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ACCEPTANCE

This dissertation, COPING RESOURCES AND EMOTIONAL NEGLECT AMONG INDIVIDUALS WITH A SIBLING WITH A MENTAL ILLNESS, by LYNDA SHANE BLASKO, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

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ABSTRACT

COPING RESOURCES AND EMOTIONAL NEGLECT AMONG INDIVIDUALS WITH A SIBLING WITH A MENTAL ILLNESS
by
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The experience of having a sibling with a mental illness affects well siblings in a myriad of ways (Marsh, 1998). In the present paper the term *well siblings* refers to those individuals who have a sibling with a mental illness but who do not have a mental illness themselves. They face unique stressors due to disruptions in the sibling relationship and in the family (Corrigan & Miller, 2004). The stressors commonly experienced by well siblings include stigma, objective and subjective burden, intense and conflicting emotions, disruptions in family of origin, interpersonal and intrapersonal difficulties, difficulties with the mental health system, and over reliance on maladaptive stress coping resources (Greenberg, Kim, & Greenley, 1997; Lukens, Thorning, & Lohrer, 2004; Marsh, 1998; Marsh & Dickens, 1997b; Riebschleger, 1991). Research describing disruptions in family of origin suggests that well siblings also are experiencing emotional neglect (Lukens et al.; Marsh; Marsh & Dickens). This paper presents a synthesis of literature on the stressors well siblings experience and their attempts at coping with stress. For this study, 133 participants completed 3 instruments: (a) demographics questionnaire, (b) the Coping Resources Inventory for Stress (Matheny, Curlette, Aycock, Pugh, & Taylor, 1987), a measure of perceived stress coping resources, and (c), the Childhood Trauma Questionnaire (Bernstein & Fink, 1998), which includes an emotional

neglect scale. Participants with siblings with a mental illness were compared with participants whose siblings do not have a mental illness. Results indicate significant relationships between well siblings and emotional neglect and between emotional neglect and effective stress coping. However no significant relationship was observed between well siblings and effective stress coping. Therefore, having a sibling with a mental illness seems a risk factor for emotional neglect, but is not itself a risk factor for poor stress coping. The present study suggests that it is emotional neglect which is a risk factor for poor stress coping. The clinical implications of these results are discussed as well as the research implications and limitations of the study.

COPING RESOURCES AND EMOTIONAL NEGLECT AMONG INDIVIDUALS WITH A SIBLING WITH A MENTAL ILLNESS

by
Lynda Shane Blasko

A Dissertation

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in
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ABBREVIATIONS

CRE	Coping Resource Effectiveness (CRIS scale)
CRIS	Coping Resources Inventory for Stress
CTQ	Childhood Trauma Questionnaire
NAMI	National Association for the Mentally Ill

CHAPTER 1

COPING RESOURCES AND EMOTIONAL NEGLECT AMONG INDIVIDUALS WITH A SIBLING WITH A MENTAL ILLNESS: A REVIEW OF THE LITERATURE

The present article reviews and analyzes the literature on *well siblings*, individuals who have a sibling with a mental illness but who do not have a mental illness themselves. The focus is on the manifestations of stress, resources for coping with stress, and the benefits well siblings perceive result from having a sibling with a mental illness. The first section presents a history of mental health literature regarding families with a mentally ill child and an argument for the relevance of examining well siblings. After that is a synthesis of the findings regarding the many stressors well siblings face. Next, is a review of the ways in these individuals cope with stress and a discussion of the perceived benefits from having a sibling with a mental illness. The article concludes with a discussion of clinical and research implications. In an attempt to give voice to well siblings, this article synthesizes the literature on well sibling that address the stressors faced by the group, their attempts at coping with stress, both adaptive and maladaptive, as well as the areas they have identified as positive outcomes of having a sibling with a mental illness.

Background

Mental Illness and the Family

One family member's mental illness affects the other members of the family. Research on the impact of mental illness on the family typically examines the effects on

parents, spouses, and offspring. Until recently, effects on siblings were neglected or ignored, with very little research exploring this population (Greenberg, Kim, & Greenley, 1997; Halvorson, 1997; Judge, 1994; Lukens, Thorning, & Lohrer, 2002). The new research focus is not surprising, as the sibling relationship is receiving more prominence and being recognized as one of the most stable, consistent relationships across time (Judge; Seltzer, Greenberg, Krauss, Gordon, & Judge, 1997). The sibling relationship is the most enduring of all human connections; it is a life-long affiliation that precedes that of spouse (partner) and offspring, and outlasts that of parents (Cicirelli, 1982; Gerace, Camilleri, & Ayres, 1993). The literature commonly refers to *well siblings* as those individuals who a) have a sibling with a mental illness and b) do not have a mental illness themselves. The effects of mental illness on well siblings are distinct from the effects on other family members, including parents (Spaniol & Zipple, 1994) and offspring (Kinsella, Anderson, & Anderson, 1996; Marsh, 1994; 1998).

Prevalence

In addition to the enduring nature of the sibling relationship, siblings represent a significant population. Reports from the U. S. Census Bureau (2001) indicate that 80% of individuals have at least one sibling. According to the National Institute of Health and the U.S. Department of Health and Human Services (2001) mental illness occurs in 20% of children (American Academy of Child and Adolescent Psychiatry, 2002). It is responsible for significant impairment in 10% of children (The National Advisory Mental Health Counsel Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). Therefore, mental illness has the potential to affect millions of siblings who do not themselves have a mental illness. Potential effects of

having a sibling with a mental illness thus may be far-reaching and therefore warrant study.

History of Psychological Literature on Well Siblings

The initial research on well siblings occurred during the 1940's, 1950's and 1960's. It concentrated on the role well siblings could play in illuminating the etiology, then thought to be entirely environmental, of schizophrenia (Judge, 1994). Family members were examined in order to understand how the family environment caused disorders such as schizophrenia (Morris, 2002; see Ingham, 1949; Lucas, 1964). In the late 1960's researchers determined that the family environment was not to blame for mental illness, and Hoenig and Hamilton (1966) introduced the concept of family burden. Family burden refers to family members experiencing difficulties as a result of having a relative with a mental illness, but not as the cause of their family member's mental illness. With the family environment no longer to blame for the cause of mental illness (Dixon, 1997), the importance of the family in mental health research switched to examining the family's role in the care of the member with a mental illness (Reinhard, 1994).

As a result of deinstitutionalization trends in the United States in the 1970's and 1980's, parents became the primary caregivers for the mentally ill (Earl, 2005; Horwitz & Reinhard, 1995; Horwitz, Tessler, Fisher, & Gamache, 1992; Lively, Friedrich & Rubinstein, 2004; Schene, Tessler & Gamache, 1994). As parents age, their own failing health and mortality pose a significant threat to their ability to care for their children with mental illness (Greenberg, Kim et al., 1997; Horwitz & Reinhard). As parents began to age-out of caretaking roles, researchers' focus turned to siblings to continue the care of

the individuals with mental illness (Earl; Greenberg, Kim et al.; Greenberg, Seltzer, Orsmond & Krauss, 1999; Hatfield & Lefley, 2005; Jewell & Stein, 2002; Seltzer et al., 1997).

The last 15 years have seen a proliferation of research on well siblings (e.g., Hatfield & Lefley, 2005; Smith, Greenberg, & Seltzer, 2007). This research has illuminated several stressors faced by well siblings, many stress coping resources, as well as benefits well siblings attribute to their experiences of having a sibling with a mental illness. In addition, several books written by clinicians and well siblings convey similar themes (i.e., Marsh & Dickens, 1997a; Neugeboren, 1997). Clinicians published their impressions of the impact of having siblings with mental illness on the lives of their well sibling clients (Marsh & Dickens, 1997a; Safer, 2002). Common themes among well siblings were presented based on clinical experience and anecdotal evidence. Well siblings' personal experiences in the form of memoirs and self-help books for other well siblings (i.e., Moorman, 1992; Neugeboren; Simon, 1997; Swados, 1991) gave voice to the perspectives and unique concerns of this group of individuals. Several common themes emerge from these accounts such as the desire of well siblings to be visible and to be validated for their experiences- experiences which include several stressors in personal and interpersonal spheres, and an awareness and recognition of positive aspects of their experiences.

Identified Critical Factors Affecting Well Siblings

The literature examining the lives of well siblings indicates they experience significant stressors including caregiving responsibilities, anticipation of future caregiving, stigma, disruptions in their family of origin, intense and conflicting emotions

including the cycle of grief, cognitive distortions, personal and interpersonal concerns, professional concerns, and an inadequate mental health system.

Current Caregiving and Anticipation of Future Caregiving

One stressor that has received a significant amount of attention in the well sibling literature is stress associated with both current caregiving activities and anticipation of future caregiving for their sibling with a mental illness (Denberg, 1996; Earl, 2005; Greenberg, Kim et al., 1997; Greenberg, Seltzer et al., 1999; Han, 1995; Horwiz, 1993; Horwitz & Reinhard, 1995; Jones, 1997; Jewell & Stein, 2002; Lukens et al., 2002; Lohrer, 2002; Marsh, 1998). Several factors associated with current and anticipated caregiving have been examined, including relationships within the family, pressure from family members, gender, and race. The family appears to be influential on both current caregiving and future expectations of caregiving reference. The lack of availability of parents is a predictor of sibling involvement (Horwitz, 1993), as well as parental requests for well sibling involvement (Jewell & Stein). The closeness of the relationship with the family is a predictor of current caregiving and expectations of future caregiving (Earl). In addition, the current relationship with the ill sibling (Jewell & Stein), and the closeness of the relationship during adolescence with the ill sibling (Greenberg, Kim et al.) predict current and future caregiving.

A potential factor influencing caregiving is gender. Although the role of gender as a factor influencing caregiving is not as clear as family relationships, results from research studies are conflicting as to whether the gender of the well sibling influences caregiving. Horwitz (1993) found that gender did not significantly predict caregiving, however, in two other studies, females were more likely to provide care than males

(Greenberg, Kim et al., 1999) and females reported providing greater amounts of caregiving than males (Earl, 2005). Gender was also found to predict anticipation of future caregiving, with well sisters reporting higher expectations for caregiving than well brothers (Greenberg, Seltzer et al., 1999).

Another potential factor influencing caregiving is race. Results for the influence of race in well sibling caregiving are also inconclusive. In one study, no difference was found in current caregiving between Black and White well siblings (Horwitz et al., 1992). However, another study found that although there was no difference in caregiving between Black and White parents; Black well siblings were more likely to provide care for their ill siblings than White well siblings (Horwitz & Reinhard, 1995). A third study showed well siblings of color were more likely than White well siblings to provide caregiving (Earl, 2005).

Physical distance between the well sibling and the sibling with a mental illness has also been shown to negatively impact both current and future expectations of caregiving (Horwitz, 1993; Lohrer, 2002). Well siblings' expectations of future caregiving are also associated with several other positive influences, including annual household income, current caregiving, and whether the ill sibling is in a residential treatment facility (Lohrer). Some additional barriers to expectations of future caregiving include demands from their own family (Earl, 2005; Hatfield & Lefley, 2005), career demands (Earl), negative feelings about the behaviors associated with the illness, assumptions that the ill sibling will be resistant to mental health treatment, and fear that the ill sibling will be noncompliant with medication (Hatfield & Lefley).

Associated with objective burden of caregiving are issues of finances, time, and the perceived care needs of their sibling (Hatfield & Lefley, 2005; Horwitz & Reinhard, 1995). Well siblings report difficulty from financial and time constraints, and difficulty balancing the needs of their new family with the needs of their family of origin and their mentally ill sibling (Marsh, 1998). Additionally, well siblings tend to have poor knowledge of available legal assistance (Lohrer, Lukens, & Thorning, 2002).

Another barrier to caregiving is "subjective burden," which "refers to whether family members perceive themselves as carrying a burden and intrapsychic strains (i.e. stigma) that families experience in coping with a mental illness" (Greenberg, Greenley, & Brown, 1997, p. 41). Subjective burden is contrasted with objective burden, which "refers to the tangible stressors related to the care of persons with mental illness" (Greenberg, Greenley et al., p.41), such as money and time. Research indicates that gender does not predict subjective burden (Greenberg, Kim et al., 1997). However, race was found to influence subjective burden, with Black siblings reported significantly less subjective burden than White siblings (Horwitz & Reinhard, 1995). A greater amount of subjective burden was found to be associated with greater symptomology of the ill sibling (Friedrich, Lively, & Buckwalter, 1999; Greenberg, Kim et al.; Lefley, 1987), and younger siblings reported experiencing more subjective burden than older siblings (Greenberg, Kim et al.).

Stigma

A majority of well siblings experience stigma (Lukens et al., 2004; Marsh, 1998; Thorning & Lukens, 1999). The experience of stigma as a result of having a relative with a mental illness is a cause of psychological distress (Ostman & Kjellin, 2002). In addition

to affecting those with a mental illness, stigma also affects family members. Goffman (1963) coined the term "courtesy stigma" to refer to "the prejudice and discrimination that is extended to people not because of some mark they manifest, but rather they are somehow linked to a person with a stigmatized mark" (Corrigan & Miller, 2004, p.538). A significant portion of family members report difficulties in their relationships with friends and members of their extended families as a result of having a family member with a mental illness (Corrigan & Miller; Ostman & Kjellin). The stigma well siblings face encompasses a lack of understanding, insensitivity, intolerance, avoidance and discrimination from both friends and acquaintances, resulting in feelings of sadness, disappointment, and shame (Corrigan & Miller; Lukens et al., 2004).

Family Disruptions

Well siblings experience significant disruptions to their family of origin. They report feeling invisible within their family (Lukens, Thorning, & Lohrer, 2004; Marsh, 1998; Marsh & Dickens, 1997b). Well siblings also report feeling that their needs were not met while growing up (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens, 1997b). They indicate that their family life revolved around their ill sibling (Thorning & Lukens, 1999), report experiencing a sense of abandonment (Marsh & Dickens, 1997b), and they indicate that they felt they were forgotten family members (Marsh, 1998). Well siblings report loose boundaries within the family, as well as role confusion, with well siblings growing up too fast and taking on parentified and therapeutic roles (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens, 1997b). "Replacement Child Syndrome" describes situations in which the well sibling strives for perfection in order to accommodate the parents (Marsh, 1998); they describe attempts to behave, succeed, and strive to be perfect

in order to compensate for their ill sibling (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens, 1997b), and some report acting out or acting crazy in order to seek attention from their parents (Lukens et al., 2004). In addition, well siblings report experiencing grief for the loss of a normal childhood (Marsh, 1998; Lukens et al., 2004) and family life (Marsh, 1998). They also report developmental issues including problems with trust, intimacy, identity, and separating from the family (Marsh, 1998; Marsh & Dickens, 1997b).

Intense and conflicting emotions

Well siblings report experiencing intense and conflicting emotions. They report experiencing cycles of grief and loss, including denial, anger, and bargaining, cycles which often repeat themselves, as a result of the cyclical nature of mental illness (Riebschleger, 1991). Issues of grief and loss include the loss of the person they once knew (Marsh, 1998; Lukens, et al., 2004; Reibschleger), and the loss of the sibling relationship and the loss of parents who are consumed by grief and the needs of the ill sibling (Marsh, 1998). They also experience fear, anger, frustration, resentment, depression, helplessness, hopelessness, and survivor's guilt (Lukens et al., 2002; Lukens et al., 2004; Marsh & Dickens, 1997b; Samuels & Chase, 1979). Survivor's guilt includes feelings that one's own health was achieved at the expense of their sibling, possible reticence to embrace the richness of their own lives, as well as ignoring their own problems (Marsh, 1998). In addition, well siblings experience intense and conflicting emotions directed at their parents including anger, frustration, and resentment (Lukens et al., 2004). Research results support the hypothesis that well siblings undergo a process

involving six phases, in order to adjust to their sibling having a mental illness (Mulhabauer, 2002).

Mental Health System

Overwhelmingly, well siblings report that the mental health system is inadequate in responding to their needs (Kinsella, Anderson, & Anderson, 1996; Marsh, 1998; Riebschleger, 1991; Thorning & Lukens, 1999). Well siblings feel ignored by mental health professionals (Marsh, 1998). Well siblings identified several areas in which the mental health system could attend to their needs more appropriately such as providing support, validating their emotions and experiences, and telling them that their sibling's illness and the resultant family disruptions are not their fault (Kinsella et al.; Reibschleger). They desire education about their sibling's illness and in life skills, including assistance and modeling in communication and problem-solving skills (Kinsella et al.; Landeen et al., 1992; Reibschleger). They requested mental health providers recommend or provide well siblings with support groups, individual and family therapy (Kinsella et al.). And well siblings requested that clinicians include them in their siblings treatment planning, and that treatment includes a focus on the family's strengths (Kinsella et al.; Riebschleger).

Stress and Coping

Resources for coping with stress are often referred to as adaptive and maladaptive (Carver, Scheier, & Weintraub, 1989; Folkman & Lazarus, 1988; Klein, Turvey, & Pies, 2004). Adaptive coping refers to those coping skills that serve to minimize stress in the short and long term (Folkman & Lazarus; Matheson, Skomorovsky, Fiocco & Anisman, 2007) In contrast, maladaptive coping refers to those resources which, although may

result in short term reduction of stress, result in a return of the stress to similar or greater levels in the long term. In addition, maladaptive coping may lead to interpersonal difficulties (Anshel, 2000; Folkman & Moskowitz, 2000; Klein et al.; McCrae & Costa, 1986; Walker, Zona & Fisher, 2005; Zuckerman & Gagne, 2003).

Well siblings acknowledge that many of their attempts to protect themselves from stigma are maladaptive (Lukens et al., 2004). Furthermore, several of the ways in which they attempt to cope with some of the numerous stressors they face are maladaptive. For example, well siblings report difficulty creating and maintaining relationships, both romantic and non-romantic (Kinsella et al., 1996; Marsh, 1994; Marsh & Dickens, 1997b; Lukens et al., 2004). They describe having difficulties with boundaries, trust and intimacy, which inhibit their ability to establish intimate relationships (Marsh & Dickens, 1997b; Lukens et al., 2004). In addition, well siblings describe various attempts to protect themselves from stigma and misunderstanding by others. By creating protective shells and avoiding others, they prevent themselves from experiencing and enriching personal and social relationships (Lukens et al., 2004). Thus, well siblings often remain isolated and lonely (Marsh & Dickens, 1997b).

Well siblings also report utilizing other types of maladaptive coping with the similar goal of protecting themselves from intense negative emotions. These include cognitive distortions, psychic numbing, internalizing emotions and engaging in unhealthy escapism (Kinsella et al., 1996; Marsh & Dickens, 1997b). In conjunction with the use of maladaptive coping skills, well siblings experience problems with their self-concept (Marsh, 1994). Self-concept is a construct with many manifestations, but across several studies, well siblings consistently report difficulties with such aspects of self-concept as

self-esteem, self-efficacy, and self-worth (Marsh, 1994). Furthermore, it is likely that well siblings may think that they do not deserve to be happy or to have intimate relationships that their sibling with mental illness is not capable of having. Several studies describe well siblings experiencing guilt at their health in the wake of their sibling's disease (e.g., Marsh, 1994). Previous studies have linked negative self-concept and negative emotions with the use of maladaptive coping (e.g., Walker et al., 2006). As such, harboring guilt may lead to continued use of maladaptive coping.

These examples of maladaptive coping resources lead to additional stressors for these individuals. Therefore, it is not surprising that well siblings report experiencing poor emotional functioning, which often includes difficulty maintaining relationships, psychic numbing and emotional constrictedness, immaturity, feelings of incongruence, and poor self-esteem (Kinsella et al., 1996; Lukens et al., 2004; Marsh, 1994).

Adaptive Coping Resources

Although well siblings utilize several types of maladaptive coping skills, they also engage in a variety of adaptive coping skills. These skills include seeking support from others, through spiritual faith, and from acquiring knowledge about their sibling's illness. In addition, well siblings utilize cognitive distortions and healthy escapism to protect themselves from the constant awareness of their sibling's illness and from the reactions of other people (Kinsella et al., 1996; Lukens et al., 2004; Marsh, 1998).

The closeness of the relationship between the well sibling and their ill sibling prior to the onset of their illness is associated with the well sibling's use of both emotion-focused and problem-focused coping (Halvorson, 1997). In addition, the well sibling's use of both emotion-focused and problem-focused coping are associated with their

experience of subjective burden (Halvorson). There is only one study which compares the stress coping of individuals whose siblings do not have a mental illness with people whose siblings have a diagnosis of schizophrenia and with people whose siblings have a diagnosis other than schizophrenia (Morris, 2002). This study indicated that people who have a sibling with a mental illness other than schizophrenia might cope with stress differently than those who have a sibling with schizophrenia. The study found that well siblings of schizophrenics utilize more problem-focused and emotion-focused coping than those whose siblings have a mental illness other than schizophrenia (Morris). Furthermore, the study also indicated that well siblings of schizophrenics utilized more problem-focused coping than those whose siblings did not have a mental illness (Morris).

Well sibling's psychological well being is also affected by several other factors. For example, their psychological well being is greater the further their home is from the home of their sibling with a mental illness (Seltzer et al., 1997). This indicates that moving further away from their sibling constitutes a form of adaptive coping. The frequency with which well siblings interact with their mentally ill siblings is not significantly associated with well sibling depression or self-concept, and it does not impact the relationship with the ill sibling (Halvorson, 1997). Therefore, while altering the amount of time spent with their sibling may constitute adaptive (or maladaptive) coping on an individual basis, as a group it does not.

Positive Consequences

Although the literature on well siblings highlights several stressors, interpersonal and intrapersonal difficulties, and maladaptive coping, the research indicates that well siblings do not perceive their experiences as wholly negative. There is an abundance of

information within the literature indicating that well siblings perceive significant positive consequences of their experience of having a sibling with a mental illness. Some well siblings indicated that there were positive consequences in general (Marsh & Dickens, 1997b); however, many specific benefits were also identified. These benefits include increased empathy, compassion, tolerance, patience and non-judgmental attitude (Kinsella et al., 1996; Lukens et al., 2004; Marsh & Dickens, 1997b). In addition, well siblings attribute several life skills such as the ability to develop a sense of independence, self-reliance, resiliency, and assertiveness to their experiences of having a sibling with a mental illness (Kinsella et al.). Furthermore, they often perceive experiencing a better family and social life, having a special closeness within their family of origin, having a greater appreciation for life and mental health, and having a healthier perspective and priorities (Marsh & Dickens, 1997b).

Limitations of the Current Literature

Discussed above is one major limitation with the literature: The literature contains a limited view of well siblings as only a coping resource for their sibling with a mental illness instead of looking at them as individuals with their own experiences and needs. Another big problem with the literature is a tendency to focus on only one type of well sibling. The preponderance of well sibling literature utilizes samples that lack diversity. Many of these samples were recruited from support groups such as the National Association for the Mentally Ill (NAMI), or are recruited directly through their siblings with a mental illness (Song, Biegel, & Milligan, 1997). There is no reason to assume that the typical or majority of well siblings are members of support groups, therefore results from these studies likely do not reflect the experiences of most well siblings. In fact, it is

very possible that the majority of well siblings, those who are not receiving assistance and support from groups such as NAMI, face greater stress and have less resources for coping. The most common mental illnesses are depression and anxiety disorders, and schizophrenia and schizoaffective disorder account for 1% of the population (American Psychiatric Association, 2000). Hence, there are many well siblings of individuals with these and other disorders who are not represented by the literature. The only study that compares types of well siblings (between those whose sibling has schizophrenia and those with any other mental illness) reports differences in stress coping between these groups (Morris, 2002). Therefore, study of other types of well siblings is warranted. Therefore, more representative research might yield different results.

Another limitation of the literature is that the samples consist predominantly of individuals who are Caucasian, female, middle to upper class, and who are middle-aged (Fisher, Benson & Tessler, 1990; Morris, 2002). There are only three studies comparing the caregiving experiences and burden between Black and White well siblings (Earl, 2005; Horwitz & Reinhard, 1995; Horwitz et al., 1992). Mental illness does not discriminate based on race/ethnicity, sex, age, or socioeconomic status (American Psychiatric Association, 2000), therefore, one cannot assume that results from these studies are representative of all well siblings. Finally, it appears from the current literature that well siblings, although they seem to utilize some adaptive coping, may be lacking additional adaptive coping resources. It is not clear from the current literature if there are specific adaptive coping resources that well siblings tend to not utilize. Further research on well siblings could analyze this, with the goal of creating interventions

designed to enhance adaptive coping resources, and ultimately, reduce interpersonal and intrapersonal difficulties.

Clinical Implications and Reflections

The well sibling literature indicates that well siblings are a group of individuals who experience high levels of stress, and may lack adequate stress coping resources. Clinicians can respond to this information by continuing to give these individuals a voice, to acknowledge their experience, and to work with them on building more adaptive stress coping resources. Mental health professionals can identify well siblings as needing assistance earlier in their lives, and intervene by listening to them, providing support and education, and by normalizing their experience.

Clinicians have the opportunity to have a tremendous impact on well siblings by acknowledging their experiences as unique and stressful, validating those experiences, and by encouraging visibility and voice for well siblings. These individuals could be empowered by the simple act of acknowledgement from mental health professionals that their experiences are difficult, and worthy of being understood. Mental health professionals should be aware of the effects of having a well sibling to use this information to intervene on their behalf.

Clinicians can respond to this information by recognizing that by having a sibling with a mental illness, these individuals are likely to have many issues related to this experience, many of which have never been addressed. An extremely powerful tool may be that of listening to these individuals, encouraging them to talk about this experience, and acknowledging the associated stress. Therapists have the opportunity to empower well siblings by providing them support and encouragement, and the opportunity to be

seen as individuals with their own concerns, rather than merely trying to attend to their sibling's and family's concerns.

Clinicians can create or locate support groups for well siblings and encourage well siblings to attend such groups. Additionally, family therapists can play a vital role in the well-being of well siblings. They can identify well siblings and provide them with information such as the common responses and effects of having a sibling with a mental illness, and normalize their experience. Family therapists can advocate for them by informing parents of the effects on well siblings and encouraging families to address well siblings' needs.

The family therapist has a dual role in addressing the needs of the parents meanwhile protecting the well child(ren). By encouraging parents to identify and take advantage of all opportunities for support, clinicians can help parents understand the importance of seeking out other adults for support, so that they do not lean on their children. Parents can be taught how to stop reinforcing their well children's parentified behaviors and how to encourage them to take/maintain a child role in the family. Clinicians simultaneously will reinforce for the well children that they do not need to be perfect or sick to receive attention, while reminding parents of the importance of encouraging their well children and telling them that they are loved, wanted, and appreciated.

To attend to the needs of the whole family, family therapists should teach parents not to neglect the needs of their well children. Well children need to be taught that their emotional experience is normal, and allowed to experience their intense and often

conflicting emotions. Clinicians can help educate families about the grieving process that well children (and parents) experience when a child in the family has a mental illness.

It is also very important for therapists to encourage connections among well siblings. In addition to individual, group, and family therapy, well siblings could be encouraged to connect to extended family members, neighbors, and peers.

Therapists can begin to empower well siblings by listening to them, encouraging them to tell their stories, and acknowledging their experiences. Well siblings may need to be encouraged to identify and acknowledge the effects of having a sibling with a mental illness. Clinicians may ask well siblings how their experience of having a sibling with a mental illness has affected them, their life, and their role in their family. There are several issues that clinicians can attend to that will empower well siblings. For example, therapists may want to address the issue of survivor's guilt. Well siblings could benefit from being told, and reinforced that they are not responsible for their sibling's illness; and their health is not responsible for their sibling's mental illness. It would be useful to explore well sibling's thoughts regarding their role in their family, and their possible fears of success and/or failure.

Therapists could encourage well siblings to examine the ways in which they cope with stress. By exploring coping skills with well siblings, clinicians can help their clients recognize their adaptive and maladaptive coping skills. This recognition could lead to an exploration of adaptive coping skills that clinicians may teach or encourage well siblings to learn and practice.

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CHAPTER 2

COPING RESOURCES AND EMOTIONAL NEGLECT AMONG INDIVIDUALS WITH A SIBLING WITH A MENTAL ILLNESS

Well siblings are individuals who have a sibling with a mental illness but do not have a mental illness themselves. Historically, research on the effects of mental illness on the family has neglected well siblings (Greenberg, Kim, & Greenley, 1997; Halvorson, 1997; Judge, 1994; Lukens, Thorning, & Lohrer, 2002). More recently, however, they have begun to receive some attention. This new focus on well siblings is not surprising, as the significance of the sibling relationship is receiving more prominence as it is recognized as one of the most reliable and long-standing relationships (Judge; Seltzer, Greenberg, Krauss, Gordon, & Judge, 1997). Although the last 15 years have witnessed an increase in the number of studies focusing on well siblings, the preponderance of these studies relegate them to mere resources for their ill siblings (Morris, 2002).

Well siblings are affected by their experience in many ways, and they face numerous stressors as a result. These stressors include caregiving burden, stigma, intense and conflicting emotions, family disruptions, difficulties dealing with the mental health system, and maladaptive stress coping (Greenberg et al., 1997; Lukens, Thorning, & Lohrer, 2004; Marsh, 1998; Marsh & Dickens, 1997; Riebschleger, 1991).

Interestingly, despite the paucity of research on well siblings, they represent a significant population. In addition to the enduring nature of the relationship, the sheer presence of siblings is astounding. According to the U.S. Census 80% of individuals have

at least one sibling (2001). Mental illness occurs in 20% of children and is responsible for significant impairment in 10% of children (U.S. Department of Health & Human Services (2001). Therefore, mental illness has the potential to affect millions of well siblings, and therefore warrants further study.

Research suggests that emotional neglect may occur with well siblings as the parents attempt to care for their offspring with a mental illness (Hatfield & Lefley, 2005). Emotional neglect is defined as "the failure of caretakers to provide a child's basic psychological needs, such as love, encouragement, belonging, and support (Bernstein & Fink, 1998, p.2). Such failures do not need to be intentional for the effects of emotional neglect to occur (Forward, 1989). For example, unintentional emotional neglect may occur when a parent is chronically ill or a child is chronically ill (Cook, 1991).

Well sibling literature illuminates several stressors resultant from their experience of having a sibling with a mental illness. These stressors include caregiver burden, family disruptions, stigma, and intense and conflicting emotions. A preponderance of the literature indicates that well siblings experience significant stress associated with caregiver burden (Earl, 2005; Greenberg, Seltzer, Orsmond, & Krauss, 1999; Horwitz & Reinhard, 1995; Lukens et al., 2002). This stress includes both objective and subjective burden resultant from actual and anticipated caregiving activities (Earl; Greenberg et al.; Han, 1995; Horwitz & Reinhard; Jewell & Stein, 2002). Objective burden refers to the concrete aspects of caregiving such as the actual time or money spent in caregiving activities, whereas subjective burden refers to the individuals' perception that they are experiencing burden.

Disruptions in their families of origin result in significant interpersonal and intrapersonal difficulties (Lukens, Thorning et al., 2004; Marsh, 1994; 1998; Marsh & Dickens, 1997). These include feeling not only that their needs were not met by their family, but that they were responsible for attending to the family's needs, and often took on parentified or therapeutic roles in their families (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens). They strive for perfection, attempting to make up for their sibling's imperfections (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens).

Family disruptions cause developmental issues for well siblings including problems with trust, intimacy, identity, and separating from the family (Marsh, 1998; Marsh & Dickens, 1997). Family disruptions and attempts at understanding and coping with their sibling's mental illness lead to well siblings experiencing many intense and often conflicting emotions. These emotions include grief for the loss of a normal childhood and family, as well as grief for the loss of the sibling they once knew (Lukens et al., 2004; Marsh, 1998; Reibschleger, 1991). Well siblings also experience fear, anger, frustration, sadness, resentment, depression, helplessness, hopelessness, and survivor's guilt (Lukens et al., 2002; Lukens et al., 2004; Marsh, 1998; Marsh & Dickens, 1997). Survivor's guilt refers to the feeling that they achieved their own mental health at the expense of their sibling's (Marsh, 1998). This guilt likely interferes with their ability to establish and maintain successful intimate relationships. In addition, their guilt may interfere with their ability to utilize more adaptive stress coping techniques.

Well siblings acknowledge that many of their attempts to protect themselves from stigma are maladaptive (Lukens et al., 2004). For example, well siblings report difficulty creating and maintaining relationships, both romantic and non-romantic (Kinsella et al.,

1996; Marsh, 1994; Marsh and Dickens, 1997; Lukens et al., 2004). They describe having difficulties with boundaries, trust and intimacy, which inhibit their ability to establish intimate relationships (Marsh & Dickens; Lukens et al., 2004). In addition, well siblings create protective shells and avoid others; they prevent themselves from experiencing and enriching personal and social relationships (Lukens et al., 2004). Thus, well siblings often remain isolated and lonely (Marsh & Dickens).

Furthermore, well siblings report utilizing other types of maladaptive coping with the similar goal of protecting themselves from intense negative emotions. These include cognitive distortions such as psychic numbing and identity problems, as well as internalizing emotions and engaging in unhealthy escapism (Kinsella et al., 1996; Marsh & Dickens, 1997).

Maladaptive coping leads to additional stressors for these individuals. Therefore, it is not surprising that well siblings report experiencing poor emotional functioning, which often includes difficulty maintaining relationships, psychic numbing and emotional constrictedness, immaturity, and feelings of incongruence (Kinsella et al., 1996; Lukens et al., 2004; Marsh, 1994). In conjunction with the use of maladaptive coping skills, well siblings experience problems with their self-concept (Marsh, 1994). Self-concept is a construct with many manifestations; across several studies well siblings report difficulties with such aspects of self-concept as self-esteem, self-efficacy, and self-worth (Marsh, 1994).

Although well siblings utilize several types of maladaptive coping skills, they also engage in a variety of adaptive coping skills. These skills include seeking support from others, through spiritual faith, and from acquiring knowledge about their sibling's illness.

In addition, well siblings utilize cognitive distortions and healthy escapism to protect themselves from the constant awareness of their sibling's illness and from the reactions of other people (Kinsella et al., 1996; Lukens et al., 2004; Marsh, 1998).

The only study to compare the stress coping of individuals whose siblings do not have a mental illness with people whose siblings have a diagnosis of schizophrenia and with people whose siblings have a diagnosis other than schizophrenia (Morris, 2002) suggests that people who have a sibling with a mental illness other than schizophrenia cope with stress differently than those who have a sibling with schizophrenia.

There are two major limitations of the literature on well siblings, a lack of diversity among respondents and a biased focus on well siblings as a resource for meeting the needs of their siblings with a mental illness (Fisher, Benson, & Tessler, 1990; Morris, 2002). With the exception of three studies comparing Black and White well siblings, the majority of samples consist almost entirely of Caucasian respondents (Earl, 2005; Horwitz & Reinhard, 1995; Horwitz, Tessler, Fisher, & Gamache, 1992). In addition to a lack of racial/ethnic diversity, subjects are typically recruited from support organizations such as the National Association of Mental Health (NAMI) whose membership is overwhelmingly Caucasian, female, middle-aged, and of middle to upper middle class (Song, Biegel, & Milligan, 1997). The most common mental illnesses are depression and anxiety disorders, however the majority of research on well siblings focuses on those with siblings with schizophrenia, which only accounts for 1% of the population (American Psychiatric Association, 2000; Fisher et al.). The focus tends to include respondents who have separated from their family of origin and commonly have started families of their own. There is a lack of research focusing on samples of young adult well

siblings who are just beginning the process of separating and individuating from their family. The present study then seeks to answer four specific questions:

Research Question 1: What is the prevalence of subjects having a sibling with a mental illness?

Research Question 2: Is there a difference between subjects without mental illness with siblings with and without mental illness regarding emotional neglect?

Research Question 3: Is there a difference between subjects without mental illness with a sibling with or without mental illness, regarding coping skills?

Research Question 4: With regard to the above analyses, based upon identified group differences in Hypothesis 2, what is the relationship of coping resources to emotional neglect?

Methodology

Participants

Participants were recruited from career exploration courses at a large, diverse, urban university in the southeastern United States. Participation was completely voluntary; however, students received research credit in exchange for their participation in this study. No student was penalized for refusing to participate.

Of the 133 participants who completed the entire research packet, 100 (73.7%) were female. With regards to race/ethnicity, there were 77 (57.9%) African-American/Black, 32 (24%) Caucasian/White, 4 (3.01%) Latino/Hispanic, 13 (9.7%) Asian-American/Pacific Islander, 1 (.75 %) Middle Eastern, and 3 (2.3%) other participants (3 did not respond). The mean age of participants was 23.70 (range = 18-48, SD= 5.26). With regards to socioeconomic status, participants reported a median annual

household income range of $45,000-54,999. None of the participants reported membership in NAMI or related support groups.

The sample was divided into two groups by whether or not their sibling has a mental illness as defined by the DSM-IV-TR (American Psychiatric Association, 2000) as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress . . . or disability . . . or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. xxxi). The well sibling group (n=14) is composed of 8 (57.1%) females and 6 (42.9%) males. Their ages ranged from 20-47, with an average of 26.21 years (SD = 7.807). Of the well siblings, 6 (42.9%) identified as African-American/Black, 4 (28.6%) Caucasian/White, 1 (7.1%) Middle Eastern, 1 (7.1%) Asian-American/Pacific Islander, 1 (7.1%) multi-ethnic, and 1 (7.1%) declined to report race/ethnicity. The median annual household income range of the well siblings was $55,000-64, 999. The participants reported their siblings' illnesses as Bipolar Disorder (14.3%), Major Depressive Disorder (42.9%), Anxiety Disorder (7.1%), Autism (7.1%), Psychotic Disorder (7.1%), Developmental Disorder (7.1%), Uncertain (7.1%), and diagnosis missing (7.1%). Of note, participants were given seven options regarding their siblings' diagnosis including: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Other (please specify), and Uncertain (please describe your experience/what you have observed). Four participants chose the other category and wrote in their siblings' diagnoses. It is not clear whether the participants reported their perception of their siblings' diagnoses or if these represent professionally confirmed

diagnoses. Of their siblings with a mental illness, 9 (64.3%) were female and 5 (35.7%) are male, with an average age of 24.14 years (range = 12-51, SD = 11.1).

Procedure

All participants were informed of their rights as human research subjects, including the right to not participate in the study. This research was conducted in accordance with the Institutional Review Board (IRB) and adhered to American Psychological Association (APA) ethical guidelines for research. All information collected was anonymous; responses contained no identifying information such as name or social security number.

Instruments

Coping Resources Inventory for Stress. The Coping Resources Inventory for Stress (CRIS; Matheny, Curlette, Aycock, Pugh, & Taylor, 1987) is a pencil-and-paper self-report instrument containing 280 true-false items measuring perceived resources for coping with stress. In addition to an overall Coping Resources Effectiveness score (CRE), the CRIS yields 15 scales measuring specific coping resources, and 5 validity scales. Each scale yields a percentile score, with a range of values from 0 to 100.

Matheny, Aycock, Curlette, and Junker (1993) provide a description of the 15 coping resource scales, which include 12 primary scales and 3 composite scales, as well as five validity scales. The primary scales are: Self-Disclosure, “a measure of the tendency to disclose freely one’s feelings, troubles, thoughts, and opinions” (p. 817); Self-Directedness “measures the degree to which persons respect their own judgment for decision-making and, therefore, demonstrate assertiveness in interpersonal relationships” (p.817); Confidence “measures the ability to cope successfully, that is, to gain mastery

over one's emotions in the interest of reaching personal goals" (p. 817); Acceptance "measures the degree to which persons accept their shortcomings and imperfections and maintain a positive and tolerant attitude towards others and the world at large" (p. 817); Social Support "measures the availability and use of a network of caring others (usually family members and friends), which acts as a buffer against stressful life events" (p. 817); Financial Freedom "measures the extent to which persons are free of stressful financial constraints on their lifestyles" (p. 817); Physical Health "measures the person's overall health condition, including the absence of chronic disease and disabilities" (p. 817); Physical Fitness "measures one's personal health practices, especially physical exercise" (p. 817); Stress Monitoring "measures one's awareness of tension build-up, situations and events that are likely to prove stressful, and one's optimal stimulation range" (p. 817); Tension Control "measures one's ability to lower arousal through relaxation procedures and thought control" (p. 817); Structuring "measures the ability to organize and manage resources, such as time and energy" (p.817); and Problem Solving "measures the ability to resolve personal problems" (p.818). The 3 composite scales are: Cognitive Restructuring which "measures the ability to change one's thinking in the interest of reducing stress" (p. 818); Functional Beliefs "measures beliefs that are helpful in preventing stressful situations and in lowering stressful arousal" (p. 818); and Social Ease "measures the degree of comfort one experiences in the presence of others" (p. 818).

Curlette, Aycock, Matheny, Pugh, and Taylor (1992) report high internal consistency reliability for the CRE (.97) and the 12 Primary scales (.84 to .97) as well as high test-retest reliabilities after a four-week period for the CRE (.95) and the 12 primary scales (.76 to .95). A comprehensive overview of reliability and validity studies of the

CRIS is provided by Matheny, et al. (1993), which indicates excellent psychometric properties for the CRIS.

Childhood Trauma Questionnaire. The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) is a 28-item self-report instrument measuring history of abuse and neglect during childhood. All items begin with the phrase, "When I was growing up", and are endorsed on a 5-point Likert-type scale with response options of "never true"; "rarely true"; "sometimes true"; "often true"; and "very often true". The only scale that was used is Emotional Neglect, an empirically derived scale with scores ranging from 5 to 25 (Bernstein & Fink). Emotional neglect is operationalized by Bernstein and Fink as "the failure of caretakers to provide a child's basic psychological and emotional needs, such as love, encouragement, belonging, and support" (p.2).

Bernstein and Fink (1998) provide a discussion of internal consistency and test-retest reliability as well as content, construct, and concurrent validity.

Demographic Questionnaire. The Demographic Questionnaire utilized in this project is a revised version of the questionnaire created by Lukens and Thorning for The Sibling Project (Lukens & Thorning, 2000). Permission to make any necessary changes to the questionnaire was obtained by Lukens (personal communication, April 11, 2005). Lukens reported that validity of the questionnaire is currently in the final testing stage, and is based on face validity and concurrent validity with a similar demographic questionnaire created by Jan S. Greenberg. Two research studies have been completed using the questionnaire (Lohrer, 2002; Lohrer, Lukens, & Thorning, 2002) as well as one study that incorporated a revised version of the questionnaire (Earl, 2005).

Research Hypotheses

The present study examined four specific hypotheses.

Research Hypothesis 1: Well siblings represent a noteworthy proportion of the population.

Research Hypothesis 2: Well siblings will report higher levels of emotional neglect than individuals whose siblings do not have a mental illness.

Research Hypothesis 3a: Well siblings will report lower perceived stress coping resources on a measure of general coping resource effectiveness

Research Hypothesis 3b: If well siblings report lower perceived stress coping resources on a measure of general coping resource effectiveness well siblings will also report lower levels of perceived stress coping resources on three composite coping scales: cognitive restructuring, functional beliefs, and social ease.

Research Hypothesis 3c: If well siblings report lower perceived stress coping resources on a measure of general coping resource effectiveness well siblings will report lower levels of perceived stress coping resources on four specific coping scales of self-disclosure, self-directedness, social support, and acceptance.

Research Hypothesis 4: There is a relationship between emotional neglect and stress coping resources.

Analysis

Power analysis suggested a sample size of 128 (Hopkins, 2000). To address the research questions, the respondents were divided into two groups, those who have a sibling with a mental illness and those whose siblings do not have a mental illness. To address Research Question 1, the planned analysis path was to calculate the percentage of respondents who report having at least one sibling with a mental illness. Research

Question 2 was analyzed with a one-way ANOVA comparing two groups over Emotional Neglect, as measured by the CTQ. Research Question 3 was analyzed with a) a one-way ANOVA comparing the two groups over the CRE scale score on the CRIS, followed by b) three ANOVAs comparing the groups on the three CRIS composite scales: Cognitive Restructuring, Functional Beliefs, and Social Ease, and finally by c) four ANOVAs comparing the two groups on four of the individual CRIS scales: Acceptance, Social Support, Self-Directedness, and Self-Disclosure. In order to control for Type 1 Error due to multiple analyses, CRIS composite and individual scales (Research Hypotheses 3b and 3c) were only to be analyzed if group differences were found for CRE. Research question four was analyzed with a Pearson product-moment correlation among Emotional Neglect, CRE, Cognitive Restructuring, Functional Beliefs, and Social Ease.

Results

Research Question 1

In order to address the prevalence well siblings among the participants, the percentage of the entire sample with one or more siblings with a mental illness was calculated. The resultant percentage indicates that 10.5% of the sample has a sibling with a mental illness.

Research Question 2

Table 1 lists the descriptive statistics for the variables used in the next three hypotheses. A one-way analysis of variance (ANOVA) (using group membership as the independent variable) was conducted to assess the significance of difference between mean emotional neglect scores. As predicted, a statistically significant difference was observed ($F_{1,131} = 13.677$, $p < 0.000$). However, Levene's test of homogeneity of

variances was significant at the 0.05 level, indicating a lack of homogeneity of variances between the two groups on emotional neglect. Therefore, a Mann-Whitney U test was conducted to assess the difference between median Emotional Neglect scores. As predicted, a statistically significant difference was observed ($U_{14,\ 119} = 449.50$, $p = 0.004$). The means and standard deviations for the well siblings and subjects whose siblings do not have a sibling with a mental illness were $M = 12.00$, $SD = 4.85$, and $M = 8.34$, $SD = 3.33$ respectively.

Table 1

Descriptive Statistics of Emotional Neglect and Stress Coping Scales

Scale	M	SD
Emotional Neglect[a]	8.72	3.67
Coping Resource Effectiveness[b]	64.10	14.63
Cognitive Restructuring[b]	65.05	22.66
Functional Beliefs[b]	58.38	20.81
Social Ease[b]	67.63	22.76

[a]Minimum possible score = 5; Maximum possible score = 25
[b]Minimum possible score = 0; Maximum possible score = 100

Research Question 3

A one-way ANOVA was conducted to assess the significance of difference between mean Coping Resource Effectiveness (CRE) scores. No significant differences were found. Since CRE scores across the two groups were not significant no further analysis was conducted for specific CRIS scales.

Research Question 4

In order to address the relationship of coping resources to Emotional Neglect, a Pearson product-moment correlation coefficient was conducted. Emotional Neglect and Coping Resource Effectiveness are significantly correlated (r (131)= -0.453, $p < .001$). This indicates that individuals reporting neglectful environments tend to also have lower reported perceived overall coping resources. Emotional Neglect was also significantly correlated with the three composite scales of the CRIS, Cognitive Restructuring (r (131)= -0.336, $p < 0.001$), Functional Beliefs (r (131)= -0.292, $p < 0.001$), Social Ease (r (131) =

-0.353, $p < 0.001$). This indicates that again those who reported neglectful environments perceived less effective stress coping thoughts, attitudes and behaviors.

Discussion

The present study asked 133 individuals if they had a sibling with a mental illness, if they experienced emotional neglect as a child, and how they cope with stress. Of particular note, 14 of the 133 participants (10.5%) reported having one or more siblings with a mental illness. The significance of this finding lies in the fact that the prevalence of well siblings has never before been addressed. It is important to remember that this study only addressed individuals who have siblings, omitting the 20% of the population who are only children (U.S. Census, 2001). This suggests that one might expect to observe well siblings comprising 8.4% of the general population of the U.S. Based on current population calculations which amounts to roughly 25 million Americans (U.S. Census, 2007).

One of the main findings is that participants with ill siblings reported significantly more emotional neglect than those participants with siblings. Further Emotional Neglect was associated with lower overall coping as well as lower perceived coping resources on the three CRIS composite scales. The implications of these findings are that well siblings are not inherently at risk for deficits in stress coping. In other words, having a sibling with a mental illness does not appear to cause problems coping with stress. However, well siblings are at high risk for emotional neglect, and emotional neglect is a risk factor for lower coping resources. Thus, it appears that if well siblings can be protected from emotional neglect, their stress coping resources will not be affected.

The mean difference in emotional neglect scores is practically as well as statistically significant. Scores on the CTQ scales are converted to intervals (Bernstein & Fink, 1998). Although the mean difference between the two groups is only 4 points, this amounts to a difference in intervals from an average of none to minimal emotional neglect to the next interval of some to moderate emotional neglect. Practically speaking, a mean of 4 points can be the difference between experiencing emotional neglect or not.

The relationship between emotional neglect and well siblings supports findings from previous studies (e.g. Lukens et al., 2004). In qualitative studies well siblings have described their family environments as not meeting their needs (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens, 1997). They have reported feeling that they were invisible in their families of origin, and that the family life revolved around their sibling with a mental illness (Lukens et al., 2004; Marsh, 1998; Marsh & Dickens; Thorning & Lukens, 1999). The results of this study not only reinforce previous findings that well siblings experience emotional neglect, but the strength of association found in this study implies that well siblings are at a substantial risk for emotional neglect.

It is interesting to note that there were no significant group differences on the general Coping Resources Effectiveness scale, which would suggest having an ill sibling alone does not seem to be related to an overall perception of one's coping resources. There are two potential implications of these results. It is possible that the sample size was not large enough to detect significance. The relationship may be clearer with a larger sample. However, it may be that well siblings are experiencing deficits in particular coping resources, and assets in others. Continued research in this area will need to

determine if relationships exist between well siblings and the individual stress coping resource scales.

Limitations and Research Implications

There are several limitations of the current study. A primary limitation of this study is the small sample size of well siblings. Not only is the size of the sample of well siblings very small, it is drawn from a geographically limited population of college students. Replication studies are necessary, using much larger and more diverse populations. Although the sample was diverse with regards to race/ethnicity and sex of respondents, as well as sibling's diagnosis, it was not possible to determine if demographic factors influenced results.

Because of the relatively small sample size of well siblings, non-statistically significant results are inconclusive, thus, the small sample size limits the ability to find significant differences between groups with the current data (Aron & Aron, 1999). Future research with larger samples could reexamine the general coping scales as well as the individual scales that were not part of this study's primary analysis. Further research is also necessary to understand the similarities and differences between well siblings and people who do not have a sibling. This group of individuals was excluded from this study; however, research has yet to provide support that they cope with stress in similar or different ways that individuals who do have siblings (whether the siblings have a mental illness or not). Having a sibling may have an effect on coping that supersedes the deficits in coping that occur as a result of having a sibling with a mental illness, thus providing a protective factor.

Associated with the small sample size of well siblings was the inability to analyze a relationship between well siblings and each of the individual stress coping scales. Further research with larger samples of well siblings would enable a greater understanding of the relationships between well siblings and specific stress coping resources.

Another limitation of the study was the lack of voice it allowed well siblings. Replication studies could include qualitative explorations in conjunction with quantitative data, thus allowing well siblings greater voice to discuss their reactions to the data. It would be a worthy study to present well siblings with the results from the coping resource inventory, and to allow them to respond to their results, and ask them to interpret the findings based on their life experiences.

It is also interesting to note that not one of the 133 participants in this study reported membership in NAMI. This raises serious questions as to the generalizability of previous research that recruited samples primarily through NAMI and related associations. It is imperative that research continues to identify well siblings through the general population, so that the experiences of well siblings are understood, not just those well siblings who either joined, had access to join, or were encouraged to join a support group. The needs of these individuals may be significantly different than those well siblings, who either choose not to join, or who do not have advocates supporting them and referring them to such support groups.

One interesting finding of this study was the diversity of well siblings. The well siblings were more diverse with regards to individual characteristics, and their siblings'

mental illnesses were also more diverse than reported in previous studies. These results reinforce the importance of utilizing more diverse samples of well siblings in analysis.

Clinical Implications

Although continued research in this area is necessary, it is imperative that clinicians regard the results of this study, as well as previous research, and incorporate this into their work with families. Mental health professionals may be in a position to reduce childhood abuse (Malekpour, 2004). Clinicians can intervene by addressing the issue of neglect with families, and possibly save many well siblings from emotional neglect. These interventions could have far reaching impacts, as emotional neglect is associated with loneliness, social isolation, psychological distress, self-injurious behaviors, dissociation, and negative self-esteem (Loos & Alexander, 1997; Nicholls, 2002; Wark, Kruczek, & Boley, 2003).

Clinicians need to be wary that they do not overcompensate and pathologize well siblings. Because having a sibling with a mental illness appears to be a significant risk factor for emotional neglect, clinicians could assess all clients who indicate having a sibling with a mental illness for emotional neglect. Such assessments could help the clinician identify areas such as stress coping that may have been affected as a result of emotional neglect.

Clinicians working with well siblings who report a history of emotional neglect need to assess their clients' stress coping resources. Clearly emotional neglect is associated with many of the attitudes, beliefs, and behaviors associated with poor stress coping. Emotional neglect is significantly negatively associated with: 1. perceived overall effectiveness of coping resources; 2. feelings of comfort/ease in interactions with others;

and 3. the thoughts and beliefs about stress and one's ability to cope with it. Therefore, clinicians need to educate these clients regarding the relationship between emotional neglect and stress coping. This serves the dual purpose of normalizing their experiences, as well as providing support for them. Clinicians can also advocate for increased social support by providing and or referring well siblings to support groups. By providing education and support, clinicians empower their well siblings, and help them to gain a voice.

It is also important for clinicians to reinforce that having a sibling with a mental illness is not in and of itself a risk factor for poor stress coping. Previous research has indicated that there is a link between stress coping and well siblings; however, this study suggests that the link is actually between emotional neglect and stress coping. Having a sibling with a mental illness does not cause a well sibling to have difficulties coping with stress.

Summary

The current study presents some interesting findings regarding the relationship among emotional neglect, stress coping, and having a sibling with a mental illness. First of all, it is clear that a significant percentage of the population has a sibling with a mental illness. Second, well siblings are at a significant risk for experiencing emotional neglect. And finally, a direct relationship does not exist between having a sibling with a mental illness and stress coping. However, the attitudes, beliefs, and behaviors associated with stress coping are directly linked with emotional neglect. Therefore, poor stress coping is not an inherent outcome of having a sibling with a mental illness. By protecting well

siblings from emotional neglect, well siblings can be shielded from the harmful effects, which include poor stress coping.

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