Below the Parapet

A phenomenological exploration of adult inter-personal relationships for individuals who grew up with a sibling with a severe mental illness

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PLEASE NOTE THAT THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR CONFIDENTIALITY REASONS:

Within the Methodology Section: My relationship to the research

Within the Discussion Section: Personal Reflexivity

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Preface

This portfolio represents the final part of my journey towards becoming an Integrative Counselling Psychologist. When I began my doctorate in October 2014, I didn’t realise the extent to which it would impact me both professionally and personally. It has granted me the space to make sense of my own history; to understand and work through my own childhood experiences and, in particular, to understand how growing up with a sister with severe mental illness (SMI) shaped my way of relating to others and being in the world.

I was drawn to psychological therapy not only through this but also through curiosity; I have always believed in, and noticed, the possibility for change. During my childhood I found it incredibly helpful to focus on what may be possible and what the future may bring for my family and for myself. I learnt from my own experience the importance of holding hope for ourselves and for others, even in seemingly desperate situations; the hope we can do things differently, that we can make different choices and that we can have new beginnings. I have a deep respect for both human frailty and for the inner resilience we can tap into. I consider life itself to be a paradox: where there is suffering, there are opportunities: where there is loss, there are new beginnings.

This research is the culmination of my journey so far. Because of my history, I have a special interest in siblings who have grown up with a brother or sister with SMI and in how these individuals are impacted in their adult life. Previous research in this area has focused primarily on the child with the illness or their parents. Where there has been a focus on the siblings, it has been to establish what is needed to keep them engaged in their brother or sister’s care, with scant attention given to what they, themselves, may experience or need *outside* of any caregiving role.

This is a curious parallel process: those individuals overlooked in their childhoods, have, for the most part, continued to be overlooked in the research. The current study aims to redress that balance and hopes to stimulate not only more research, but also more support, for those individuals.

Abstract

Siblings of those with severe mental health illness (SMI) have long been overlooked in research and, what interest there has been, seems to have been borne out of the desire to establish how best to engage them in providing care and support for their mentally ill brother or sister when their parents are no longer able to. The present study looks beyond this to how siblings themselves may have been impacted by their childhoods and what support they may need outside of any caregiving role. In particular, the current study focuses on how their childhood experiences may impact their inter-personal relationships in adulthood. Six adult participants gave accounts of their experiences, participating in semi-structured interviews. The interview transcripts were then analysed, using Interpretive Phenomenological Analysis. Four superordinate themes are identified: The Stabiliser, The “Me,” The “I” and Surviving and Striving. The superordinate themes explore the experiences of the participants in regards to self and relationships. Many of the siblings in this study display signs of chronic anxiety and insecure avoidant attachment style. In addition, they display a very real difficulty in holding compassion for themselves, having recognition of their needs or managing conflictual situations. Furthermore, an entirely new finding has come out of this research, that these siblings display signs of defence mechanisms of binary thinking, omnipotent control and the creation of a false-self. The present study draws on attachment theory, parentification and post traumatic growth, to highlight clinical and research implications for Counselling Psychology. These include suggestions for supporting siblings in addressing their own suffering in order to restore trust in themselves, in their inter-personal relationships and in the life process itself.

Key words: siblings, well siblings, mental health, severe mental illness, complex families, family roles

Introduction

Chapter overview

This chapter provides an overview of the theoretical, social and cultural context of the present study.

When I carried out my literature review, I undertook a selective search (using PsycINFO) of English-language publications relating broadly to siblings and mental health/illness. The following key words were used in the search: Sibling*, Mental health, Severe mental illness*, Family*, Family roles, Parenting. I included papers from peer-reviewed publications as well as grey literature sources such as reports from charitable and not-for-profit organisations.

Although 9,276 papers came up in the search, I filtered out papers that were more than 20 years old unless they were of particular importance or relevance to the current study (which reduced the papers to 5,840).

I also filtered out those papers considering the impact on siblings of having a brother or sister with intellectual or physical disabilities, rather than mental illness. There are several reasons for this exclusion. Firstly, there has been significantly more research carried out into the experiences of siblings of those with a physical disability and what support they may need. Consequently, there is significantly more provision made for these siblings and their parents in terms of information and support. Secondly, and even more importantly, the emotional and psychological challenges of living with a brother or sister with SMI (as opposed to a brother or sister with an intellectual or physical disability) are entirely different. Where there is a child in the family with SMI, there is likely to be a huge amount of fluctuation in the symptoms and, therefore, significant unpredictability in terms of how and when the illness may impact the family. Indeed, psychotic symptoms such as delusions, hallucinations, cognitive defects and mood changes are, by their very nature, unpredictable (Rungreangkulkij and Gilliss, 2000). Furthermore, it is probable that their brother or sister will, at times, have serious difficulties with affect regulation, resulting in the potential for hostility and aggression towards the sibling or other family members, as well as the potential threat that their brother or sister may harm themselves. In addition, societal attitudes towards families with a child with a physical disability and those with a child with SMI are wholly different. For all of these reasons, I made an active choice not to include papers about siblings of those with an intellectual or physical disability in my literature review.

It is noteworthy that only two papers come up in a search specifically looking at inter-personal relationships of siblings of those with SMI. Both papers were written in 1990s and the focus of both was entirely focused on how to keep the sibling engaged in the care of their brother or sister with SMI, rather than the siblings' own experiences of inter-personal relationships. Howitz and Rutgers' (1993) research suggested that sibling support was greatest when both parents were deceased but siblings did not often undertake arduous and time-consuming tasks of parental caregivers. The researchers concluded, therefore, siblings are considered a supplement to, but not a replacement of, governmental provision of basic support. Han (1996) found that the siblings' impression of the way their family functioned during childhood was directly related to both the quality of the adult sibling relationship and the amount of the support they would give their brother or sister.

Finally, I did not include papers that were solely focused on what families or siblings need from health care providers. Whilst this is an important area to explore, it is not the focus of the current paper.

Impact on the family

SMI is a term used by the National Health Service to describe pervasive psychiatric conditions (including personality disorders, schizophrenia, bipolar disorder and psychosis). As I will discuss further in the rationale for this study, I hold that these psychiatric conditions, described in The Diagnostic and Statistical Manual of Mental Disorders (currently DSM-5), represent a medicalised focus, and therefore do not always capture the complexities of SMI and can limit our understanding. Nonetheless, it is useful to note that, according to the NHS around 1% of the UK population have SMI. If this estimate is correct this represents several million family members (parents and siblings) that are directly impacted by a relative with SMI in the UK alone.

When a child suffers from SMI the entire family can experience overt stigma (Liegghio, 2016; Sin et at., 2008) and considerable stress (Liegghio, 2016) as well as a loss of predictability and coherence of everyday life (Lukens et al., 2004). The majority of studies into family experiences have, to date, focused on parents and relied on parental self-reports (Greenberg et al., 2021). Darmi et al. (2017) carried out a hermeneutic phenomenological study into the subjective, lived experience of 16 parents from Athens (14 mothers, 2 fathers) of a child with psychosis. They found participants displayed disenfranchised grief over multiple losses and experienced increased levels of emotional burden. They also experience profound guilt over having contributed or not prevented the disorder, feeling they were not good parents and feeling ambivalent towards their child. Their study suggests this guilt is compensated for by absolute dedication to their unwell child's care at the expense of their own well-being.

Lavis et al.'s (2015) qualitative longitudinal research looks at the impact of early intervention services in the United Kingdom for first episode psychosis on carers' experience. They highlight that, with so much care now being outside clinics, there is an urgent need to pose the question who can, and should support carers of those with psychosis and in what ways. The majority of carers in this study were parents (55), predominately mothers (42) or partners (9). Siblings represented only two of the 80 participants. The paper describes the distress of the carers as being palpable and highlights the carers' feelings of shock, anger, loss and uncertainty. Some parents explicitly articulated reward in their interviews. They talked of the situation having reinvigorated an "active parenting" that had been previously lost and demonstrated an ambivalent mix of loss, entrapment, closeness and continuity.

Mazur and Mickle (2017) examined the content of publicly accessible, active internet forums specifically designed for parents of those with SMI to identify the key stressors and concerns of 146 parents. The parental concerns expressed, focused on the effects of the child's illness on themselves, their feelings of helplessness, their need for advice on coping and the stress of child discipline.

Furthermore, Greenberg et al.'s (2021) recent research controlled for the genetic vulnerability of parents to neuroticism, bipolar, schizophrenia and depression, and found that, even those parents with no predisposition to mental health issues, were impacted negatively in terms of their psychological well-being and physical health. This highlights just how important it is to recognise the very real cost to relatives who are living with someone with SMI and the need to support those individuals.

In another piece of recent research, Rachamim et al. (2021) identified complicated grief (understood as unrelenting grief after death of a loved one) as being experienced by nearly half of their 78 participants, all of whom were first degree relatives of individuals with severe chronic mental illness. This type of grief is associated with a higher prevalence of posttraumatic and depression symptoms and poorer physical health. In their study, despite time having elapsed since the onset of SMI, their participants showed marked distress, yearning for the person they once knew, self-blame, bitterness and anger. It is noteworthy that this research included a higher prevalence of siblings (39.7%) than most previous research has included. Indeed, historically, the majority of research into how a child with SMI impacts the family has focused on the impact a child with SMI has on their parents (especially their mother) and, until recently, siblings have been largely invisible to academics and statutory health and social care organisations (Bowman et al., 2013; Sin et al., 2014).

Over the last 20 years there has been a growing awareness of the need to recognise the impact a child with SMI may have on their siblings (this relationship may comprise of biological siblings, half siblings, stepsiblings, adoptive siblings and foster siblings). This awareness, however, seems to have been driven by the desire to establish what these siblings may need in order to support and care for their mentally ill brother or sister when their aging parents are no longer able to (e.g. Hoffman et al., 2007; Lukens et al., 2002; Smith et al., 2007; Smith and Greenberg, 2008). The support the siblings themselves may need seems not to have been given much attention.

Adults with a brother or sister with SMI report that their experience of growing up affected both their personality and their development (Lukens et al., 2004). Whilst some research suggests not all effects of growing up with a sibling with SMI may be detrimental (e.g. Sanders, 2012; Sanders and Szymanski, 2013; Sin et al., 2008), the majority of research indicates that siblings growing up with a brother or sister with SMI can experience a difficult and traumatic childhood that can affect their own health and well-being.

Indeed, they can feel stigmatised (Corrigan and Miller, 2004; Leigghio, 2016; Muralidharan et al., 2014), fearful that their sibling may harm themselves or others (Katz et al., 2015; Lukens et al., 2004), experience burden, guilt and anger (Barak and Solomon, 2005; Lukens et al., 2004; Stålberg et al., 2004) and feel pressured to be “good” so as not to add to their parent’s burden (Lukens et al., 2004; Porr, 2010).

Furthermore, what adolescents experience in terms of positive family dynamics (cohesion) and negative family dynamics (conflict), influences their mental well-being and social functioning in emerging adulthood (Fosco et. al., 2012). Perhaps unsurprisingly then, siblings of those with SMI have been found to have an elevated risk of experiencing psychopathology (Bowman et al., 2013; Ma et al., 2015). Ma et al.’s (2015) systemic review is based on 39 studies and assessed approximately 7,278 participants across seven geographic locations. Their findings highlight a lack of comprehensive and methodologically robust research into sibling of children with SMI. The importance of this is not hard to see when we recognise that these siblings are exposed to the same genetic, family and individual risk factors as their brother or sister with SMI (Kilmer et al., 2008).

Moreover, research suggests that it is highly likely that siblings of children with SMI will continue to experience disruptions in family relationships into adulthood. Indeed, siblings have significantly more social problems, including issues with conflict resolution, than other individuals (Ma et al., 2017). Relational disruptions may also extend to relationships specific to adulthood and those outside the childhood family system, such as marriage and parenthood (Abram, 2009). The latter can have a detrimental intergenerational effect that may contribute to a perpetuating cycle of maladaptive relationship formation (Ma et al., 2017). Abrams' (2009) paper also highlights that siblings report difficulties with establishing and maintaining romantic relationships.

Furthermore, the recent research from Rachamim et al. (2021) also suggests that the experiences of being a first degree relative of an individual with SMI may lead to depression thus producing maladaptive changes in beliefs with respect to trust and intimacy, self-efficacy and self-esteem which, they posit, could impact attachment style. Indeed, they called for future studies to shed more light on trajectories of both complex grief and attachment in caregivers of close relatives with SMI.

Despite this, however, there has been scant research focusing on siblings lived experience outside of any potential caregiving role (Ma et al., 2017; Sin et al., 2012). Even more specifically, there appears to be no research into how growing up in a family where one child has SMI affects siblings' experiences of future relationships with their wider families, their romantic partners and, indeed, their own children.

The sibling as a child

When one child in the family develops SMI, changes inevitably occur across familial relationships. Young siblings with a brother or sister with SMI report that the whole family's attention centres on concerns about their brother or sister (Sin et al., 2008). Siblings perhaps unsurprisingly, feel pressured to be "good" and to always "do the right thing" so as not to add to the parent's burden or do anything to upset them further (Lukens, 2004; Porr, 2010). Unsurprisingly then, adult siblings report that, during their childhood, they felt invisible, isolated and angry (Lukens et al., 2004). This is, perhaps, to be expected given that families in this situation also display impaired functioning in affective responsiveness and involvement.

Lukens et al.'s (2004) research used focus group methodology and grounded theory analysis. In five different focus groups, they asked siblings to describe the impact of having a sibling with SMI. The participants in their study conveyed the profound impact their brother or sister's illness had on their personality and development both in the past and over time. Their research adds a breadth of descriptive material relating to the emotional concerns, mental well-being and challenges that siblings face. This is both helpful and enlightening. They highlight the need for more qualitative information and more diverse samples as their sample includes both predominantly middle-class white females who were actively involved in their siblings' care and willing to reflect on their experiences.

Ma et al. (2017) found in their systematic review, that, in relationships between the parents and the sibling without the SMI, there tends to be less affection, less time spent together, more aversive tones in communication and more noncompliance (when compared to families where no child has SMI). This is particularly true for the mother-sibling relationship. These researchers also found that siblings are often required to take on caregiving roles (such as monitoring and preventing their brother or sister from acting inappropriately) but receive little recognition or reward for them. Moreover, siblings felt these tasks were dictated to them and they had little input in decision-making, leaving them feeling powerless and invalidated. In addition, many siblings of a mentally ill brother or sister report experiencing fear due to the unpredictability of the illness, as well as concern over whether their sibling may harm themselves or others (Katz et al., 2015; Lukens et al., 2004; Sin et al., 2008). Research indicates this fear is not unfounded: those with SMI are more likely to engage in violent behaviour compared with the general population. Indeed, Douglas et al. (2009) found psychosis to be significantly associated with a 49%–68% increase in the chances of violence; Kageyama et al. (2015) found family violence in patients with schizophrenia to be as high as 60% over a lifetime and Newhill et al. (2009) found that 73%

of patients with Borderline Personality Disorder engaged in violence over their one-year study period.

Children living with a brother or sister with SMI are indeed, therefore, at risk of experiencing violence either towards themselves or witnessing it towards other family members. Indeed, many adult siblings of a brother or sister with SMI report experiencing violence as children, which they found both frightening and traumatic (Lukens et al., 2004). Unsurprisingly, research has shown that children exposed to violence can suffer from attentional bias to threat and anxiety (Briggs-Gowan, 2015).

Moreover, Ma et al.'s (2017) review found that sibling-sibling relationships, where one has a mental health illness, contained significantly less warmth and shared activity, and more bullying, conflict and aggression. Importantly too, much research indicates that hostility, aggression and violence between siblings is linked to delinquency (Bank et al., 2011; Buist, 2010; Feinburg et al., 2011). Indeed, Bank et al. (2004) found sibling aggression predicted antisocial behaviour and substance use independent of parent-child and peer relationships. Echoing this, Kilmer's (2008) research found the siblings in their study to be extremely highly stressed, with a sizable number evidencing high levels of maladjustment and problem behaviours.

Barak and Solomon's (2005) quantitative research used self-report questionnaires to explore the perceptions of 52 siblings living with a brother or sister with schizophrenia compared to 48 controls who were not living with a brother or sister with schizophrenia. These siblings reported greater objective burden (i.e. the burden that stems from the mental illness itself, such as the person's behaviour towards family and property, the risk of suicide, disturbances to family routine and distraction from the sibling's own activities) as well as greater subjective burden (i.e. the burden of the feelings the illness evokes such as fear, anger, helplessness, sadness, pain, loss, anxiety, embarrassment, guilt, worry and empathy). In addition to burden, siblings often report feelings of guilt (Lukens et al., 2004; Stålberg et al., 2004). Indeed, many express feelings of "survivor's guilt" blaming themselves for being free of the SMI that affects their brother or sister (Torrey, 2013).

The sibling as an adolescent/young adult

Sin et al.'s (2008) phenomenological research into the experiences and needs of siblings of individuals with first-episode psychosis provides a rich insight. They set out to address the apparent oversight of looking at the impact on siblings of having a brother or sister with SMI, having found a number of studies recognising the role they played in the family without any focus on how this may affect them. Ten siblings (aged 16-30) took part in semi-structured interviews and they found that siblings were greatly affected by the onset of psychosis in their brother or sister and affected not just their mental well-being but also their social development. All participants in their study described feelings of being overwhelmed by the psychological impact of their brother or sister's illness and talked of their worries and fears for themselves and for their brother or sister. They also identified social stigma and fear of embarrassment as stopping them from bringing friends home from school or sharing their experiences with close friends and teachers.

This is in keeping with Leigghio's (2016) analysis of in-depth, semi-structured interviews with adolescent siblings which found they experienced considerable stress and encountered overt stigma. This included embarrassment, rejection by peers and a loss of social status within their communities. Unsurprisingly then, siblings can feel that they should keep details of their sibling's illness from others (Barak and Solomon, 2005; Sin et al., 2008, 2012).

Sin et al.'s (2012) built on their previous phenomenological study (2008). Thirty-one siblings (aged 11-35) took part in semi-structured interviews in order to gather their perspectives and accounts of their lived experiences. Interestingly, most siblings did not identify themselves as carers despite most of them playing a significant part in their brother's or sister's life. In addition, some siblings in their study talked of how their brother's or sister's illness had challenged their perspectives about future relationships and raising children of their own. In common with their previous research, they highlight how as all participants were approached through the brother or sister with the SMI, or their parents, their participants may have biased the recruitment of siblings towards those who remain close to their brother or sister. None the less, Sin et al.'s research provides much needed, rich insight into the experiences of adolescent and young adult siblings.

Furthermore, Watson's (2019) quantitative research into the impact of having a brother or sister with SMI on young adults (in terms of their familial relationships and their psychosocial functioning) found that the majority scored in the severe range or above on measures of depression, anxiety and stress, signifying high psychological distress in this population. Conversely, Gardner's (2016) quantitative research reported that adolescents had a higher than average quality of life, as well as scoring higher than average on their closeness with peers, siblings and parents. It has to be recognised, however, that Gardner's findings may not be trustworthy due to the low participant number (seven) and lack of control group.

There is much to suggest that siblings contribute significantly to one another's development of social skills, social understanding and identity formation (Feinberg et al., 2012). This view is supported by Ma et al.'s (2015) review: drawing on developmental psychopathology frameworks, they suggest that, because siblings have similar genetic backgrounds and are likely to be raised in the same environment, they are more likely to experience significantly more problems in psychosocial functioning than siblings without a brother or sister with SMI. Indeed, they may have difficulties navigating social situations due to less developed social skills, including important skills in conflict resolution.

Fosco et al.'s (2012) research also highlights the importance of family functioning during adolescence. Their large-scale longitudinal study of adolescents found that family relationship quality (cohesion and conflict) predicted growth and maintenance of effortful control, and ultimately, subjective well-being, emotional distress and aggressive behaviour in emerging adulthood. This is in line with much other research. Fienberg et al.'s (2012) review suggests that conflict in the sibling context may put individuals at risk of relational difficulties with peers, which may lead to problems at school. Moreover, experiencing sibling aggression is linked to delinquency (Bank et al., 2011; Buist, 2010; Feinberg et al., 2011) and antisocial behaviour (Bank et al., 2011). In addition, Yabko et al.'s (2008) research revealed that bullying and victimisation within the sibling relationship significantly increased the likelihood of peer victimisation.

There is, then, much to suggest in the literature that exists, that some siblings can become what Barak and Solomon (2005) call the "secondary victims" of the mental illness.

The sibling as an adult

Adult siblings with a brother or sister with SMI report that their feelings from childhood can last through into adulthood. Indeed, many report still experiencing guilt, anger, shame, fear, disappointment, suspicion and hostility (Barak and Solomon., 2005; Lukens et al., 2004; Stålberg et al., 2004). This is in line with Barak and Solomon's (2005) findings that those with a brother or sister with SMI experience fear of rejection, difficulty trusting others and forming relationships, all of which may lead to problems of intimacy and commitment. In addition, if they experience aggression from their mentally ill brother or sister, they are also more likely to become the victim or perpetrator of intimate partner violence in adulthood, controlling for the effects of parental violence in childhood (Norland et al., 2004).

Adult siblings also report still experiencing stigma by virtue of their association with their mentally ill brother or sister (Corrigan and Miller, 2004; Leigghio, 2016; Muralidharen et al., 2004). Indeed, there can be a lack of understanding among acquaintances and friends which can bring feelings of shame (Corrigan and Miller, 2004). Moreover, concern over being judged for having a brother or sister with SMI can extend to potential partners; adult siblings report feeling unsure that someone would wish to be connected to a family with mental illness (Lukens et al., 2004).

Research indicates that adult siblings, when involved in their sibling's care, can feel marginalised and patronised by mental health professionals who exclude them from care planning whilst, simultaneously, requesting crisis placement and assistance from them

(Lukens et al., 2002). This has also been found in more recent studies that, in addition, suggest, as well as psycho-education about their brother or sister's illness, adult siblings would like mental health providers to be more available to answer questions and help clarify their role in future care (Dickson-Baures' 2015; Friedrich, 2008). Furthermore, Dickson-Baures' (2015) research exploring growth opportunities from growing up with a sibling with SMI with five female siblings (aged 25-32), postulates that adult siblings may well benefit from gaining productive individualised coping strategies, including participating in individual therapy. This is latter piece of research is an interesting study providing, as it does, an indication of what type of support siblings may benefit from. However, a limitation of the study, which the researcher herself identifies, is that the participants were all recruited via a service from whom they were already actively seeking support and their views and needs may not be the same as siblings who have not reached out for support for themselves.

Parentification and attachment theory

Given the findings that siblings with a brother or sister with SMI are often required to take on caregiving roles (Ma et al., 2017) and report feeling pressured to be "good" so as not to add to their parent's burden (Lukens et al., 2004; Porr, 2010), it is helpful to consider whether these children are, in fact, parentified. Parentification occurs when a child takes on roles and responsibilities traditionally reserved for adults, in times of demanding situations. It can interrupt or interfere with childhood development and can result in poor differentiation of self from family of origin both during childhood and adulthood. There is agreement across different theoretical orientations that types of parentification fall into either "emotional" or "instrumental" parentification (Chase, 1999). The first is responding to the emotional needs of a parent or sibling, which, in the context of this study, includes being "good" or acting as peacemaker or confidant to their parents. The latter includes doing household chores or looking after their sibling with SMI or younger siblings because their parents' attention is taken up with their unwell brother or sister.

This pressure is to be “good” in these circumstances is understandable; children *need* their parents and, therefore, learn to readily respond to what their parents need from them (Chase, 1999). Assuming some adult-like responsibilities can be beneficial to a child, providing a sense of belonging and usefulness (Chase, 1999). However, when a child is consistently doing too much, especially without recognition or are not given the love and attention they need in order to feel supported, they can believe their needs are less important than those of others.

Interestingly, some of the earliest references to parentification, even before it was named as such, were Friedman’s (1964) discussion of the “well sibling” role in schizophrenic or neurotic families, Brody and Spark’s (1966) concept of the family “burden bearer;” and Ackerman’s (1966) notion of “the family healer who take on the role of peacemaker” (p.83). All of these relate to the sibling being used (intentionally or not) to stabilise family interactions at the expense of their own well-being.

Research suggests that the degree of perceived fairness of the assigned responsibilities determined the nature of the impact (Chase, 1999; Saha, 2016). Furthermore, Levine (2010) found that an optimal level of parentification fosters internalisation of responsible and accountable behaviour and may promote psychological well-being, provided the responsibilities are age-appropriate, reasonable and validated by family members. Dial (2014) also emphasises the importance of age-appropriateness and acknowledgement.

Attachment theory helps clarify the process of parentification, which inevitably disrupts the appropriate developmental stages involving early attachment (Chase, 1999). In particular, ongoing relational patterns (or attachment style) may be impacted in those who have experienced parentification when growing up (Chase, 1999). Indeed, parentification can result in attachment issues and poor relationships (Chase, 1999; Jurkovic et al., 2001). This is, perhaps, unsurprising given that the parentified child often relinquishes their emotional needs to meet the needs of their parents or siblings, ultimately disrupting their future functioning and, potentially, their ability to form adult attachment relationships

(Hooper, 2007). In line with this, Sanders (2013) analysed the attachment scores in siblings after their brother or sister's diagnosis, and found they showed statistically significant lower attachment scores with their maternal figure (though not their paternal figure) compared with scores before diagnosis.

Adult attachment styles are conceptualised as "secure" (when both attachment-related anxiety and attachment-related avoidance are low), "pre-occupied" (when attachment-related anxiety is high), "dismissing" (when attachment-related avoidance is high) or "unresolved" (when both attachment-related anxiety and attachment-related avoidance are high). Importantly, "secure" attachment has been shown to be linked to a perceived positive climate within the home, family cohesion, adaptability, satisfaction and low levels of family conflict (e.g. Cowan et al, 1996; Diehl et al., 1998; Harvey and Byrd, 2000; Mikulincer and Florian, 1999; Pfaller et al., 1998; Riggs et al., 2007). Moreover, Mikulincer and Florian (1999) found that low levels of perceived family cohesion, adaptability and expressiveness were related to "dismissive" attachment style and high levels of perceived familial conflict were related to "pre-occupied" attachment style.

In the context of the current study then, an individual's experience within their family in terms of functioning, conflict resolution, cohesion and satisfaction are all impacted by having a sibling with SMI; *all* play an important role in the development of attachment styles. Those experiences are very likely, therefore, to impact their experience of adult inter-personal relationships.

Post traumatic growth

It is important to recognise, of course, that not all of the effects of growing up with a sibling with SMI may be detrimental. Linley and Joseph (2004) propose that, in order to be comprehensive, any understanding of reactions to trauma and adversity should take account of the potential for positive and not only negative changes. While research into the effects of stress and trauma has historically focused only on the negative effects on the individual, more recent research has begun to focus on possible positive outcomes, particularly, post traumatic growth (PTG). PTG can be thought of as "positive psychological change experienced as the result of the struggle with highly challenging life circumstances" and it emphasises the transformative potential of someone's experiences with highly stressful circumstances. The positive changes of PTG are thought to occur in five domains: new possibilities, relating to others, personal strength, appreciation of life, and spiritual change.

Specifically, in relation to children, Little et al. (2011) point out that not all of those exposed to trauma go on to develop maladaptive behaviour. Many are, in fact, resilient and return to baseline levels of functioning and some even experience an improvement to their psychological functioning. Historically, there was relatively little research into PTG in children, but Meyerson et al.'s (2011) systematic review into PTG in children and adolescents found a positive association between PTG and other positive outcomes, specifically, positive affect, hope and competency beliefs.

Furthermore, in Sanders (2012) and Sanders and Szymanski's (2013) studies, PTG was considered specifically in relation to siblings of people diagnosed with a mental disorder. They found that adult siblings of those diagnosed with a mental disorder reported higher PTG scores that those without a brother or sister diagnosed with a mental disorder. Interestingly, however, those who took an active role in caregiving experienced less PTG than participants who did not take a caregiving role. In addition, Sanders et al.'s (2014) mixed methods research into siblings with a brother or sister with SMI found that some siblings felt their experiences fostered maturity, strength and an orientation to achieve. Although, for many, it appeared this was at the expense of their own emotional needs. Interestingly, Sanders (2012) study of 33 siblings found that siblings performed statistically better than the population mean on experiential emotional intelligence: the ability to perceive, respond and manipulate emotional input (without necessarily understanding it), but statistically worse than the population mean on strategic emotional intelligence: the ability to understand and manage emotions (without necessarily perceiving or fully experiencing them). It is important to recognise, however, that Sanders (2012) research was largely quantitative and, therefore, as he himself points out, does not allow for an understanding of siblings' unique stories.

Sin et al.'s (2008) phenomenological study found that some siblings in their study felt their experiences made them more compassionate and tolerant towards others with mental illness. These researchers highlight, however, that the participants in their study were approached through the service users (i.e. their brother or sister with SMI) which, in itself, may have created a bias toward the general picture of a closer sibling relationship. In addition, as discussed above, the researchers found that, alongside their felt increase in compassion and tolerance towards others with mental illness, they also experienced feelings of resentment, blame, guilt, loss and embarrassment. In addition, all of their participants described feelings of being overwhelmed by the psychological impact of the illness on their own lives and emotional wellbeing.

In their follow up study, Sin et al. (2012) also found some siblings identified other positive changes in themselves and positive effects on their own personal development. Indeed, their findings revealed a theme of resilience with some siblings reporting that the experiences have made them a stronger and better individual, and had brought the family closer together. Again, however, these siblings also reported experiencing a range of complex, conflicting and often intertwined emotions including feelings of burden, stress, denial, despair, detachment, embarrassment, fear (for themselves, their siblings and their family), guilt, helplessness, loss and grief, resentment, shock and sorrow.

Barak and Solomon's (2005) participants were asked, among other things, how much they felt that coping with their brother or sister's schizophrenia had developed or reinforced their personal strengths. They found that their participants rated themselves more sensitive to others and more able to use problem solving skills than the siblings in the control group. Although, in keeping with Sin et al.'s research, they also reported more intense negative feelings than the control group (i.e. anger, disappointment, suspicion, guilt and hostility) as well as experiencing more burden and shame.

Current service provision in the UK

In terms of support groups for adult siblings of those with SMI, there is, currently, very little provision in the UK (either via online platforms or in person groups) that are purely for adult siblings. Many of the groups currently running are for carers in general (and are mostly attended by parents) or are for carers to attend along with the person with SMI.

The NHS currently signpost two main organisations for siblings of those with a mental illness: Sibs/Young Sibs and the Siblings Network (part of Rethink Mental Illness). Sibs/Young Sibs focus, however, is on siblings of those with long-term physical or learning disabilities, with seemingly no reference to the specific challenges faced by siblings of those with mental illness. The Sibling Network currently has only three local sibling groups running across the entire UK (March 2021).

In, 2007 Rethink Mental Illness set up the Siblings Network, a project aimed to support individuals with a brother or sister with mental illness. They were awarded Lottery Funding in 2010. The aim of the project was to build a community to support and empower siblings of people with mental illness to better support their brother or sister and look after their own well-being. They provided online resources, factsheets, blogs, stories and local sibling support groups, workshops and events.

In their 2013 project evaluation and review (Evaluating the Siblings Network, 2013), Rethink identified key areas where they felt the project had had a particular impact on siblings using their service; specifically, they felt better informed as to how to look after their own well-being, as well as how to support their brother or sister and help them recover. They also felt they had support with establishing their own identity and gained a sense of being part of a community. Unfortunately, however, the project has ended and Siblings Network significantly reduced the level of support offered to siblings both in terms of online resources and local sibling support groups, something I will return to in the discussion section.

There is also currently an independently run peer support group that meets monthly in Brighton called Sibling Link. This has been set up by two siblings, both of whom lost their brothers to suicide. Their website offers blogs and local resources as well as information about upcoming meetings.

Rationale for the present study

It is clear that the impact on children of growing up with a sibling with SMI can be profound and affects both their development and their mental health (Ma et al., 2015). In addition, it is clear that they may continue to be impacted throughout their adulthood, facing significant challenges of their own in terms of their inter-personal relationships, both within their family of origin and outside it. Inter-personal relationships can be thought of an association between two or more people where there is a strong bond, including familial relationships, close friendships, work colleagues and romantic partners.

Historically, the vast majority of research in this area was focused on the parents' needs rather than the siblings. Although the last 20 years has seen an increase in recognition of the needs of siblings growing up with a brother or sister with SMI there is still much to be done. It would appear that a family member with SMI does not just absorb the energy and attention of their parents at the cost of the other children in the family; they have also seemingly absorbed the energy and attention of researchers and health professionals.

In addition, research interest in siblings appears to have been driven primarily by a desire to find out how best to engage them in providing care and support for their mentally ill brother or sister. It is then, important to recognise that the challenges siblings face *outside* their potential care-giving role have largely gone unnoticed. Of particular significance is the stark lack of research into how siblings who have grown up with a brother or sister with SMI experience their adult inter-personal relationships even though the evidence suggests they are more likely to experience fear of rejection, have difficulty trusting others and have issues with commitment (Barak and Solomon, 2005). In addition, as we have seen, they also are also more likely to become the victim or perpetrator of domestic violence. Moreover, Jewell (2000) found that, while some adult siblings of a brother or sister with SMI employ coping strategies such as seeking out information and support, many others use strategies such as dissociation, drugs and alcohol, denial or withdrawal from peers and family.

Finally, as we have seen, in common with many areas in psychology, research in this area has used predominantly quantitative methodologies. Whilst these standardised measures can yield incredibly useful information, they do not allow participant's voices to be heard. Because of this, they can limit our understanding of the participants' lived world. Qualitative research, on the other hand, provides us with an in-depth understanding of human experiences, thoughts and emotions as they exist in the real world. This type of research inevitably deepens and enriches our understanding of the phenomena in question.

In addition, much of the existing research uses the Diagnostic and Statistical Manual of Mental Disorders (currently DSM-5) to categorise the participants in terms of their brother or sister's mental illness. In line with Counselling Psychologists' position, it is important to highlight here that, whilst the DMS-5 provides an interdisciplinary language for clinical teams and provides a comprehensive classification tool, it fails to give attention to cultural and social-economic contextual issues and the potential socio-political biases in the system's construction (Boyle, 2007). In addition, it does not consider the complex interplay between class and gender that may be affecting individuals and fails to acknowledge the potential socio-political biases in the system's construction. This research, in contrast, will allow the participants themselves to decide whether their brother or sister's mental illness was, or is, "severe" as the researcher wishes to be not only cautious, but also continuously mindful, of the co-constructed nature of reality in relation to diagnosis (Boyle, 2007). It is, after all, the siblings' reality and their experiences, which have the potential to furnish us with new understandings and new insights.

This research explores how people who have grown up with a sibling with SMI experience their adult inter-personal relationships. The aim is to give mental health professionals, and in particular, Counselling Psychologists, an insight into what kind of support those individuals may need if they seek therapy and also, potentially, engage and support those who don't. It also aims to support siblings directly (through them accessing future publications based on these research findings) and through informing service providers (such as Rethink). Importantly, this research also aims to disrupt the current discourse and engage both social services and educators in discussion around the needs of this marginalised group. It also aims to influence policy makers by highlighting the importance of ensuring clinicians and parents understand the possible long-term effects on siblings of having a brother or sister with SMI and, in light of that, consider what support those siblings may need *outside* of any potential caregiving role.

Methodology

Chapter overview

In this chapter, the methodological basis of this study is explained. The focus is on the theoretical underpinnings of the research method chosen, the rationale for this choice and, finally, the methodological procedure.

Research question and initial methodological selection

The research question asked: *"How do people who have grown up with a sibling with SMI experience their adult inter-personal relationships?"* I wanted to explore how these siblings experience their relationships. In line with my experiences and that of some of my clients, I was interested if they too had noticed any patterns in their choice of partner and way of relating to them or indeed, in any of their other relationships. I was attempting to shed light on what may/or may not be challenging for them around issues such as trust, showing vulnerability or managing conflict.

As I wanted to explore these ideas and experiences in depth, I knew from the outset that I would be using a qualitative methodology. Whilst quantitative methodologies are incredibly useful for systematically collecting and analysing data in order to test a hypothesis, they would not allow me to gather the rich, in-depth data I was seeking.

I initially gave consideration to other methodologies, in particular, Narrative Analysis (NA), which would have been an alternative to phenomenology, as both methodologies place the focus on the participant and both are socially constructivist. In addition, in both methodologies, the aim is for the researcher to be reflexive and mindful of their role in shaping the narrative.

However, in NA, the primary focus is on the structure of the narrative itself (Murray, 2003) rather than the focus being on the experience of the participants. Indeed, in phenomenological research, people are considered instrumental in the uncovering of the meaning of experience. In contrast, narrative researchers are typically more interested in how people make sense of their experience through their narrative and, as such, the focus is on how the narrative relates to sense-making via genre or structure (Smith et al., 2009). NA then, can be thought of as being interested in how stories get told, whereas phenomenology is more interested in the content of those stories.

I felt phenomenology, therefore, was the best fit for this particular research question as my desire was to explore the content of my participants’ stories about their lived experiences of their adult inter-personal relationships. Furthermore, interpretive phenomenology allows researchers to actively make use of their own lived experience and, as such, would allow me to use my own experience and meaning making in the analysis. Indeed, phenomenology recognises the impossibility of “bracketing” when we are researching something in which we are a stakeholder. Instead, the focus is on undergoing a process of reflexivity to provide a credible and plausible explanation of participants’ accounts whilst avoiding making assumptions.

Epistemological standpoint

Epistemology can be defined as how a researcher comes to know about knowledge. As such, it is an important consideration in conducting research as it reflects the world view of the researcher and, inevitably, has a bearing on the way research is carried out.

Philosophers use epistemology to look at the way we think about the nature of the social world and of our being (our ontology). In research, then, our epistemology informs how we conceptualise the nature and status of our research (Finlay and Ballinger, 2006).

Finlay and Ballinger (2006) suggest considering the following questions in order to identify our own epistemological commitment:

1. *What understanding am I aiming for?*
2. *What kind of knowledge can I possibly gain?*
3. *How do I understand the role of the researcher?*

Finlay and Ballinger (2006) see these questions as fundamental to our research choices. I will, therefore, use them to consider the epistemological stance that underpins this study.

The aim of this study is to understand the subjective experience of siblings with a brother or sister with SMI in their adult inter-personal relationships. As an interpretive phenomenologist, I believe the way our perceptions and experiences are socially, culturally, historically and linguistically produced. Our situatedness determines our understanding and thus it is important to recognise that two researchers studying the same phenomenon may well interpret and understand that phenomenon differently (Finlay and Ballinger, 2006).

I consider each individual, and their experiences, to be unique, thus, the focus is on a participants' experiences with an attempt to avoid generalisations. I acknowledge, however, that some level of generalisation inevitably occurs, in particular, when making an examination of convergence and divergence.

As an interpretivist phenomenologist, I acknowledge that it is impossible to be objective; my identity and standpoint will shape the research process and findings in a fundamental way. In addition, any understandings gained will remain provisional, partial and entirely dependent on context.

The recognition of the uniqueness of experience is consistent with a phenomenological viewpoint. I hold that the role of the researcher in the generation of knowledge is both active and intertwined. As such, I fully acknowledge that, whilst every effort was made to bracket my experiences, it is neither possible, nor desirable, to provide a pure experience of the participants' experience, as knowledge produced is inevitably filtered through researcher's interpretation of the data. It is also important to note that the aim of "bracketing" is not to "purify" the participant's experience, more to have clarity around who is saying, and meaning, what.

Finally, I see research as co-constructed; a joint product of the participants, myself and our relationship with meanings negotiated within particular social contexts. In addition, I recognise I am implicated in the research process by influencing the collection, selection and interpretation of data; I recognise that my prior experience and understandings will inevitably affect how I construct what I see.

Rationale for using IPA

Interpretive phenomenological analysis (IPA) is not the only phenomenological approach to psychology. Indeed, there are a group of phenomenological approaches which all share the basic tenets of interpretive phenomenology, but each have their own particular articulation. Van Manen (1990) also draws on and connects phenomenology and hermeneutics. His particular interest is the field of education, health and nursing and the phenomenological investigation of everyday practice. His is, therefore, an approach to teaching and how this influences, and is influenced by, the social, political and psychological development of learners rather than focused on individuals and their personal meaning making in their everyday lived experiences, which is what the current study is concerned with.

Langdridge (2007) articulates critical narrative analysis which is strongly informed by Ricoeur and aims to include, in the analysis, an identification of key narratives and the hermeneutics of suspicion. This is the mode of interpretation that seeks to understand by peeling back the layers of meaning, to go beneath the surface for what is hidden (Langdridge, 2007). In contrast, IPA involves a “double hermeneutic” (Smith et al. 2009), with the researcher making sense of the participant, who is making sense of the thing itself. This combination of phenomenological and hermeneutic insights is an integral part of IPA methodology. It attempts to get as close as possible to the personal experience of the participant whilst recognising that this becomes an interpretive endeavor for both the participant and researcher (Smith et al., 2009). In this way IPA allows the focus to be on the personal meaning making and sense-making of individuals (Smith et al., 2009) and, as such, is most suitable for the current study. It is noteworthy too that IPA’s original focus was on identity in relation to pain, contextually not so different to the current study. Indeed, IPA has much to offer to our understanding of the experience of illness, where participants are spontaneously and actively engaged in making sense of unexpected things that happen to them and their sense of self and identity.

In this study, IPA allows exploration of a particular phenomenon (how people experience adult inter-personal relationships) as they appear in a particular context (when those people have grown up with a sibling with SMI) and facilitates a detailed examination of their lived experience. IPA’s idiographic lens will allow exploration of the research question in depth, from the perspective of the participants and helps capture the texture and richness of each particular participant. In addition, IPA lends itself to examining, in detail, not only the experiences of individuals, but also the circumstances of those individuals (Smith et al., 2009). Indeed, IPA was intended to bridge the divide between cognition and discourse and, because of this, lends itself to exploring this area, as it will inevitably be diverse, both in terms of the lived experiences of the participants and their circumstances.

Family structure, dynamics, socioeconomic background, culture and understandings will all play a part in the experiences of the participants.

Finally, a huge strength of IPA is the ability to get *underneath* the stories that are told. This participant group, because of their childhood experiences and the felt need for them to be “good” and to always “do the right thing” within their family structure, are likely to present the organised stories that have been told many times over the years and feel completely true to them. Because of this, it would be easy to hear these stories, see the seemingly well-adjusted participant and entirely miss any real understanding of their experiences. For the current study, then, IPA is the only methodology that could sensibly be used as it allows the researcher to go beneath the surface to look for what may be hidden whilst still privileging the lived experience and the participant meaning-making. Indeed, it is through IPA’s mode of interpretation, with its identification of key narratives and the hermeneutics of suspicion, that truly allows us to get an understanding of the participants’ lived experiences.

IPA methodology and philosophical underpinnings

IPA was developed in the 1990s with philosophical underpinnings in phenomenology and hermeneutics (Eatough & Smith, 2008). It connects phenomenology (the study of structures of consciousness as experienced from the first-person point of view) and hermeneutics (the theory of structure of methodology and interpretation), with an idiographic lens (Smith et al., 2009).

Phenomenology is a philosophical approach to the study of experience; it is interested in the experience of being human in terms of things that matter to us and constitute our lived world. In phenomenology, of particular interest is what happens when the everyday flow of life takes on a particular significance and thus becomes “an experience”. Thus, the approach is committed to the examination of how people make sense of major life experiences and aims to engage with the reflections that happen when people are engaged with “an experience” (Smith et al., 2009).

IPA is an interpretive endeavour and, as such, is informed by hermeneutics. Access to experience is always dependent on what participants tell us about that experience and the researcher then needs to interpret that account in order to understand their experience (thus engaging in a double hermeneutic). IPA accepts the impossibility of the researcher gaining direct access to the participant’s experience and rather, acknowledges that what is produced is an interpretation of their experience.

IPA can be thought of as idiographic and thus concerned with the “particular” rather than nomothetic (which is interested in making claims at the group or population level). IPA’s commitment to the “particular” operates at two levels. Firstly, it is committed to detail and, therefore, analysis that is thorough and systematic. Secondly, it is committed to understanding how particular experiential phenomena has been understood from the perspective of particular people, in a particular context (Smith et al., 2009).

IPA does not eschew generalisations, it just prescribes a different, more cautious, way of establishing them. Indeed Harré (cited in Eatough & Smith, 2008) postulates that attention to the idiographic is an intrinsic part of psychology that allows us to understand more universal structures. IPA’s idiographic commitment can be thought of as a microscopic lens which allows the detailed examination of unique, individual lives. Unsurprisingly then, IPA uses small, purposively selected and carefully situated samples and aims to find a reasonably homogeneous sample so, within that, convergence and divergence can be examined in some detail.

The four major phenomenological philosophers, Husserl, Heidegger, Merleau-Ponty and Sartre, were all committed to thinking about how we might come to understand our lived experience but all took the project on in a distinctive way (Smith et al., 2009). IPA attempts to these four philosophers’ ways of thinking.

Husserl was interested in finding a means by which individuals might come to know their own experience of a particular phenomenon with a depth that would allow them to understand the essential qualities of that experience. He felt that, in this way, it was potentially possible to illuminate an experience for others too. He postulated that to “go back to the things themselves”, we need to focus on things in their own right rather (and our inward perception of them) rather than seeing them as objects in the world that we fit into our pre-existing categorisation system. To do this, Husserl suggested we “bracket” our taken-for-granted world in order to concentrate on our perception of that world. He believed our examination should include a detailed description and reflection upon every salient particularity of the phenomena being studied. Husserl’s work helps IPA researchers to focus on the process of reflection. It was Husserl who set the agenda for detailed and systematic examination of the content of consciousness: our lived experience (Smith, et al., 2009).

Heidegger was a student of Husserl, but believed Husserl’s approach to be too theoretical. He went on to set out the beginnings of the existential and hermeneutic emphases in phenomenological philosophy. He was concerned with the ontological question of existence itself and the practical activities and relationships we become caught up in: those things that make our world meaningful (Smith et al., 2009). Heidegger also questioned the possibility of any knowledge outside of an interpretive stance and thus introduced the idea of hermeneutic phenomenology. Heidegger then gave IPA researchers the hermeneutic lens and well as the understanding that people are “thrown into” a world of objects, relationships and language. Thus, our being in the world is always perspectival and “in relation to” something.

Merleau-Ponty was more interested in the subjective and embodied nature of our relationship to the world and how that leads to the primacy of our individual perspective on the world. He asserted that while we can observe and experience empathy, we can never truly share another’s experience because it relies on, and belongs to, their embodied position in the world (Smith et. al, 2009). For IPA researchers, Merleau-Ponty’s view that the body shapes the core character of our knowing about the world is critical. Even if we cannot entirely capture it, Merleau-Ponty believed the body-in-the-world must not be overlooked.

Sartre emphasised that we are caught up in projects in the world. To Sartre, it is the action-orientated, meaning making, self-consciousness that engages and interacts with the world we inhabit. Indeed, he felt the self is not a pre-existing entity to be discovered but rather, over time, we evolve and become ourselves. IPA researchers take from Sartre then, the concept of people being engaged in projects in the world and the embodied, interpersonal and moral nature of those encounters.

Validity and quality

The criteria for judging validity in qualitative research are an important topic both in relation to phenomenological studies and research using other qualitative methodologies (Langdridge, 2007). This is not only due to the relative newness of qualitative methodologies compared with the more established methodologies of quantitative research but also, more problematically, due to the diversity of the methodologies which all require different methods of judgement (Yardley, 2000).

Yardley (2000), in the context of health psychology, recommends four very useful, broad and flexible criteria to guide the validity of qualitative research: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. Throughout the research process I employed these to guide my thinking as recommended by Smith et al. (2009) who see Yardley's criteria as accessible, broad ranging and offering a variety of ways of establishing quality. In addition, as recommended by Smith et al. (2009), throughout the research process I held in mind the concept of the independent audit. This is a powerful way of checking the validity of one's research report by ensuring that somebody can follow a coherent chain of evidence that leads from the initial raw data all the way through to the final report (Yin, 1989). The aim of the independent audit is to ensure that the account produced is a credible one. However, unlike inter-rater reliability, used in other methodologies, it is not an attempt to ensure the account is the only credible one. Rather, the independent audit allows for the possibility of a number of legitimate accounts; the concern, therefore, is with how systematic and transparent the account is. Smith et al.

(2009) call for IPA researchers to take quality and validity seriously. However, they also see IPA as a creative process and, as such, call for validity to be applied flexibly as different studies will require different measures.

In the discussion section, I will return to this topic and consider my utilisation of both Yardley (2000) and Smith et al.'s (2009) recommendations regarding validity and quality in the current study.

Ethical considerations

This research was granted ethical approval by the Metanoia Research Ethics Committee (Appendix C) following a comprehensive Ethics Application Process and Field Work Risk Assessment (Appendix B). The study's ethical implications were considered in depth, in accordance with the British Psychological Society's Code of Ethics and Conduct (2009). Procedures on areas such as potential distress, anonymity and debriefing were carefully considered and allowed for in the design.

The potential impact of this research on both the participants and myself as the researcher was fully recognised and steps were taken to ensure appropriate support was available. Participants were informed that their contribution would be anonymised and their identity kept confidential throughout. Participants were told they have the right to withdraw from the study at any time up to, but not after, data analysis began. Had they chosen to withdraw, their data would have been destroyed and no longer used in the study. No participants chose to withdraw from the study.

As participants were putting themselves in a position of vulnerability in opening up to me about their experiences of having a sibling with SMI, it was important that they felt psychologically held. I felt confident (by both my training and my 10 years' experience as a therapist) to manage the boundaries and to contain my participants. Before undertaking interviews, I discussed with participants their options for support, and let them know that, should they become distressed during their reminiscences, I would stop the interview.

Should this have happened, I would have employed my own therapeutic skills in this instance, including the use of techniques such as grounding (Rothschild, 2000) and bringing the participant back in to the present and current surroundings. This was not needed.

I took time to debrief my participants carefully after the interview; I reviewed the interview with them and discussed how they felt about what they had said and what it was like for them to talk to me. My purpose for debriefing was to allow space to deal with any stress or arousal that my participants may have felt from talking about their life for the purposes of the research and to ensure that, if they did feel stress or arousal, I could put safety measures in place, such as discussing self-care and accessing support from others. None of my participants expressed stress or arousal after the interviews.

In addition, the purpose for debriefing was to give space for any questions my participants had about the study in general or about their own experiences of taking part. Several of my participants expressed an interest in knowing what I expected to find in my study and, indeed, whether their experiences matched other participants' experiences.

I considered, ahead of carrying out the interviews, what I would do in the event of a participant, prior to or during the interview, expressing an interest in my stake in the research. As I hold that it is important to remain as authentic and open as possible, I decided I would, if asked, share my own experiences after the interview had been concluded so as not to disrupt (or interrupt) participants own thought processes. I would have provided a brief outline of the fact I grew up with a sister with SMI and how it sparked an interest in me about the impact of growing up with a brother or sister with SMI. As none of my participants queried my stake in the research, this was not necessary.

The interviews took place in hotel reception or lounge areas in different locations that were convenient for each participant. I ensured we were sitting away from other people in order to maintain privacy. I was careful to attend to my own safety by ensuring that my husband was aware of my location and timings. I also arranged to call him as I left so that he would be alerted to a possible issue by the absence of my call. In addition, because of the nature of the interviews and my own relationship with the material, I knew it was important for me to attend properly to my own self-care. During the time of interviewing and data analysis, I sought support from my own therapist, my primary supervisor and my research supervisor. I knew, if necessary, I could ask for additional sessions from my therapist. I also decreased my client workload so that I could create time to nurture myself and spend extra time with my husband, children and friends doing things outside my project work, which provided me with nurturance and support.

Participant criteria

As the aim of IPA analysis is to provide in-depth insight into the individual lived experience of the participants, careful analysis is more important than a large sample size. I was, therefore, looking for only six participants. Indeed, because of the idiographic approach I was taking, I was concerned with understanding particular phenomena in particular concepts and therefore could only consider a small sample size. The case by case analysis of transcripts takes time and my aim was to write in detail about the perceptions and understandings of each of the participants. Furthermore, six participants are deemed sufficient for developing meaningful points of similarity and difference (Smith et al., 2009).

I was looking for participants who would grant me access to these phenomena (those who have grown up with a sibling with SMI) rather than a population. My wish was to find a fairly homogeneous sample for whom the research question would be meaningful (Smith et al., 2009). As such, I was happy to include both men and women who have experienced this within their childhood families. Therefore, Inclusion Criteria were individuals who:

- Were 30 years of age or older (so as to have had the opportunity to form and experience adult style relationships). No upper age restriction was considered necessary, as experiences throughout adulthood are relevant to the study

- Grew up in the same house as a biological sibling (to create homogeneity within the participant group) who the participant felt had/has SMI

Exclusion Criteria were individuals who:

- Felt they were likely to be caused distress by discussing their childhood experiences in relation to their brother or sister with SMI
- Were unable to give consent
- Were unable to conduct the interview in English

Recruitment strategy and participant information

As a clinical psychotherapist who regularly delivers talks and workshops on various aspects of mental health to schools and various corporations, I had the opportunity of taking my recruitment posters (Appendix A) to the talks with me and letting the talk attendees know about my research. At the end of my talks, I took a moment to explain the focus of the study, the inclusion and exclusion criteria and signposted anyone interested to the recruitment posters on the resource table. I expressly sought and obtained the permission of whichever school or organisation I was delivering the talk to, in order to check that they were happy for me to do this.

Five of the participants were attendees on talks or workshops I had delivered. One participant had heard about the research I was doing and expressed an interest in taking part. I had an exploratory conversation with each of the potential participants and made it clear to them, during that conversation, that if they decided, for any reason, they did not wish to take part in the research, there was absolutely no obligation for them to do so. The purpose of the exploratory conversation was to establish whether they met the participant criteria. It also gave me the opportunity to talk about what being involved in the research would entail and answer any questions they had. During each of these conversations, I discussed the potential impact taking part in this research may have on the participants, asked whether they felt they may become distressed (as per my exclusion criteria) and checked whether they had appropriate support in place should they need it following the interview.

Only one potential participant was excluded as she misunderstood the focus of the study (believing it to be focused on children with a brother or sister with SMI, rather than adults). This participant understood when the focus was explained to her. I also signed-posted her to some extra support regarding her own situation.

I then followed up with an email to thank the six participants for their willingness to take part in the research, as well as to arrange time and venue and let them have a copy of the information sheet (Appendix D) and consent form (Appendix E). Once I had six participants I stopped promoting my research at my talks.

The interviews took place between 5 April 5 2019 and 22 October 2019. Detailed demographical and biographical information is not included in the study in order to protect participants anonymity. All participants were White British, although one participant has an Arab father. All are parents now themselves. Five of the participants are female and one male, all of whom were aged from 32 to 48 at the time of the interview. The brothers and sisters with SMI were aged from 31 to 50; three still lived at home with their parents. All but one of the siblings had tried to commit suicide at least once. All were, at the time of the study, still alive. Four of the participants also had a parent with mental health issues. All of the participants left home between 17 and19 years of age. Although unintentional, the uniformity in ethnicity and being parents fits with Smith et al.'s (2009) recommendation for a homogeneous sample. As the majority of attendees at my talks and workshops are White British, this homogeneity simply reflects the people who attend my talks; my access to minority groups was, therefore, more limited due to my recruitment strategy. This is something I explore more in the discussion.

Data collection

Interviews were semi-structured and lasted around one hour. My research supervisor and I discussed how this was long enough to allow rich data to emerge without being too tiring for the participants. The interviews were recorded on a digital recorder which were transferred to my (password protected) computer on arriving home and deleted from my recorder as soon as this was done. I took additional hand-written notes during the interview. All interviews were transcribed verbatim to prepare for the subsequent analysis. The recordings were destroyed when data analysis was complete. The transcripts and other data were destroyed once my research viva was completed and amendments were deemed to have been successfully met.

Interview schedule

The interview schedule was prepared early on in the design process so that it could be submitted with the research proposal that formed part of my ethics application form (Appendix B). The schedule was informed by the research question, my literature review and my knowledge of the subject area; specifically, I considered how the interview schedule could provide deeper exploration of the research question, whilst drawing on previous research (and gaps in the research) and my own understandings drawn both from my personal experience and observations I made in my clinical practice. The schedule included a list of five broad questions (Appendix F). I did my best to remain as open minded as possible when asking questions and to be prepared to be surprised. I was aware that my own experience could be entirely different to others and that my participants could have found their experiences to be partly, or even entirely, positive.

Prior to beginning the interview, I collected some straightforward data (family structure, birth order, whether their sibling had any diagnosis of mental health issues etc). I then used the interview schedule as my guide. I used it lightly and added prompts where appropriate. I opened the interviews by asking my participants a generic question about how they felt their childhood family situation may have impacted their lives, and ways of being in relationships now. This led to them talking about their childhood, the roles they played within their family and their lived experiences of their inter-personal relationships.

Transcription

The interviews were transcribed verbatim, in accordance with the guidance by Smith et al. (2009). The transcript, therefore, includes all the words spoken by the researcher and the participant. Long pauses are noted where they existed. Due to time constraints, I used the services of a professional transcription company recommended to me by my research supervisor. They are a company who have knowledge of encryption and data protection and have experience of transcribing interviews for doctoral students. The recordings were encrypted during transfer and encrypted and stored offline while they were at the transcriber's disposal. All electronic files were deleted after the transcriptions were delivered. I formatted the transcripts by turning to landscape view and adding wide margins either side, to prepare for the analytic process. The texts from the transcripts included all hesitations, pauses, errors and repetitions. My detailed, analytic interpretations of the data is interweaved throughout the quotes in the analysis.

Analytic strategy

I followed the six steps suggested in Smith et al. (2009), which gave me a useful framework to guide my analysis of the data.

Step 1: Reading and re-reading. I read through the transcripts while I listened to the recordings, to ensure accuracy. I then anonymised the transcripts by allocating pseudonyms to each of the six participants. I also removed all other names, locations and any other identifiable information. In line in Smith et al.'s (2009) recommendation, I then immersed myself in the transcript of each interview whilst, once again, listening to the audio. I wanted to ensure that the participant remained the focus of my analysis. By listening closely to the audio, I was able, in subsequent re-readings of the transcripts, to still “hear” the voice of the participant as they shared their experiences. I noted down my initial “loud” thoughts in order to “bracket” them off for a while.

Step 2: Initial coding. I then underlined the text that stood out to me in the transcript and began to examine and explore the semantic content and language use in the transcripts. I used the left-hand side of my transcript to make my initial notes giving special attention to why I thought the text that I had underlined felt important. In line with what Smith et al. (2009) call descriptive level analysis, I looked to make meaning from each participant’s meaning making. I also took care to stay close to the text and, in doing so, stay close to each participant, in order to avoid, as much as possible, only seeing what I was looking for. Instead, I did my best to maintain an open mind and keep a clear phenomenological focus by staying close to the participant’s explicit meaning. I focused on what each participant was actually saying, even when they went “off topic”, seeing whatever they spoke about as relevant. I wanted to understand what they may be saying about themselves and their experiences. I began to identify ways in which each participant talked about, and understood, different issues. I paid close attention to how they described the things that mattered to them and the meaning of those things for them. I paid attention to descriptive comments: those that described the content of what the participant had said. In doing this, I paid attention to key words, phrases or explanations which the participant used when describing things that mattered to them (events and experiences in their lifeworld). I held, as Smith et al. (2009) suggest, that we can understand what matters to participants by paying attention to their descriptions, assumptions and emotional responses.

Step 3: Developing emergent themes. I then used the right-hand margin of each transcript to condense the left-hand side, carrying out a meta-interpretation. These interpretative notes helped me to understand how, and why, each participant had their particular concerns. I looked at their language choices, thought about the context of their concerns (their lived world) and identified more abstract concepts as recommended by Smith et al. (2009). In my analysis, in the right-hand margin, I looked to identify three distinct processes with different foci (allocating different text colours to each process). These were the descriptive, linguistic and conceptual processes. I noted how the transcript reflected the way in which the content and meaning were presented by each participant.

For the descriptive process I focused on the key words, phrases and explanations. I also paid attention to the descriptions, assumptions and emotional responses. For the linguistic process, I focused on pronoun use, pauses, laughter, repetition, tone and degree of fluency. I also noted where metaphors were used and, in line with Smith et al.'s (2009), suggestion, found them to be a particular powerful part of the analysis.

I also paid attention to the conceptual comments; those that were engaged at a more interrogative and conceptual level. I allowed interesting features in each participant's transcript to raise questions for me. These questions inevitably prompted further reflections and, as Smith et al.'s (2009) suggests, often prompted me to re-analyse the data; it made me look back at the transcripts and review my earlier comments in light of what the participant had said later on as it gave clues to where I have may made unhelpful assumptions or where my participant may have contradictory or split ideas around a given experience. This sometimes furnished me with tentative answers, sometimes not. However, these questions allowed me to work at a more abstract level.

Analysing the conceptual comments was, without doubt, the most challenging stage. I sought out my participants overarching understandings of the matters they were discussing. There was also, during this stage, an element of personal reflection as, inevitably, I drew on both my own experiential and professional knowledge. This helped me to sound out the meaning of key events and processes for my participants. By doing this, I aimed to move away from superficial and purely descriptive analysis and add depth to the analytic process. I took care, however, to ensure the interpretation was stimulated by, and tied to, the participant's words. As Smith et al. (2009) recommend, I constantly held that the analysis was always primarily about the participant and that I could simply use myself to help make sense of the participant and their lived world.A sample page of transcription can be seen in the appendices (Appendix G).

Step 4: Searching for connections across emergent themes*.* I then explored the chronologically ordered themes I had for my first participant and looked for patterns and connections in order to see how the themes fitted together; I held the research question in mind as I did so. My aim was to provide a structure that would allow me to highlight the most important elements of my participant's account. I was able to produce a list of themes which I could track back to the transcript via page numbers (Appendix H). I looked for recurrent themes (putting "like with like" and developing a name for the "cluster"). I was aware that this was not interpretative or particularly creative but it allowed me to start the process of thinking about the emergent themes and group them together. I was able to start to identify patterns between the themes and produced a table of emergent themes (Appendix I).

Step 5: Moving on to the next case. I then moved on to the next participant following the same procedure for that, and all of the remaining, cases. I ensured I gave myself time and space between each participant so that I returned to each one fresh. I did this to ensure that, as Smith et al. (2009) recommend, I treated each case on its own terms as much as possible in order to do justice to its own individuality. Whilst recognising that there would be an inevitable influence by what I had already seen, the time and space I took between cases gave me the best chance of "bracketing" the ideas emerging from the analysis of the previous cases, as much as is possible. In doing this I did my best to honour IPA's ideographic commitment and allow new themes to emerge for each subsequent case.

Step 6: Looking for patterns across cases. The final step in my analysis was looking for themes across the six cases. I used a large table to set out my emergent themes for each case. I looked for connections there were across cases and noting the similarities and differences. Initially, I struggled with this step, constantly relabelling and reconfiguring themes and trying too hard to fit them into neat, well defined boxes. In order to free up my thinking and allow more creativity I took several large (A1) sheets of paper and drew out overlapping circles, which enabled me to explore different ways of clustering my emergent themes. It was only on my third attempt, however, that the emergent themes began to generate the sub-themes in a way that made sense to me and, from there, my superordinate themes appeared (Appendix J).

Throughout this process, I stayed as close as possible to the participants' narratives. I fully recognise, however, that analysis is always co-constructed; as I moved beyond the descriptive to work more within the hermeneutic circle, meanings were taken by me, the researcher, from the participant data and I recognise that these would not be the same if they were analysed by another researcher for whom different themes or quotes may have stood out. In this way, I recognise that IPA is a joint product of the research and the researched. I aimed, through this, to connect with the participants' worlds through taking an inquisitive approach to understanding their meaning making.

The superordinate themes represent more general areas of meaning found, in some form or other, in the *all* of the participants' stories. The subordinate themes are the distinct aspects of the superordinate themes which are not necessarily shared by every one of the participants but nonetheless illuminate relevant and important experiences in the participants' lives.

Analysis

Chapter overview

This chapter explores the detailed analytic interpretations of the interview transcripts. The experience of adult inter-personal relationships for those who have grown up with a sibling with SMI was explored, described and reflected upon in considerable depth. This exploration was not only of the participants' individual experiences but also to the similarities and differences between the participants. The analysis provided rich and meaningful themes which are presented and discussed in depth here. Due to the volume of data, not all aspects of the participants' stories can be included, so I have chosen the aspects I feel most closely relate to the research topic and are most prevalent and enlightening.

Throughout this analysis, the voices of all participants are strong; quotations are provided throughout to provide transparency. After each quote, the pseudonym initial and page number is included in parenthesis [X1] in order to aid clarity and transparency. Minimal biographical details are included where necessary to provide an understanding of the context of the quotes or my understanding of them.

There is, deliberately, very little connection to the literature or existing theories through this section, as this is reserved for the discussion section that follows. The only theory I have drawn on in this section is social philosopher George Mead's (1967) idea of the "I" and the "Me." The reason for sharing Mead's work here is that, when clustering my themes, two of the clusters related so strongly to Mead's philosophical idea of the "Me" (what we learn through our interaction with others and their attitudes to us) and the "I" (how we, as individuals, then respond to those attitudes) that I felt compelled to use them as superordinate themes. These themes are explained more below.

With the exception of when participants are talking about their childhoods or earlier lives, this analysis is written in the present tense; this was done in order to bring their stories to life as much as possible for the reader. In this section, then, I aim to provide an opportunity for readers to immerse themselves in the lived experiences of the participants. The superordinate and subordinate themes are summarised below and in table 1.

The Stabiliser refers to the role participants had both in their childhood family as children and also now, as adults. In this theme, the role participants feel they play and the functions they feel they carry out are explored and discussed.

The "Me" explores what Mead (1967), refers to as the "socialised self" where people learn to see who they are by observing the responses others have to them and their actions. The "Me" is, therefore, learned in interaction with others who inhabit the environment we find ourselves in. This learning comes directly from others' attitudes towards us which, once internalised in the self, constitute the "Me." According to Mead, of particular importance is how significant others treat us based on how they see us as being. In this theme then, participants' sense of self is explored and discussed, as well as how that plays out in their ongoing interactions with others.

The "I" explores what Mead (1967) refers to as the "active" aspect of the person; it is the response of the individual to the attitude of the community, reacting, as it does, within the context of the "Me." According to Mead, in this way, we construct responses based on what we have learnt from others' attitudes. In this theme, then, participants' internal processes, thoughts, emotions and desires are explored and discussed.

Surviving and Striving allows space for exploring and discussing any particular positive strengths or qualities the participants feel they have gained from their childhood experiences; things they see as helpful or constructive about their way of being in the world.

Table 1

Superordinate themes and corresponding subordinate themes

Superordinate themes	The Stabiliser	The "Me"	The "I"	Surviving and Striving
Subordinate themes	Bringing peace, normality and sanity	Conflict avoidance and eruptions	It's ridiculous	Focus on achievement
	Trying to create the happy family	I can't say "no"	Anxiety and rumination	Independence and capability
	Frustration and acceptance of parents' limitations	Oversharing	A place of my own	

Before the analysis, I have chosen to share here vignettes for each of my participants in order to help readers get a sense of them as individuals and to bring their stories to life. As previously mentioned, pseudonyms have been used and details are minimal so as to maintain anonymity.

Nadia is a married white British woman who, at the time of the interview, was in her early thirties. She is a mother to two primary school aged children. Growing up, she was the middle child with an older brother and a much younger sister. Her older brother suffered from a severe form of obsessive-compulsive disorder throughout childhood. The main themes for Nadia are that of still feeling she is the peace-maker in her family of origin, being conflict averse and her frustration at, what she sees as, her lack of assertiveness (whilst having no difficulties being an able advocate for others).

Owen is a married white British male who, at the time of the interview, was in his late forties. He is a father to three children. Both him and his older sister were adopted (with different birth parents). His sister suffered from probable attachment disorder and borderline personality disorder and has made multiple suicide attempts. She was emotionally and physically abusive to Owen throughout their childhood. The main themes for Owen are that of needing to be the "good" one for his parents, feeing both frustrated and sad about his parents' experiences and struggling with conflict and affect regulation in his adult inter-personal relationships.

Sarah is a married British woman with two school aged children. She has an Arab father and a white British mother. At the time of the interview Sarah was in her late thirties. Growing up she was the middle girl between two boys. Her older brother suffered from severe depression, attention deficit disorder and probable autistic spectrum disorder. Her father was verbally abusive towards her and her brothers. The main themes for Sarah are her people pleasing tendencies, her underlying chronic anxiety and her inability to find her voice in the face of potential, or real, conflict.

Annie is a married white British woman who, at the time of the interview, was in her early forties. She is a mother to two children. Growing up she was one of two children. Her older brother suffered from severe anxiety and depression, bipolar disorder, psychotic episodes, alcohol abuse and has attempted suicide on one occasion. Annie's father was an alcoholic who was physically abusive to both her mother and her brother. The main themes for Annie are her perceived childhood role to be "nice," kind" and to "never cause any trouble," her frustration and difficulties with her family of origin as an adult, her tendency to over-analyse things and her inability to say "no."

Jane is a white British woman who is in a relationship but not married. She is a mother to two primary aged children. At the time of the interview she was in her early forties. Growing up, she was one of two children. Her younger brother had behavioural issues from birth and was diagnosed with attention deficit disorder at a young age. From 12 he abused drugs and alcohol and in his late teenage year became addicted to heroin. Her mother had her own significant mental health issues and numerous somatic disorders. The main themes for Jane are her need to not upset her parents (as a child and still now), her inability to stand up for herself with her partner in the face of conflict and her inability to voice her own needs.

Kelly is a single white British woman who has a young son whom she chose to bring up alone. At the time of the interview she was in her early forties. Growing up she was one of two children and her younger brother suffered from severe depression and anxiety and became addicted to drugs and alcohol. He also suffered from drug-induced psychosis and has made multiple suicide attempts. Her mother was an alcoholic throughout her childhood. The main themes for Kelly are her tendency to people-please, her chronic anxiety, her fear of showing vulnerability and her difficulties in committing to a partner.

The Stabiliser

Under this superordinate theme there are three subordinate themes:

- Bringing peace, normality and sanity

This theme examines how participants make sense of what they believe they were expected to bring to their families as a child and what they believe they are expected to bring to their families now.

"There was always a sense that I had to be good, because Mum and Dad were coping with quite a lot."

- Trying to create the happy family

This theme explores how the participants experience their own, or others', desire to be a happy family.

"Mum still wants to hang onto that dream of a family that's all together and all happy families which, which we all know it isn't."

- Frustration and acceptance of parents' limitations

This theme explores the emotional aspects of participants' experiences of their childhood families in relation to how their parents handled, and continue to handle, their family situation.

"They didn't really have any help and no one really knew and understood what, you know, what they were going through."

The first of the superordinate themes explores how participants see their role in their childhood family both as children and adults. Participants' perceived roles in their childhood families is the first theme to be explored; their starting point in life is the starting point here in the analysis too. The definition of stabiliser is "A thing that is used to keep something steady or stable." This feels like a fitting description for the role many participants played, and continue to play, in their childhood families.

Bringing peace, normality and sanity. Participants' childhood roles remain central to their experience of themselves now, as adults, in relation not only to their families but also in their wider lives. This subordinate theme, then, explores the participants' experiences of these roles and their perceived function within their family systems.

Nadia reflects on her familial role as a young girl with a brother with SMI both in terms of her role and her functionality:

> I do remember being, [brother], just some of the issues he had, just kind of getting moving you know, to kind of, I think I said before, that he got stuck and, so just trying to, you know, get to school on time and that sort of thing, and I do remember being kind of the aid or the negotiator, just to try and help my mum get him up and out the door. So yeah, and just little ploys, like I remember we used to have Pac-Man on the computer and I used to try and say "[brother, brother] if you get dressed you can play one game of Pac-Man" and that sort of thing you know, just little things to try and persuade him to get moving, to get out the door. [N29]

Nadia had a clear role in helping distract her brother and, in that way, helping her mother to get her brother out of the door in the mornings. The use of the word "aid" is interesting; she saw herself as an extension of her mother, someone to help and smooth things over. There is a sense here of the parentified child (Chase, 1999); someone expected to help manage their sibling's difficulties "I definitely was trying to help my mum with the way that, you know, my brother was." [N30] There was also great importance placed here on getting her brother "moving" and, interestingly, she, herself, now finds it hard to be anything other than busy and purposeful in her adult life. Nadia goes onto reflect more on the family dynamic:

> There was always a sense that I had to be good, because Mum and Dad were coping with quite a lot. [N30]

It seems there was an unspoken understanding, or to use Nadia's own word, a "sense" that she had to be "good" in order not to make things worse for her parents. This is something Jane, whose brother has SMI also felt, "Well, I was definitely the good one!" [J1].

Both Nadia's "There was *always* a sense" and Jane's "I was *definitely* the good one!" indicate quite binary thinking that may have helped them both, as children and even now, have a sense of certainty that was lacking in their environments (McWilliams, 2020). Owen, whose sister has SMI echoes this feeling of needing to be "good." He highlights here how he "actively thought" that he needed to be a "good boy" for his parents, so as not to add to the burden already placed on his mother and father:

> I remember actually thinking I don't want to do anything that gets my parents so upset as my sister was making my parents, so I kind of actively thought I need to be nice, I need to be a good boy for Mum and Dad. [O4]

In a similar way to Nadia and Annie, Owen uses quite extreme language, indicating binary, or dichotomous, thinking, "I don't want to do *anything.*" Like Owen, Nadia was also aware of her parent's struggles in coping with her brother's SMI and the pressure those struggles may have been putting on their marriage:

> Mum and Dad had quite a tumultuous relationship when we were growing up, so there was quite a lot of arguing. I always ensured that I didn't do anything to make that any worse. I mean that's why they argued, because they you know, they were finding it really hard to cope with [brother]. [N30, 31]

Note, again, the extreme language "I *always* ensured that I didn't do *anything*," indicating the binary, or dichotomous, thinking (McWilliams, 2020). It is also striking how these childhood decisions, not to do *anything*, are expressed by Owen and Nadia in almost exactly the same words. There is a sense that, for Nadia, being anything other than "good" would have been the final straw, the tipping point, for her parent's marriage. In addition, it seems inconceivable, or perhaps unconsciously intolerable, that she herself may ever have put any extra pressure on them or caused any arguments herself; she locates the sole cause of her parent’s arguments as being entirely down to them coping with her brother’s difficulties, “I mean that’s why they argued,” even though it is unlikely their difficulties stemmed from one singular cause. Nadia also reflects on how she also took on the role of helping with her younger sister:

> My brother and actually my sister, my mum, says that I was a real mini mummy to my sister, so I think I, because my brother started getting poorly when my sister, around the time that my sister was born, so mum was having to deal with [brother] who was getting poorly, and then also with a tiny baby. So, I think I was a mini mum to my sister, because I was seven years older than her. [N28]

Nadia doesn’t seem unhappy when reflecting on these memories and yet, clearly, there was an expectation that she could, and would, help both with her brother and also, because of the demands of his SMI, with her sister when she was born. She, herself, highlights the fact her sister was a “tiny baby” for whom she was a “mini mummy.” The choice of the words, “tiny baby” highlights Nadia’s acute awareness of the fragility of her sister when she was an infant in need of care. One gets the sense she, herself, was no longer allowed to be “tiny” even though she, at the time, was only seven years old. The description vividly captures the sense of responsibility she, as a small child herself, may have felt.

Kelly, too, reflects on her role in her childhood family and the expectations that existed:

> Kelly: I was just forgotten about and it was just “Well Kelly’s alright, because she is the strong one so we won’t worry about her, she’s fine!”
>
> Interviewer: So being the strong one was your role?

> Kelly: Yes, still now. To be honest, even now, I'd be very nervous of disappointing my parents. [K1,2]

Kelly was, and still is, seen as "the strong one" in her childhood family; the one who didn't, and still doesn't, need worrying about "even now." Kelly links disappointing her parents to her role as "the strong one" and to being "fine" as if, should she not be "strong" or "fine" she will, somehow, upset and disappoint them. Owen also felt there were expectations from his parents:

> Almost one of my roles was to be a nice child against a naughty child…I never would have gone off the rails or anything like that. [O4]

Owen implies not only that there was no room for another "naughty child" but also that he felt the need to be very different to his sister. He took what he saw as, the opposite role to her; the "nice child against a naughty child." His statement "I *never* would have gone off the rails," is also interesting. It is something he refers to again later in the interview when he is recalling a recent family argument:

> After that Dad said "Right, I'll have a chat with her." So, Dad then had a chat with her and she was like, "You all gang up on me," and just completely went off the rails and then she blamed me and him and sent some really nasty text messages, really nasty emails, um, to both of us, really vindictive and I kind of bit my tongue. [O9]

"Going off the rails" refers, metaphorically, to a person whose difficult or socially unacceptable behaviour causes chaos similar to the chaos that ensues after a train derailment. The latter usually causing injury, possible death and, always, huge disruption. This is a life or death binary and highlights Owen strong desire to stay on the rails where it is safe, far away from the chaos and potential danger. Indeed, one wonders if Owen was, unconsciously, “trained” not to go off the rails so that he did not cause any additional chaos within the family. Note, as well, the contrast in how he talks about his sister’s behaviour, “*really* nasty messages, *really* nasty emails…*really* vindictive” to the way he talks about his own behaviour “I kind of bit my tongue.” There is an energy when he talks about his sister’s behaviour that simply isn’t there when he talks of his own. Owen experienced physical violence in the hands of his sister when he was young and in the context of this, his desire to “stay on the rails” makes sense:

> Looking back there were so many kind of clues along the way; one incident, her picking on me when I was in a swimming pool or had a paddling pool over my back that’s a one-off, that’s quite funny ha-ha, but actually when you look at the pram shaking and the “torture chair” [a game his sister made him play] and breaking my collarbone that, I would imagine, has got to have some kind of impact on anyone’s kind of psyche and subconscious way of going through life. [O22]

Owen emphasises here the confusion he felt as a young child, the games his older sister liked to play that were seemingly meant to be fun but had sadistic undertones. He highlights the clues he missed as a child that things were not as they should have been. Owen also talks of how these experiences would have “some kind of impact on anyone” but does not elaborate on what that might be. Note too, how he refers to the impact this may have on “anyone” rather than the impact it may have had on *his* psyche and way of being, as if he finds it difficult to consider himself here.

Like both Owen and Nadia, Annie, whose brother has SMI, also saw and, indeed, still sees, her role as being one of causing as little trouble as possible:

> I just kept my head down and I remember my mum used to say “Oh I don’t know what I’d do without you cos you just, you just get on, you never cause any trouble”

> and I think probably I, I literally did my best to sort of not put my head above the parapet, if you know what I mean? Not be any trouble, you know, be nice, and kind and work hard and, um, and not cause anybody else any, them not to have to think of me really, um, and think I still do that, that's become, that's expected of me now. [A2]

Annie not only felt the need to "be nice, and kind and work hard," she also felt her parents should "not to have to think of me." Annie seems both resigned and sad about the fact that her role in her family seems unchanged. As there was with Nadia, there is a sense here of the parentified child (Chase, 1999), highlighted by Annie's sharing of her mother's phrase "I don't know what I'd do without you." There is something curious about Annie's mother, or maybe Annie herself, attributing this to "you just get on, you never cause any trouble". To be so indispensable implies Annie was performing a crucial function within the family and yet that function wasn't, and perhaps still isn't, recognised or acknowledged.

When Annie talks of doing her "best to sort of not put my head above the parapet," she explicitly checks that I can understand her stating, "if you know what I mean?" Perhaps this is something her family did not understand and she needs to check I do. There is a sense of her removing herself or, at least, staying low, in an attempt avoid the dangers of the battle going on around her. Similarly, Jane, whose brother has SMI, also remembered her tendency to remove herself from the situation, albeit more physically:

> I was thinking the other day, that I used to just do things, and just not tell them what I was doing, like, just not to upset them. I went to Blackpool, like, for a night to see a band and stayed with a friend, she [her mother] didn't know where I was. I told her I was staying at a friend's house. Don't know how I managed to get to Blackpool from where I lived! (laughs) I was like 16 or something. [J3]

Jane clearly felt her parents had enough to cope with and did not want to “upset them” more than they needed to be, but there is a sense of her actively wanting to absent herself too. Her laughter at her resourcefulness implies a certain admiration for her younger self. When she reflects on her mother not knowing where she was that night it is hard not to wonder whether there was a more general lack of knowing about her. Like both Annie and Jane, Sarah also talks about needing to remove herself when she could:

> I’d spent a lot of time in my bedroom, with my cat. I had my animals, they were my, yeah, my cat used to be in my room, and that was honestly my sanctuary. [S3]

It seems, for Sarah, her bedroom, with her cat, was her safe place; somewhere where she could escape to and get away from the battle. She reflects on her role within her family when things weren’t going well:

> My role was keeping the peace, was always trying to divert the conflict…I’d also try and change the situation by being overly people pleasing. [S2]

Sarah clearly felt she needed to divert the conflict by whatever means she could. Her feeling of being “overly people pleasing” implies an effortful performance on her part; a performance intended to manage, or change, the atmosphere. Indeed, there is a sense of her dancing a well-rehearsed, choreographed dance in order to minimise the casualties in whatever battle was being fought. Her bedroom gave her respite from this, providing, as it did, a place where she could be herself, rather than the diversionary object. It also seems as if she found a diversionary object of her own, in her cat.

Trying to create the happy family*.* This subordinate theme explores how the participants’ family systems work now. It allows examination of the dynamic between different family members and, in particular, how the different family members perceive the family as functioning, or not functioning, now. It includes the hopes some family members carry for something “other” than what currently exists.

Owen reflects on how, within his childhood family, his mother tries hard to maintain a sense of family and unity, whereas he, himself, feels the reality is anything but. Indeed, he highlights the family split that, to him, is so apparent, despite the pretence during traditional family celebrations:

> It’s almost come full circle where now the family is almost splitting off…Mum still wants to hang onto that dream of a family that’s all together and all happy families which, which we all know it isn’t. [O11-13]

Owen plays “happy families” to keep his mother’s dream alive and clearly believes that everyone is complicit in the pretence of a happy family stating “we all know it isn’t.” The “all” here represents a form of splitting (McWilliam,2020): his mother versus the other family members. His mother, too, seemingly wanting the unhappiness to be cut out and sent elsewhere. Owen also talks with some detachment and resignation of their family going back to how it used to be. The only real energy seems to be stemming from his mother and her desire to “hang on to that dream of a family”:

> There isn’t really a family unit. Mum kind of said “I want there to be a family unit” but the reality is it’s not…we just come together for Christmas and Easter, maybe one other time, someone’s birthday, um, but yes, not traditional family, it’s not the happy family. [O25]

Owen’s equating of a “traditional” family with a “happy” family reveals, perhaps, how he is still, unconsciously, taking in his mother’s and/or society’s fantasy of what a family “should” be like. Annie, like Owen, also feels her mother is the person in her family most driven to keep the family functioning. Annie feels immense pressure from her mother to play her part in helping to bring the family together after breakdowns but is reluctant to do so:

> I make it clear, I say what my boundaries are and nobody really listens. And even if I say, “Look, you’re not listening to me, I’ve said I don’t want to do this,” I get pulled back in…I get talked around and after some time has lapsed, I get guilt-ridden into feeling like I’m not a nice person. [A13]

Note the words Annie uses about the force she feels, “I get pulled back in” and “I get talked around,” there is a real sense of the physical pull she is fighting against. She clearly feels guilt and self-doubt if she doesn’t succumb to the pressure. There is a sense for Annie that she needs to be “nice” rather like Owen’s sense he should play “happy families.” Both of these defined by the external world: what they do and who approves. It feels, to Annie, as if she is in an untenable situation: she has to choose between feeling she is not a “nice person” or doing what is asked of her and then feeling manipulated and trapped. Annie reflects on a recent changing perception of her mother:

> I suppose that is where I’m going, “Right, okay,” I have always thought of her as this whiter than white figure. I’m not saying she’s done it deliberately or anything like that, but now I’m seeing it a little bit more for what it is, in that we’ve all got our roles and every time we try and break out of those a bit, it suits everybody for me to stay in that role. The only person it doesn’t suit is me, really, but I’m not very good at saying that. [A15]

Annie’s frustration is clear: previous attempts to “break out” of her role have failed and all family members continue to play the roles they have been assigned. There is a sense of confusion here, though, about who is allowed to do what; “we’ve all…we try…it suits everybody…me…the only person.” She is also questioning the perception she had as a child of her mother being morally beyond reproach, “whiter than white.” Once again, this highlights Annie’s binary thinking (McWilliam,2020); she is clearly more able to question her childhood family system and the roles that everyone played, but is positioning them as wholly right or wholly wrong, wholly good or wholly bad, rather than being able to hold each person as the nuanced and complex beings they are. Nadia similarly reflects on how her role now in her family remains unchanged from her childhood:

> I have always been kind of negotiator, the middle one, the one that’s tried to make everyone talk to each other. [N10]

There is a possible double meaning when Nadia calls herself “the middle one”; she is both the middle child in the family and feels put in the middle of sorting out family disputes or disagreements. Sarah, similarly, feels she has to sort things out when there has been a breakdown in communication in her childhood family:

> No-one says sorry in our family and nobody knows how to apologise. And, nobody can sit and have a conversation about the thing that’s annoyed them, without absolutely exploding, so they won’t do it directly, they all come into me, to initiate the peaceful, making amends…why is everybody expecting that of me? [S9,10]

Like Nadia, Sarah clearly feels frustration at her family’s expectation that she will sort things out for other family members. It is noteworthy that she asks why everyone is expecting this of her, rather than asking why she is expecting this of herself. There is a sense of things being left unsaid for fear of people “exploding.” Note that Sarah mistakenly says “they all come into me” instead of “they all come to me”, unintentionally revealing just how intrusive this is for her, so much so, that she unconsciously feels they are invading her very being. There is a sense of her feeling *their* anger and frustration being placed within *her* body and the explosion then happening inside her.

Frustration and acceptance of parents' limitations. This subordinate theme explores feelings of frustration from the participants about how things could, or should, have been dealt with in relation to their brother or sister with SMI. It also examines participants' understanding around their parents' experiences. Annie reflects on her mother's handling of her brother with SMI:

> I find that frustrating sometimes with my brother, because she won't react to what my brother has done. Everything is how it's made *her* feel and I think to some degree I can separate my brother's behaviour, some of it is very much rooted in mental illness, and some of it isn't. I find that some of it is just his personality and his choices that he makes. He is an adult and he is responsible for those things and I think my mother lets my brother off the hook with everything for fear of upsetting the applecart and triggering the mental health issues. I think you can have expectations about how somebody behaves in your house without that being anything to do with their mental health issues. I think in a way he's got off quite lightly with not thinking about anybody else other than himself and I think my mum has definitely facilitated that. [A8]

Annie's frustration here is palpable; her mother's reluctance or inability, to make her brother think for himself has perhaps left *Annie* feeling that she to think of everything. Again, there is splitting in evidence (McWilliam, 2020) with Annie trying to separate out her brothers' behaviour as being either rooted in his mental illness or his personality and by her use of the words "everything," "anything" and "anybody." Annie wants her brother to be held accountable, even if that means "upsetting the applecart," so that, he himself, has to, metaphorically, pick up and restack the apples. There is a sense of Annie feeling that her mother is stopping her brother from learning how to think of other people, respect their needs and ultimately, to grow. Kelly, whose brother has suffered from SMI since he was very young, also feels her brother's difficulties were not helped by her father's reactions to them:

> He [her father] has protected my brother and I so much from any pain, we don't know how to deal with it. That's how, that's how I feel [brother]'s problems started. It's interesting actually, um, just like, just like a simple thing with [brother] was, every time my brother got arrested for one thing or another, my Dad would be the one there sorting it out, he'd be like "oh no, no, no" even taking the blame for some points, you know? Um, just this whole, just the shielding of like, cos sometimes you've got to feel the pain to, you know, to learn. [K11]

Kelly feels her father was overprotective, effectively "shielding" her brother both from emotional pain and from the police when he was arrested. Kelly refers to her father sorting out her brother's arrests as "a simple thing," highlighting, perhaps, just how complex some situations were within her family unit. She feels that her father's desire to "shield" her brother, a word meaning to "protect from a danger, risk or unpleasant experience," may well have contributed to his difficulties. It is noteworthy that there is no mention of whether he may have contributed to hers. There is a sense here of Kelly having felt the pain and her, perhaps, still feeling it now; her doing the learning, instead of her brother. Owen, similarly, feels frustration at the lack of consequences that were put in place around his sister's incredibly challenging behaviour:

> Mum says "well look you know what it's like, you always want to look after the weakest and most vulnerable." …and she was like, "I'll forget about that in a few days' time." I'm thinking well, that's why she's still doing it! That's exactly why she still does it because there's no consequence, it's like dealing with a little child. [O11]

His mother seems to be appealing to Owen's understanding as a parent himself, when she says "you know what it's like" and he does, indeed, respond in a parental way "it's like dealing with a little child.” However, the way he feels his sister should be parented is clearly at odds with how his mother feels she should be parented and the frustration is clear. Owen feels the need for his sister to have consequences and this brings to mind the consequences Owen himself has suffered as a result of his sister’s behaviour. Owen also reflects, however, on the cost of his sister’s SMI on his mother:

> I genuinely feel desperately sad for my mum because she’s always been the sweetest, nicest woman to have to deal with that and Mum kind of is a real worrier so I know that she would have lost thousands of hours of sleep just worrying about [sister] and then possibly worrying about me and the effect that [sister]’s having on me in those days…I feel less sorry for me than I do for, for my mum. [O25,26]

There is more evidence of splitting here (McWilliam, 2020) as Owen describes his mother as the “sweetest, nicest woman.” He is keen to stress his understanding of the difficulties his mother has faced and the concern he feels for her, above any pity he has for himself. Like the other participants, Owen has seemingly not developed an ability to relate compassionately to himself, it is the “cost” to his mother that causes him significant upset. He is acutely aware of the “thousands of hours” of sleep his mother will have lost worrying about his sister’s SMI but note how tentative he is when he says his mother may “possibly” have been worried about him as a child too and the effect his sister may have been having on him. Like Owen, Jane also seems be very aware of the cost of her brother’s SMI on her mother. She talks of how this has impacted her mother’s ability or desire to connect with others:

> She’s tried to disconnect from as many people as she possibly can at the moment, well, over the last few years, I think it's with my brother. I think she's ashamed of what's happening, or she just doesn't have the energy for any relationships. [J13]

Jane wonders whether it is because her mother feels ashamed of her brother or simply a lack of energy that is making her disconnect from those around her, perhaps metaphorically, pulling the plug on her relationships in order to save as much energy for herself and their family situation, as she can. Nadia also reflects, with some sadness, on how hard it has been for her parents; in particular she talks of how attitudes to mental health were different when she was growing up and how the stigma and lack of understanding would have left her parents feeling isolated and stressed while dealing with her brother's SMI:

> If it were to happen to us now we would have so much help and there'd be that much more understanding and it wouldn't be such a stigma to talk to people about it. Whereas 30 years ago I imagine there was a huge stigma and they didn't really have any help and no one really knew and understood what, you know, what they were going through. See, so it's a lot, I think a lot of the arguments were just because they felt totally out of control…I think it just caused a lot of angst and stress. [N31]

Nadia holds that the stigma around mental illness at the time she was growing up will have impacted her parents, potentially silencing them and, perhaps, blocking any help that may have been available, if, indeed there was any. Her language here is, however, very minimising. She moves quickly away from "us" (considering herself as well as her parents) to "them" (her parents); Nadia, like both Owen and Jane, is seemingly more able relate compassionately to her parents than to herself. Note too, her use of the word "just" when she is actually talking of how her parents "felt totally out of control" and again when she talks of them experiencing "a lot of stress and anger." It is also noteworthy how much all of the participants talk about their parents, in a way that parents normally talk of their children.

The “Me”

Under this superordinate theme there are three subordinate themes:

- Conflict avoidance and eruptions

This theme examines how the participants deal with conflictual situations, the emotions it brings up for them and their associated behaviours.

“I don’t like conflict…I think generally I will be calm, calm and calm and then I blow.”

- I can’t say “no”

This theme examines how the participants respond to requests to help and how this may impact their lives.

“I do try and keep everything, everyone together…that’s my problem, I can’t say no.”

- Oversharing

This theme explores participants’ sense of regularly feeling they have shared too much of themselves with others.

“I feel like I put myself out there a bit too soon. I think, why did I say that?”

The second superordinate theme explores what Mead (1967) describes as the “socialised self” of the participants. The participants observed how others responded to them as children and, through that, gained an understanding of who they are. Their “Me” was learned through their interactions with others and their attitude towards them, attitudes which were internalised in their self. The subordinate themes in this section, therefore, are all in the service of being The Stabiliser.

Conflict avoidance and eruptions*.* In this subordinate theme, the focus is on the participants’ understandings of their processes around conflict and their perceptions of their resulting behaviour. Nadia reflects on her desire to avoid arguments with her husband:

> I withdraw, yeah, so think probably we don't argue because I avoid arguments as well. It, it would all be mental, it would all be in my own head. I'd be having the arguments and the discussions in my head rather than actually with him. [N18]

Note Nadia's use of "all"; "it would *all* be mental, it would *all* be in my own head" again using extreme language and indicating dichotomous thinking (McWilliam, 2020). She talks of actively avoiding arguments with her husband. When she states it is all "in my own head" there is a sense of her somehow being dismissive of her process, even the use of the word "mental" with its pejorative second meaning, highlights her belief that she may be making more of things than she should and perhaps this is *her* mental health problem. She finds it hard to put words to her feelings and goes on to share that this also happened to her when she had an issue with someone who helped look after her children a few years ago:

> I used to always have this dialogue going on in my brain and yet never actually verbalise the flipping thing! I never actually, so it was almost like I was having the argument or the conflict in my brain, making it worse, imagining what it could be like, but in reality, it probably would never have been anything like that, but I never had, never was able to verbalise what the problems were. [N37, 38]

Nadia feels incapable of saying what she wants to. Her irritation with herself is clear, as is the frustration she feels as things build up inside her in response to her loud inner dialogue. Verbalising what she is thinking feels, at times, impossible for her. Note, once again, her use of the word "always" and "never," the latter of which, she uses no less than four times within the quotation. It is also interesting Nadia uses the word "reality," a word used by both Kelly and Owen when they too are comparing what they are thinking to what is actually happening. It is as if they know what they are imagining does not always fit with reality but they feel unable to change it.

The inability to speak up, feeling silenced by overwhelming emotions, is something Sarah also experiences; she reflects here on what happens to her when she has a disagreement with her husband:

> If we have a disagreement, I'm the quiet one, and he will just sort of vent and rant and, and I hear it, I hear it, I hear it and almost can't put into words how I'm feeling at that moment in time, I have to go away and think about it, I don't have the words or I feel overwhelmed by my reaction to it, and it stops me from then articulating and saying how I feel. [S12,13]

Sarah's embodied response feels totally overwhelming and leaves her unable to articulate anything at all. The repetition of "I hear it" is interesting. In common with many of the participants, Sarah had to do a lot of "hearing" as a child and, perhaps, became good at blocking out the "rant" by separating herself. Indeed, this could be her way of getting the space and time she needs to deal with what is happening. It is easy to imagine her putting her hands over her ears while she says this because the overwhelm is palpable; she is rendered speechless in the midst of the disagreement and is acutely aware of her inability to show or express her feelings. She also talks of, at times, physically removing herself "I have to go away and think about it," which is reminiscent of when, as a child, she would retreat to her bedroom with her cat. She reflects more on how conflict makes her feel:

> If [husband] shouts I can't bear that, it just sends this physical response into my body…I don't cope well with conflict at all, I'm very conflict averse. Even, you know, a healthy disagreement. I sort of, I didn't ever witness that growing up, it was just rage. [S11,12]

Sarah vividly captures here how her husband shouting "sends this physical response" into her body; her husband's voice, when raised, feels intrusive and forceful and leaves her feeling powerless in the face of it. Note, again, how she talks of the shouting sending a physical response "*into* my body," almost as if the anger is being forced inside her, just as she feels it is by her childhood family.

Owen, also, highlights his fear of conflict:

> I was always very wary of any kind of confrontation, be it raised voices or just being challenged or anything at all which may well have stemmed from that toxic environment where there was so much shouting and abuse. [O13].

Owen's fear of conflict, triggered by either "raised voices or just being challenged," is a clear legacy from his childhood and highlights just how hypervigilant he remains to any possible risk of escalation. He remembers his home environment as "toxic," the definition of which is "something very harmful or poisonous." When Owen states how his wariness "may well have stemmed from that toxic environment" it brings to mind a poison he has had to swallow, something that he was forced to take and something that still lives on within him. There is a sense of this toxicity creeping into his adult life, impacting him and, at times, silencing him, in the face of potential conflict.

Interestingly, there are times, when Owen moves from being passive into being actively aggressive; he talks of how things occasionally make him "flip" and how in the past "I might have kicked something or lashed out at something." [O18] This is reflected in some of the other participants narratives. Nadia also reflects on how she can suddenly snap and she reflects here on a recent eruption she had:

> If I'd been able to be assertive I would have said before it got on top of me, you know, "[father in law], you need to leave, you need to leave me to do this,'' so I would have been able to say something to, but it just got worse and worse and then in the end I snapped, totally wrong, that was my problem…if I'd been more able to

> be assertive then I would have, a situation like that wouldn't have happened, I would have been able to just kind of stop it. [N33, 34]

Nadia is self-critical around "snapping"; highlighting what she sees as her inability to be assertive and her subsequent frustration with herself when it finally comes out in what she feels is the "wrong" way. Note how she chastises herself for being "*totally* wrong," another example of the extreme, binary language (McWilliam, 2020) which does not allow for a compassionate understanding of her ways of dealing with such a complex interaction. In addition, she carries the fantasy of having great power, or omnipotent control (McWilliam, 2020), over the situation, "if I'd been more able to be assertive…that *wouldn't have happened*." Like Nadia and Owen, Annie feels she avoids conflict and does everything she can to remain calm but can also eventually "blow":

> I don't like conflict, I can have, I can have arguments with my family but I never argue with anybody else, and I don't like raising things that are uncomfortable, with other people." [A16] "I'll suddenly blow. I think generally I will be calm, calm and calm and then I blow and everything comes out and everybody's like, "Ooh, where did that come from?" [A25]

Again, we can see the extreme language in the use of the words "everything" and "everybody" indicating the all-or-nothing thinking that is so prevalent in the participants' narratives. Annie clearly finds arguing uncomfortable and something she simply won't do with anyone outside the family, but within the family she can "blow." This choice of the word "blow" is interesting as it has multiple meanings; the focused outbreath, the hitting of something (or someone) and explosions or eruptions. In addition, the repetition of "calm" gives the sense of Annie willing herself to stay in this state for a considerable period of time before "blowing". There is a sense of a dormant volcano that everyone forgets has the ability to erupt. When Annie does "blow", she seems to be less self-critical of her actions than Nadia and, instead, experiences frustration about being made to feel she should, somehow, handle things differently:

> Why do I always have to be the one that is sensible and dealing with things in a grown-up way? Why can't I be completely irrational and throw my toys out the pram? How don't I get permission to have a tantrum? [A24]

Annie explicitly questions why she has to deal with things in a "grown-up" way. Note, too, the language around how she'd like to be allowed to behave; to be "completely irrational", throw her "toys out the pram" and "have a tantrum". These phrases vividly capture the ways of expressing anger that were, in all likelihood, not possible when she was a child; there is a sense of her never having had the opportunity to be anything other than "grown-up." Indeed, like the "good" child, there is a sense of her still waiting for permission. This is the cost, perhaps, of having to grow up too quickly and be the child her parents needed; the child who did not demand too much and who did her best to ensure they did "not have to think of me really." [A2]

Like Nadia, Annie and Owen, Jane also tries to avoid conflict and when she does experience it, the emotions around the situation build up inside her:

> Jane: I really don't like conflict, I try to avoid it, just bottle it up. When I'm angry, probably quite a few passive-aggressive (laughs) um, things go on.
>
> Interviewer: And what sort of things, what would that look like? Your passive aggression, what would that look like?
>
> Jane: Tidy the kitchen in a passive-aggressive way (laughs). Sometimes it comes out and I have to hit something, like a pillow, or the wall. [J21,22]

Jane laughs at herself for being passive-aggressive and yet, when in a conflictual situation, she experiences a huge amount of unexpressed frustration and anger. Again, this is a repetition from her childhood family where she clearly learnt the safest thing was to be passive, to not express her anger or frustration but, instead, keep it inside. It is noteworthy that, even in anger, she is doing what a “good” girl would do and is cleaning the kitchen. Jane goes on to share how, after an argument with her partner, she does everything she can to placate him and make everything better:

> If he’s angry with me, I'd just try to like, take the blame for anything and then make him feel better, even if it’s not my fault. [J23]

This vividly highlights the need Jane has for the conflict to pass, for her partner to “feel better” and the lengths she’ll go to in order for this to happen, even if this means taking the blame for things which are not her responsibility. It would appear that her desire for her partner to feel better is so much more important than her own need to be heard. Indeed, like many of the participants, Jane can only feel alright if everyone else is alright and, because of this, the “bad” feelings have to be kept hidden and buried deep inside, just as they were when she was a child. Kelly also talks of the discomfort she feels in the face of conflict and her desire to make things better:

> I find it [conflict] very uncomfortable, very uncomfortable, it’s not something that naturally, I’ll tell you how I, yeah, so, I don’t really, how do I deal with it? I think I deal with it, as in, talk, talk but then I come away feeling insecure, vulnerable, feeling I’ve messed up, um, and I want to fix it. Now what that fixing is, I don’t know, it’s like I wish there hadn’t been the conflict. [K15]

Kelly clearly experiences conflict as incredibly difficult, note that she repeats twice that she finds it “very uncomfortable” stressing just how deeply it affects her. She recognises her desire to fix things but her emotional responses leave her feeling “insecure,” “vulnerable” and that she has “messed up.” The vulnerability, disallowed in childhood, can seemingly still not be borne in adulthood. In addition, the unconscious pretence of control, driven by her omnipotent defence mechanism (McWilliam, 2020), is revealed by the sense of responsibility she carries that she, alone, has to somehow “fix it” and even that she can, somehow, go back and stop things from happening. Kelly reflects on how this stops her from being assertive in her relationships:

> The fear is there that I might say the wrong thing. It sounds ridiculous when I say it out loud. You know, that I might say the wrong thing and that will cause conflict. This is how I would feel. I would be worried that I would say the wrong thing, that it would then cause conflict, it would then cause distance, that would then end the relationship. I would literally catastrophise it that much. [K46]

Kelly experiences conflict as incredibly threatening to a relationship to the point that it stops her from feeling able to be assertive with partners; her catastrophising literally stops her from having a voice in her relationships when it comes to communicating about what is acceptable in her world and what isn’t. In addition, we can, once again, see the omnipotent defence mechanism at work (McWilliam, 2020) when she twice refers to her fear that she would “cause conflict” simply by saying the “wrong thing.” As a child, this defensive control belief might have created a sense that she had the power to cause or stop things by changing herself: moulding herself into what she believed others needed her to be and saying what she believed others wanted, or needed, to hear, rather than making the “catastrophic” mistake of saying “the wrong thing.”

I can’t say “no.” This subordinate theme explores the participants’ experiences of saying “no” in responding to demands made on them by others and situations where they may feel they should offer their time and energy to others. Nadia reflects on what she sees as her inability to say “no”:

> I do try and keep everything, everyone together and everything working and you know, take on, that’s why I think I should go on an assertiveness course, just to try and be able to say “no,” because, that’s my problem, I can’t say “no.” [N32]

Once again, Nadia uses language that indicates binary thinking (McWilliam, 2020); “everything” and “everyone.” There is a sense that saying “no” would be divisive and yet Nadia is clearly conflicted; she recognises trying to “keep everything, everyone together and everything working” doesn’t, work for her as, ultimately, this causes her a “problem.” Interestingly, though, she sees this as both a current, and an ongoing, issue. Similarly, Annie also reflects on her inability to say “no” and the resulting over commitment she experiences:

> I quite often find myself stressing about the fact that I haven’t seen people or whatever and that we haven’t seen so and so for so long or whatever. And it doesn’t always come into my mind whether I actually would like to see them or whether that is a relationship that is worth investing in. And I’m trying to think more like that now, actually, because I’m constantly too busy trying to do too many things. I offer to do things all the time that I haven’t got time or don’t necessarily want to do (laughs) because I don’t want to say “no.” I don’t say “no” enough to all sorts of things. [A16]

Like Nadia, Annie uses extreme language indicating the binary, all-or-nothing thinking (McWilliam, 2020), such as stating she is “constantly” and “all the time” too busy trying to get things done. Note, though, how her language indicates some confusion about how total this really is when she says they are things she doesn’t “necessarily want to do.” Annie clearly, however, feels unable to say “no”, resulting in her feeling over-stretched and stressed. She notices, and laughs at, her lack of thinking about whether she actually wants to invest her time and effort in a particular relationship or specific situation, “it doesn’t always come into my mind.” There is a strong sense that she operates at a very automatic, unconscious level in putting others needs before her own; she feels she must step forward, offer to help and be willing to do whatever is needed. Kelly, also, reflects on her inability to say “no”:

> I worry about what people think a lot, I’m a bit of a people-pleaser, I do worry about what people think. I don’t like people thinking bad of me or anything like that. And that’s why I would also say, be very, “yes” to things, I’d say “yes” to something before I’d even thought about it…I’m keen to please, eager to say “yes,” when ultimately, I then end up letting people down and, of course, that’s worse. [K53, 54]

Kelly seems to use the words “keen” and “eager” as if they are *positive* positions to take and yet, by rushing to say “yes to something before I’d even thought about it” she fails to give herself any time to think about her own needs. Note too, the clear assumption that if she does not do what people want or request of her, they will automatically think “badly” of her. It is as if there is only “good” and “bad” available and “bad” is to be avoided at all costs. Indeed, she believes that not doing what they need, or want her to do, renders her no longer “good” or “pleasing” to them.

Oversharing. This subordinate theme allows us to explore some of the participants’ tendency to overshare their personal information, or feelings, with others, even when it is not requested from another. Nadia reflects on her tendency to overshare:

> I would have a problem being an over-sharer rather than an under-sharer. I, my friends know all my problems, think sometimes “gosh, why did I tell you all about stuff?’’ [N25]

Nadia is puzzled about her tendency to share “all” of her problems with others, interestingly, labelling this oversharing as a “problem” in and of itself. It is also interesting that there are only these two options for her, to be an “over-sharer” or an “under-sharer,” another indication of her binary thinking (McWilliam, 2020). It feels as if some external other determines the “over” or “under” rather than her deciding herself what she wants to share. Owen also reflects on his openness with others:

> I’m sort of very open with, you know, even kind of strangers, so there was a guy, a business consultant that came into work who was kind of mentoring the different heads of departments. Quite early on I was very open with him about my sister and, and quite in-depth, you know? [O15]

Owen does not seem upset about being so open but, like Nadia, seems quite puzzled by it, especially as it was with someone he didn’t know, a relative “stranger” to him, as he points out. Annie too has a sense that she over-shares:

> I just think sometimes I overshare with people that I don’t know very well, weirdly because I want people to feel comfortable to tell me things. I almost feel like I try and fast-forward a relationship and I’ve become conscious of that in the last couple of years, that I feel like I put myself out there a bit too soon. I think, “Why did I say that? They didn’t need to know that.” [A21]

Annie is critical of herself for what she sees as oversharing, note that she even uses the word “weirdly” to frame her explanation for this oversharing as wanting people to feel comfortable to tell her things. It is noteworthy that her benchmark is what the other needs, rather than what she wants, “they didn’t need to know that.” As we know, however, Annie was told by her mother she wouldn’t have known what to do without her, so, in all likelihood, Annie played a pivotal role in making the people in her family, and the difficult situations they found themselves in, more comfortable. This was her way of being loved so she may believe love has to be paid for by sharing. Indeed, the need to “fast-forward a relationship” feels like a desire to secure more love for herself; perhaps she never felt there was quite enough left over for her when she was doing her best to not put her “head above the parapet.” [A2]

The “I”

Under this superordinate theme there are three subordinate themes

- It’s ridiculous

This theme focuses on behaviours and feelings the participants struggle to understand.

“I still can’t quite work it all out in my own head”

- Anxiety and rumination

This theme explores the emotional legacy of growing up in a sub-optimal environment.

“I literally get myself in a cycle of worry…I’ll always look at the worst-case scenario first.”

- A place of my own

This theme explores the participants’ experiences and processes around commitment and what happens for them when things don’t go well between themselves and their partner.

“Whenever I get stressed about anything, I just imagine being in a little cottage on my own.”

This third superordinate theme explores the active aspect of the person, or as Mead (1967) describes it “the response” to the “Me.” As discussed, others attitude to us become internalised in the self to become the “Me.” This section, therefore, explores how the participants respond to their “socialised selves” and, how they make sense of, and respond to, their perceptions of themselves.

All of the subordinate themes represent the participants’ ways of responding to the “Me” they each hold. The struggles they have, at times, to understand their ways of being, the anxiety they feel and their tendency to withdraw when things go wrong, *all* stem from their response to the attitudes of others that have been internalised in the self to become the “Me.”

It’s ridiculous. This subordinate theme explores the behaviours or feelings the participants notice in themselves that don’t always make sense to them, that seem strange or inexplicable and yet significantly impact the choices they make and the ways they act. Nadia begins by talking of her frustration at her perceived inability to be assertive:

> I’m not assertive at all! Which is really bizarre because I’m a [profession], and so if I was on the phone negotiating or you know, in a room negotiating, I could be incredibly assertive, but I can’t on my own behalf, I can’t say anything, I just get upset and get like you know, like shaky and, yeah, so no, I’m not assertive at all! [N33]

There is a sense here of Nadia’s bewilderment at her inability to be assertiveness in her personal relationships, despite being able to be assertive at work on behalf of others. This bewilderment is both striking and poignant; Nadia spent her childhood doing things on behalf of others and clearly uses this skill successfully in her career. When, however, she feels the need to be assertive for herself, she clearly has an incredibly visceral response and finds herself withdrawing and feeing unable to speak. Nadia feels both bemused and exasperated with her inability to respond. Sarah also struggles, at times, to understand her behaviours and here she reflects on her choice of partners before she married, and her confusion as to why she allowed herself to be treated the way she did:

> I’ve had a couple of quite unhealthy relationships where, clearly, I was being taken advantage of and treated quite badly and I just didn’t, I didn’t do anything about it…I kept going back to him and he was a shit. I shouldn’t have been in that relationship.

> But I didn’t value myself enough or I just, that was the way I grew up. I don't know. [S13]

Sarah’s language here is tentative, “I just” and “I don’t know.” She is not sure how much she can trust her thoughts or understandings about why she may have stayed in these unhealthy relationships. There is also another indication of binary thinking when she considers whether it is her lack of valuing herself or the way she grew up that made her stay, seeing them as distinct and separate reasons, rather than connected and interwoven. She also talks of how she can find it hard to trust her husband to look after their children:

> I think it’s trusting [husband] to be a good enough dad, for me. Yeah, I’m going away tomorrow, and he’s going to be looking after the girls. I’ve basically made myself, because we had a bit of a bust up at the Bank Holiday weekend, I’ve made myself go, I just need some time to myself, I know that, but I feel really anxious about doing it, and it’s not [husband] who I’m anxious about. When I really sit and think, why I am anxious? It’s just me leaving the children with a man, I think, I don't know. I still can’t quite work it all out in my own head. It’s so ridiculous, that’s what my childhood has done to me. It makes it really hard just to relax about really normal situations. [S27]

Sarah questions whether her husband will be a “good enough dad” for her. She is explicitly referring to his role in their children’s lives but there is a sense that part of her is also wishing he might take a paternal role with her, make her feel safe and looked after, and, perhaps, make up for what she lacked in her own childhood. Interestingly, her husband is 15 years older than her. Sarah clearly struggles to understand her anxiety and seems to chastise herself for being “ridiculous” and unable to “relax about really normal situations” and yet, her childhood was far from normal and she did not always feel safe or secure within her family home. Kelly also questions her choice in partners and what she may have been seeking from them:

> I had an older boyfriend as well who was 17 years older than me, did I go into that thinking he could look after me? I don't know. [K4] They've all [previous partners] been 10 years plus [older], like they, um, superior isn't the right word at all; Secure? Safer? Physically safer? [K25]

Kelly openly questions her tendency to be drawn towards older partners and expresses curiosity about whether she wants to be looked after. Like Sarah, Kelly may be seeking what she lacked in her childhood when she grew up with her brother with SMI. However, through therapy, Kelly came to realise these older men, who seemed to be "secure" and "safer", also tended to be controlling. Kelly, like so many of the participants, may have been unconsciously looking for more "available" versions of their own parents. Here Kelly shares what came up for her in therapy:

> She was a very experienced therapist, um, she used a word though that was very, like, from what I was telling her they're all quite controlling as well, um, but that's so not me, that's so not me. That's so not me…but everybody did want it their way, their way or nobody's way, yeah. [K27, 28]

Kelly uses extreme language such as "all," "everybody" and "nobody" indicating the binary thinking (McWilliam, 2020) already highlighted in so many of the participants narratives. Note, in addition, Kelly's repetition of the phase "that's so not me" suggests she is still struggling to reconcile that part of herself with how she consciously sees herself as opposed to the unconscious processes that may be playing out. Indeed, this "not me" stance has a feeling of defensive passive aggression and highlights the confusion she, like other participants, has about the “I” and the “Me.” She is responding from the “I” to the attitudes of others that have been internalised in the self to become the “Me.”

Anxiety and rumination. This subordinate theme allows participants’ own mental well-being to take centre stage. Interestingly, and poignantly, this theme came up late in both the interviews and the analysis; a reflection, perhaps, of the participants’ lives and the lack of focus on their own mental well-being throughout. This theme, therefore, allows us to explore the participant’s own mental health together with their way of managing these challenges. Kelly reflects on her regular bouts of anxiety, which began in childhood:

> It was like, “Oh, well, Kelly’s alright, she’s fine.” But in reality, I was having all this inner anxiety that I still suffer with daily. I mean, it’s not debilitating, I crack on, I’m very aware of it, I try not to project it. [K49]

Kelly’s anxiety was clearly not acknowledged by her childhood family when she was younger. Indeed, her family apparently seemed oblivious to her challenges; being told she was “fine” perhaps left little room for Kelly to be anything other than that. Whilst she acknowledges she suffers with anxiety on a daily basis, the way she talks about it feels dismissing and, almost, punitive, “it’s not debilitating, I crack on.” It feels as if there is little room for self-care or recognition of any options available if she doesn’t want, or doesn’t feel able to, “crack on.” The use of this phrase is interesting, “crack” also means to break; perhaps Kelly fears that if she doesn’t “crack on” she may, instead, break or crack up? Note, once again, the reference to “reality,” perhaps revealing an awareness that the “I” and “Me” selves are not real. It is also interesting that she tries “not to project” her anxiety onto her son, perhaps because, at some level, she knows that it was projected onto her and does not wish to repeat that. Kelly expands on how her anxiety manifests in her life:

> I literally get myself in a cycle of worry. [K50] I'm not a negative person but I'll always look at the worst-case scenario first. [K53]

The hypervigilance Kelly experiences is palpable; the "cycle of worry" feels continuous. It is noteworthy that, even when she is talking about her tendency to look at the worst-case scenario first, she feels the need to state she is not a "negative person." It seems she can't give herself permission to be anything other than positive. Importantly, though, this hypervigilance and tendency to look at the worst-case scenario first, shows her need, still now, to prepare for the possible catastrophe that may arise because no-one else could, or would, manage it. Like Kelly, Sarah acknowledges anxiety is a big part of her life:

> I normally exercise as a way of managing my anxiety or if I'm feeling a bit discombobulated, that's my thing, take the dogs for a walk, go swimming or whatever, that's how I've always dealt with everything. When I got to uni, I just used to run and run and run, and that really was my way of clearing my head, but only ever really, puts a sticky plaster on the feeling doesn't it for the short term? It's still there, you're not fixing it, you're just feeling better, fixing the symptoms that you're feeling at that moment in time. [S31]

Sarah clearly uses movement and distraction to manage her anxiety. When she shares how she would "run and run and run" when at university, there is a sense of constant motion, almost as if she was trying to outrun her emotions and the accompanying bodily sensations. It feels very dangerous to sit still, as if the sanctuary of her bedroom has become too oppressive. Indeed, there is still a sense of her still running from her anxiety, just using different methods now to do so; the "sticky plaster" is just taking a different shape to cover past trauma. She talks more about how she experiences anxiety:

> It’s a physical anxiety there, that’s, I live with that feeling of, and it’s a feeling before I can even put words to it. [S36]

Sarah’s anxiety is a very embodied, constant way of being; the “sticky plaster” helping, but clearly not facilitating full healing. Annie too, experiences anxiety and talks of her tendency to over-analyse things:

> I do think about things for a long time afterwards and unpick them. What did so and so mean by that? And I over-analyse things. [A25]

Annie talks of wanting to “unpick” things and “over-analyse” interactions she has had. There is a sense of her unpicking stitches that have gone wrong and wishing she could put them right as she questions and doubts what people might have meant in various situations. Again, there is a feeling of hypervigilance; she is on guard around how people are feeling about and towards her. There is also a sense here, again, of the omnipotent control defence (McWilliam, 2020): that people’s feelings, and various situations, could be changed by Kelly changing herself.

Jane reflects on her tendency to experience overwhelm and depression when she feels vulnerable for any reason:

> It’s not very easy at all [to show vulnerability], no. I tend to go into a bit of a, like a depression or like a, I just feel like I want to go to bed and don't want to get out again. [J16]

Jane feels a strong desire to withdraw when she feels vulnerable or low. Like Sarah, she feels the urge to retreat to her bedroom and, once in her bed, not “get out again.” She reflects on whether she allows her partner to see her vulnerability:

> A little bit, maybe. You just have to kind of, I think it's just the fact that you just have to keep going and just, something that I was the same when I was younger, so you just have to keep going with things and not really show it. [J21]

Just as she did in her childhood, she clearly feels she has to keep going and not show those around her how she is feeling. This is similar to Kelly's sense of needing to "crack on." Indeed, the statement "you just have to keep going" is also similar to Kelly's sense of there being no viable option other than to keep doing what needs to be done. This is something that is so striking all the way through this analysis; there is no sense that things could have been different.

A place of my own. This subordinate theme allows exploration of the participants' internal thought processes around committing to relationships, as well as their thought processes when there are difficulties within their romantic relationships. It goes on to explore the strategies the participants' put in place, either practically or emotionally, that allow them to manage both of these situations. Sarah reflects here on when she met her husband:

> When we met he was far more, "Come on let's" and I was like, "I'm just going to keep my place" and I kept renting my own place, thinking at some point he'll be a shit and I'll be glad I've kept my, my little flat. [S19]

Sarah seemingly carried an expectation, when they first met, that, "at some point," she would, inevitably, be let down by her husband. Interestingly, she wanted to keep the safety net of her own "little flat"; there is a sense she needed to feel, just as she did as a child, that she could escape if she needed to. This desire for a safe haven still persists now when things are difficult between them:

> Whenever we have hiccups in our marriage, I don't ever think, "Oh, god, I just want out of this, because I want to be with somebody else." I often think, "I just want to be out of this and I just want to be on my own." [S11] Whenever I get stressed about anything, I just imagine being in a little cottage on my own with the kids and my dogs and never actually having to have a relationship because it's just too bloody complicated. [S29]

Sarah's way of coping with marital "hiccups" is through visualising an alternative, single life elsewhere; still with animals as her own diversionary objects, albeit, this time with her dogs rather than her cat. Note that "hiccups" describe bodily spasms, with unknown cause, that we can feel are intolerable and try to control. Given that they also mean "temporary or minor problems or setbacks" it is interesting that "hiccups" trigger thoughts of the end of her marriage. Perhaps, though, the knowing she can go, enables her to stay. She seemingly does not see a different relationship as offering any kind of refuge but rather, her refuge would come from having "a little cottage" on her own. Life without a relationship represents a far less stressful and less complicated option to her. She reflects on how hard she finds it to be vulnerable:

> I think I put up so many walls around me. [S22]. I find it quite difficult to be vulnerable on a day-to-day basis with my husband, I keep my guard up a little bit. [S33]

Clearly, Sarah's "walls" go beyond the emotional walls she puts up, to the physical walls of her own flat or her imagined cottage: both represent places she can escape to and be safe in, if things don't work out. The "guard" she keeps up implies a need to protect herself; to be wary and watchful. This feels like a part-self that may have been split off to protect the victim-self. It is noteworthy how all of the participants seem to split up and configure the self into certain parts that seemingly do different jobs:

> I don't want to be a victim about it [her past], I just want to get on with it, you know. I'm just happy when I'm on my own, and that's just the way, it's shit, but that's what it does to you, I guess. [S37]

Despite recognising it's "shit," Sarah holds a belief that, for her, being in relation with another means compromising her happiness. Note that Sarah also used the word "shit" earlier both when referring to her previous partner and how she believed her husband may behave. Interestingly, like Sarah, Nadia also talks about a place she still owns:

> My flat, I still kind of, I still, even though it's not, it's, well it is in my name still. It's my bolt, my running away (laughs)…It's a one-bedroom tiny house! (laughs) and it's actually still in my maiden name. I'm like "Keep it in my name just in case I need to run!" But no, it's not because I'm even concerned that I would ever need to do that! [N15,17]

It appears to be important to Nadia that the house she owns is still in her maiden name and her words, "just in case I need to run!", whilst said in jest, are still striking. Perhaps her different part-selves have different needs. Both Sarah and Nadia have this fantasy and, in reality, kept their own properties when they married. In their language they also both seem to want to "minimise" their properties, both the real ones and the imagined; Sarah's describes her flat as "small," her imagined cottage would be "little" and Nadia describes her house as "tiny." It is as if they are minimising the needs they have. Nadia jokes about her house being her "bolt," one assumes she was planning on saying "bolt hole" and, yet, she does not say more than the "bolt." Bolts, of course, are different to holes; they keep doors locked *and* they keep things held together. In addition, of course, “bolt” is another word for moving quickly away from something dangerous or frightening.

Jane reflects on her difficulties in committing to relationships prior to wanting children:

> I found it difficult to commit to people before that [wanting children], I would often end relationships, I think it was just at the age, it was like, “Right, okay, you need to, if I want children then I have to, I have to do this,” um, before that, I would often end relationships, yeah, all of the previous relationships that I had before that, I ended after about a year, there was definitely a pattern to that (laughs)! [J30,31]

Prior to wanting children, Jane clearly found it hard to stay in relation with another. It feels almost as if committing to a relationship, in order to have children, was at personal cost to herself. It is noteworthy that she, like all of the participants, actively chose to have children, this is, after all, a familiar role to all of them, as parentified children. Perhaps becoming parents gave them all the opportunity to do what they were “trained” to do but, this time, in the appropriate context. Jane goes on to reflect on what she finds hard about being in her current relationship:

> Jane: I just feel like there's not much support there, but I’ve always just done everything for myself. So, it, maybe he doesn’t think that I need it, maybe. I don’t ask for help with anything. [J8] So, if it's something I think that he's not going to like, then I find it difficult to do that [ask for help]. I think, like, he doesn't show his anger very much either, so like, I would *feel* that he was angry, I wouldn't necessarily see that he was angry, but I would feel that he might be angry about it.
>
> Interviewer: So, you will often not ask?

> Jane: Yes. Often. I would often just try and do it myself. I do that all the time (laughs). [J25,26]

So rather than asking for support, Jane tries to do everything for herself, just as she did in her childhood home. This is clearly a legacy from her childhood, she carries a fear of provoking displeasure or anger in the other. Jane, it seems, is on high alert, hypervigilant to the mood of her partner or, more specifically, tries to anticipate, or “feel” when her partner “might be angry” if she were to ask for help. Jane reflects on finding the “noise” of romantic relationships hard:

> I just like peace and quiet. I like to choose what I want to do, I feel like I can develop more as a person by myself, I feel like the relationship is in direct opposition to that. [J38]

There is a sense of Jane having sacrificed the “peace and quiet” she craves, in order to become a mother. She clearly also sees being in a relationship as diametrically opposed to developing herself as a person. Indeed, it feels as if this is a battle for her, almost a fight to the death; herself or the relationship. Kelly, who actively chose to be a single mother, also sees relationships as incredibly difficult:

> I’m fiercely independent, yeah, moved out of home when I was 19. [K3] I just see it [relationships] as hurt, and isn’t that awful? I do though, potential pain, that’s how I see it. [K10]

Kelly uses the word “fiercely” when describing her independence, a word that highlights, perhaps, how important her independence is to her. Indeed, it feels as if her independence is something she feels she needs to guard, aggressively and actively. Clearly, she associates relationships as bringing with them a huge risk of pain but chastises herself for feeling that way. This chastising of self is something all of the participants are very good at doing. She reflects more on why she finds maintaining relationships difficult:

> I have never been able to maintain a relationship, in my mind I have already kind of ended the relationship before it's even had a chance…it's going to go wrong anyway so I'll just withdraw. [K5,6] I just wouldn't commit to anything. I would say the right things but in theory, in my head, I'm thinking, "There's no way I'm going to follow that through!" [K36]

There is a feeling once again of the apparent compliant child "I would *say* the right things" but with the internal rage, shown when she says to herself "*there's no way.*" This is similar to the passive aggression seen in both Jane and Owen. Kelly carries a conviction that she can't maintain a relationship; she clearly believes she somehow ends relationships before they have a chance to become more serious by withdrawing from her partner. This self-fulfilling prophecy is something Kelly has experienced many times. She reflects on the ending of her last relationship:

> It was Easter last year actually, and then one morning I thought, "Well this wasn't, this isn't, this isn't working," so I said to him, that morning, I said, "This isn't working is it?" and he said, "No, I'm not happy". Now, I'm just going to be completely honest as well, I didn't even hang around to even talk about it to be fair, I got my stuff together and off I went and I've never, ever spoken or seen him since. I am very much, that was it, barriers down. [K13]

Kelly had no desire to explore what may, or may not, have been working between her and her partner, rather, it feels as if she wanted to flee from the situation and give herself as much distance as possible. The suddenness and permanency of the ending is striking and yet is understandable if you are holding a belief that relationships are synonymous with hurt. Rather like Sarah's "walls", Kelly puts her "barriers" firmly in place. There is a sense of Kelly trying to protect herself from further pain by not showing vulnerability and, instead, withdrawing and barricading herself in. She herself, goes on to reflect on her avoidance of showing vulnerability:

> I'm just not very good at relationships but I think there's a reason for that, I do and I do believe it comes down to this vulnerability and that I can't, I just can't put myself, I keep saying can't, I don't *want* to put myself in that position…I don't want to be vulnerable. [K17]

Kelly's vulnerability, in common with many of the other participants, seems to have been highly defended as a child, and is dealt with omnipotently as an adult (McWilliam, 2020). She goes from stressing, and repeating, that she "can't" put herself in a vulnerable position to saying she doesn't "want" to put herself in that position; almost as if it occurs to her, whilst talking, that it may be a more conscious decision than she had previously realised.

Surviving and Striving

Under this superordinate theme there are two subordinate themes

- Focus on achievement

This theme explores the participants' ways of being both at school and at work.

"My role was very much the good boy, the one who didn't muck up, who did try to do well at school"

- Independence and capability

This theme explores the participants' sense of how they feel they cope with life, both every day and when things are more challenging.

"If all the shit hits the fan, then I'm the one in there making sure everybody's dealt with"

This last superordinate theme explores how the participants feel their childhood experiences may have positively shaped them and impacted their way of being in the world throughout their lives to date. It explores how the participants see themselves in terms of their abilities, attitudes, tenacity and drive.

Focus on achievement. In this subordinate theme, the participants discuss their perceived roles and attitudes towards school, work and achievement. When Nadia reflects on her roles in life, she brings her work ethic and organisation skills to the forefront of the discussion:

> I've always been quite the hardworking one, always worked hard. [N28] I try and be as organised, I mean, I'm ridiculously organised, and that's the only way I can cope with my life. [N32]

Nadia sees her work ethic as being in place from a very early age, from school through to her work life now. Note how she sees being organised as being "the only way" she can cope: she cannot see another way of being. When she talks about her organisational skills and corrects herself from saying "I try and be organised" to saying she is "ridiculously organised." The use of the word "ridiculous," demonstrates, perhaps, an understanding that this degree of organisation is not really needed or that she may be ridiculed by others, or by herself, for it. In all likelihood, it allows her to maintain her omnipotence by supporting her control fantasy (McWilliam, 2020); a fantasy that allows her to believe she can control her life and everything around her. Nadia's work ethic and ambition have also influenced her choice in partners, here she reflects on her desire for a partner to be as driven and high achieving as she, herself, is:

> I know the sort of man that I like, which is my (laughs) which is [husband] but I don't, so, and I guess I've always gone for like the sporty, good looking guys, high achievers. But the two post-university, the reason we broke up, I broke up with both of them was because they weren't achieving and I was, they just didn't have, like, the drive that I needed them to have. [N2]

Nadia clearly holds drive and achievement as important in life, both in herself and in her partner. Indeed, her partner clearly needs to reflect her own values; perhaps the thought of someone else depending upon her feels intolerable. Sarah, who left home at 18 for university and never moved back, reflects on how her home life influenced her focus at school and her desire to be independent:

> There had just been too many arguments, and I just had had enough, treading on eggshells, just couldn't do it anymore, I actually really wanted to get a good education and I really wanted to go to uni, and I really wanted to earn my own money, get my own house and just be free of needing them for anything, you know? [S21]

Sarah's desire to be "free of needing" her family meant she channelled her energies into her education and into becoming financially free from a very early age. Being independent from her parents was clearly a strong driver for her; the "eggshells" became too painful to keep walking on. She goes on to reflect on the fact that her focus on education gave her much more than economic freedom:

> If I get good A Level results, then I'd get into a good uni, and then I'll get a good degree, and I'll get a good, I was just constantly needing that element of external validation and proof that I was clever enough and able enough, and I could be by myself and be okay. [S23]

Sarah’s focus on her education provided her with a great many things; not just with the promise of economic and practical freedom but also with much-needed external validation, proof that she was clever enough and able enough to survive on her own. This external validation is, of course, also another example of her need to people please; her need for others to be pleased with her in order to feel alright in herself. Jane, still in academia now, also focused on working hard at school:

> I was the kind of the one who was good at school, which no-one else in the family was [J1] I’m well educated and that impacts my kids. [J4]

Jane takes pride in her ability to work hard and achieve academically. She also recognises how her being “well educated” positively impacts her children and serves her well too. There is also an implicit suggestion here that her own parents were not educated enough to positively impact her or her brother. In addition, there is a sense of Jane enjoying this difference between her and her family stating, as she does, “no-one else in the family was [good at school].” Her life in academia clearly continues to be a core part of her identity. The theme of being a hard worker is also felt by Annie when she reflected on how, despite being actively involved in helping manage her brother’s episodes, she is still incredibly conscientious:

> With everything that has gone on with my brother, I’ve never missed a day’s work [A23]

Annie takes pride in being both reliable and hardworking although there is a sense here of felt pressure to be “superhuman” and not allow any vulnerability to show through. Owen reflects on how he was at school and for his parents:

> My role was very much the good boy, the one who didn't muck up, who did try to do well at school…it sounds a bit big-headed but I had lots of friends, I was popular, I was sporty and I made friends that way, and I was the good boy with Mum and Dad…I decided to definitely be normal. [O5]

Owen recognises how his role may have served him well both in school and at home. He can recognise his efforts to do well at school and be "the good boy" are fundamental to his way of being: he still works hard, has good friends and a loving family of his own. It is interesting, however, how being "normal" is synonymous with being "good". It vividly captures his desire to be something entirely different from his sister. It is noteworthy too that he almost apologises for potentially sounding "a bit big-headed" something stemming, perhaps, from his sister during their childhood. He states, "I always got the impression that [sister] was jealous of me and the gap between us was growing and growing." [O5]. Owen's desire to take the opposite position of all-good versus all-bad, perhaps limits his ability to take the "good enough" middle ground, where limitations can be owned and self-compassion and vulnerability can be shown.

Independence and capability. This subordinate theme allows exploration of the participants' sense of independence and capability. It allows for discussion around how they see themselves in terms of decisiveness, problem-solving and coping in a crisis.

Nadia reflects on her ability to be very decisive at home, with her husband, around family matters:

> I'm probably the stronger one, the more likely to say, "I think we should do this" and [husband]'s like, "Right, alright" (laughs) rather than the other way around. [N16]

Nadia clearly feels both decisive and capable around making important decisions for her own family now. It would appear, as a mother, she knows what she wants and voices it;

a reflection, perhaps of this role being familiar to her and something she feels very capable of doing. Indeed, she even feels she is probably the “stronger one”, just as she was at home with her brother with SMI.

Kelly, who left home at 19, reflects on how different she is at work as opposed to in romantic relationships where, as we have seen, she struggles to be assertive for fear of it ending the relationship:

> Funny enough, at work I’m completely different, at work I am the most assertive person ever. [K54]

Kelly highlights this contrast, clearly recognising the difference in her way of being in her personal life and how she is at work. Annie, who also left home relatively early, at 18, also reflects on her independence, citing a trip she took to Australia to bring her brother home after a suicide attempt:

> I think, having branched away and I’m quite practical and I am quite independent. My mum always says my brother’s got no common-sense, whereas I’m great in a crisis. I obviously didn’t enjoy my trip to Australia with my brother, but I was the person to do it, because if all the shit hits the fan, then I’m the one in there making sure everybody’s dealt with, that you’ve spoken to this person. I’m good from that point of view. [A29]

Annie believes her active choice to “branch away” from her family, a term referring “to leaving the main part of something,” has made her more practical and independent than she was previously. She makes it clear she “didn’t enjoy” the trip to Australia but felt she was the only one able to do it. Perhaps, however, this is a way of Annie being able to feel special when she did not grow up feeling she was. This has clearly, also, been her role over the years, she has been the one who has been expected to deal with crises in her family due to her brother’s SMI and she clearly feels she can, and does, step up. There is a sense of pride around being “great in a crisis”. Note too, the repetition of the word “good” when she states “I’m good from that point of view.” Once again, like so many of the participants, she equates being “good” with making sure everyone else is supported and alright.

Discussion

Chapter overview

In this section, the findings from the analysis are discussed and considered in the context of the existing literature. There is also a critique of the methodology and a discussion of the limitations of the study. In light of the findings of the present study, the implications for clinical practice are then explored, as are the suggestions for future research.

Situating findings within the literature

In the introductory chapter of this study, existing research considering the impact on siblings of a brother or sister with SMI, across the different developmental stages, was reviewed. The stages related to childhood, adolescence and adulthood. Unsurprisingly, despite not being explicitly referred to within the interview structure, these developmental stages were each explored by the participants during the interviews, some in great depth. This has provided further, rich data that add to our understanding of the participants’ experiences during childhood and the ongoing impact their childhood has had on their adult inter-personal relationships.

Previous research has found that siblings, as children, felt pressured to be “good” and to always “do the right thing” so as not to add to the parent’s burden (Lukens, 2004; Porr, 2010). In line with this, the participants in the present study, reported a strongly felt need to be “good” and not cause any additional upset or concern to their parents when they were children. The present study builds on previous research by highlighting the different ways this plays out within the family dynamic: participants reported staying out of the way (or, as one participant put it, not putting their “head above the parapet”), diverting attention away from conflictual situations (by distraction or being overly people pleasing) or simply by getting on with things and coping alone. It is, then, not surprising that adult siblings have reported feeling invisible and isolated during their childhood (Lukens et al., 2004).

At the heart of many of the participants’ experiences in the present study is the sense that they did what they could, and still do, to redress the balance within their family structure: to not cause trouble, to work hard, to “do the right thing” where possible. This comes, however, at a personal cost to them; some of the participants report having felt, and continuing to feel still now, pressure to be the “strong” one that can be relied on when needed. This brings with it a sense that they will somehow let down, or disappoint, their families if they are anything other than that. This echoes previous research where siblings have reported experiencing both burden and guilt (Barak and Solomon, 2005; Lukens et al., 2004; Sin et al., 2012; Stålberg et al., 2012).

The present study, however, goes further than previous research in uncovering some of the more complex emotions these siblings experience. There is a sense of frustration in many of the participants’ narratives. This frustration centred primarily around parents not having clear boundaries or setting consequences around their sibling’s behaviour for fear of triggering an episode in them. In this way, many of the participants felt their parents facilitated some of the unacceptable behaviours and, in doing so, did not deal with the situation in the best possible way. There is also, however, recognition that times were different when they were growing up (with more stigma and less support), that their parents did the best they could and that the cost to their parents was, and often continues to be, significant, in terms of stress, anxiety and, often, pressure on their parents’ marital relationship. This echoes the research carried out by Darmi et al. (2017) which found that parents felt profound guilt which resulted in compensation through absolute dedication to their unwell child at the expense of their own well-being. It is noteworthy too that the participants in this present study seemingly found it easier to notice, and highlight, the cost to their parents much more readily than any cost to themselves, something that previous studies have not uncovered.

Previous research suggests that it is highly likely that siblings will continue to experience disruptions in family relationships into adulthood (Ma et al., 2017). In line with this, at the heart of many of the participants' experiences is the sense that they, still now, can be required to negotiate between family members; to sort things out, bring reason to challenging situations and to pull everyone together. This often creates tension within the family system; there is a pressure to play certain roles and to pretend things are different, in an attempt to create the illusion of a "happy family." This study also builds on previous research findings by highlighting how individuals feel their parents don't always consider what they, as the "well sibling," might need or want. However, they also recognise their difficulty in voicing those needs and upholding their own boundaries.

In line Ma et al.'s (2017) findings from their systemic review, all of the participants in the present study, without exception, expressed difficulty with conflict resolution. The present study builds on these previous findings by presenting the participants' experiences of these situations. For many, conflictual situations trigger deeply embodied feelings, a desire to withdraw (due to emotional flooding) and an inability to verbalise a response. Additionally, some of the participants reported a tendency to finally "erupt", "blow" or "flip" when the inner noise simply became too much to contain: their suppressed anger being expressed either through passive aggression or loudly, suddenly and uncontrollably, rather as a child would express anger. This regression is, in many ways, understandable; the pressure to be "good" as children may have left the participants feeling unable to express their anger or frustration.

A key finding from this research, and something that has previously not been recognised, is that the siblings displayed signs of very specific defence mechanisms, this is something that has not been found in previous research and clearly has important clinical implications.

It was with Freud's publication of *The Ego and the Id* (1923) that analysts shifted their interest from the contents of the unconscious to the processes by which those contents are kept out of consciousness (McWilliams, 2020). With the structural theory provided by Freud, analytic therapists were able to make sense of how we all develop ego defences that are adaptive to our childhood environments but can, very often, be maladaptive later on in our adult lives. In her book *The Ego and the Mechanisms of Defense* (1936), Anna Freud further explored the idea that the primary function of the ego is to defend the self against anxiety (from powerful instinctual strivings or upsetting reality experiences) or guilt feelings. It should, then, not be surprising that the participants in this study displayed signs of two specific defence mechanisms.

Firstly, it is striking how often the participants in the current study, define situations in extreme terms, regularly using words such as "always," "never," "totally," "anything," "everything," "everybody" and "nobody." These words highlight their propensity towards binary, or dichotomous thinking which is also known as "splitting of the ego" or simply "splitting." This is a powerful process that is thought to derive from a pre-verbal time, before the infant can appreciate their caregivers have both good and bad qualities and can provide both good and bad experiences (McWilliams, 2020). This is one of the ways that, as infants, we organise our experiences as we are unable to experience ambivalence. In adult life "splitting" can remain as an appealing way to make sense of our complex experiences especially when they are threatening to us (McWilliams, 2020). Indeed, it can both reduce anxiety and maintain our self-esteem but it involves distortion of reality that is not helpful. Indeed, it can leave a person unable to make sense of the nuances of any given experience, event or interaction.

Secondly, many of the participants demonstrate omnipotent control: a defence mechanism that protects the ego from feelings of vulnerability. Omnipotent control gives a person the sense that one can influence one's surroundings and has some agency (something that may, of course, have been missing from the participant's real experiences in childhood). This is a critical dimension of self-esteem (McWilliam, 2020). In infancy the fantasy that one controls the world is normal and naturally shifts from primary omnipotence to a phase of secondary omnipotence when one of the caregivers are believed to be wholly powerful. There is a natural desire in youngsters to believe that their parents can cushion them from all the dangers of life as they become aware of them. Ultimately, however, when there is a secure enough early life, this gives way to an understanding that no-one's potency is unlimited (McWilliam, 2020). Whilst some residue of omnipotence remains in us all and contributes to feelings of agency and effectiveness, for some, the need to feel a sense of omnipotent control and, therefore, to interpret experiences that way, can remain compelling.

In the present study, as is common with omnipotent thinking, the participants' narratives reveal their fantasy of having great power over difficult situations they face; they have a belief that they can change, or control, what is happening around them, simply by changing their thinking or behaviour. With omnipotent thinking, the experience of self and others is divided into good and bad (McWilliams, 2020). and this is demonstrated in the participants' language. Throughout the analysis in this study, the participants can be seen to be idealising (attributing overly positive qualities) or devaluing (attributing overly negative qualities) themselves or their behaviour and doing the same when talking about their family members and partners. Whilst omnipotent control helps a child cope with difficult feelings and circumstances, it can, if not resolved, cause suffering in adulthood. This suffering comes from the accompanying denial of the emotional and psychological needs of the self. Whilst many adults with omnipotent thinking appear, in many ways, to do well in their lives, there is an underlying inability to be vulnerable in relationships and an impaired capacity to trust the self and others. The present study is unique in highlighting the impaired ability participants' have to hold their own emotional and psychological needs in mind; many talked of finding it hard to maintain trust in their partner (or in their relationship) during disagreements and conflictual situations and many talked explicitly of the discomfort and difficulties they experienced in showing vulnerability to others.

It is important to consider why, when defence mechanisms tend to derive from early childhood experiences, we see this in the participants in this research. The answer is twofold. Firstly, four out of the six participants shared that one, or both, of their parents had mental health issues of their own, including chronic somatic disorders, emotional dysregulation, alcoholism and severe anxiety. Research indicates this would have increased the chances of their brother or sister having SMI. Indeed, about a third of children of parents with SMI go on to develop SMI themselves by the time they reach adulthood (Rasic *et al.,* 2014). It also means that infancy and childhood experiences for the participants would, in all likelihood, have been far from optimal.

Secondly, it is important to recognise that, whilst SMI tends to be diagnosed during adolescence when the symptoms are more apparent, it is recognised that certain difficulties and behaviours are normally present long before any official diagnosis is made. Indeed, Chanen and Thompson (2014) suggest that instead of thinking in terms of risk factors for adult mental illnesses we should think of them as pre-cursors. These pre-cursors will inevitably directly impact the environment and the family dynamics these siblings were immersed in from a very early age.

There is, for example, a clear association between early mood problems and the onset of adult mood disorders (Wals and Verhulst, 2005). Furthermore, Chanen and Thompson (2014) highlight that, despite diagnosis of personality disorders remaining controversial before 18, there is a long-standing general agreement that personality disorders have their roots in childhood and adolescence. Indeed, research shows that the underlying dimensions of borderline personality disorder features (conceptualized as impulsivity, negative affectivity and interpersonal aggression) might also be relatively stable in children (Chanen and Thompson, 2014). In addition, those children may also display attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, substance use, depression and deliberate self-harm.

Similarly, premorbid developmental and social impairments have been well documented in adult schizophrenia (Hollis, 2018). Children who go on to develop schizophrenia in adolescence or adulthood are more likely to have experienced premorbid social impairments and enuresis (late onset of urinary continence), difficulties in acquisition and refinement of language and gross motor delays (Hollis, 2018; Hyde et al, 2008).

Holding an awareness of these factors (rather than focusing on the crisis point of the family and ultimately potential diagnoses during late adolescence) can help us understand the formation of defence mechanisms in siblings of those with SMI.

Unsurprisingly, perhaps, this study also highlights the difficulty adult siblings can have with being assertive; they can feel a need to be what others want them to be (even when those others are not of huge personal significance to them) with little reference to their own needs, wants or desires. Thus, many of the participants in this study reported an inability to say “no” to things they don’t have the time or inclination to do. This seems to be inextricably linked to wanting to please others, to be liked and to always do the “right” thing. There is a sense of the personal cost of giving too much of themselves and of them being left feeling overwhelmed, exhausted and, at times, resentful. Interestingly, although perhaps unsurprisingly, most of the participants felt able to be assertive on behalf of others and to act as advocates, be that in a work capacity or on behalf of their children. This, of course, might be something that is very familiar to many of them from their childhoods; protecting their brother or sister with SMI would likely have been seen as a “good” behaviour by their parents.

Previous research suggests adult siblings experience feelings of guilt, anger, shame, fear, disappointment, suspicion and hostility through into adulthood (Barak and Solomon., 2005; Lukens et al., 2004; Stålberg et al., 2004). The participants in the present study also report struggling with their emotions, both in terms of managing them and in understanding them. The present study builds on this previous research by highlighting how siblings are puzzled by their own anxieties. They have fears of speaking up, getting things wrong and trusting another but these fears seemingly don’t fit with their understandings of themselves. Indeed, they perceive these behaviours as “bizarre,” “ridiculous” and “not me,” and yet, acknowledge that these ways of being are enduring.

Unsurprisingly then, previous research suggests that siblings have an elevated risk of experiencing psychopathology (Bowman et al., 2013; Leigghio, 2016; Ma et al., 2015) and, in line with this, many of the participants in the current study talked of their own mental health issues. In particular, several participants reported experiencing significant, and chronic, anxiety. In addition, the present study highlights the very real sense of these difficulties not being acknowledged, or even seen, by their childhood families. Importantly, the present study suggests this pattern is enduring, not least because the participants, themselves, struggle to acknowledge their own mental health needs and feel, instead, that they must be strong, keep going and hide any struggles from their partners, their families and from the world.

The focus of this study is exploration of adult inter-personal relationships for individuals who grew up with a sibling with SMI. Clearly everything mentioned so far has the potential to impact a person's way of relating to others. In order to focus more deeply on the participants' experience of their inter-personal relationships, it is now useful to consider attachment styles, parentification and post traumatic growth.

In relation to how siblings' attachment styles may be impacted by growing up with a brother or sister with SMI, it is noteworthy that the participants in the present study displayed elements of an insecure "dismissing" attachment style (Wallin, 2000). They have a desire to be self-reliant, can find it hard to commit to relationships and withdraw from their partners when things don't go well. These findings build on Rachamim et al.'s (2021) research which suggested that first degree relatives of an individual with SMI may lead to depression thus producing maladaptive changes in beliefs with respect to trust and intimacy, self-efficacy and self-esteem which they posited could impact attachments styles. They called for more research to shed more light on trajectories of attachment in caregivers of close relatives with SMI.

As discussed, it is likely that these siblings experienced stressors during infancy and childhood, long before any official diagnoses of their brother or sister was made (if diagnoses ever were). These stressors were likely to have come about either from challenges their parents personally faced (in terms of their own mental health issues) and/or from the behavioural and psychological pre-cursors demonstrated by the brother or sister who later went on to develop SMI in adolescence. There is every reason to believe these childhood stressors will have impacted their relationship with their primary caregiver(s) and, thus, influence their adult attachment style.

Moreover, many of the participants find romantic relationships challenging in other ways; they can lack the ability to be assertive, struggle with conflict resolution and have an accompanying sense of hypervigilance around their partners' moods. Many of the participants, therefore, hold the belief that a life lived alone could be psychologically and emotionally safer and easier. The resurgence of an old belief, perhaps, that they can only truly rely on themselves. This builds on Sin et al.'s (2012) phenomenological study where the participants talked of how their brother or sister's illness had challenged their perspectives about future relationships.

Johnson's (1994) work around character styles has also not been considered in previous research and yet he provides an incredibly useful model for considering the difficulties many of the participants face in terms of their adult inter-personal relationships. Johnson's schizoid style is characterised by an avoidance of deeply intimate relationships and an underlying desire to be independent. At times of conflict, those with this character style tend to withdraw and can be passive-aggressive. In addition, they have thoughts that are not always connected to feelings due to a propensity to "intellectualise" instead of "feel." Johnson sees their defences as being that of perfectionism and dissociation. In addition, they tend to be hard on themselves and tend to gravitate towards harsh relationships (Johnson, 1994). This study, therefore, suggests that siblings of a brother or sister with SMI, may tend to have a schizoid character style. Further clinical research could be carried out to explore this further.

This study also draws on parentification to aid our understanding of the impact having a brother or sister with SMI and, thus, allows us to consider this finding in light of pervious research into parentification. All of the participants in the current study seemed to have experienced either emotional parentification (being the peacemaker, the diversionary object or the confident to their parents) and/or instrumental parentification (doing household chores, or helping with their unwell, or younger, siblings). Some research suggests that those experiencing parentification can go on to experience PTG (Hooper et al., 2007). Indeed, in the present study, the participants also showed what can be thought of as the adaptive side of the defended self or the adult version of the parentified child. Supporting Sanders et al.'s (2014) research, the participants in the present study experience themselves as hardworking, focused and reliable individuals who believe they can survive whatever life throws at them. They have maintained, throughout their lives, a belief that they are, indeed, the "strong" ones; in line with this they hold a sense of capability, see themselves as problem solvers and feel able to be relied upon in a crisis. This latter finding is a similar finding to Barak and Solomon's (2005) study that found their participants rated themselves as more able to use problem solving skills (compared with those without a brother or sister with schizophrenia). All of these, of course, are the messages the participants in the present study seem to have been given, as children, from their childhood families as they grew up. However, the participants, nonetheless, feel their ability to be independent serves them well. Indeed, there is a sense of pride in their ability to manage whatever it is they have to deal with and enjoyment of the fact they feel more than capable of relying upon themselves. In line with this, Dial (2014) found that adults who had experienced parentification felt mature and strong as well as being motivated to do well in their careers. It is noteworthy that all of the participants in the present study left home before the age of 20 and all are high-functioning, successful people in their chosen fields. Understanding the potential positive side of siblings' experiences and, specifically, when and how post traumatic growth may occur, may be used as a foundation for further therapeutic work by helping us consider the facilitation of post traumatic growth as a valid therapeutic aim.

Overarching concept. To conclude the discussion of the study's findings, I will now focus on an overarching concept, that of sense of self. In the analysis, I used George

Mead’s (1967) philosophical idea of the “I” and the “Me.” The reason for sharing Mead’s work there was that, when clustering the themes, two of the clusters related so strongly to Mead’s philosophical idea of the “Me” (what we learn through our interaction with others and their attitudes to us) and the “I” (how we, as individuals, then respond to those attitudes) that I felt compelled to use them as superordinate themes. The sense of self, however, is a concept that flows throughout the entire analysis and transcends all of the superordinate themes.

In order to discuss this further, I it is helpful to consider the concept of the true-self and false-self, first introduced into psychoanalysis by Donald Winnicott in 1960. Winnicott saw the true-self as occurring when the fit is “good enough” between the infant and mother (or primary caregiver). The good enough mother will meet the omnipotence of the infant and, to some extent, make sense of it. Over time, as she does this repeatedly, the infant’s true-self begins to emerge through the strength given to their weak ego by their mother’s responses to, and her implementation of, the infant’s omnipotent expressions (Winnicott, 1965). Winnicott (1965) describes the true-self as the self that is based on spontaneous, authentic experience and as allowing an individual to feel “alive” and “real.”

In contrast, Winnicott (1965) saw departure from the true-self and the development of the false-self as occurring when the mother (or primary caregiver) overrides, overlays or contradicts an individual’s original sense of self. Indeed, Winnicott believed that the false-self is created through failure on the part of the mother (or primary caregiver) to adapt well enough to the infant’s needs resulting in the infant’s “compliance.” This process can then become a template for later relationships where the individual holds the desires of others in mind above their own. Indeed, Winnicott (1965) saw the infant as getting seduced into a compliant false-self that, as the infant grows, builds up a false set of relationships and attains a show of being real. However, the false-self, at its worst, can leave a person feeling empty and dead behind the façade (Winnicott, 1965).

It is also recognised that, in parentification, a child adapts to the parent’s needs and create a system of care for their parents or sibling while simultaneously deserting their true-self (Wells et al.,1999). In this way, parentified children, to varying degrees, build psychic structures that are adjusted to the environment they find themselves in but can be unfavourable for their identity (Borchet et al., 2020). This false-self has the appearance of being real and is presented to others, and the self, as being so (Winnicott, 1965).

In the present study, many of the participants talked of feeling a need to play certain roles as children and, indeed, still now; to be the “good” one, the “strong” one, the “hardworking” one, the “helpful” one, the “nice” one, the “people pleasing” one. In playing these roles and adapting to the family’s needs, there is an inevitable departure from of their true-self and an abandonment of their own needs. The participant’s puzzlement at why they feel or act in certain ways was clear (e.g. “that’s so not me!”) and their propensity to be mailable in the face of other people’s needs (without reference to their own) suggest a disconnection, at times, from their true-self and a suggestion that they are, instead, unconsciously, operating from their false-self. Indeed, Winnicott (1965) believed that the true-self is so defended that it is largely, if not completely, unconscious, hence the participants’ puzzlement at their behaviours. However, by operating from their false-self, they risk basing their relationships on compliance and acquiescence and, in doing so, losing touch with the spontaneous, creative, real and alive sense of themselves (Winnicott, 1965).

Evaluation of the study

The present study achieved its aim of gathering in-depth accounts about how siblings, who have grown up with a brother or sister with SMI, experience their adult romantic relationships. The findings of this study, therefore, contribute to, and expand, our understanding of what those siblings may experience, and may benefit from, going forward.

The data provided by the participants were rich and comprehensive. This study builds on Lukens et al.’s (2004) research in which the participants conveyed the profound impact their brother or sister’s illness had on their personality and development. Furthermore, the participants in the present study build on Sin et al.’s (2008) phenomenological research which found that siblings’ social development was greatly affected by growing up with a brother or sister's illness. Indeed, the present study sheds further light on the siblings' experiences of their inter-personal relationships; they spoke about their childhoods, their relationships with their families-of-origin now, as well as their friendships and their experience of themselves at work.

In addition, the present study speaks directly to Sin et al.'s (2012) findings that reveal a conflict between the strength and resilience the adolescent and young adult participants reported and the complex and intertwined emotions they experienced including feelings of burden, stress, denial, despair, detachment, embarrassment, fear, guilt, helplessness, loss, grief, resentment, shock and sorrow. Indeed, the present study not only speaks to this conflict, it also provides us with more detail and aids our understanding of how this conflict plays out in their inter-personal relationships.

Whist the study population was small, it was within the suggested guidelines for IPA (Smith et al., 2009). I will now further consider Yardley's (2000) and Smith et al.'s (2009) criteria for assessing validity and quality, addressing the points that warrant discussion. I will also explore the limitations of the present study.

Methodological critique. Throughout the research process I have kept a coherent chain of evidence from the initial raw data to the final write-up via the research questions, the research proposal, the interview schedule, the recordings and annotated transcripts, the table of themes and the draft reports through to the final report. Throughout this journey, I have used research supervision to do mini-audits of my work at various stages. I shared my initial annotations and my initial thoughts about themes with my supervisor and we engaged in active discussion about them. My supervisor was able to add what he felt was interesting and important in the transcripts and to challenge me where appropriate. The concept of the independent audit as recommended by Smith et al. (2009) has, therefore, has been an incredibly useful tool to add to the validity of the present study.

Yardley's (2000) criteria has also been extremely useful. She emphasises the need for *sensitivity to context* and calls for researchers to pay attention to findings from previous research. The focus of this study emerged from a gap in the literature and from the identified need to gain an understanding of how siblings who have grown up with a brother or sister with SMI experience their adult inter-personal relationships. The literature was reviewed and explored systematically, acknowledging research that highlights the voices of siblings. Yardley also talks of the need to be sensitive to the broader socio-cultural context of the study and the way in which "normative, ideological, historical, linguistic and socio-economic influences" may interplay with the beliefs and behaviours of both the researcher and the participants. This is a strength of IPA as it bridges the gap between cognition and discourse by privileging meaning making in the participants' experience. Furthermore, the analysis uses quotations throughout, allowing the reader to hear the voice of the participants and see the interpretations alongside the raw data. I have also endeavoured to honour the context of the interaction with the participants by including an in-depth reflexivity section. Yardley (2000) also emphasises the need to be aware of the way the relationship between the researcher and participant affects the collection of data and meaning (including the balance of power). Again, this is a strength of IPA as it specifically emphasises the importance of the relationship between the researcher and the participant and the effect it has on the data and interpretation. The present study, in common with other IPA research, also uses relevant substantive literature to help orient the study and any findings are related to relevant literature in the discussion (Smith et al., 2009).

Yardley (2000) also calls for research to show *commitment and rigour* in terms of the competence and skill of the researcher and the time engaged with the topic. She argues that the completeness of the data in terms of whether the sample is adequate for the task, as well as interpretation, are both key criteria of rigour. The present study's sample was entirely adequate for the purposes of this research and the interpretation took place as several stages of in-depth, detailed analysis of the raw data.

In line Smith et al.'s (2009) recommendations, Yardley (2000) also calls for *transparency and coherence* in the presentation of the findings. She emphasises the need to be clear and cogent as well as for the research findings to be persuasive to those knowledgeable about the topic being researched. The present study has attempted to be transparent throughout the research process and to present the findings in a clear and logical manner by using independent audit as a way of thinking throughout.

Finally, Yardley (2000) postulates that the ultimate way of judging the value of any research is in whether they have *impact and importance* in the wider world. If research is to be considered valid, she suggests, it has to have an effect on people's beliefs or behaviour. As will be outlined below, the present study highlights many implications for clinicians working with clients who have grown up with a brother or sister with SMI. In addition, as is also discussed below, I have clearly outlined her intention to contact the relevant organisations (those signed posted by the NHS and others) with a view to engaging in discussion around what would be helpful in terms of support to individuals in this group.

Limitations of the study. The findings of this study have illuminated the lived experience of six adults who grew up with brother or sister with SMI. These findings, however, cannot be generalised because of the small sample and the nature of the methodology used.

In addition, given that five of the six participants came from talks and workshops I run, mainly for parents, the homogeneity of the participants was to be expected. Given the subject of my talks, the participants were likely to be parents (and thus are likely to have been in, or still be in, a committed relationship). This means my access to those who have not been in a committed relationship (by choice or circumstance), as well as those who are not parents (by choice or circumstance), was limited.

Furthermore, by making an active choice not to include papers on siblings of those with intellectual or physical disabilities rather than mental illness, I am unable to know how much my findings may (or may not) be similar to this research.

The majority of people who come to my talks are also White British and, therefore, my access to minority groups was limited due to my recruitment strategy.

Implications

The findings from the present study fit well within the existing literature and provide promising suggestions for both clinical practice and future research, both of which will be explored in this section.

To date, what little interest there has been in siblings appears to have been driven primarily by a desire to find out how best to engage them in providing care and support for their mentally ill brother or sister when their parents are no longer able to. Whilst useful to statutory bodies, it is crucially important to recognise that the challenges siblings face *outside* of their potential care-giving role have largely gone unnoticed.

Implications for practice for those working with children/adolescents. It is clear that the childhood experiences of these siblings can have a profound effect their own mental well-being and on their way of relating to others. Through considering parentification as an almost inevitable consequence of having a brother or sister with SMI, this research has been able to highlight protective factors that can support children in this situation. Specifically, parents can be supported in understanding the importance of providing healthy boundaries around roles and responsibilities assigned to their “well” children. In addition, parents can be encouraged to ensure these roles and responsibilities are age-appropriate, reasonable and acknowledged by family members (Dial, 2014; Levine, 2009). In this way, the dysfunctional aspects of parentification can be defused. Lamory (1999) suggests that communication between home and school can contribute positively to the sibling’s healthy development in terms of their social and academic endeavours. In particular, educators and parents alike can support these children in developing healthy peer relationships, discovering their own personal needs and interests and having support in balancing academic accomplishment with their personal and social development.

Parents, educators and clinicians alike can provide validation of these children’s feelings and help them recognise, and voice, their own needs. The tendency towards perfectionism may be challenged so that these children can build a robust understanding that we cannot always give of our best and that we all, at times, make mistakes and get things wrong. In addition, parents and clinicians might encourage these children to practise self-compassion by learning how to talk to, and about, themselves kindly and supportively. In these ways, these children can be helped to feel visible, valued and to maintain connection to their true-selves.

In summary, in relation to children who are currently living with a brother or sister with SMI, there is a need to disrupt the current discourse: policy makers, social services and educators need to engage in discussion around how these children, and their families, can be more supported to ensure the children's roles and responsibilities are managed, their contribution to their family acknowledged and they are supported in developing a balance between their academic accomplishments, their personal needs and their social development. These children should have the opportunity to attend either individual or group therapy so that clinicians can support them in making sense of their family situation and ensuring, as much as is possible, that it does not negatively impact their lives or their relationships going forward.

Implications for practice for those working with adults. It is clear from the present study that adult siblings may have very real difficulty in recognising what impact their childhood may have had on them. This is in stark contrast to their ability to recognise what others in their family-of-origin may have experienced during their childhood and may still be experiencing now. To this end, they can display a great deal of understanding and compassion for others but display a startling lack of understanding and self-compassion about their own experiences. Clinicians could encourage these clients to reflect on what may have been challenging for them in their childhood through active discussion and engagement in thinking about what advice they would give to their younger self now. In addition, clinicians might help these clients develop self-compassion (Johnson, 1994) so that, rather than being harsh, critical or judgemental towards themselves, they become more able to recognise, sit with and, ultimately, address their own suffering, within the safety of the therapeutic relationship.

Importantly, the findings of this study illuminate how siblings can face significant challenges in terms of their adult inter-personal relationships. These challenges are often caused by defence mechanisms that take the form of splitting, omnipotent control and the creation of the false-self. Clinicians might help these clients become more aware of their defence mechanisms (what they are and how they display themselves) and to recognise that these mechanisms, whilst entirely appropriate given the circumstances of their childhood, may not be useful or helpful for them now.

Clinicians are, of course, also likely to meet these defence mechanisms in the therapy room. Clinicians could, therefore, usefully pay attention to the language these clients use in order to highlight the dichotomous thinking that can limit their client's ability to see, and hold, the "grey" areas of any given situation. Helping these clients recognise that the world, and the people in it, are complex and nuanced, is important for supporting them in their relationships going forward and a key part of their therapy. Splitting, in adult life, is a powerful way to make sense of complex experiences, especially when they are threatening, but they always involve unhelpful distortion (McWilliams, 2020). The clinician may notice these clients holding only one, usually extreme view, of oneself, another or of life itself (Johnson, 1994). Clinicians could usefully question the extreme language of splitting when used by these clients in order to help them begin to recognise, and be curious, about their dichotomous thinking and consider alternative ways of viewing themselves, others and different situations.

In addition, clinicians could also usefully pay attention to any sign of omnipotent thinking when working with this client group. These clients may express a belief that they can find the answer to every problem and have to ability to do whatever needs to be done. In addition, their narratives may reveal a fantasy of having great power over difficult situations they face and a belief that they can change, or control, what is happening around them simply by changing their thinking or behaviour. These beliefs may engender in the therapist an understandable feeling that there is no work to be done. Furthermore, clinicians may experience frustration from feeling the client in front of them is functioning perfectly well in the world and does not require psychotherapeutic support. Clinicians may find it helpful, therefore, to hold that their client's vulnerability may well be hidden, not only from others, but also from themselves. In addition, where there is omnipotent thinking, these clients experience of self and others may be divided into good and bad. These clients, therefore, may initially idealise the clinician and have an accompanying desire to be a "good patient." They may feel the need to impute special value and power to those they depend upon emotionally, including their therapist. In addition, a by-product of idealisation and the associated belief in perfection is that imperfections in the self are hard to bear. Consequently, fusion with their idealised therapist is an appealing remedy (McWilliams, 2020) but brings with it a risk of devaluation. Clinicians, therefore, might usefully communicate explicitly, at the beginning of the work, that the clinician may get things wrong, say something that doesn't fit with the client or, unintentionally, cause them upset. In the event of this happening, the client can be encouraged to bring this back into the therapy room so that it can form a vital part of the work between clinician and client. Without this being explicitly stated, there is a risk that, should there be a rupture, primitive devaluation can occur and these clients may simply withdraw and cease attending therapy.

Clinicians may also find it helpful to hold in mind that, on occasion, they may encounter omnipotent attacks from these clients. Joan Symington (Symington, 1985) talks about the survival aspect of omnipotence that help us understand these attacks can be understood as attacks on dependency on the therapeutic relationship. This dependency can bring reminders of feelings helpless and un-held.

Abrams (2009) points out these siblings often present as high-functioning independent, achieving, responsible individuals whose symptoms of dysfunction and pain are hidden. This is certainly true in the present study. She poignantly calls this "a paradoxical mix of apparent adjustment and secret distress" (p309). The aim of psychotherapy for these clients then is to restore trust; trust in the self, trust in the significant other and trust in the life process itself (Johnston, 1994). The therapeutic objectives are to restore the flow of instinctual self-expression and to help the client connect with their authentic, true-self.

Winnicott (1965) talked of the need to, first and foremost, *recognise* the false-self personality and highlighted the need for clinicians to recognise that they must first talk only to the false-self *about* the true-self. According to Winnicott, there will then be a point of transition when the clinician gets in touch with the true-self which can result in a period of dependence from the client/patient onto the clinician before the patient is able to work on their true-self.

Furthermore Cresci (2019) helpfully discusses the value of clinicians pairing the true and false-self paradigm with their awareness of countertransference feelings. She posits that the paradigm may provide a clearer explanation for the origins of negative countertransference seeing it as a reaction to the client's defensive false self. This understanding, she suggests, can help us to know our clients more profoundly. Indeed, clinicians might usefully hold this knowledge, and sensitively share with their client when they are able enough to tolerate it, in order to understand, together, how this false-self may have limited their options so that they can begin to develop their true personhood in treatment and then, ultimately, out in the world.

Importantly, the true-self is likely to require active construction as these clients are unlikely to have any real sense of their true-selves. To this end, clinicians might encourage these clients to reflect on their needs, goals and relationships. In addition, to help these clients reconnect to their true-self, clinicians could show them how to ground themselves, help them connect more with reality and encourage them to stand their ground in circumstances where they may feel threatened.

This study has also highlighted how adult siblings can have a difficulty in experiencing intense affect; either being disconnected from it or becoming overwhelmed by it. Where a client is disconnected from their emotions, the clinician can help them become more embodied by encouraging them to slow down, breathe calmly and to listen to what they may be feeling in their bodies. Where a client is overwhelmed by their emotions, it is important clinicians work only at the speed that is comfortable for their client and hold clients’ windows of tolerance in mind. Where there is significant trauma, it is helpful to do what Levine (2015) calls “pendulating” in and out of their window of tolerance.

It is an integral part of the therapeutic journey that these clients are encouraged to express any negativity or rage they are feeling and experience what it is like *not* to lose contact with the therapist when they do so. Indeed, they need to feel what they didn’t as children: that they can be something other than “good,” “nice,” “strong” or “helpful” and that they will *still* be welcomed and met. This is crucial for all clients for whom attachment is the main failure but the importance is worth highlighting for this client group. The clinician, then, assists in the development of those attachments and commitments, in order that client develops, where necessary, earned “secure” attachment (Wallin, 2000). It is this earned “secure” attachment which they then transfer out into the world.

In summary, there is a need to provide for adults who grew up with a brother or sister with SMI; they need supporting not only in how to care for their brother or sister with SMI but also with their *own* psychological well-being. In Sanders and Szymanski’s (2013) research they go beyond this and suggest that, if the caregiving task is overwhelming, siblings may benefit from distancing themselves from the experience in order to create new meanings and facilitate PTG. They also suggest that including siblings in the therapeutic process of their brother or sister with SMI will not suffice if the mental health system will not acknowledge their needs.

Specifically, many siblings need support in building trust in themselves and others through understanding their defence mechanisms, learning how to recognise and communicate their needs and learning to practise self-compassion (Johnson, 1994). In this way, they can begin to reconnect with their true-selves and feel more able to connect meaningfully in their inter-personal relationships. These adult siblings should have the opportunity to attend either individual or group therapy so that clinicians can support them in all of the areas outlined. Indeed, Dickson-Baures’ (2015) research exploring siblings’ growth suggests that, in addition to psychoeducation and supportive groups, they would welcome the opportunity of individual therapy in order to develop productive individualised coping strategies.

As mentioned in the rationale for the present study, there is currently very little provision in the UK for adult siblings of those with SMI (either via online platforms or in person groups). Despite Rethink's Siblings Network highlighting the insufficient support for siblings on matters that directly affect them (Rethink/Canning, 2006 and 2011) the focus of groups that are running appear to have reverted back to how these siblings can best support their brother or sister with SMI with little reference to the siblings themselves. For example, the Rethink support group in London currently (accessed 9th March 2021) purports to offer support to siblings and yet the focus of their group is to "discuss the ways you can support your sibling, and the rest of your family, both emotionally and practically." The present study suggests that, instead, it would be helpful for support groups to offer a place where these siblings can reflect on their *own* challenges and consider what support they may need. Indeed, it may be helpful for these siblings to be encouraged to acknowledge their painful experience and to be assisted in making meaning from it for themselves. Specifically, they could be assisted in recognising their own mental health needs, learn how to practise self-compassion and recognise and communicate their needs to others.

As previously mentioned, there is one independently run peer support group that meets monthly in Brighton called Sibling Link. This has been set up by two siblings, both of whom lost their brothers to suicide. At the time of completing this thesis, I have already connected with Sibling Link and offered to support them in their work. On 3rd June 2021, I ran an interactive webinar for the siblings who attend their support group. In addition, on 22nd September 2021, I ran a continued professional development webinar for the British Psychological Society to share my research findings and discuss how clinicians could apply these findings to their work. The attendees included psychologists and psychotherapists who work with both child and adult siblings, both in the NHS and privately. Further dissemination will involve making contact both Rethink and Sibs/Young Sibs with the intention of opening up, and engaging in, active and constructive discussion around further support that can be provided. In the autumn of 2021, I also launched a new website called supportforsiblings.com offering information, advice and further resources to adult siblings as well as parents and teachers.

Suggestions for future research. The present study offers insights to researchers in the field. It is important, however, that further research is carried out to looking at different minority groups to establish whether cultural expectations and norms affect the impact of growing up with a brother or sister with SMI. In addition, further research is needed looking at gender differences; the majority of research in this area has focused on female siblings. This could be because women are, traditionally, more likely to take on caregiving roles or it could be that women are more willing to take part in the research. Whatever the reason, it is important to explore whether men and women who grow up with a brother or sister with SMI are impacted differently and what those differences may be.

Further research is also needed to look at the experiences of individuals who grew up with a sibling with SMI who have not married or had families (through choice or circumstance) in order to get an understanding of *their* lived experiences and thoughts around their inter-personal relationships. It is entirely possible that the impact of growing up with a brother or sister with SMI may be *even* greater on these siblings than on the siblings in this present study.

As mentioned in the discussion section, the participants' in the present study seemingly display signs of what Johnson (1994) calls a schizoid style, showing, as they did, a distrust of romantic relationships, an underlying desire to be independent, conflict aversion, a tendency to withdraw at times of conflict, as well as a tendency to be harsh on themselves. Due to the number of participants in the present study, it is impossible to generalise this to all siblings. It would be helpful t to carry out clinical research to explore this further.

Finally, further research is needed to consider what facilitates PTG in these individuals; this research is important in order to identify those most at risk when growing up with a brother or sister with SMI. It would also provide crucial further information into what extra support children should be offered if they are growing up in this situation.

Conclusion

Within this chapter, I have evaluated this study and considered its limitations and its strengths. This paper goes beyond the literature that already exists by highlighting the needs of siblings seeking therapy. In addition, this paper provides useful information for policy makers, support groups and educators about the importance of recognising the immediate and long-term impact on siblings of growing up with a brother or sister with SMI.

This paper suggests we need to recognise siblings of those with SMI carry the impact of their childhood experiences with them into adulthood. Not only are they at an elevated risk of experiencing psychopathology themselves (compared to siblings who have grown up with typically developing brothers and sisters) but their psychosocial functioning and their functioning within relationships, is also likely to be adversely affected.

Many of the siblings in this study display a very real difficulty in recognising their needs, holding compassion for themselves and dealing constructively with conflictual situations. Furthermore, many participants in the present study display the defence mechanisms of binary thinking, omnipotent control and the creation of a false-self. The presence of these defence mechanisms strongly suggest that these individuals would benefit from some therapeutic support to address their own suffering in order to restore trust in themselves, in their inter-personal relationships and in the life process itself.

I would like to finish this thesis by thanking, once more, the participants who made this research possible by sharing their personal experiences with me. I hold a hope that as a result of this research, others growing up with a brother or sister with SMI can be supported so that they *can* feel safe enough to put their head above the parapet.

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Appendices

Appendix A – Recruitment Poster

Did you grow up with a brother or sister with a severe mental health illness?

I am an experienced Psychotherapist who, as part of my doctoral training, is carrying out research exploring how adult siblings, who grew up with a brother or sister with a severe mental illness, experience their adult intimate relationship(s).

I am, therefore, looking for adult siblings (aged 30 or over) to take part in my research. This will involve taking part in an interview which will last approximately 1 hour. It will be held in a quiet (but public) venue near to where you live. You do not currently need to be in an intimate relationship to take part.

If you may be interested in being part of this project please feel free to call or email me so that we can arrange an initial phone conversation to discuss it further.

Hester Bancroft

BSc (Hons) Psych, MBPsS, NLP Master Prac
British Psychological Society No: 287845

My telephone number is: 07775 880330
My email address is: hester.bancroft@metanoia.ac.uk
My website is: www.effectivesteps.com

Appendix B – Ethics Application Form

Research Ethics Application Form

The Metanoia Research Ethics Committee

This form is to be used by candidates and staff, and for any external body wishing to access Metanoia Institute for the purposes of research. The Metanoia Research Ethics Committee must approve all research undertaken by staff and candidates prior to the commencement of the study. If ethical approval has been obtained from a recognised Research Ethics Committee, the letter of approval must be submitted to the Metanoia Research Ethics Committee prior to the commencement of the study together with the application to Metanoia's research committee. You will need to complete the ethics form and also complete a risk assessment for the project work. Risk assessment materials are included at the end of this document. Please read these guidelines carefully, to ensure that you submit the correct documentation.

Approved proposals may be audited at random in order to verify that they comply with the ethical requirements/guidelines of the Metanoia Research Ethics Committee.

All applicants should familiarise themselves with the appropriate code of professional ethics e.g. the British Psychological Society's *Code of Human Research Ethics* (2011) (available to download at www.bps.org.uk); the British Association for Counselling and Psychotherapy's *Ethical Guidelines for Researching Counselling and Psychotherapy* (Bond, 2004) and the updated *Ethical Framework for the Counselling Professions* (both available to download at www.bacp.co.uk); and the Health Professions Council's Standards of conduct, performance and ethics (2008) available to down load at www.hpc-uk.org). Applicants should also familiarise themselves with the Data Protection Act (1998). Information and guidance on this is provided by the Information Commissioner's Office (available at: www.ico.gov.uk) - and also the Research Governance Framework for Health and Social Care (2005) (available to download at: www.dh.gov.uk/PolicyandGuidance/ResearchandDevelopment).

Consistent with BPS and BACP guidance, ethical conduct needs to be viewed as a process. Hence, ethical matters should be continually reviewed and addressed throughout the course of the project and in consultation with your research supervisor. If there are significant changes to your research design, you should consider the ethical implications of these changes and consider also, in consultation with your research supervisor, whether formal ethical approval needs to be obtained again.

Before completing this form, you should discuss the ethical implications of your research with your research supervisor.

Statement of ethical approval

Candidates should append the ethics approval letter to their research report. Candidates should not start data collection until ethical approval has been obtained from the Metanoia Research Ethics Committee.

Statutory data collected as part of a candidate's employment

Candidates do not need to seek approval for the collection of data obtained as part of their normal professional work roles and under statutory powers. However, should a candidate intend to use the data to address a research question outside their 'normal work role' ethical approval will be required. Permission for the access to and use of the data for research purposes should be provided by the employer with reference to the data protection act. In such cases, this committee does not approve the collection of data but only its use as part of the candidate's research project. In order to assist the committee in its deliberations candidates are advised to provide a paragraph outlining the capacity in which they are obtaining the data.

Purpose of this form

This form is reviewed by the Metanoia Research Ethics Committee in order to assess the ethical implications of your research project and your response to these implications. The research cannot proceed until ethical approval has been obtained. Applicants may be asked to review and re-submit this form in the light of the Research Ethics Committee's decision regarding whether ethical issues have been adequately identified and addressed prior to starting the research work.

Once completed, **two** copies of this form should be submitted to the Metanoia Research Ethics Committee, accompanied by:

	Please tick box
• Two copies of your finalised research proposal.	√
• Two copies of any research materials such as participant recruitment advertisements, letters/email communications to participants, information sheets and consent forms.	√
• Two copies of research materials such as interview schedules, topic guides, published questionnaires, or other research protocol materials.	√
• Letter of consent from any organisation where researcher is conducting, either interviews, focus groups, surveys, observations etc.	N/A
• Evidence of permission to access data, or provide justification where permission is not required.	N/A
• A letter of approval from a recognised Research Ethics Committee if ethical approval for the study to take place has been required from another organisation (e.g. NHS, MoD, etc.).	N/A

DETAILS OF APPLICANT AND RESEARCH SUPERVISOR

1.1. Applicant's name: Hester Bancroft

1.2. Email address: hester@effectivesteps.com

1.3. Telephone number: 07775 880330

1.4. Research supervisor(s) name, qualifications and contact details:

Dr Russel Ayling, HCPC registered Clinical Psychologist and Psychoanalytic Psychotherapist. Joint Interim Head of Programmes, Counselling Psychology at Regent's University, London

1.5 Institution/contact details (if applicable):

N/A

1.6 Do you have any external funding for this project? Yes/No (please circle)
If yes, please provide brief details including the name of the funding body:

No

1.7. Project title: Echoes from a different childhood

1.8. Start and End date

Research will begin as soon as ethical approval has been received and the aim is to complete it by Autumn 2019

ETHICAL CONSIDERATIONS

	YES	*NO*	*N/A*
1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? Please attach a copy of any recruitment letters and information sheet to be used.	**YES**		
2. Is the project based on voluntary participation?	**YES**		
3. Will you obtain written consent for participation?	**YES**		
4. If the research is observational, will you ask participants for their consent to being observed?			**N/A**
5. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw?	**YES**		
6. Will you ensure that participants are not subtly induced, either to participate initially, or to remain in the project?	**YES**		
7. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer?	**YES**		
8. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	**YES**		
9. Have you made provision for the safe-keeping of written data or video/audio recordings?	**YES**		
10. Will you debrief participants at the end of their participation?	**YES**		

11. Have you ensured that your research is culture/belief/ social system sensitive and that every precaution has been taken to ensure the dignity, respect and safety of the participants?	**YES**		

If you have answered 'NO' to any of the questions listed in 1 to 11 above, then please provide further details on a separate page and attach it to this application.

	YES	NO	N/A
12. Does your research involve offering inducement to participate (e.g. payment or other reward)?		**NO**	
13. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, what will you tell them to do if they should experience any problems (e.g. who they can contact for help.)	**YES**		
14. Is there an existing relationship between the researcher and any of the research participants? If YES, please describe the ethical implications and the safeguards in place to minimise risks.		**NO**	
15. Will the project involve working with children under 16 years of age? If YES, please describe parental consent and safeguarding procedures.		**NO**	
16. Will your project involve deliberately misleading participants in any way? If YES, please explain why this is necessary.		**NO**	
17. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval.		**NO**	
18. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? If YES, please describe on a separate sheet.		**NO**	

If you have answered 'YES' to any of the questions listed under 12 to 18 above, then please provide further details on a separate page and attach it to this application.

EXPANDING ON QUESTION 13:

I recognise that there is a risk of my participants experiencing psychological distress or discomfort because of the nature of the topic. Before undertaking interviews, I will discuss with participants their options for support, and will discuss with them that, should they become distressed during their reminiscences, I would stop the interview. It is my intention to employ my own therapeutic skills in this instance, including the use of techniques such as grounding (Rothschild, 2000) and bringing the participant back in to the present and current surroundings.

It will also be important to take proper time to debrief my participants carefully after the interview, which would include:

- Reviewing the interview and discussing how the participant feels about what they have said and what it was like for them to talk to me.
- Discussing what they are going to do to put safety measures in place if they need to (e.g. not driving immediately after the interview if they need some time to gather themselves).
- Ensuring they can get enough support from people around them after the interview should they feel they need it.

CANDIDATE DECLARATION

I have read the BACP and the BPS guidelines for ethical practices in research and have discussed this project with my research supervisor in the context of these guidelines. I confirm that I have also undertaken a risk assessment with my research supervisor:

Signed:………………………

Print Name **Hester Bancroft** Date 12th October 2018
(Applicant)

RESEARCH SUPERVISOR DECLARATION

- As supervisor or principal investigator for this research study I understand that it is my responsibility to ensure that researchers/candidates under my supervision undertake a risk assessment to ensure that health and safety of themselves, participants and others is not jeopardised during the course of this study.
- I confirm that I have seen and signed a risk assessment for this research study and to the best of my knowledge appropriate action has been taken to minimise any identified risks or hazards.
- I understand that, where applicable, it is my responsibility to ensure that the study is conducted in a manner that is consistent with the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (see http://www.wma.net/e/policy/b3.htm).
- I confirm that I have reviewed all of the information submitted as part of this research ethics application.
- I agree to participate in committee's auditing procedures for research studies if requested.

Signed:………………………

Print name **Dr Russel Ayling** Date 13th November 2018
(Supervisor)

STATEMENT OF ETHICAL APPROVAL

This project has been considered by the Metanoia Research Ethics Committee and is now approved.

Signed:………………………………………

Print name……………………………… Date…………………………………………
(On behalf of the Metanoia Research Ethics Committee)

Please note that the Metanoia Research Ethics Committee meets twice during each academic year. Submissions between these meetings are dealt with by chair's action in consultation with one other committee member.

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT

This proforma must be completed as part of the research ethics submission for all field/location work. It is to be completed by the person carrying out the field/location work (which in most cases is the candidate) in conjunction with the research supervisor.

FIELD/LOCATION WORK DETAILS

Name of person carrying out field/location work (usually the Candidate) **Hester Bancroft**

Name of research supervisor **Dr Russel Ayling**

Telephone numbers and name of next of kin who may be contacted in the event of an accident

Mr Simon Rees (husband) 07778 989585

Physical or psychological limitations to carrying out the proposed/location work

None

Any health problems (full details) which may be relevant to proposed field/location work activity in case of emergencies.

None

Locality (Country and Region)

Public spaces in Berkshire/Buckinghamshire (coffee shops or local cafes)

Travel arrangements

Driving in my own car/comprehensive insurance

NB: Comprehensive travel and health insurance must always be obtained for independent overseas field/location work.

Dates of travel and field/location work

To be arranged

FIELD/LOCATION WORK NEXT OF KIN Mr Simon Rees 07778 989585

Hazard Identification and Risk Assessment PLEASE READ VERY CAREFULLY

Doctorate in Counselling Psychology and Psychotherapy by Professional Studies 2018-19 List the localities to be visited or specify routes to be followed **(Col. 1).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 2).**

Examples of Potential Hazards:

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia) Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution. Demolition/building sites, assault, getting lost, animals, disease. Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range. Lone working: difficult to summon help, alone or in isolation, lone interviews. Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio- economic differences/problems. Known or suspected criminal offenders. Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime. Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task. Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury. Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye- damage. Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

1. LOCALITY/ROUTE	2. POTENTIAL HAZARDS
NONE	NONE

Risk Minimisation/Control Measures PLEASE READ VERY CAREFULLY For each hazard identified **(Col 2),** list the precautions/control measures in place or that will be taken **(Col**

3) to **"reduce the risk to acceptable levels",** and the safety equipment **(Col 5)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 3),** categorise the fieldwork/location work risk for each location/route as negligible, low, moderate or high **(Col. 4). Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.**

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork/location work tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individual's fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork/location area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

3. PRECAUTIONS/CONTROL MEASURES	**4. RISK ASSESSMENT** (Low, moderate, high)	**5. SAFETY EQUIPMENT**
RESEARCHER'S HUSBAND WILL KNOW LOCATION AND TIMINGS OF THE INTERVIEWS. RESEARCHER WILL TELEPHONE HUSBAND AS SHE LEAVES THE INTERVIEWS	LOW	NONE NEEDED

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork/location work period and additional precautions taken or fieldwork/location work discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker/ location worker (Candidate)

Hester Bancroft

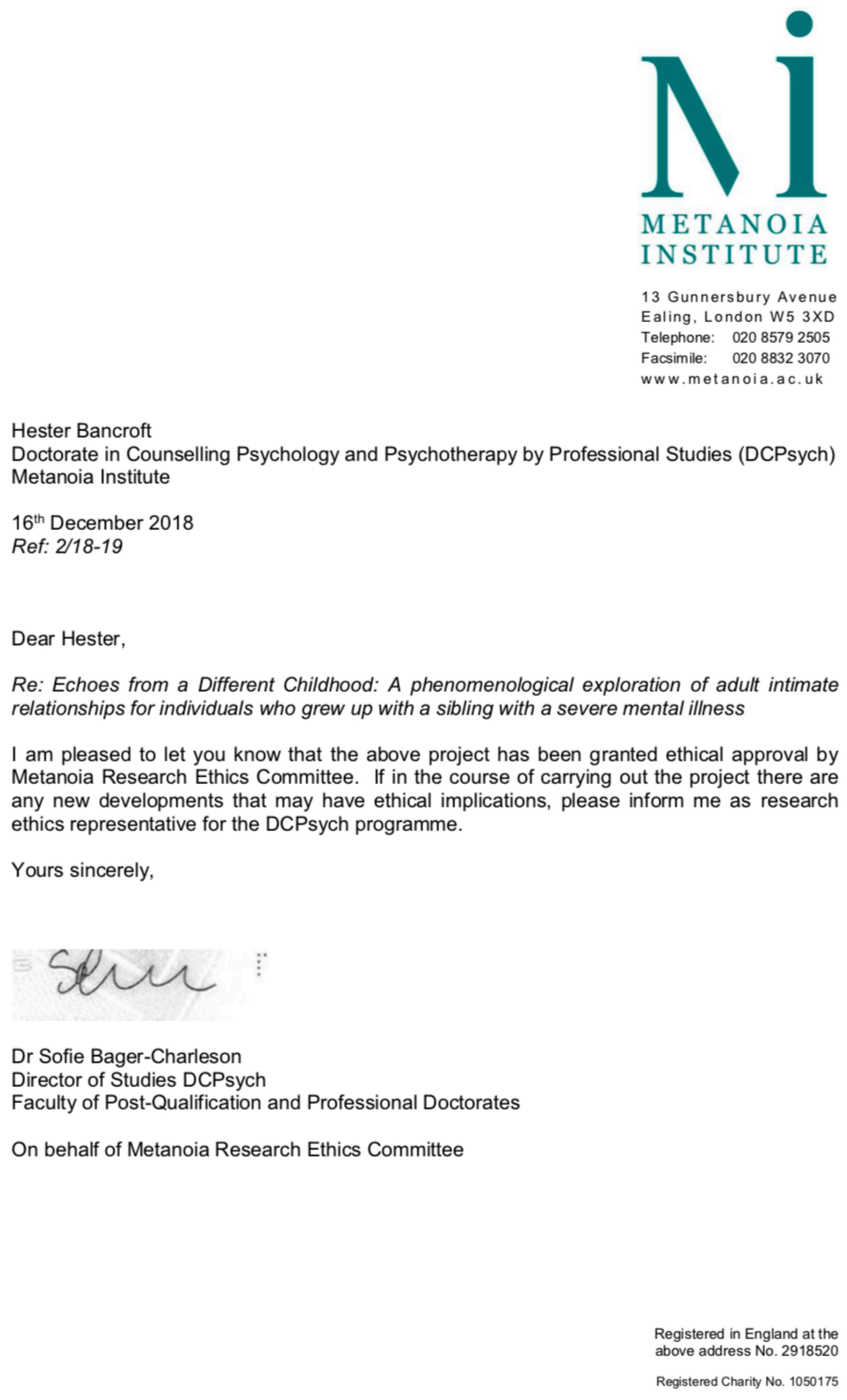
Date: 13.12.2018

Signature of candidate's Research Supervisor

Dr Russel Ayling

Date: 13.12.2018

Appendix C – Ethics Approval Letter



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Hester Bancroft
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

16th December 2018
Ref: 2/18-19

Dear Hester,

Re: Echoes from a Different Childhood: A phenomenological exploration of adult intimate relationships for individuals who grew up with a sibling with a severe mental illness

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Dr Sofie Bager-Charleson
Director of Studies DCPsych
Faculty of Post-Qualification and Professional Doctorates

On behalf of Metanoia Research Ethics Committee

Registered in England at the
above address No. 2918520

Registered Charity No. 1050175

Appendix D – Information sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Dated: *date of the interview*

ECHOES FROM A DIFFERENT CHILDHOOD

How siblings who grew up with brother or sister with a severe mental illness experience their adult intimate relationships

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for taking the time to read this information sheet

The purpose of the study

When one child in the family develops a severe mental illness, changes inevitably occur across familial relationships. Historically research has focused on the impact a child with a severe mental illness has on their parents There has, however, been a growing awareness that siblings are also impacted.

Until recently, however, there has been scant research focusing on siblings lived experience outside of any potential caregiving role. More specifically, there appears to be no research into how growing up in a family where one child has a severe mental illness affects siblings' experiences of their future intimate relationships.

I plan to address this by carrying out and completing research over the next year (i.e. by the Autumn of 2019).

The reasons why you have you been chosen

You, along with 5 other participants, have been chosen to take part in this study as you, yourself, are a sibling (aged 30 or over) who has grown up in the same house as a brother or sister with a severe mental illness. In addition, you have indicated that you are interested in taking part in the research.

As we will have discussed, during our initial telephone conversation, you feel it unlikely that you will be to be caused distress by discussing your childhood experiences in relation to this.

Your participation is entirely voluntary

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time up to, but not after, the start of data analysis and without giving a reason. Should you withdraw, your data will be destroyed and no longer used in the study.

What happens if you decided to take part

We will agree on a quiet, neutral, public place to meet near to your home. There you will take part in an interview with the me that will take around 1 hour. This interview will be recorded and later transcribed. All of your material will be anonymised and your identity kept confidential throughout.

The possible disadvantages and risks of taking part

There is no known risk in participating in this project. However, as I explained when we spoke, should you unexpectedly become distressed during your reminiscences, I will stop the interview. In this instance, I will employ my own therapeutic skills, including the use of techniques such as grounding (Rothschild, 2000) to bringing you back in to the present and current surroundings.

The possible benefits of taking part

We hope that participating in the study will help you. However, this cannot be guaranteed.

It is hoped that what emerges from this study will be of interest to other Psychotherapists and Counselling Psychologists working with individuals who have grown up with a brother or sister with a severe mental illness.

In addition, it is hoped that this research will be of interest to siblings themselves who wish to understand more about how their childhood experiences may have affected how they experience their adult intimate relationships.

Finally, it is hoped that this research will educate policy makers are alert to the possible long-term implications for the individuals with a sibling with a severe mental illness so that clinicians, parents, educators and, indeed, policy makes are alert to the potential needs of these individuals.

Confidentiality

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection legislation of the United Kingdom.

What happens to the results of the research study

This research will be published as part of my postgraduate dissertation. It is likely to be published in the winter of 2019. If you would like me to do so, I would be very happy to send you a copy of the paper. Please do let me know if you would like me to do this.

Please be assured that you will not be identified in any report/publication.

Ethics Committee Approval

The Metanoia Research Ethics Committee has reviewed and approved this study.

Contact for further information

If you need any further information you can contact either myself or my research supervisor.

Researcher: Hester Bancroft

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Research Supervisor: Dr Russel Ayling,

Address: Regent's University London, Inner Cir, London NW1 4NS
email: aylingr@regents.ac.uk
telephone: 020 7487 7700

Thank you for taking part in this study

You will be given a copy of this information sheet and a copy of the signed consent form to keep

Appendix E – Consent Form

CONSENT FORM

Participant Identification Number:

Title of Project: Echoes from a different childhood

Name of Researcher: Hester Bancroft

Please initial box

1. I confirm that I have read and understand the information sheet dated ....……………………for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐
3. I understand that my interview will be taped and subsequently transcribed ☐
4. I agree to take part in the above study. ☐
5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

__________________________ Name of participant	______________ Date	______________________ Signature
HESTER BANCROFT __________________________ Researcher	______________ Date	______________________ Signature

1 copy for participant; 1 copy for researcher

Appendix F – Interview Schedule

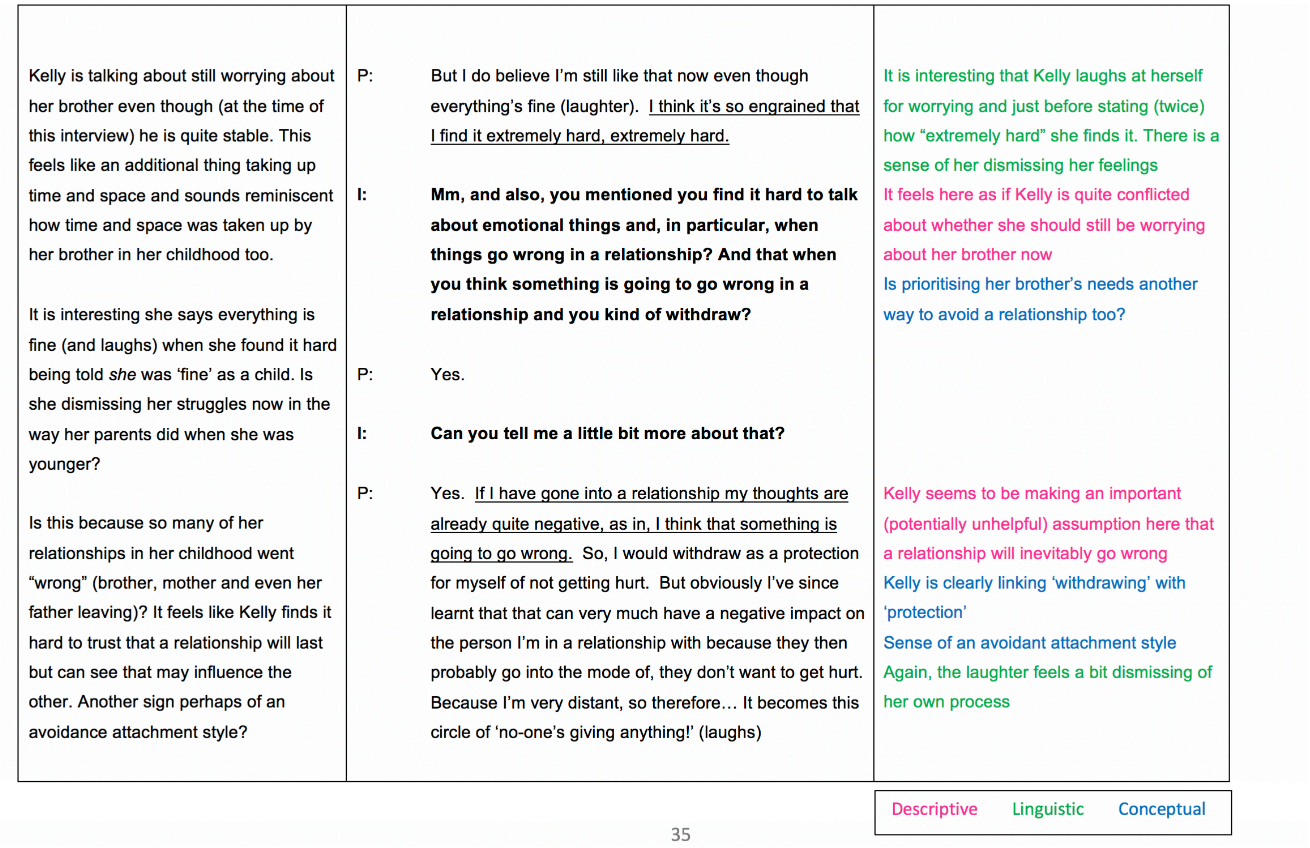
INTERVIEW QUESTIONS

The Research question asks, *"How do people who have grown up with a sibling with a SMI experience their adult intimate relationships?"* The broad questions I will be exploring with participants are:

- *Have you noticed any patterns (good or bad) in your intimate relationships? Both in choice or partner and/or your way of relating to them?*
- *What have you found challenging in your relationship(s) if anything?*
- *How easy has it been for you to trust your partner(s) both in terms of committing to and relying upon them?*
- *How easy has it been for you to show your vulnerability?*
- *How does conflict with your partner make you feel and how might you behave?*

I intend to remain as open minded as possible when asking these questions and am also prepared to be surprised. I appreciate that my experience may be entirely different to others and that my participants may have found their experience to be partly, or even entirely, positive.

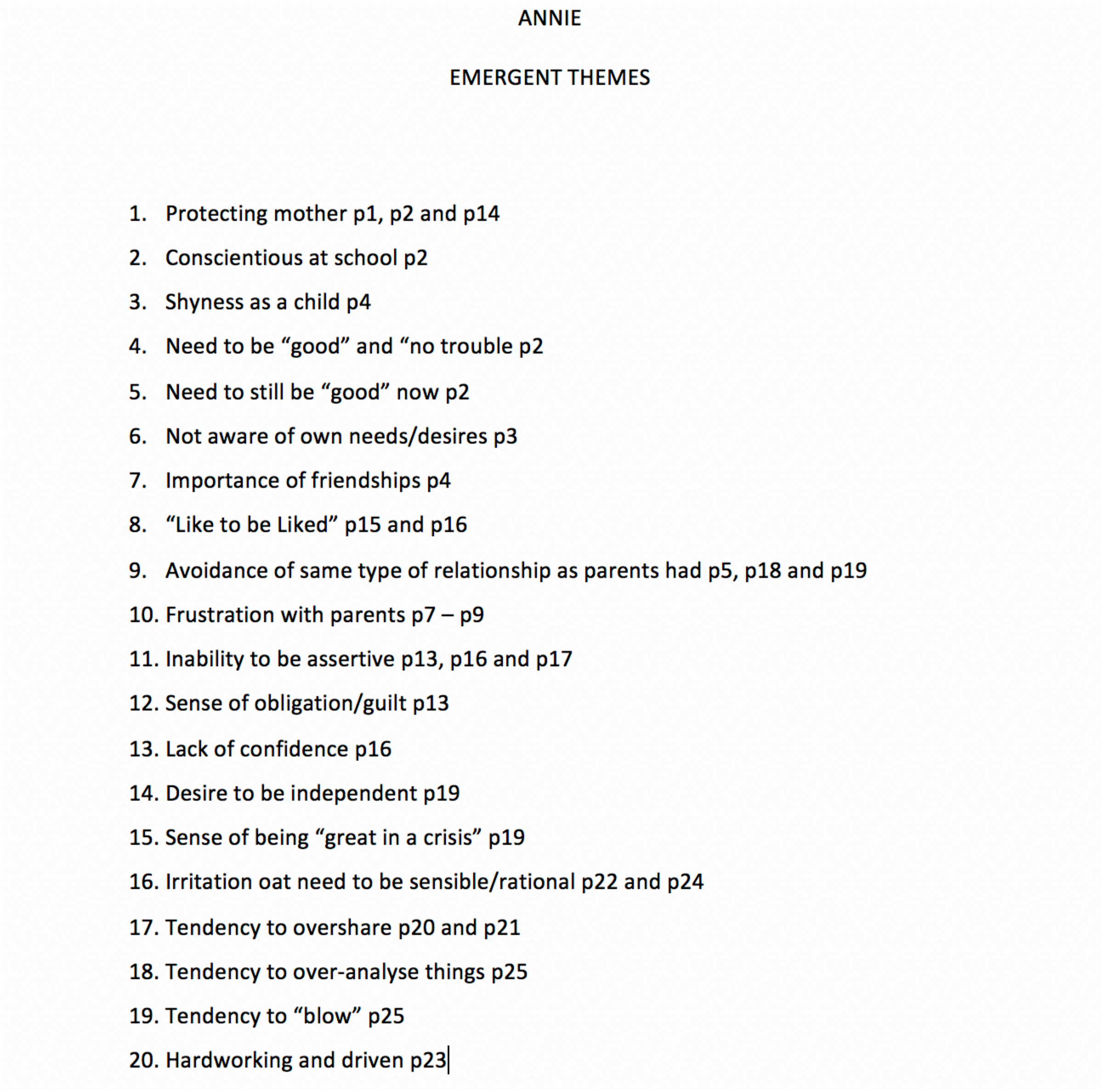
Appendix G – Transcript Analysis



Kelly is talking about still worrying about her brother even though (at the time of this interview) he is quite stable. This feels like an additional thing taking up time and space and sounds reminiscent how time and space was taken up by her brother in her childhood too.	P:	But I do believe I'm still like that now even though everything's fine (laughter). I think it's so engrained that I find it extremely hard, extremely hard.	It is interesting that Kelly laughs at herself for worrying and just before stating (twice) how "extremely hard" she finds it. There is a sense of her dismissing her feelings
	I:	**Mm, and also, you mentioned you find it hard to talk about emotional things and, in particular, when things go wrong in a relationship? And that when you think something is going to go wrong in a relationship and you kind of withdraw?**	It feels here as if Kelly is quite conflicted about whether she should still be worrying about her brother now Is prioritising her brother's needs another way to avoid a relationship too?
It is interesting she says everything is fine (and laughs) when she found it hard being told *she* was 'fine' as a child. Is she dismissing her struggles now in the way her parents did when she was younger?	P:	Yes.	
	I:	**Can you tell me a little bit more about that?**	
Is this because so many of her relationships in her childhood went "wrong" (brother, mother and even her father leaving)? It feels like Kelly finds it hard to trust that a relationship will last but can see that may influence the other. Another sign perhaps of an avoidance attachment style?	P:	Yes. If I have gone into a relationship my thoughts are already quite negative, as in, I think that something is going to go wrong. So, I would withdraw as a protection for myself of not getting hurt. But obviously I've since learnt that that can very much have a negative impact on the person I'm in a relationship with because they then probably go into the mode of, they don't want to get hurt. Because I'm very distant, so therefore… It becomes this circle of 'no-one's giving anything!' (laughs)	Kelly seems to be making an important (potentially unhelpful) assumption here that a relationship will inevitably go wrong Kelly is clearly linking 'withdrawing' with 'protection' Sense of an avoidant attachment style Again, the laughter feels a bit dismissing of her own process

Descriptive Linguistic Conceptual

Appendix H – Emergent Themes

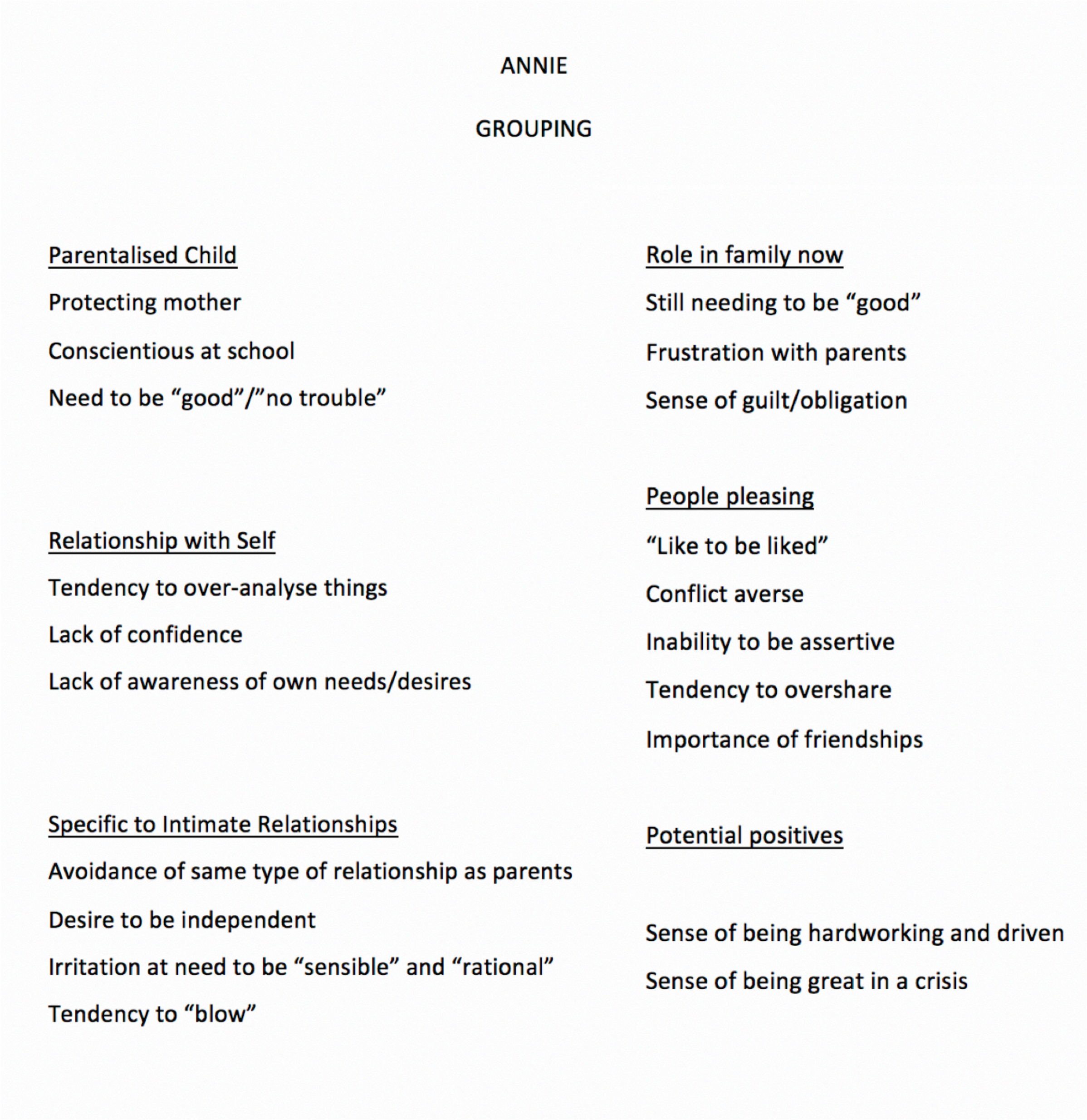


ANNIE

EMERGENT THEMES

1. Protecting mother p1, p2 and p14
2. Conscientious at school p2
3. Shyness as a child p4
4. Need to be “good” and “no trouble p2
5. Need to still be “good” now p2
6. Not aware of own needs/desires p3
7. Importance of friendships p4
8. “Like to be Liked” p15 and p16
9. Avoidance of same type of relationship as parents had p5, p18 and p19
10. Frustration with parents p7 – p9
11. Inability to be assertive p13, p16 and p17
12. Sense of obligation/guilt p13
13. Lack of confidence p16
14. Desire to be independent p19
15. Sense of being “great in a crisis” p19
16. Irritation oat need to be sensible/rational p22 and p24
17. Tendency to overshare p20 and p21
18. Tendency to over-analyse things p25
19. Tendency to “blow” p25
20. Hardworking and driven p23

Appendix I – Grouping of Themes



ANNIE

GROUPING

Parentalised Child

Protecting mother

Conscientious at school

Need to be "good"/"no trouble"

Relationship with Self

Tendency to over-analyse things

Lack of confidence

Lack of awareness of own needs/desires

Specific to Intimate Relationships

Avoidance of same type of relationship as parents

Desire to be independent

Irritation at need to be "sensible" and "rational"

Tendency to "blow"

Role in family now

Still needing to be "good"

Frustration with parents

Sense of guilt/obligation

People pleasing

"Like to be liked"

Conflict averse

Inability to be assertive

Tendency to overshare

Importance of friendships

Potential positives

Sense of being hardworking and driven

Sense of being great in a crisis

Appendix J - Overlapping Circles