wounded, first by their family experiences and then by the lack of comprehension—in themselves as well as others—of the reasons for their hurt, anger, and disconnection. Simon (1997) writes in her memoir about growing up with a mentally ill sibling: “As ‘healthy’ siblings, we have wondered if our experience even counts; after all, we are not suffering the tragic and inexplicable illnesses of our brothers and sister. But we, too, have come through tragedies” (Simon, 1997, p. 41).

Survivor’s Guilt

Survivor’s guilt is experienced by siblings simply because they have been spared mental illness themselves. Though neither of their faults, one sibling has remained well; the other endures mental illness. The tragic unfairness of this reality is likely to induce an irrational sense of guilt: that somehow the health of one sibling has been achieved at the expense of the other. Siblings may be resistant to embrace the successes of their own lives—the adventures, opportunities, relationships, and accomplishments that derive from a life fully lived. Sensitive to the disparities between the two lives, they may have difficulty enjoying the pleasures denied to a brother or sister.

The guilt that you feel can be debilitating. A lot of times you don’t want to have success. You cover up your success because the ill family member is missing so many good things in life. And you feel bad about getting those yourself. If you have a girlfriend or fiancée, you want to play that down. (Marsh, 1998, p. 274)

Survivor’s guilt may also incline siblings to ignore their own problems. After all, how can they complain about a life that is so much better than that of their brother or sister?

Replacement Child Syndrome

Siblings who have lost a brother or sister to biological death may place themselves in the role of a “replacement child” who must gratify the needs of their devastated parents. A similar reaction may occur among siblings who are dealing with mental illness. Striving to be perfect children or modeling themselves after an idealized brother or sister, siblings may accommodate parents who seek a substitute for their stricken child or may deny themselves opportunities for healthy rebellion. Struggling to offset the hopes of their parents, siblings may create a flawless public persona that contrasts the emptiness within (Marsh & Dickens, 1997).

Positive Versus Negative Adjustment

There is a growing body of research indicating that in facing the challenges of mental illness, the lives of many family members are transformed in positive ways through the experience (Lukens, Thorning, & Lohrer, 2004). In a study of resiliency in families of persons with mental illness, Marsh and her colleagues (1997) found that almost all (87.8%) of the 131 family members sampled could describe one or more personal strengths that they had developed as a result of coping with the challenges of mental illness. These strengths took many forms, including enhanced coping skills, a strengthening of family bonds, increased personal competence, and a greater appreciation of the sibling’s own life and well-being. Kilmer et al. (2008) conducted a longitudinal study of siblings of children with SMI, providing evidence that the well siblings had experienced significant adversity and were an extremely high stressed sample. There was a considerable variability in sibling adjustment and factors associated with positive adjustment were identified. Roughly half of the well siblings had above average levels of

personal strengths and a low probability of developing SMI themselves. However, one in six of the well siblings had a high to extremely high probability of being identified with an emotional or behavioral disorder. For this reason, it is necessary for clinicians to assess the needs of siblings. The researcher indicated a need for more research regarding gender differences in siblings as a determinant of adjustment as well as how socioeconomic status may influence adjustment. The nature and quality of the caregiver-child relationship, siblings' early development, caregiver resources, extra-familial variables, and other factors were noted as some variables that may influence sibling functioning and differentiate those siblings evidencing positive adjustment versus maladaptation. It is important not to assume that all individuals with siblings with a SMI will develop difficulties. Many actually develop strengths. However, the majority of the literature suggests that most do experience a high degree of difficulty. The degree of difficulty depends on the resources that individual has to cope.

Future Caregiving

The expectation that an individual may have to care for their mentally ill sibling in the future may also contribute to the difficulty they encounter in their lives. Since many are expected to take on care giving roles even in childhood, that role may also be expected to carry over into adulthood. As a part of the family life cycle, parents obviously age and may become debilitated physically and mentally and then pass away. They are not capable of caring for their children for the rest of their lives. Smith, Greenberg, and Seltzer (2007) examined sibling expectations to provide future instrumental or emotional support for a brother or sister with schizophrenia when parents became disabled or died. Data came from a sample of 137 siblings participating in a

longitudinal study of aging families of adults with schizophrenia. Early socialization experiences, the quality of sibling relationship, and personal caregiver gains propelled siblings toward a future caregiving role, whereas geographic distance and beliefs about the controllability of psychiatric symptoms reduced expectations of future involvement. Hatfield and Lefley (2005) conducted interviews with 60 sibling respondents who had a sibling with a SMI. Most stated that they expected to have some involvement in the life of the ill member. Only 8% said that they would not be involved at all. Their involvement was more likely to be in providing social support to their relative than in providing such instrumental help as housing, monitoring medication, or helping with household chores. The most often mentioned difficulties in providing care were demands by their own families while trying to care for their siblings (61%) and the distances they lived from their relative (57%). Over a third of the siblings said that negative feelings about their relative's behaviors were barriers. The expectation of being in a caregiver role may also put strain on intimate relationships in the future as well as when one moves on to start their own family. The burdens of caring for a sibling with a SMI may interfere with the caregiver role in the family that the well sibling may have in the future.

Future Partner Relationships

The above sibling-specific themes may contribute to the translation of early sibling relationships to later partner relationships. Marsh (1998) describes siblings as “frozen souls” who are struggling with ongoing trauma and with loss and grief, sometimes cutting off or compartmentalizing painful feelings in their effort to survive. This cutting off of feelings has implications for their development later in life, as well as in future relationships.

I am just learning, at age 49, that I can be me. I have only just begun to identify what I want and who I really am. I adapted my behavior at home totally in the interest of keeping the equilibrium in the family. I felt responsible for making everyone happy. I took on emotions of others as something I had to fix. I developed a pattern of putting others before myself, lost my identity in relationships. (Marsh, 1998, p. 266)

As they are growing up, siblings may feel estranged from peers who know little about mental illness, be reluctant to invite friends to visit an unpredictable home environment, and worry about the reactions of a boyfriend or girlfriend. Some siblings find it easier to avoid dealing with their social world. “I didn’t have time to think about how isolated I was from other people my age. I felt unattractive and unlovable in high school and didn’t date” (Marsh & Dickens, 1997, p. 72).

In adulthood, siblings describe an interpersonal legacy that is characterized by problems with trust and intimacy, fear of rejection or abandonment, and reluctance to make a long-term commitment. An additional problem is the continuation of earlier attitudes or roles that interfere with mature adult relationships. For instance, siblings who have minimized their own needs as they were growing up may develop an excessive need to please others or lose sight of personal needs in relationships. Likewise, adult siblings who inappropriately continue a care giving role face the dual risks of choosing a troubled partner who need their nurturance or alienating someone who prefers not to be parented. One sibling said she had cared for her brother since her twenties. Occupied by this role, “I continued to treat men in a motherly way, not in a ‘girlfriend’ way” (List, 1996, p. 37).

Partner Choice

Partner choice, given what has been discussed above, may be influenced by an early sibling relationship especially when that sibling relationship requires much more emotional energy; like for example when a person has a sibling with a SMI. An individual of course may have become an extremely resilient person due to this early experience and may have become a better stronger person—more tolerant, empathic, and compassionate. However, many state that they have significant problems in their adult relationships. Many of their difficulties result from the continuation of earlier patterns that have become maladaptive in the present. In an effort to cope with a painful reality, individuals in this situation may shut down emotionally, avoid close relationships, and become precariously dependent on the approval of others (Marsh, 1998).

A question may be what might influence partner choice later in life given a person's history of having this experience. Social psychologists posit that in intimate relationships, individuals include the other in the self, meaning that in an intimate relationship the individual acts as if some or all aspects of the partner are partially the individual's own. The individual may perceive the self as including resources, perspectives, and characteristics of the other (Aron, Aron & Smollan, 1992). Deutsch and Mackesy's (1985) interpretation of self-partner similarities in close relationships suggests that there is mutual influence on each other's self schemata, creating an overlap of traits between them. Much of this research that has been conducted uses an Inclusion of Other in Self scale (IOS), in which respondents selected the picture that best describes their relationship from a set of Venn-like diagrams each representing different degrees of overlap of two circles.

Lewandowski and Sahner (2005), refer to attachment theory to describe how an individual might choose a partner, suggesting that a previous relationship can influence partner choice in future adult romantic relationships. The primary attachment figure is of course the parent in infancy; however, as an individual progresses through life other relationships influence attachment and attachment style. Namely, influences on the self due to previous relationships may influence subsequent relationships. Aron et al. (1992) refer to a self expansion model, through which people achieve expansion via the process of inclusion of other in the self. This also states that people seek out partners who will increase their knowledge and offer new experiences that would thereby enhance the self. Inclusions of other in the self is the amount of cognitive overlap between two people in a close relationship such that the closer two people are, the more they begin to include aspects of the other person in their own identity.

When individuals experience a turbulent previous relationship, filled with pain and chaos, their ability to choose a partner and sustain a healthy relationship becomes defected. The influence that this sibling relationship has had on one's self and self concept is profound in many cases, such as the ones mentioned earlier. The sibling comes to experience several emotions within themselves and within the context of the family. They become confused about roles and who they are, confused about their experience, and carry this confusion throughout their lives. The next chapter will describe how the trauma of this early relationship influences an individual and how it might inhibit one's ability to choose and maintain healthy relationships through the lens of trauma theory.

CHAPTER IV

TRAUMA THEORY

The idea of trauma has existed for centuries. An association between psychological trauma and hysteria had been noted ever since psychiatry has tried to be a scientific discipline. As early as 1859, the French psychiatrist Briquet started to make connections between the symptoms of "hysteria" and childhood histories of trauma (McFarlane & Van Der Kolk, 1996). In 1887, Jean-Martin Charcot described how traumatically induced "*choc nerveux*" could put patients into a mental state similar to that induced by hypnosis. This so-called "hypnoid state" was believed to be a necessary condition of what Charcot call "hystero-traumatic autosuggestion". Thus, Charcot became the first to describe both the problems of suggestibility in these patients, and the fact that hysterical attacks are dissociative problems--the result of having endured unbearable experiences. Overriding interest soon followed after some years of research conducted by Charcot and his pupils, especially during World War I. "War neurosis", for many psychiatrists, was essentially a disease of the will. Hence, largely for political reasons, the medical diagnosis of posttraumatic stress in Germany during World War I and during subsequent decades was recast as a failure of the individual soldier's willpower. As a result, treatment consisted of physiological exercises that were very painful. Rather than endure these treatments, many preferred front-line duty and were thus considered "cured." In the period following World War I, the leading German psychiatrist Bonhoeffer and his colleagues founded a school of thought that regarded

traumatic neurosis as a social illness that could only be cured by social remedies. Pierre Janet, a student of Charcot, proposed that when people experience "vehement emotions," their minds may become incapable of matching their frightening experiences with existing cognitive schemes. As a result, the memories of the experience cannot be integrated into personal awareness; instead, they are split off (dissociated) from consciousness and from voluntary control. Thus, the first comprehensive formulation of the effects of trauma on the mind was based on the notion that extreme emotional arousal results in failure to integrate traumatic memories. Until psychoanalysis crowded out competing schools of thought, Janet's clinical observations were widely accepted as the correct formulations of the effects of trauma on the mind. Slowly, his legacy was forgotten and it was not until the 1980's in which his extensive work on trauma, memory, and the treatment of dissociative states was integrated with contemporary knowledge of PTSD. Following World War II, veterans again reported re-experiencing their traumatic combat-related symptoms of hyperarousal, through an acute syndrome referred to as "battle fatigue" or "combat exhaustion" (McFarlane & van der Kolk, 1996). After clinicians listened to the narratives of Holocaust survivors and then treated thousands of male and female veterans from the Vietnam War, the mental health community recognized the clear existence of post-traumatic stress disorder (PTSD) as a psychological syndrome. Finally, in 1980, the American Psychiatric Association officially included this disorder in the DSM-III. The public recognition of an actual trauma-related diagnosis helped many veterans to affirm the reality of their suffering following deployment. Similar legitimacy was also attached to the presenting concerns

of survivors of childhood sexual abuse, physical abuse, emotional abuse, domestic violence, and other natural and man-made traumatic events (Basham, 2008).

Professional knowledge about trauma and its treatment has expanded since the American Psychiatric Association formalized the diagnosis of posttraumatic stress disorder (PTSD) in 1980. When one hears the word “trauma”, PTSD is automatically often of. Many definitions of trauma exist. However, one who has experienced trauma does not necessarily have a diagnosis of PTSD, nor might they exhibit related symptoms. The DSM-IV-TR states that the essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor. This may involve direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to one’s physical integrity. Witnessing an event that involves death, injury, or a threat to the physical integrity of another person can produce symptoms. Learning about an unexpected/violent death, serious harm, or threat of death/injury experienced by a family member or other close associate can also induce symptoms. Mentioned in the DSM-IV-TR is that learning that one’s child has a life threatening illness can cause PTSD. Not mentioned, however, is that learning that a family member has a mental illness and then observing the symptoms of that mental illness directly might be linked to feelings of being traumatized, or even experiencing classic symptoms of PTSD a phenomenon similar to vicarious or secondary traumatization (McFarlane & Van der Kolk, 1996). Again not mentioned is the fact that the neglect well siblings in particular experience when a sibling has an SMI can also be traumatic.

Trauma refers to an event or an experience that involves the imposition of severe (or traumatic) stressors. Figley (1995) offers a definition of trauma which classifies it as an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience that shatters a sense of invulnerability to harm, rendering this person acutely vulnerable to stressors. Herman (1992), on the other hand, concludes that trauma overwhelms an ordinary system of care that gives people a sense of control, connection, and meaning in the world. Traumatic responses often include a set of neurobiological reactions along with an affective experience of terror and powerlessness (McEwan, 1999). Making a distinction between events that are traumatic, traumatic responses, and PTSD is important.

In order to fit a diagnosis of PTSD, one's response to an event may involve intense fear, helplessness, or horror. In addition, this person may endure persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, and persistent symptoms of increased arousal. Of course, this disturbance must cause clinically significant distress in social, occupational, or other areas of functioning. While a clinician may deem adjustment disorder as a more appropriate diagnosis through viewing the situation, like having a sibling with a SMI, as not as extreme as something like being in combat, having a sibling with a SMI can be extremely distressing. This hypothesis ties in with the fact that siblings of those with a SMI are often indeed "forgotten". This chapter will focus solely on trauma; however, this is not to say that all individuals in this situation will necessarily be impacted negatively or traumatically. It is important, however, to stress the fact that being a sibling of someone who has a SMI can be traumatizing. This trauma is important to consider because it may impair social and

occupational functioning among other things such as views of the self. A large part of social functioning is of course relationships. The focus of this thesis is to explore how having a sibling with a SMI impacts the self and future intimate relationships, and exploring this phenomenon through the lens of trauma theory will be interesting because it isn't something that is looked at as classic "trauma".

The Role of the "Self" in Trauma

Allen (2005) states that trauma—being overpowered and rendered helpless—is an assault on the self.

All structures of the self—the image of the body, the internalized images of others, and the values and ideals that lend a sense of coherence and purpose—are invaded and systematically broken down... While the victim of a single acute trauma may say she is 'not herself' since the event, the victim of chronic trauma may lose the sense that she has a self." (Herman, 1992, p. 76)

A large part of the treatment of trauma, therefore, is healing the self. The development of the self proceeds in tandem with establishing relationships with others. Self-development emphasizes separation, autonomy, self-definition, individuality, responsibility, etc. Relatedness to others entails attachment, care giving, intimacy, love, and connectedness. Developing the self and developing relatedness are mutually enhancing, not mutually exclusive; interdependent. We can best appreciate the impact of trauma on the self from a developmental perspective. The self concept begins developing in the latter part of the second year, when the toddler begins attaching words to the self. By middle to late childhood, self concept becomes quite complex through growing more

self critical and contrasting the real self with the ideal self. With a foundation in trauma, many persons focus on very low self worth, undermining their self. Those who are traumatized almost always blame themselves. Taking responsibility can be seen as a last-ditch effort to preserve some sense of control. “This effort to rescue the core self from a sense of helplessness is laudable; the worst thing for the “I” is helplessness. But the “me” pays a high price: low self-worth” (Allen, 2005, p. 105). For example, an individual who has grown up with a sibling with a SMI has chronically endured trauma. This trauma existed throughout development. Although one may not automatically recognize this, their possible experience of low self-worth may be attributed to the fact that they have chronically endured traumatic events throughout their life. This is some of the core work in the treatment of trauma; rebuilding one’s own view of themselves through self understanding and exploration.

The Self in Relationships

As stated earlier, the “me” is formed to a substantial extent in relationship. Looking at others is like looking into the mirror. How you see yourself reflects how you are seen by others, how you are treated by them, and how you feel in relation to them. When one has a sibling with a SMI, the view of the self is affected. In turn, this self formulation also may affect other relationships. What can make a positive impact is investing time into relationships that enhance self-worth rather than being in relationships that may diminish this even more. Of course, this often doesn’t happen because those with trauma may unconsciously attempt to perpetuate negative views of themselves by entering relationships that are not healthy. Although this perspective is similar to Object

Relations Theory, which will be discussed later, it is important to note this phenomena when talking about trauma affecting the self in relationships.

Coping with trauma invariably will have a strong impact on attachment relationships, no matter what the source of trauma. Trauma can interfere with one's capacity to make use of attachment relationships. Trauma embedded in close relationships, like that of sibling relationships, is usually the most difficult to beat, especially when the relationship ought to provide a feeling of security. We all develop models of how relationships go, based on recurrent patterns of interactions. Earlier models, however, always serve as a foundation for later relationships.

When going through this phenomenon, unaffected siblings may experience some of the relational affects as those who have faced classic trauma. For example, they may experience things such as isolation, yearning, and dependency. One of the most natural responses to trauma is trying to stay away from people. If an individual has been hurt in some kind of attachment relationship in their life, whether directly or indirectly, a natural tendency is to maintain emotional distance within future relationships. Many individuals use this strategy to cope; however, this becomes an ineffective strategy because while seeking safety in isolation, vulnerability and depression may occur inadvertently. Isolation may then cause a yearning for closeness, love, affection, and protection. "A paradox is at work here: the history of trauma abets isolation but also fuels attachment needs. Isolation thus alternates with longing for much-needed care giving, closeness, and intimacy" (Allen, 2005, p. 119). Driven by attachment needs, many persons eventually find relationships that provide affection, protection, nurturance, and intimacy. Of course, trust in such relationships is hard won, achieved only over a long period. Seemingly

overwhelming needs become focused on the one individual who can meet them within the context of safety. In excess; however, dependency paradoxically undermines security. The fear of being injured may gradually give way, only to be replaced with a fear that the relationship will end, particularly to the degree that the individual feels he/she has burdened their partner with intense needs. To complicate things even further, dependency and fear of abandonment may endanger feelings of resentment and hostility associated with a sense of being trapped and vulnerable.

Coping with Trauma in Context

Contemporary trauma therapy practice models are phase oriented and synthesize knowledge about the neurobiology of trauma along with psychodynamic constructs within the social context (Basham, 2008, p. 437). Phases progress in such a way: the first involves helping the client to strengthen self-care. When the client begins to achieve this, they may start to talk about the effects of the trauma on his/her life. After gaining perspective regarding how the trauma has affected psychological and social identities and relationships, they may eventually begin to feel empowered; like they are survivors and have become stronger.

No studies to my knowledge exist regarding trauma theory and treatment as it applies to growing up with a sibling with a SMI. I imagine that in this context, the phases of treatment would still apply the same. Physical and psychological self care would be a first step before beginning to address what the actual trauma experience is. One might realize that having had a brother or sister with a SMI has affected them in several ways, but again, it does not constitute what one may think of as a classical traumatic experience. The clinician would have to help the client come to the realization, educate

them about trauma, and then begin to address instances in which the trauma has affected their life. Following this and exploring how this phenomenon has affected the self, relational identities, and other areas of their life, maybe the client would begin to feel that they have reclaimed who they are. Having witnessed and dealt with several unfortunate situations, they may begin to move forward.

Lively, Friedrich, and Rubenstein (2004) conducted a study to examine the effect of illness behaviors of persons with schizophrenia on well siblings. They found that there was a high level of behavioral disturbance associated with hallucinations and delusions. Other disturbing behaviors included verbal abuse, disruption of the household routine, mood swings, and property damage. Instruments included the Impact of Illness Behavior Scale, used with a national sample of 752 siblings associated with the National Alliance for the Mentally Ill (NAMI). The majority of the respondents were white and female. As years lived with the ill person increased, the behavior scores became significantly lower, indicating more stress. This research indicates that observing symptoms of SMI can be extremely distressing for well siblings.

Studies have been conducted regarding the effects on well siblings of those with cancer, which can be seen as a similar situation in that both sets of well siblings may be susceptible to a number of adjustment difficulties such as depression, anger, anxiety, feelings of guilt, and social isolation (Murray, 1999). Suggested in these qualitative studies is the fact that these adjustment difficulties may be a result of the loss of, or separation from, the attachment figure; the mother who is busy caring for the child having health issues. One account of a healthy sibling of one with cancer reads:

I began to feel hatred for my sister. I often thought if I got sick, maybe I, too, would receive presents and sympathy. My sister stood bathed in the spotlight, and I'd been thrown into the corner. I resented her. I thought everyone was totally insensitive to me. People would always ask me how she was doing, never how I was doing. (Murray, 1995)

Spinetta (1981) conducted a three-year longitudinal study of families in which a child was diagnosed with cancer. Findings showed that siblings suffer at least as much as, and probably more than, the patients because of unattended emotional responses to the illness. Cairns, Clark, Smith, and Lansky (1979) used an exploratory design in which they looked at the impact of childhood cancer on both the patients and their healthy siblings in 71 families. Measurement instruments included the Piers-Harris Children's Self Concept Scale, to assess the children's perception of themselves; the Bene-Anthony Family Relations Test, to assess perceived family roles; and the Thematic Apperception Test (TAT). The study revealed that siblings of children with cancer have significant anxiety and periods of depression. They also feel isolated from parents, extended family members, and friends. Based on the Family Relations Test sex differences were noted with respect to the feelings respondents assigned to themselves. Hamana, Ronen, and Rahav (2008) conducted a study which examined healthy children's responses to a sibling's cancer and its aftermath, with particular scrutiny directed toward these healthy siblings' stress factors, duress responses, and coping resources. The researchers investigated role overload as these siblings' stress factors, anxiety and psychosomatic symptoms as their duress responses, and self-control and self-efficacy as their coping

resources. Participants comprised 100 (53 boys and 47 girls) healthy siblings ages 8 to 19 years. Outcomes revealed that the stress experienced by healthy siblings of a child with cancer correlated significantly with those siblings' duress responses. Therefore greater role overload was linked with high levels of state anxiety and more psychosomatic symptoms. Likewise, these siblings' stress factors correlated significantly with one of their personal resources; lower role overload was linked with greater self control. Furthermore, personal coping resources correlated significantly with healthy siblings' duress responses. These studies had a fairly large sample size and used standardized measures in analyzing the data they had come up with. However, no demographic information, such as race, ethnicity, and social class was identified.

As far as future relationships in which one of the partners has a trauma history is concerned, Arzi, Solomon, and Dekel (2000) state that being in close contact with and emotionally connected to a traumatized person becomes a chronic stressor. This is known as secondary trauma theory, which contends that individual stress symptoms are communicable, and those who are close to the trauma survivor can be "infected" with trauma symptoms (Catherall, 1992; Figley, 1995). Of course, none of the studies document trauma in this context; that of having grown up with a sibling with a SMI, and what the effects are in relationships as a result of this. Most document couples in which a partner has experienced war, abuse, and genocide.

Goff et al. (2006) used the broad definition of "traumatic events" in order to collect data on a variety of traumatic experiences and did not limit the type of data that were included. Participants were at least 18 years old and had been in a committed relationship for at least one year. The sample size was only 17, with each partner being

interviewed separately. Using open-ended, semi-structured qualitative interviews, results yielded that both increased and decreased communication occurred equally, as well as did increased and decreased cohesion/connection. Most couples also experienced increased sexual intimacy problems as a result of trauma. All couples were heterosexual (Goff et al., 2006). De Silva (2001) gathered information through five case studies of men and women ages 20-40 to illustrate that individuals who have faced non-sexual trauma can experience later sexual functioning and relationships. The negative reactions caused by trauma often lead to shame, self-loathing, and self blame. These all tend to fuel depression. The researcher also states that imposed helplessness, which happens at the time of the traumatic events, can become learned helplessness. This contributes to an inclination to 'give up'. The sense of loss and isolation commonly resulting from trauma also contribute to depression. This depression can then contribute to a reduced sex drive. Healthy intimacy in couples or partners in a committed relationship, whether they are heterosexual, homosexual, married, or cohabitating is characterized by the following criteria: they communicate openly, non-defensively and spontaneously, they respond with empathy, they negotiate conflicts by accommodating and compromising with each other, and they affirm each other's vulnerabilities (Wilson & Kurtz, 2000). Factors related to trauma that may hinder healthy intimacy include depression, social distance, anxiety, fear of rejection, and fear of inadequate performance. The aims of the therapeutic relationship should be to create a safe and contained environment in which the individual or couple can share their thoughts and feelings honestly and openly with respect and compassion and to attain a good level of mutual empathy. Dysfunctional communication patterns and cognitive distortions need to be identified and eliminated. The therapist should aim to

shift the individual or couple with positive reframes (Mills & Turnbull, 2004). The literature findings indicate that most studies have small sample sizes and do not pay attention to issues of race, class, ethnic groups, and same sex relationships.

This chapter regarding trauma theory describes the definition of trauma and why growing up with a sibling with a SMI constitutes a traumatic situation. Based on the history of trauma, certain situations are regarded as trauma while others are not. Typically, one may not see the current phenomenon as traumatic. The literature regarding those in this situation proves otherwise. Clients who have faced such a situation may experience lives in which their issues have gone unaddressed, or addressed in an unsuccessful manner due to the fact that the situation is not traditionally seen as traumatic. The chapter goes into detail about the role of the self in trauma, and in future relationships in which a person has faced trauma. Treatment in this context is also talked about briefly.

Some points to take away from the chapter and from trauma theory include 1) trauma is an assault on the self, with each structure (body image, internalized images of others, values, and ideals) being broken down to the point that a sense of self may be lost; 2) how an individual sees him/herself reflects how he/she is seen by others and how her/she feels in relation to them. Therefore, when an individual has grown up with a sibling with a SMI, they may perceive themselves as not worthy of love and attention due to their siblings and parents not meeting those attachment needs; and 3) the trauma of growing up with a sibling with a SMI influences a tendency to maintain emotional distance in the future, creating an individual who may later strive for those attachment needs while at the same time being weary of trusting their partner.

The next chapter will focus on Object Relations theory and how it can be applied to people who have grown up with a sibling with a SMI and how the theory can be tied into future relationship development.

CHAPTER V

OBJECT RELATIONS THEORY

This chapter will briefly describe the history of Object relations theory, outline key points, and relate these points back to its application to growing up with a sibling with a SMI. It is applicable in this context because the sibling relationship is one in which internalization of that relationship occurs and is translated in other relationships. Classically, one may apply this theory more so with the parent-child relationship, because often these are the primary caregivers. However, a lot can be said of the sibling relationship and what a “well” sibling may internalize from having a relationship with a sibling with a SMI.

History

Object relations theory, like trauma theory, had many different influences throughout history to shape what it means today. It has been regarded as one of the classic psychodynamic theories, and therefore has shifted and molded its concepts for years. From the beginning there has existed a lively tradition of dialogue, interaction, and even argument within and between the schools, often studied through British and American traditions. Main proponents of the British school are Melanie Klein, Ronald Fairbairn, Harry Guntrip, Donald Winnicott, and John Bowlby. Among the American school are Margaret Mahler, Otto Kernberg, Thomas Ogden, and James Masterson.

Object relations theory addresses the absolute, primary need for attachment and the harm that can come if that need is not met. Bowlby concluded that attachment is a

primary, absolute need in human beings. Winnicott's contribution highlights the importance of the quality of relationships, and how the nature of object experiences influence development. He also stresses the need to balance attachment with the capacity to be separate. Winnicott also came up with the concept of "True Self". He believed that attachment needed to be flexible and genuine enough to nurture the "true self", which is at the core of personality. A true self, according to Winnicott, cannot emerge if the child feels he/she must be attuned to the needs of others in the family system and if she needs to be a certain way in order to be recognized and acknowledged. What happens instead is that the child may develop a "False Self," one that seeks to suppress individuality and molds itself to the needs of others. Uniqueness, vibrancy, and difference are all submerged. Melanie Klein, Ronald Fairbairn, and Harry Guntrip presented very specific ideas about what the internal object world can be like. The internal world comprises representations of self and other, representations formed by ideas, memories, and experiences of the external world. A representation has an enduring existence, and although it begins as a cognitive construction, it ultimately takes on a deep emotional resonance. For example, memory images of a mother may turn into an object representation of the mother. Similarly, the various images of the self as they are experienced within make up the self representation. These representations are not observable and may not reflect the actual situation, but they are the content of the internal world and the building blocks from which relationships with the self and with others are ultimately formed.

Margaret Mahler, an American object relations theorist, added to the study of psychological development a schema that explains how a child makes attachments to

significant others, internalizes those attachments and yet ultimately blossoms into a separate, autonomous individual through separation/individuation.

Object relations theory is based on the belief that all people have an internal, unconscious world of relationships that is different than what is going on in their external world of interactions with people. The theory focuses mainly on the interactions that people have with others, on the processes through which they internalize these interactions, and on the role these internalized object relations play in psychological terms (Flanagan, 2008, p. 122). An important aspect of object relations theory is that it looks more closely at how needs are met or not met in relationships. Object relations theorists also wrote extensively about the defenses, paying particular attention to how they pertain to relational issues.

Defenses in Object Relations

The defenses in object relations theory serve to manage parts of the self and others; to keep them in, get them out, and control them (Flanagan, 2008, p. 141). Defenses have adaptive, useful functions. They attempt to put some order into chaos, and can be the basis for the adult faculty of discrimination and the capacity to differentiate good and bad. Central to object relations theory is the belief that human beings are incorporative by nature. This means that we are constantly taking in from the world outside ourselves messages, ideas, attitudes, whole people, parts of people, and good and bad experiences. Incorporation, introjections, and identification as defenses can be understood to exist on a fluid continuum with introjection somewhere in the middle. Incorporation occurs when the distinction between self and other has only barely been achieved and when there is a sense of the object being allowed in part or whole.

Introjection describes the process of internalizing aspects of the object of whole relationships with objects. It is a type of internalization that is more advanced than incorporation. In identification, selective and valued parts of another are internalized, but remain unconscious. Mature identification is not merely a copying of someone else's traits, but actually making those traits uniquely a part of the self.

Rivalry, the competition among siblings for the exclusive or preferred care from the person they share, is mentioned in literature as a typical and important aspect of the development of the sibling relationship. Envy and jealousy are also mentioned in the literature, and if these desires are not acted upon, undue defenses or reaction formations may occur (Neubauer, 1983). When an individual has grown up with a sibling with a SMI, these desires will still exist, but are often not acted upon due to the condition in which the sibling may be in. Therefore, those undue defenses may occur. It may be a crucial moment in the life of the child when rivalry is given up, when the child feels abandoned and turns away from the exclusive tie to the object, albeit the sibling or parent. Reaching such a turning point has a permanent influence on the child's subsequent psychic functioning, which may express itself in a variety of ways. It may lead to detachment and isolation, or to a premature search for substitutes, or to substantial gains in individuation and differentiation.

Special attention should be paid to defenses in the context of this situation through object relations theory because we can see how defenses may manifest in later relationships. Marsh (1998) interviewed several people regarding adult intimate relationships that grew up with siblings with SMI, many of them describing themselves as having issues with trust and intimacy, fear of rejection, and being reluctant to make

long term commitments. We can see how internalization and introjection occurs. The well siblings take in the ideas and messages from the relationship with the object, or the sibling with the SMI and/or parents, and therefore these ideas and messages manifest themselves in later relationships.

Object Relations in Context

Now that the history and key points of object relations theory have been outlined, application of the theory in the context of the sibling relationship, when one sibling has an SMI and the other doesn't, can be better understood. Agger (1983) states that a child's sensory perceptions of siblings can occur almost as early and with as much frequency as those of the maternal object. Also, in adult life, transference aspects of a predominately sibling nature may emerge to govern interpersonal relationships, self-concept, and ego functioning. The subjective experiences of the sibling relationship and its interpretation arouse powerful feelings, stir up anxiety, and activate defenses. These internalized views of the well sibling in relation to the sibling with the SMI condition the well sibling to anticipate interpersonal outcomes and, in doing so, motivate and govern emotions and behavior. Because these internalized modes of perception and synthesis are largely unconscious, they are difficult to change without substantial clarification, interpretation, and working through (Agger, 1988). It is not about the fact that the individual has a sibling with a SMI, but it is about what he/she makes of it through internal meaning that carries the formative power. The role relationship between self and object may either satisfy a sense of self or jeopardize it. With what may be such a turbulent relationship between the self (the well sibling in this case) and the object (the sibling with the SMI), turbulence is what may be internalized. As mentioned in the phenomenon chapter, the

experience of being a forgotten family member, the experience of survivor's guilt, and the experience of replacement child syndrome may be internalized in terms of object relations theory. This is the internal representation the well sibling may have of their sibling relationship. It is not only the sibling relationship that will have certain object representations that will be affected, but the object representations within the parent/child relationship will also be affected (Kohut & Wolf, 1978). What may be the case is that the later relationship may hold many of the themes their early relationships with their parents and sibling had.

Object Relations and Partner Choice

Nichols and Schwartz (2001) state that development moves ideally from an immature state of symbiotic attachment to the source of gratification (the caregiver) to a mature state of separateness from, but emotional attachment to the caregiver as a separate individual, not an extension of or merged with the self. In adulthood, then, the theory states that one aspect of a mature motivation for a sexually intimate or partner relationship includes the ability to seek and enjoy sexual pleasure along with a reasonably balanced perception of the partner as a separate person of equal value, rather than a distorted perception that blurs self-object boundaries and renders the other merely a vehicle to gratification or emotional security. Object relations theory sees the blurring of self-object boundaries as fairly common in early stages of relationships, which at a deep level is a transaction between hidden internalized objects. Self needs encompass the individual's physical, sensual wants in conjunction with one's sense of self esteem, identity, and ego functioning to manage these aspects of self, all of which are largely unconscious internal objects—mental images of self and other built from experience and

expectation. Healthy adult self and attachment needs are defined by the person's ability to experience self and other as separate, though connected, and to hold an integrated, balanced view of the self and other as composed of both strengths and flaws. This achievement is referred to as "whole object relations", which is an ongoing state of emotional development. Woody, D'Souza, and Russel (2003) conducted a study with adolescents recalling the motives for their first sexual experience through the lens of object relations theory. The results showed that the adolescents' motivation came from self and attachment needs, characterized as healthy and unhealthy. Females reportedly more so wanted to feel safe and cared for, while both equally stated feeling loved and valued was an important factor. Adolescents who have faced familial stressors, such as being in a family in which SMI exists, are more likely to have compromised object relations, using unhealthy motivations to enter in unhealthy intimate relationships. These adolescent relationship patterns then influence later experiences of adult relationships, likely to also be unhealthy.

Blum and Shadduck (1991) suggest that every object-choice is based on and modeled after one's primary relationships, whether one seeks out the object or seeks to become the object. In object-choice, there is an attempt to repeat and/or rework conflictual aspects of the original objects and the self. That is, object-choice can be examined in terms of the degree of repetitive torment versus reworking and growth. So what is known is that our internalization and identifications as well as our choices of love-objects are determined by our history of object relations. Blum and Shadduck (1991) attempt to go further by determining whether an aspect of a "lost love-object" will be internalized or sought after or both through several case examples. The child

identifies and internalizes many of the aspects of the primary caregivers. A complex developmental process beset with conflicts, compromises, active structuring and restructuring occurs. Gradually and eventually needs are fulfilled or frustrated and a self is structured. One chooses other beyond the family, eventually choosing an other for the primary position. Blum and Shadduck's (1991) research through case examples reveals that their respective choices of love-objects attempt to repeat and/or rework conflictual aspects of themselves and their original objects. Repeated original feelings of misery, constriction, and victimization were found in the case examples. Short of extricating themselves from the current relationships, there seemed to be no way of achieving greater autonomy, self-respect, and personal initiative. In one of the examples; however, the relationship provided more opportunity for growth and mutuality.

Abend (1984), again using case examples, illustrated that siblings often choose partners who resemble their siblings, both physically and emotionally. The author focuses on, in these case examples, on opposite sex siblings and suggests that the younger sibling is more likely to seek a future partner that resembles the older sibling. The sibling relationships focused on were positive ones, however, free of conflict and turmoil.

Parens and Saul (1971) noted that certain ubiquitous life events in addition to ego maturity activate object relational differentiation. These include parental separation, birth of siblings, or actual object losses including that of sibling objects. They point out that the siblings are not only an object with whom one plays, but is also assigned roles that have social significance. Graham (1988) conducted a longitudinal study using 35 cases over a period of 23 years, ages between 26 and 40. There was evidence through these examples that the role of the sibling in their sibling relationships served as the basis for

the range of relationships with peers, partners, and coworkers. Also found was that the nature of these attachments often seemed to be a better and more immediate indicator of the quality and potential of marital relationships than were the more distant and iconic relationships with the parents. Siblings increased their impact when they were lost or operated as especially frustrating or damaged objects. This was only demonstrated in six of the 35 cases, in which the reaction to the lost or frustrating siblings inherently created a loss of initiative or autonomy through guilt, detracting from self-development.

The literature applying object relations to the choice of partner relationships and partner choice often used case study and case examples to illustrate findings. Only one of the studies mentioned having a sample of 35, still a fairly small sample. Interviews with a larger sample would have been much more useful. Appreciated is that Graham (1988) did conduct longitudinal research. Most studies within this topic also failed to provide demographic information such as race, ethnicity, class, etc., through which dynamics could be totally different.

From the perspective of object relations theory in this context, some key points which can be drawn from this chapter and later integrated into the discussion chapter are: 1) object relations looks at how needs are either met or not met in relationships; 2) when an individual is growing up in a family in which their sibling has a SMI, both the sibling relationship and the parent relationship are compromised in some way; and 3) the components of those compromised relationships are internalized and individuals carry with them an internal meaning and preface for other future relationships.

CHAPTER VI

DISCUSSION

As described in this study, children who have grown up with a sibling with a SMI often face issues of their own through the cycle of development which may manifest especially in future relationships and particularly in intimate ones. These “well” siblings may experience a host of feelings related to not getting their needs met by primary caregivers, who are often focusing much of their time, energy, and attention on the sibling with the SMI. Also, the sibling relationship in itself may be conflicted. As one of the earliest and closest relationships in one’s life, and as a relationship that is intended to promote companionship and emotional support, the conflicted relationship in which these things may be compromised serves as a model for later relationships.

The phenomenon chapter described the family life cycle and development throughout, and how disruptions in the family life cycle can affect individuals. With this phenomenon clearly being a significant disruption, the chapter goes on to describe what the “well” sibling might particularly be vulnerable to. This may be issues such as lack of trust and self-esteem, trouble in school, difficulty separating from the family, and feeling as though their needs are not being met. Well siblings may experience feelings of abandonment, resentment, and may feel like they have lost not only a sibling, but also a parent. They may feel guilty that they are emotionally healthy compared to their sibling, or they may feel that they have to compensate for their sibling and be the “perfect” child. With everything just described, it is almost inevitable that these things translate into later

partner relationships, through the choice of their relationships and how the relationships are maintained. Care giving burdens of the sibling with the SMI, or the expectation to provide care, may also add stress to the well sibling and interfere with his/her adult life. The reason for this is explained through the two chosen theories, trauma theory and object relations theory.

Through the lens of trauma and the emergence of the PTSD diagnosis, growing up with a sibling with a SMI would not classically be deemed as trauma. Through the exploration of the definition of trauma and given the experiences one faces when they have a sibling with a SMI; however, trauma is actually an accurate way of describing what the “well” sibling has faced in this situation. Growing up in a family in which one might witness symptoms such as a delusional, hallucinatory, suicidal, erratic, or violent behavior can be very traumatic. Visiting a family member on an inpatient mental health unit can be traumatic. Learning that a close family member has a SMI can be like experiencing a loss; also very traumatic. Having the dual loss of a sibling and a parent, who is so invested in the sibling with the SMI, could also be deemed a traumatic situation. Given that a case was made above for the fact that having a sibling with a SMI is indeed traumatic, trauma theory suggests that if an individual has been hurt directly or indirectly in another attachment relationship a natural tendency is to maintain emotional distance within future relationships. While the individual attempts to seek safety in isolation, depression may inadvertently occur due to this method of coping. When the individual does finally enter an intimate relationship, trust is hard won and the individual may constantly feel as though their partner may leave them and abandon their needs, flinging them into a feeling of a continued lack of safety. The feelings they experience

within the intimate relationship begin to duplicate that in their early relationships, in which their parents abandoned their needs and in which their sibling abandoned their hopes for companionship. Feelings of resentment and hostility begin to surface, causing extreme stress on the current intimate relationship.

This also ties into object relations theory, in which the whole basis is the integration of early relationships into the self and thus in later relationships. Human beings are incorporative by nature, thus they incorporate and internalize aspects of early relationships, which translates to later relationships, governing and motivating emotions and behavior based on the early relationship. All of this is of course, is unconscious, which makes it so hard to work through. These object representations are what make it so hard to enter intimate relationships as well as sustain them healthily.

Through interweaving the two theories, the two may seem to intersect as applied to the phenomenon but are actually very different. Again, main points of trauma theory are: 1) trauma is an assault on the self, 2) the individual's perception of the assaulted self reflects how they are seen by others and how they feel in relation to them, and 3) the trauma of being in this sibling relationship influences the tendency to maintain emotional distance in the future while still yearning for those attachment needs. Main points of object relations theory are: 1) needs are either not met or met in relationships, 2) growing up with a sibling with a SMI compromises object relations within the sibling relationship and the relationship the well sibling has with the parent, and 3) the components of those compromised relationships are internalized and the well siblings carry with them an internal meaning and preface for future relationships. Trauma theory suggests that this trauma affects how an individual sees him/herself and how others see the individual.

This fits with object relations in that the compromised sibling relationship and the compromised sibling/parent relationship will affect how the individual sees him/herself, as well. This interplay will then create a cycle of compromised relationships based on the trauma and based on object relations that are not fully developed. For example, if an individual feels as though their needs have been neglected and they are not worthy of affection, efforts on behalf of a future partner to prove that they are worthy of this attention will eventually get exhausting. Individuals who have siblings with SMI are more likely to give up, thus making it easier for their partners to give up as well.

For clinicians practicing from these two different models, the presentation of the individuals would look different as well as the conceptualization of what is internally going on. Trauma is looked at as a real assault on the self, while in object relations needs are either met or not met through relationships. In both situations, relationships later will be affected. From the framework of trauma theory, the client may be seen as emotionally distant while at the same time yearning for those attachment needs such as love and affection. Memories of the trauma they had faced would probably appear split off from their consciousness. A clinician would most likely attempt to empower the client, helping them to work through their trauma, recognizing that they had endured and lived through a difficult event, and looking for ways to help heal the self, establish a higher value of the self, and divert the blame away from the self. From the framework of object relations theory, a client would present as having internalized so much of their previous relationships with their siblings and parents and incorporating it into their current relationships or desire for an intimate relationship. Helping clients to see the connection and bringing this into consciousness through exploration of previous relationships would

be the focus of the clinician. At the point of bringing the unconscious into the consciousness, the client would be able to recognize patterns and work towards change. Working from an integrated model, a clinician could assess unconscious object relations patterns and with this assessment implement interventions which could assist an individual or even a couple to enact behavioral changes, leading to the self empowerment of the individual who had grown up under these circumstances.

Of course, there are both strengths and limitations of the current analysis. Strengths include the fact that the literature regarding the experience of having a sibling with a SMI offers many personal, firsthand accounts of the experience, really giving the researcher an in depth picture of the experience. Most of the literature also points out that these siblings are under researched and calls to professionals to conduct more of it. Although the literature rarely provides accounts of this situation through the lens of either of the theories, it does provide good models for understanding the sibling experience under other circumstances through the theories.

As someone who has a sibling with a SMI, I have firsthand experience as to what it is like to grow up in this situation. This has made me passionate about the research and has allowed me to have good insight into the process of exploring different feelings and experiences of others who have faced this.

Limitations include, as mentioned, the fact that there are virtually no peer-reviewed studies relating the phenomenon with the two selected theories of trauma and object relations. Some studies related the theories to growing up with a sibling with a physical illness, such as cancer, which is helpful towards the understanding in that the experiences are similar; namely the feelings of loss, guilt, resentment, etc. They are;

however, two different phenomena. Clearly, having a sibling in which there is a chance that due to their terminal illness they may not be present is much different than having a sibling who can be emotionally unavailable.

In this exploration, a “traditional” family was referred to; a family in which there is two caregivers and two siblings, one of whom has a SMI. Of course, there are families with much different dynamics. Some may have multiple siblings who have SMIs. Some only have one caregiver, some two or more. Not much attention is paid to different family dynamics in this study in order to allow things to be in simpler terms. This may account for the fact that many studies regarding families are so skewed in that they only focus on what is regarded as a traditional family to keep things simpler. We all know, however, that families are not simple by any means. Little attention is paid to the gender of the siblings, specific ages impacting the situation, and other stressors which may exacerbate the situation. The study also focuses so heavily on the negative impact this may have on the “well” siblings. This is not to say that all individuals that have siblings with SMI will be negatively affected. One may have incredible strengths, actually, which have come from their early life experience. Thus, later relationships may be healthy. Also, since I have a sibling with a SMI, I as a researcher may be biased due to my own personal experiences.

Regardless of what theoretical perspective clinicians may practice from, it is important to pay attention to all dynamics of the family when working with an individual with a SMI, especially those of the siblings because they are the ones whose needs often go unmet and almost ignored in a host of settings. Being more aware of this will help to be able to provide services to the sibling; whether it be simply in integrating the well

sibling into treatment, referring the sibling out for clinical services, or helping parents recognize that the needs of the well siblings are being unmet. Also, for individuals who are in adulthood, it is important for clinicians to pay attention to family dynamics of their childhood. It may be a clue, as to why they have difficulty with relationships later in life.

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