A PSYCHOSOCIAL STUDY OF YOUNG ADULTS' EXPERIENCES OF THEIR SIBLING'S MENTAL ILLNESS

A thesis submitted in partial fulfilment of the requirements for the degree of

MASTER OF ARTS IN COUNSELLING PSYCHOLOGY

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By

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Abstract

There are a number of studies that investigate the experiences of mental illness in the context of sibling relationships. However, these studies have not focused on young adulthood and limited research has been conducted in South Africa. This research uses a psychosocial framework which combines psychoanalytic theory and social constructionism to account for individual subjectivity and social influences. This method sought to answer two main research questions: how do young adults construct their experiences of having a sibling with a mental illness and with what effects, and how might we understand the emotional investments in these constructions? Six participants were interviewed and the findings suggest that participants draw on four main discourses in constructing their siblings' mental illness: a discourse of mental illness as a sickness, a discourse of mental illness as part of the person, a discourse of mental illness as bad behaviour, and a discourse of mental illness as a spiritual issue. These discourses and the function of these discourses are discussed. Furthermore, an extract from one participant is examined in a case study format so as to explore the emotional investments in the discourse of mental illness as bad behaviour, arguing that her investments in this discourse serves to protect her by enabling her to manage feelings of not being 'good enough'.

Keywords: psychosocial research, sibling relationships, mental illness, young adulthood, discourses, psychoanalysis

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Introduction

This study aims to explore the experiences of young adults who have a sibling who has been diagnosed and hospitalized with a severe mental illness. In particular, this study adopts a psychosocial methodology and as such combines psychoanalytic theory and social constructionism in order to take into account individual subjectivity and the unconscious mind while simultaneously incorporating the social context in which the person is embedded (Hollway & Jefferson, 2005). Adopting this theoretical framework, allows us "to accommodate and interweave the social world of constructed meanings and the psychic world of emotions, anxieties, and defences, and to bring into play the structural aspects of social life alongside the structures of the mind" (Edwards et al, 2006, p. 6).

Research has been conducted in this area; however, the experience of mental illness in sibling relationships in young adulthood has been a neglected area. Additionally, limited research has been conducted in South Africa. Research that has been conducted focuses on late adulthood experiences of having a mentally ill sibling within a predominantly American context. By using a psychosocial methodology, this research seeks to answer two main questions: how do young adults construct their sibling's mental illness and with what effects, and why do they construct it in this way? By answering these questions, this research engages with both internal and psychological aspects, as well as external or social aspects of participants' experiences of their siblings' mental illness.

The first chapter of this thesis includes a review of existing literature. The literature review will discuss the following: understanding sibling relationships; sociocultural constructions of sibling relationships; experiences of sibling's mental illness; consequences of mental illness for sibling relationships; the experience of stigma; sociocultural constructions of mental illness; and sibling experiences of mental health care and mental health care practitioners in South Africa. Chapter two sets out the theoretical framework for this research describing the theoretical background to a psychosocial research methodology. In particular, this chapter serves to explain the use of social constructionism alongside psychoanalysis as the main paradigms influencing the methodology.

The third chapter describes the methodology used. The chapter addresses the research questions, sampling procedures and participant recruitment, participants' characteristics, method of data collection, method of data analysis, validity, reliability, and transferability of data, and ethical considerations. Chapter four sets out the findings of the thesis. This chapter is divided into two main subsections, namely, a discursive reading and a psychoanalytic reading of the data. The discursive readings of the interviews seek to explore the discourses that all participants draw on in constructing their sibling's mental illness while the psychoanalytic reading is added by using an extract from one participant's transcript, presented in a case study format. Chapter five is the closing chapter, which is the discussion and conclusion. This chapter incorporates the findings of the research in relation to the literature reviewed. Additionally, the researcher includes a reflection of the research process, the strengths and limitations of the study, and directions for future research.

Chapter 1

Literature review

1.1 Introduction

Sin, Moore, and Harris (2008), state that there is limited research in the area of mental illness and sibling relationships and Scharf and colleagues point out that this is particularly so in the context of young adulthood (Scharf, Shulman & Avigad-Spitz, 2005). It is important to investigate the perspectives of young adult siblings who have a sibling/s with mental health problems as the attitudes and beliefs of relatives are effectively helping to shape the world in which mental illnesses are defined and understood (Jones, 2002). In addition, research on young adults' experiences of their sibling's mental illness will provide mental health care professionals with a better understanding of experiences and perceptions of siblings of those younger individuals who need to develop lives outside of hospitals (Jones, 2002). This research is particularly relevant in South Africa due to overstretched public mental health care services and resources, as well as poor service delivery (Petersen & Lund, 2011), where family members frequently have to bear the burden of care for their siblings who are mentally ill.

This review will discuss the following: understanding sibling relationships; sociocultural constructions of sibling relationships; experiences of sibling's mental illness; consequences of mental illness for sibling relationships; the experience of stigma; sociocultural constructions of mental illness; and sibling experiences of mental health care and mental health care practitioners in South Africa. These topics are an extension of, and elaboration on, the main purpose and focus of the review, which is the experience of having a mentally ill sibling and how this mental illness impacts on the sibling relationship.

1.2 Understanding sibling relationships in early adulthood

The literature on sibling relationships during young adulthood (ages 18 to 25) has been largely overlooked and disregarded in psychology relative to the focus on the importance of parent-child relationships for the foundation of personality development (Abrams, 2009; Conger & Little, 2010; Edwards et al, 2006; Jones, 2002). Although parent-child relationships are indispensable, sibling relationships have a noteworthy and profound impact on an individual's personal, social, and emotional development (Abrams, 2009; Jones, 2002). The relationship greatly influences each sibling's identity development, individuation, management of rivalry and conflict, and facilitates the development of love, affection, acceptance, closeness, and independence between siblings (Jones, 2002; Riggio, 2006; Stocker, Lanthier & Furman, 1997; Weaver et al, 2003). However, these developments do vary as a result of familial differences in the dynamics and role expectations of siblings (Jones, 2002, Riggio, 2006). Stocker et al (1997) explored the relationship of siblings during young adulthood and concluded that the power dispute for love and affection from parents dissipates during this transition. This is such that sibling relationships during young adulthood are characterised by higher levels of warmth, affection, and independence. Thus the sibling relationship in young adulthood enters a transitioning period, whereby the relationship shifts from being characterised by power disputes and antagonism to a relationship that is characterised by love, warmth, and affection. This shift is important for individual development and for the development of the sibling relationship.

Buhrmester and Furman (1990) found that adolescents entering early adulthood distance themselves from their siblings due to a greater focus on friends, romantic partners and new interests in life which results in siblings engaging in "less quarrelling, antagonism, and competition, and issues of power and status become less relevant" (p. 65). Although siblings may physically distance themselves from one another during the young adulthood phase, their emotional bond strengthens in terms of sharing personal information and experiencing lower levels of conflict and rivalry with one another (Scharf et al, 2005). According to Scharf et al (2005), the distancing of siblings from one another in early adulthood may be a contributing factor to the increased levels of warmth and affection as well as stronger emotional bonds. This distancing facilitates the acknowledgement and understanding of each other's personal opinions and/or needs and therefore leads to less conflict between siblings. Additionally, Scharf et al

(2005) determined that siblings are closer during young adulthood as they have experienced conflicts within their own peer groups and resolved these in certain ways. The ways in which these peer conflicts are managed are then translated into the sibling relationship and handled accordingly.

Siblings entering young adulthood also experience a "socioemotional and cognitive" maturing (Scharf et al, 2005, p. 83) which naturally leads to higher levels of warmth, affection, and emotional closeness thus leading to a closer sibling relationship. Scharf et al (2005) also attribute lower levels of conflict to each sibling's need for an identity independent from his/her sibling thus resulting in lower levels of competition with one another. Although siblings may experience varying levels of conflict and closeness with one another, there are other factors that may influence the development of the sibling relationship.

1.3 Factors influencing the development of sibling relationships

There are a number of factors that need to be considered which may impact on the development and quality of sibling relationships (Buhrmester & Furman, 1990, Edwards et al, 2006, Scharf et al, 2005). These include birth order, gender, and family size.

1.3.1 Birth Order

There is limited and conflicting research around whether birth order impacts on the sibling relationship in any way (Buhrmester & Furman, 1990, Edwards et al, 2006, Scharf et al, 2005). Scharf et al (2005) suggest that birth order does not significantly influence the sibling relationship. This is based on the premise that "with age, sibling relationships become more egalitarian, and relative age, namely whether a sibling is older, or younger becomes less relevant" (Scharf et al, 2005, p. 84).

1.3.2 Gender

Numerous studies on gender and sibling relationships have been conducted (Buhrmester & Furman, 1990, Scharf et al, 2005). Studies conducted show that same sex siblings, in particular sister-sister bonds, are characterized by higher levels of closeness, affection, warmth, and intimacy (Buhrmester & Furman, 1990, Scharf et al, 2005). However, although sisters have

been described as having closer relationships, Stocker et al (1997) found that opposite sex sibling's experienced lower levels of conflict and rivalry between one another as opposed to same sex siblings.

1.3.3 Family Size

According to Riggio (2006), family size may influence the development of sibling relationships. Scharf et al (2005) and Boer (1990) found that siblings in larger families felt emotionally closer and had better relationships with their older siblings as opposed to their younger siblings. In contrast to this, smaller families may place higher emphasis on individuation and independence resulting in higher levels of conflict and rivalry among siblings (Boer, 1990; Riggio, 2006). Power is evenly distributed among siblings due to the high emphasis on individuation thus contributing to higher levels of conflict and rivalry (Niehaus, 1994; Riggio, 2006).

1.3.4 Culture, sociohistorical context and sibling relationships

The literature suggests that siblings in larger families (more typical in non-western contexts) are more collectively-orientated with a higher emphasis on *Ubuntu* defined as "humaneness-a pervasive spirit of caring and community, harmony and hospitality, respect and responsiveness-that individuals and groups display for one another" (Mangaliso, 2001, p. 24), and are characterised by lower levels of sibling competition, rivalry, conflict and struggles for power (Boer, 1990; Nkosi & Daniels, 2007; Riggio, 2006). The reasoning for this closeness shared between siblings, from a South African perspective, is possibly due to the enforced migrant labour during the Apartheid era whereby parents were forced to seek jobs distant from their households therefore compelling them to leave their children in the care of neighbours and/or distant relatives (Niehaus, 1994). Older siblings had to prematurely assume more responsibility in the household and for the well being of younger siblings (Niehaus, 1994). This did not lead to higher levels of conflict or power struggles as siblings relied heavily on one another and in turn, they developed close relationships which are said to be characterised by "affection" and "willing reciprocity" (Niehaus, 1994, p. 118). Although Westernized and traditional African societies both place high responsibility on elder siblings, there are subtle differences in these roles (Cicirelli, 1994). In Westernized families, this role delegation is

allocated informally when parents request it whereas traditional African families allocate this role formally which is embraced as a cultural tribute and vital responsibility (Boer, 1990; Cicirelli, 1994).

1.3.5 Familial structure, mental illness and siblings

Although these familial factors may influence sibling relationships in particular ways, there are significant differences within families that portray the same familial structures (Furman & Buhrmester, 1985). Nevertheless, family size, birth order, gender, culture and social context may impact on the way in which a sibling becomes involved in a mentally ill sibling's disorder and the way in which they perceive or experience it. Horwitz (1993) conducted an exploratory study in which he interviewed 108 siblings with seriously mentally ill brothers and sisters. Horwitz (1993) found that when only one well sibling was interviewed, they reported higher levels of closeness and social and emotional support. Multiple siblings seemed to divide this support amongst one other so as to lessen the burden and support given (Horwitz, 1993). Horwitz (1993) also found that with age, well siblings became more involved in their ill sibling's life in terms of providing care and social and emotional support and being more affectionate. Horwitz (1993) found that the age difference between siblings and gender differences did not impact on the support given to ill siblings. It is important to note that this research will pay attention to the ways in which the particular family structure of the participants contributes to their experiences of their sibling relationship. This research is not concerned with effect sizes and/or correlations. This research focuses on the subjectivities of participants within their particular family context.

1.4 Sociocultural constructions of sibling relationships

Sibling relationships are a socially constructed phenomenon. The construction of sibling relationships is influenced by a variety of sociocultural factors (Cicirelli, 1994, Edwards et al, 2006). According to Baron, Branscombe and Byren (2009) as individuals are born into different cultures, religions, and social settings, there may be differences in the way one perceives situations, events, and/or other individuals as well as differences in meanings, values, and/or principles about the world. This relates to differences amongst sibling relationships across contexts. Many cultures, religions, and societies shape sibling roles and responsibilities. These may vary across cultural or social groups. As such, this research takes into account the South

African context and explores the role expectations of siblings in taking care of their mentally ill sibling in this specific context. Taking into account sociocultural factors of sibling relationships provides mental health care professionals with a better understanding and a more appropriate approach to working with siblings and families of a different context from one's own.

Cicirelli (1994) determines that westernized countries construct siblings' identities by "genealogical or biological criteria, where full siblings have two biological parents in common and half siblings share only one biological parent" (p. 9). Moreover, there may be adopted, half or step brothers and/or sisters who may be considered part of the family. Families may differ in terms of the involvement the adopted, half, and/or stepsiblings have within a family structure as some adopted, step, or half siblings may not be considered a full member of that family and are possibly treated differently. In contrast to this view, African sibling identities are constructed distinctly differently from those in Westernized countries. Within an African context, siblings are defined as being an extension of specific family members (e.g. cousins are considered to be brothers or sisters), or other criteria other than a sole genetic or marital link as in Westernised countries. The development of sibling identities in Non-Westernized countries varies significantly due to different cultural, social, and geographical orientations. In Kenya siblings are identified as any children who were raised in the same home and even children in the same age category that fall within the same tribal group (Cicirelli, 1994).

In South Africa, specifically among isiXhosa families, family members are not considered as only those who stem from the same biological family, thus emphasising the importance of extended family and the significance of this in the way in which sibling relationships are constructed (Siqwana-Ndulo, 1992). Since some South African siblings do not necessarily need to be related biologically, the family size is frequently larger than those from Westernized cultures (Cicirelli, 1994; Niehaus, 1994; Siqwana-Ndulo, 1992). This psychosocial study will focus on and pay attention to the sociocultural context of participants, and the ways in which this context leads to particular constructions or discourses of sibling relationships being dominant.

1.5 Sibling experiences of mental illness

Seltzer et al (1997) suggests that there is limited research in the area of well siblings' experiences of having a mentally ill brother and/or sister. Additionally, the research in this area has been conducted with participants either in, and/or entering childhood and/or late adulthood with less emphasis on individuals entering young adulthood (ages 18 to 25) (Conger & Little, 2010; Seltzer et al, 1997).

1.5.1 Support

According to research primarily conducted in the United Kingdom and United States of America, some young adults may detach themselves emotionally and physically from their ill sibling's life (Edwards et al, 2006; Seltzer et al, 1997). This distancing was found to occur early on in a sibling's diagnosis. This distancing is due to the associated negative effects mental illness has on the life of a well sibling and the new roles which siblings have to undertake (Seltzer et al., 1997). Well siblings described assuming the role of a caregiver once parents were past the stage of assisting their mentally ill child. This role was explored in a study by Hatfield and Lefley (2005) who found that siblings were expected to provide social and emotional support which was usually a forced responsibility as family members placed high expectations on well siblings to look after their mentally ill sibling. Well siblings described feeling inadequate in providing this care which resulted in the development of an atmosphere of hostility between siblings and feelings of guilt and self-blame in well siblings (Greenberg et al, 1997; Taylor, Greenberg, Seltzer, & Floyd, 2008; Hatfield & Lefley, 2005). Furthermore, the expectations placed on well siblings produced feelings of worthlessness as they felt as though they could not live up to these and as a result this heightened the negativity and hostility between siblings, which significantly impacted on the development of the relationship (Hatfield & Lefley, 2005; Taylor et al., 2008).

1.5.2 Guilt

Seltzer et al (1997) found that well siblings experience a variety of conflicting and overwhelming emotions, namely, guilt, fear, shame, and sadness particularly associated with the stigma of having a mentally ill sibling. Furthermore, research suggests that well siblings may despise their sibling and/or feel guilty for not expressing enough concern and sympathy

(Greenberg, Kim & Greenley, 1997; Sin et al., 2008). Lukens, Thorning, and Lohrer's (2002) research indicated that well siblings' anger toward their ill sibling was due to the guilt they experienced on a daily basis: well siblings felt that there problems were insignificant compared to their ill siblings' difficulties and when moments of happiness or joy arose, these were suppressed. Well siblings were unable to revel in these joyous moments as it was too guilt provoking to see the pain and suffering their ill sibling and parents were experiencing. Jones (2002) conducted a study, which explored the experiences of families and relatives living with a mentally ill family member. Jones' (2002) study found that guilt is accompanied by guilt. Guilt is experienced as a result of feeling angry towards a mentally ill relative, which is considered unfair by well relatives. . In addition, Jones reports that well relatives feel as though the previous person is lost and has been replaced with a 'new' person. The fear of betrayal also complicates this grieving process and creates feelings of ambivalence. The ambivalence is experienced when seeing that their relative is physically the same however their personality has changed. Well relatives feel as though they have betrayed their 'old' relative and the memories they shared when accepting the 'new' relative.

1.5.3 Loss

According to research conducted by Lukens, Thorning, and Lohrer (2002), well siblings may also experience a sense of mourning and loss when having a mentally ill sibling. Well siblings may long and mourn for the sibling they knew before the diagnosis as well as whom the sibling might have become without the illness. Additionally, well siblings felt that they lost a 'normal' sibling relationship, and their freedom, privacy and control. Well siblings felt responsible for tending to their ill siblings needs thus preventing them from making daily plans of their own. This resulted in feelings of loss of control and privacy and heightened intrusiveness in their lives, as ill siblings were a priority in terms of caregiving. Jones (2002) found that families experience a variety of emotions towards their ill relatives. He discusses grief, in particular, as being a complicated process experienced by relatives of mentally ill siblings. This grief is referred to as 'complicated grief' whereby well relatives experience a 'loss' in terms of a change or difference in their ill relative's personality and/or behaviour due to the mental illness. These changes are regarded as negative as their well sibling is no longer considered to possess any positive attributes that they had prior to their diagnosis. . The process of this grief is

experienced differently by all family members and is further complicated by feelings of ambivalence. This ambivalence includes; feelings of reluctance whereby well relatives do not want to let go of the person they remember their relative used to be prior to diagnosis; and feelings of acceptance whereby well relatives accept that their ill relative is not the person they used to be.

Lukens, Thorning, and Lohrer (2002) also found that well siblings fear their ill siblings. This fear expressed itself in many forms. Some well siblings feared the unpredictability of their siblings' mental illness and the ways in which they might behave whereas other siblings feared becoming mentally ill themselves. An article published by Griffiths and Sin (2013) suggests that having a sibling with a mental illness can be an extremely challenging and traumatic experience for well siblings, which can ultimately affect their own psychological well-being. This may be due to their associated feelings of isolation and/or rejection from parents, overwhelming feelings of anger and/or guilt or an imitation of these psychological illnesses as a desperate attempt to gain attention from their parents (Sartorius, 2005): "All participating siblings described feelings of being overwhelmed by the psychological impact of a brother's or sister's onset of psychosis and the subsequent impact on their own lives and emotional well-being" (Sin et al., 2008, p. 35).

1.6 Consequences of mental illness for sibling relationships

There are a number of consequences of a mental illness diagnoses for sibling relationships (Sin et al, 2008). According to Abrams (2009), the sibling bond may weaken as the diagnosis may influence well siblings to distance themselves from their ill sibling. As previously mentioned, this is due to the pressures and expectations of well siblings as they are forced into assuming overly responsible caregiver positions, having to become independent prematurely, and experiencing feelings of guilt, shame, and neglect. Stocker (1997) conducted a study, which indicated that there are higher levels of conflict between siblings when a sibling has been diagnosed with a mental illness. Mentally ill siblings may contribute to this sibling conflict and rivalry as they continually focus on the negative aspects of the relationship thus fuelling the conflict between each other (Seltzer et al, 2008, Stocker, 1997). Additionally, the sibling bond may worsen, as previously mentioned, due to well siblings' difficulties and fears of establishing romantic and interpersonal relationships (Abrams, 2009, Edwards et al, 2006, Sartorius, 2005).

Well siblings fear that they will not be able to be intimate with someone because all their attention will be directed towards their ill sibling. Additionally, well sibling fear how their ill sibling may act in the company of others, which also generates fears of rejection or judgement from others (Abrams, 2009).

According to Abrams (2009), communication channels between family members and siblings are impaired and issues pertaining to the disorder are not discussed. This is due to a longing for normality and fear of stigma therefore families avoid talking about the disorder. This further contributes to the well siblings above mentioned fears and reluctance of starting their own family. Well siblings may blame their mentally ill sibling for relationship difficulties between friends and family members because they fear the associated stigma and judgement (Abrams, 2009, Edwards et al, 2006, Seltzer et al, 2008). Jones (2002) found that family members of mentally ill relatives would blame external factors for the onset of the disorder. This revealed that family members feared the blame and associated shame that was attached to the stigma of having a mentally ill relative. Furthermore siblings determined that they felt the stigma attached to the diagnosis of their sibling to be extremely distressing which resulted in feelings of abandonment and reclusive behaviours leading to less disclosure of this information with other persons (Sin et al., 2008). According to Sartorius (2005), "siblings report less warmth, closeness, and satisfaction in the relationship when there is a mentally ill sibling" (p.133). Furthermore, well siblings may experience higher levels of anxiety, isolation, elevated worry about their futures, as well as low levels of self-esteem. Well siblings avoid disclosing information about their ill sibling and may present themselves to others as being the only child.

Horwitz (1993) conducted a study, which discussed sibling roles in caregiving for a mentally ill sibling. Findings indicate that well siblings provide social support for their ill sibling so as to prevent their ill sibling from experiencing loneliness and isolation. Additionally, well siblings do not undertake parental roles such as providing financial support or household needs for their mentally ill sibling, however siblings were willing to provide these if required. Well siblings were found to provide more emotional support than any other, however, they were also involved in assisting with shopping, transport, crises support, and gift giving. These roles offered by well siblings provided ill siblings with optimism and support. It was found that well siblings were less involved in their ill sibling's life when their parents were still alive, however, provided

more love and affection and financial and social support when their parents had passed away. Additionally, well siblings were found to spend more time physically with their mentally ill sibling as opposed to telephonically, resulting in a closer and more intimate sibling relationship. Well siblings were found to be more willing to offer support of all kinds to ill siblings when there was reciprocity of affection and love from their ill sibling as well as an attempt to complete household tasks.

Therefore, there is research that points to associated positive effects of experiences of mental illness in siblings, including that well siblings sometimes feel emotionally and socially closer to their mentally ill brother or sister (Edwards et al, 2006; Seltzer et al, as cited by Hortwitz, 1993, Sartorius, 2005). Sartorius (2005) found that well siblings might involve themselves in their ill siblings' disorder and proudly assume the caregiver role. Additionally, well siblings can experience personal growth and learn to be more accepting, caring, patient, supportive, and selfless which strengthens the sibling bond. In sum, it is evident that well siblings experience feelings of ambivalence with regards to having a mentally ill sibling.

1.7 Experiences of stigma

Being diagnosed with a mental illness has always been surrounded by feelings of guilt and shame whereby both the mentally ill sibling and the family suffer from the stigma attached to being diagnosed with a mental disorder (Jones, 2002, Mermier, 1993, Sartorius, 2005). Stigma is a socially constructed concept (Crowe & Lyness, 2013; Veltman, Cameron, & Stewart, 2002). According to Goffman (1963), society determines the ways in which individuals are grouped within a social setting. These social settings and persons who form part of each social group establish what they consider to be normal and/or 'right' traits. Thus, individuals within a social setting become familiar with persons who fall within one's social group. When individuals from one familiar social group are faced with individuals from a different social group, there is an immediate attribution or classification of that persons "social identity". Individuals who are labelled as mentally ill are viewed as being 'abnormal' and are feared (Rosenhan, 1973). From this, we generate assumptions about the person, which may or may not be true. Goffman (1963) states that stigma develops when an individual differs from us we find that this person has "an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind- in the extreme, a person who is quite thoroughly bad, dangerous, or

weak" (p. 3). These individuals are considered insignificant, undesirable and are stereotyped and discriminated against.

According to Fink (1992), mentally ill individuals are portrayed by society as dangerous and out of control. These prejudices were generated from medieval times when mentally ill individuals were thought to possess demons. Mentally ill individuals are discriminated against as being dangerous, weak, strange, and responsible for their own diagnoses. The stigma associated with mental illness prevents individuals from attaining jobs and medical treatment, and frequently leads to financial difficulties. Mentally ill individuals are depicted by society as being dangerous due to the images portrayed on television programmes, movies, and newspapers (Fink, 1992).

Botha, Koen, and Niehaus (2006) conducted research on schizophrenic patients and their perceptions of stigma in the South Africa population. It was found that stigma is generated from cultural and religious views. In South Africa, there is a high focus on mental illness as culture-bound syndromes or as a result of supernatural powers. Schizophrenic patients reported being abused physically and verbally as well as ridiculed through name-calling, a form of stigmatisation and discrimination. There was a higher reported incidence of this in isiXhosa speaking communities. Furthermore, a study conducted by Mbanga, Niehaus, Mzamo, Wessels, Allen, Emsley, and Stein (2002) explored isiXhosa families' attitudes and beliefs of the causes of schizophrenia and found that the majority of participants perceived evil spirits and witchcraft as the cause of schizophrenia.

Stigma affects families and siblings in catastrophic ways. Stigma directly affects well siblings resulting in social discrimination, guilt about being well, loss of freedom, fear, embarrassment of the ill sibling's behaviour and illness, divisions in sibling relationships, withholding disclosure of the illness to friends and family, and reluctance to seek help (Ahmedani et al., 2013, Jones, 2002, Jonker & Greeff, 2009). The concept of stigma among psychologically well siblings has also been raised by Jones (2002) and Sin et al. (2008) who describe the associated stigma around mental illness diagnosis as extremely distressing leading to feelings of abandonment and seclusion frequently resulting in diminished disclosure of information with other persons. Jones (2002) states that families feel isolated by society as a result of stigmatisation aimed at those who are mentally ill. Additionally, families experience

stigma from professionals as a result of blaming families for the development of the individual's mental illness. In particular, in traditional psychology, mental health care professionals often blame parents for the development of a child's mental illness. This exacerbates feelings of isolation and self-blame. The experience of stigma leads well siblings to feel as though having a mentally ill sibling is a catastrophic and lifelong burden (Marsh & Johnson, 1997).

1.8 Experiences of mental health care

Jones' (2002) study, which is based in the United Kingdom, on mental illness and family relationships revealed that siblings experience extreme frustration with mental health care services. Frequently, young adults described professionals withholding a diagnosis from well relatives, resulting in a lack of understanding of their sibling's mental illness, thus heightening the exasperation experienced by siblings.

According to Lund, Petersen, Kleintjies, and Bhana (2012), South African mental health care is broken down into three levels: primary, secondary, and tertiary level care. Primary mental health care consists of community clinics and are designed to assist in providing patients with on-going medication, ensuring patients are adhering to and receiving the correct treatment as well as assessing their overall mental state. Unfortunately, due to lack of correct resources, medications, staff, and facilities, patients end up returning to tertiary level mental health care facilities as their mental illnesses are mismanaged. Additionally, it has been identified that there are a lack of community-based rehabilitation programmes at a South African level. These programmes include providing adequate and appropriate care at community level as opposed to institutionalising them at tertiary level. However, there are a lack of these services in South Africa and as a result mental health care users are rejected from their communities, default their medication, and avoid attending necessary appointments with mental health care professionals. Secondary level mental health care includes psychiatric departments within general hospitals. Research indicates that patient care at this level is mismanaged due to undertrained professionals and lack of resources. Tertiary level mental health care consists of specialist psychiatric hospitals. There is a "revolving door" pattern that occurs at this level whereby mental health care users are discharged and then readmitted shortly after due to the lack of community-based rehabilitation programmes at a primary mental health care level (Lund, Petersen, Kleintjies, &

Bhana, 2012). Well siblings play an important role in community-based care, thus it is important to explore their perceptions and experiences of having a mentally ill sibling so as to identify the effects these perceptions may have on ill siblings who rely on community-based interventions.

A study conducted by Ensink & Robertson (1999) consisted of 62 African patients from psychiatric institutions in Cape Town, South Africa who were interviewed about their experiences of psychiatric services and traditional healers. Their results varied whereby families reported that they were both satisfied and dissatisfied with psychiatric institutions and traditional healers. Respondents stated that there were poor psychiatric facilities, shortages of nursing staff, and lack of security between patient wards. Although this research explores the effects of mental illness on the sibling relationship, it also investigates well siblings' perceptions of mental health care professionals and the relevant institutions their siblings were admitted to. The ways in which well siblings construct mental illness may influence their views of mental health care professionals. Lukens, Thorning, and Lohrer (2002) conducted focus groups as part of their study and found that well siblings experienced anger and frustration towards their mentally ill sibling due to beliefs that ill siblings were purposefully deceiving and exploiting mental health care professionals, thereby constructing mental health care professionals as being easily manipulated or tricked by mentally ill individuals.

1.9 Summary

The literature reviewed above discusses both positive and negative effects of mental illness on the sibling relationship and on the well sibling. Although there is conflicting and contradictory research, siblings play an important role in each other's lives and particularly in the case when one sibling is mentally ill. As siblings play a large role in terms of love, support, and care, the sibling relationship highlights the importance of informal community care with regards to mental illness. Therefore it is important to explore the ways in which well siblings perceive or view mental illness as this will affect the way in which the sibling relationship is affected. These perceptions may vary across societies, cultures, or individuals, which may explain the contradictory findings of the literature. Most of the literature reviewed above has been conducted outside of a South African context. Although Jones' (2002) work is highly useful, we cannot assume the same within a South African context, as there may be cultural and socioeconomic

differences in the roles siblings play in each other's lives. These factors need to be considered as they play an important role in the way individual's perceive or view mental illness. In sum, the important aspects of this research are; to explore the perceptions that well siblings hold with regards to mental illness, and to explore the different ways in which these perceptions affect the sibling relationship.

Chapter 2

Theoretical framework

2.1 Introduction

This chapter will discuss the key methodology used throughout this research, namely a psychosocial research methodology. This methodology uses a combination of psychoanalysis and social constructionism, two key theoretical approaches, which are also discussed in relation to mental illness and sibling relationships. This research draws on the description of social constructionism by Edwards et al (2006) who describe its key premise as follows: "that meanings and realities are negotiated and shared between people" (p. 9). Social constructionists believe that an individual's social world, which includes their culture, religion, histories, and primary social interactions, influences the way in which a person understands or makes meaning of certain experiences. This suggests that these meanings are constructed from shared social contexts whereby individuals determine what is considered the social norm within that particular group; reality is continually changing based on past social interactions. Social constructionists consider that language and discourses effectively shape reality and define discourses as ways of knowing and being which are made available to individuals. Powerful cultural and/or political groups strongly influence and define what discourses are available to society however this may result in discrimination against other social orientations. Thus, this study is interested in the discourses participants draw on in constructing their experience of having a sibling with a mental illness. However, this study combines this social constructionist emphasis with a psychoanalytic emphasis so as to be able to show "how conflict, suffering, and threats to self, operate on the psyche in ways that affect people's positioning and investment in certain discourses rather than others" (Hollway & Jefferson, 2005, p. 19).

Psychosocial researchers are interested in employing psychoanalysis alongside discursive psychology in terms of exploring an individual's unconscious conflicts or drives (Hollway & Jefferson, 2005). Researchers are provided with a deeper and richer understanding of an individual's narrative or story when incorporating and exploring the emotional investments they make (Frosh & Saville Young, 2008). Thus, by including psychoanalysis in a social

constructionist study on participants' experiences of having a mentally ill sibling, we can explore the conscious and unconscious motives behind the emotional investments individuals have in specific discourses. By encapsulating and observing the emotional investments one makes and focusing on the processes rather than only the content of participant's narrative truths, the researcher is able to understand and explore the subjective meaning making of their experiences. According to Frosh and Saville Young (2008), the incorporation of psychoanalysis "may offer a more complete (because more individualised as well as emotion-inflected) interpretive re-description of interview material with helpful links to clinical perceptions and practices" (p. 3).

Frosh and Saville Young (2008) describe the continuities and discontinuities between social constructionism and psychoanalysis. They argue that both social constructionists and psychoanalysts are concerned with the use of language because they view reality as being constructed discursively or through language. Nevertheless, they point out that there are differences in the way each understand and interpret language and experiences. Psychoanalytic approaches are concerned with an individual's unconscious inner world and how this is expressed through external reality and in relationships with others. Thus, what an individual says is based on a reflection of their inner world, which is an expression of their anxieties and defences that have developed as a result of relational interactions during infancy and have persisted throughout their lives. Social constructionists, on the other hand, believe that language is made available to us based on the discourses that have been constructed through an individual's social context thus influencing the language that they may use (Wetherell, 2003 as cited in Frosh & Saville Young, 2008). Social constructionism is critiqued for disregarding the subjectivity of an individual and solely focusing on the social context whereas psychoanalysis has been critiqued for an over-emphasis on internal processes while disregarding the influence of one's social context. This research recognises the value of bringing these approaches together.

2.2 Social Constructionism, sibling relationships and mental illness

According to Edwards et al. (2006), from a social constructionist perspective, the meaning of being a sibling is constructed depending on whether you are a younger, middle, or older sibling. As siblings are exposed to dominant discourses constructed by society, the role of being a sibling pertains to specific ways of being in the sibling relationship. These birth positions

are socially constructed and adaptable in terms of how they are defined and who takes them up. Individuals are exposed to a variety of discourses based on one's gender, socioeconomic status, race, culture, and age. These discourses and their associated meanings shape the way in which one makes sense of what it means to be a sibling and who is classified as being a sibling within a specific social context. The way in which siblings relate to other sibling groups depends on their cultural and/or dominant discourses available to them and through interactions with their own sibling in their everyday environments (school, home, work, and so on): "sibling relationships are created and maintained through talk, activities, rituals, unwritten conversations and constantly negotiated rules and practices, much like other family bonds and friendships, rather than being 'natural' and inevitable occurrences" (Edwards et al, 2009, p. 10).

Therefore, depending on the sociocultural context from which a sibling originates, the constructions of what it means to be a sibling within the relationship will vary. These discourses shape how siblings are supposed to be and what their roles are in the relationship.

2.4 Mental illness as a social construct

According to López and Guarnaccia (2000), mental illness and behavioural problems are directly linked to the external social world. Mental illness is constructed by society and there are many social forces including culture that play a role in the ways in which we treat those who are diagnosed as mentally ill. Different cultures understand and construct mental illness differently. López and Guarnaccia (2000) term this cultural psychopathology. According to Brown (1995), language, culture, race, gender, technology, and other factors are used as tools that develop and shape the norms that shape or develop our assumptions about all factors involved in mental illness (treatment, prevalence, diagnosis). Thus, it is important to explore the cultural and social factors that are at play so as to understand the ways in which individual's construct or understand mental illness. These may vary across cultures and societies.

2.5 Psychoanalysis and Sibling Relationships

The founding father of psychoanalysis, Sigmund Freud, predominantly focused his research on parent-child relationships (Edwards et al, 2006, Lemma, 2003, Mitchell, 2003,). Freud's theory discusses how the parent-child relationship plays a vital part in the foundation of

one's personality development and that this interaction shapes the individual's future interaction style in all other object relationships. As a result, most psychoanalytic work has predominantly focused on the parent-child relationship as the central relationship in an individual's emotional and psychic development, and psychological health, side-lining the importance of the sibling relationship. The following section will explore some psychoanalytic theorists who have focused on the significance of sibling relationships.

2.5.1 Juliet Mitchell

Mitchell (2003) does not disregard the importance of Freud's Oedipal drama witnessed in the interaction between parent and child, rather Mitchell expresses the significance of the sibling relationship as an important social interaction that contributes towards an individual's psychic development and change. For Mitchell, the arrival of a sibling is a traumatic event for a child whereby the pre-existing sibling feels replaced after the realization that he or she will never be the baby again. Mitchell argues that the trauma of being displaced by a new sibling facilitates latent feelings of violence towards the new baby, which may be transferred into the siblings' wider object relationships.

According to Mitchell (2003), the new child may be perceived as a threat to the older siblings' individuality and conflicting feelings towards the new sibling may arise because "the ecstasy of loving one who is like oneself is experienced at the same time as the trauma of being annihilated by one who stands in one's place" (p. 1). Thus, older and younger siblings are faced with two contradicting internal feelings; hate, due to their displacement, and love at the thought that the baby is a replica of oneself.

Mitchell emphasises the importance of seriality in the sibling relationship. The birth of a new baby allows older siblings to learn their position in the family. She refers to the vertical relationship between parents and siblings and the lateral relationship between siblings. These positions are enforced by the mother whereby she instils that each child is unique from their sibling, however at the same time highlighting their similarity in terms of being children in relation to their parents (Hollway, 2005). As a result, this reiterates to siblings that there is equal room for all children and others that may arrive, which is referred to as 'the Law of the Mother'.

2.5.2 Melanie Klein

Alongside Mitchell's work, this research will also draw on Melanie Klein's object relations theory. Klein's work focuses on the psychic development of the baby, and argued that the most significant people in infants' lives became psychically represented as objects. The mind manipulates these objects in the mind in various defensive ways so as to manage anxiety. Klein described two different positions that became apparent during the first year of life, namely, the paranoid-schizoid, and the depressive positions (Hollway & Jefferson, 2005). The paranoid-schizoid position is the infant's primary relationship with the external world and is controlled by internal representations. According to Fonagy and Target (2003), the infant manages his or her external world through a mechanism called splitting whereby he or she "attributes all goodness, love, and pleasure to an ideal object and all pain, distress, and badness to a persecutory one" (p. 120). This can be understood in relation to the infant's hunger and mother's breast. The infant views the mother's breast as the ideal object when satisfying the infant's hunger, however, the breast soon turns to the persecutory object once absent. The breast is therefore viewed in parts as good or bad. The depressive position is characterised by the infant's ability to view the mother as a whole object, both the ideal and persecutory object. With this realization, the infant experiences guilt at expressing hate impulses towards the mother, referred to as 'depressive anxiety'. This position generates reparative fantasies of healing and restoring the loved object. It is essential that the mother does not reject or withdraw when the infant projects his or her aggressive impulses. If not, the paranoid-schizoid position perpetuates and the infant continues splitting.

Both these positions can be reactivated and present at any time throughout childhood and in adult life (Lemma, 2003) and each of these positions are associated with particular defences (e.g. splitting in the paranoid schizoid position) and emotional responses (e.g. guilt in the depressive position). A person's external world is a reflection of the person's internal psychological world and the way in which they interact with others. Therefore, the siblings will interact with each other based on their internalised self-other object relations from infancy (Fonagy & Target, 2003). This study is interested in the extent to which Klein's theory is helpful

in enabling an understanding of participants' investments in specific discourses in order to defend or protect them against anxiety (Hollway & Jefferson, 2005).

2.6 Summary

In sum, this chapter has argued that both theoretical approaches, namely social constructionism and psychoanalytic theory, hold much value when used simultaneously in interpreting and analysing research data. A psychosocial theoretical framework allows for us to explore what discourses an individual draws on in understanding mental illness and why they draw on these discourses as opposed to others. Much of the literature pays little attention to the sociocultural contexts in which siblings are situated and the ways in which their specific context plays a role in constructing their understandings of mental illness and their experiences of their siblings' mental illness. Thus by using a psychosocial approach, a person's social and cultural context is taken into account as well as individual differences, when exploring the experiences of having a mentally ill sibling.

Chapter 3

Methodology

3.1 Introduction

The following chapter discusses the questions that this research sought to answer, the ways in which participants were sampled and recruited, and the methods used in collecting, analysing and interpreting the research data. A psychosocial research methodology is used for this research. This approach combines a discursive approach with a psychoanalytic approach. A psychosocial approach is used as it allows us to explore what discourses well siblings draw on in constructing the mental illness of their siblings and why they draw on these discourses as opposed to others which are available, thereby, taking into account both the social context and individual differences.

3.2 Research questions

This research sought to answer the following discursive and psychoanalytic research questions, respectively: firstly, how do young adults construct their experiences of having a sibling with a mental illness and with what effects? Secondly, what are the emotional investments in these constructions?

3.3 Sampling procedure and participant recruitment

The researcher used a combination of purposive and convenience sampling methods. Purposive sampling is a method whereby the researcher specifies the characteristics that are required for the sampling criteria and seeks participants that possess them (Bless, Higson-Smith & Sithole, 2013). This research specifically focuses on young adults' experiences of their mentally ill siblings who had been hospitalized. This hospitalization, for the purposes of this research, was defined as being admitted as an inpatient due to a severe mental illness. This criteria requirement assisted the researcher in identifying that the sibling's mental illnesses were deemed severe or chronic. This method was also used to obtain a homogeneous sample. Recruiting a homogeneous sample means that the researcher requires a group of individuals that possess the same or similar characteristics. This is beneficial to the research as it ensures the

transferability of analysed data onto other parts of the population group. According to Bless, Higson-Smith and Sithole (2013), transferability can be defined as the extent to which the research results can be transferred or applied to other, similar contexts. The researcher is required to provide an in depth explanation of the data collection process and context, information about the researcher, and the researcher's relationship with participants. As a result, this information assists other researchers to determine whether the similarities of one researcher's findings are transferable to another context or situation. Furthermore, this approach provides a deeper understanding and accumulation of knowledge of the specific phenomena of interest, in this case sibling relationships and mental illnesses. As mentioned above, convenience sampling was also used. Convenience sampling is a sampling technique based on the availability of research participants. This research recruited participants from amongst Rhodes University students; this population group was used for convenience purposes as they were easily accessible and within close proximity, they also generally met the requirement of being a young adult.

The sampling criteria included: young adults between the ages of 18 and 25 (Conger & Little, as cited by Arnett, 2004), who attend Rhodes University as undergraduate students and have a sibling who has been hospitalized due to a chronic mental illness. The researcher aimed to recruit a fairly small sample to ensure in depth interviewing and insightful and meaningful data collection (Bless et al, 2013). The main focus of this research is to provide "a deeper insight into a complex phenomenon that might be specific and unique, and which appears in different ways in various units of the population" (Bless et al, 2013, p. 162). Therefore, a large sample size is unnecessary as the focus is on variety and not on trying to represent the larger population or generalize the gathered data.

After receiving ethical clearance and relevant permissions, Rhodes University students were verbally addressed by the researcher during one of their lecture periods. Permission was granted by the Rhodes University registrar, Dean of Students, the Head of Department from each relevant department approached, the year coordinators, and all lecturers concerned. An advertisement was read to students by the researcher indicating all the relevant information about the nature, purpose, and risks and/or benefits of the research. The researcher also posted this advertisement onto the Rhodes University staff and student portal page (appendix 1). Interested participants were asked to contact the researcher.

3.4 Participants

Six participants contacted the researcher and all were interviewed. There were no participants that dropped out of the study and all attended both interviews, one week apart. The original focus of this research was to recruit black students so as to gain a better understanding of possible sociocultural and sibling differences in an isiXhosa community. Furthermore, as family and siblings are highly involved in providing care to mentally ill relatives, especially in South Africa, a better understanding of experiences provides carers with insight into the effects of mental illness on family members and whether these experiences are shared among other isiXhosa siblings'. However, no participants who met these criteria volunteered. It was then decided to open the criteria to any racial group and language so as to increase the likelihood of participants volunteering. Only one black student volunteered for this research during the second advertising round.

Of the six participants that were recruited, five were females and one was a white male. Four of the five females were white with the fifth female being black. Participants ranged from 18 to 25 years old and were either in their 1st, 2nd, 3rd or Masters year of studying at Rhodes University. Although the criteria specified that participants needed to be in their undergraduate year of studying, this was to ensure that young adult students volunteered for the study. This presented as a problem for the researcher as one participant attended an interview, however stated that she was currently in Master's year (postgraduate). Nevertheless, she was 23 years old and fitted the sampling criteria of the study so it was decided to include her in the study and continue with the interview.

The majority of the participants in this research are young white females, which has certain implications that need to be considered. There is a greater need for research that explores cultural aspects of sibling relationships and mental illness from a black African perspective and with this study consisting of majority white Africans, it essentially reflects a more 'Westernised' perspective of these phenomenon. Additionally, certain taboos and indigenous ways of knowledge around mental illnesses are not explored extensively as only one participant from a black African group volunteered for this study therefore these findings may not be highly transferable to other black African individuals. A gender criterion was also not specified as the

focus of the study is of young adults' experiences of mental illness and the way in which this affects their sibling relationship as opposed to trying to explore differences amongst genders.

Table 1: Demographic Data for Participants

	Number of Participants (*total* = 6)
Gender	
Male	1
Female	5
Age (years)	
18	1
19	2
22	2
23	1
Year of study	
1st	2
2nd	2
3rd	1
Masters	1
Race	
White	5
Black	1

3.5 Data Collection

The interviews were conducted at the Rhodes Psychology Clinic at a time convenient to the participant. The data collection procedure involved conducting two in-depth interviews according to Hollway and Jefferson's (2005) Free Association Narrative Interview (FANI) method. This method involves asking the participants open-ended questions; using the participants' own words to stay within their meaning frame; allowing free association and divergences so as to allow for unconscious logic to surface; avoiding asking 'why' questions as these may result in general and intellectual answers which are unhelpful to the research topic;

and following up with a second interview. The FANI method can be summed up as "holding attentively to what emerges without irritably seeking to order and understand it" (Frosh & Saville-Young, 2008, p. 10).

The first interview consisted of two open-ended and semi-structured questions (see appendix 2). These questions facilitate the development of the participant's free flowing narrative with minimal talking or contribution on behalf of the researcher (Hollway & Jefferson, 2005). In other words, the participant was encouraged to freely associate. This method facilitates the expression of the dynamic unconscious, as there are no structured thought processes stimulated by close-ended specific questions. According to Hollway and Jefferson (2008, p. 209): "these associations follow pathways defined by emotional motivations, rather than rational intentions. According to psychoanalysis, unconscious dynamics are a product of attempts to avoid or master anxiety". Psychoanalytic theory states that the self will protect against feelings of anxiety. Defences are then utilized, at an unconscious level, to protect the self. These defences are present in an individual's relationships and other ways of being in the world (Lemma, 2003, Hollway & Jefferson, 2005). If a certain memory of an event is too anxiety provoking to recall, it may be remembered incorrectly and/or presented in a more desirable manner. Thus, we refer to individuals as 'defended subjects' (Hollway & Jefferson, 2005). Defences affect the discourses that an individual draws on and in turn affects the individual's ways of being in the world. The researcher is interested in these defences, which reveal themselves in the participant's narrative through "contradictions, inconsistencies, avoidances, and changes of emotional tone" (Hollway & Jefferson, 2005, p. 40). Both, the researcher and participant are considered 'defended subjects' in the research interview. This method allows the psychosocial participant to emerge as we gain access to the dynamic unconscious and the discourses a participant draws on. During the first interview, the researcher takes down notes in the participants' own words so as to remain in their meaning frame and uses these to develop further questions for the second interview (Hollway & Jefferson, 2005).

The follow up interview (see appendix 3), usually a week succeeding the first interview, was more structured in its approach. After an in depth listening to the first interview transcript and reading over field notes, I drafted up a semi-structured interview schedule (Hollway & Jefferson, 2005) for the second interview. The second interview did not allow for as much free

association from the participant and the questions asked were more specific in nature (Hollway & Jefferson, 2005). There was an increased focus in the second interview so as to further explore themes that were important but expressed through hesitations and avoidances in the first interview. These structured and more specific questions were drafted based on the information gathered in the first interview. I re-listened to the tapes and identified inconsistencies, contradictions, avoidances, hesitations, and omissions. I based the second list of questions around these so as to probe for a more detailed narrative within the second interview. Themes, which were also identified in the first interview, were further explored during the second interview in order to develop a deeper and more meaningful narrative. The second interview resulted in more information being divulged, as participants felt more comfortable and trusting (Hollway & Jefferson, 2005).

A second form of data collection included writing down field notes during interviews to identify the transference and countertransference between researcher and participant (Hollway & Jefferson, 2005). Transference can be described as the unconscious projection of feelings from the participant onto the researcher and countertransference can be described as the researcher's emotional responses towards and experiences of participants and their stories, which are recognised and reflected on (Lemma, 2003). I am also considered to be a defended subject thus my thoughts and feelings that were generated from the interview need to be explored.

According to Hollway and Jefferson (2005), from a psychosocial perspective, within the research interview, projections are understood to occur interchangeably and continually between participant and researcher. Projections occur so as to protect the self from experiencing overwhelming anxiety. When stories or memories are too anxiety provoking, we project or place the associated feelings onto others. These projections are "experience [d] through empathy" (Hollway & Jefferson, 2005, p. 46). The projected emotion may be rejected by the other individual or held, contained, and reflected back in a more manageable and less threatening manner. As the participant and researcher are both prone to projecting and identifying with one other's projections, what occurs in the research interview is a reflection of the participant's internal reality or unconscious thought. The participant will relate to the part of the self that is projected onto and identified by the researcher and vice versa (Lemma, 2003). Therefore the thoughts and feelings of the researcher are of vital importance in the analysis of the data

(Hollway & Jefferson, 2005). I reflected on the interview in a quiet space and wrote my thoughts and feelings down. I explored the reasons I felt the way I did and discussed these with my supervisor. These field notes were included as data in the data analysis.

3.6 Data Analysis

After conducting the interviews, writing up field notes and transcribing the interviews verbatim, the analysis of data began with the researcher performing a number of in depth discursive readings of the transcribed interviews (Frosh & Saville-Young, 2008). This included identifying interpretive repertoires, ideological dilemmas, and subject positions (Yates, Taylor, & Wetherell, 2001). Interpretive repertoires are shared meanings that are made available to describe social events, situations, and/or actions. According to Potter and Wetherell (1987) "interpretive repertoires are recurrently used systems of terms used for characterising and evaluating actions, events, and other phenomena" (p. 149). Ideological positions can be described as set ways of being in the world that are inexorable (Yates et al, 2001). These ways of being are significantly influenced by dominant cultural and societal norms, beliefs, and values. According to Billig et al (as cited in Yates et al, 2001), ideological dilemmas are characterised by contradictions or inconsistencies in talk. Ideological dilemmas and interpretive repertoires are constantly available in societies and facilitate the development of a conversation or talk. Ideological dilemmas "alert us to the possibility that different interpretive repertoires of the 'same' social object are themselves constructed rhetorically [through talk]" (Yates et al, 2001, p. 204). In other words, different meanings and understandings of the same social phenomena are generated depending on one's social or cultural context and the talk or language shared within these.

Interpretive repertoires and ideological dilemmas, which are available in societies place individuals into certain positions or identities, known as subject positions (Yates et al, 2001). We are placed into different subject positions depending on the different discourses or interpretive repertoires that are utilized. Subject positions make the connection between discourses or interpretive repertoires and the way in which individuals construct themselves. In my analysis I sought to identify interpretive repertoires or discourses participants draw on to describe their experiences and the subject positions that these interpretative repertoires make available, as well as the ideological dilemmas that the participants are confronted with as they draw on different

and sometimes contradictory interpretive repertoires. In addition, I sought to identify how the participant constructs and/or positions themselves and the other within their narrative. This was done through analysing the interview transcripts and identifying certain themes within their talk. These included "particular images, metaphors, or figures of speech" (Yates et al, 2001, p. 199). In particular, the researcher performed line by line coding, underlined key words, used columns on the side of the page to identify key words and then categorised the key words into broader themes.

Following this, the researcher identified specific core narratives in the interview, which highlighted any emotional 'breaches', interruptions, contradictions, or absences (Emerson & Frosh, 2004, Frosh & Saville-Young, 2008, Hollway & Jefferson, 2005). These were identified, as they are a reflection of a participant's internal world or their hidden unconscious drives or wishes (Hollway & Jefferson, 2005). These avoidances and emotional breaches represent the self-defending against anxiety. These contradictions and emotional breaches are understood to reflect part of a participant's hidden unconscious drives that are managed by the defended self, as previously discussed. These hidden drives which present themselves through the hesitations, emotional breaches, and inconsistencies, thicken the participant's narrative and allow the identification of conscious and unconscious 'reasons' for the participant to invest in certain discourses over others. This part of the analysis is therefore interested in *why* participants' employ particular interpretive repertoires, find themselves in particular ideological dilemmas, and in particular subject positions. This analysis has to include the field notes as a source of reflexivity. This is a psychoanalytic approach, which argues that one can only know the other through the self. Thus, the researcher's experience of the participant in the interview setting was of vital importance in interpreting the data (Frosh & Saville-Young, 2008).

I then conducted a psychoanalytic reading of the extract (Frosh & Saville Young, 2008, Hollway & Jefferson, 2005). Due to space constraints, I was only able to analyse one core narrative for the purpose of this research. This included numerous readings of the extract whereby the researcher drew on the participant's personal biography, which includes looking into their history and identifying patterns of actions and/or behaviours in past and current relationships. Alongside this analysis is the application of psychoanalytic concepts. In this research, Melanie Klein's Object Relations Theory, and Juliet Mitchell's Psychoanalytic

theorising on siblings, was utilized in order to understand or make sense of the participant's emotional investments in particular discourses. Lastly, as mentioned previously, the transference and countertransference present during the interview were analysed through the use of field notes so as a source of reflexivity as well as part of an additional source of data, which increased the validity across findings.

3.7 Validity, reliability, and transferability

According to Bless et al (2013), qualitative research cannot measure validity and reliability in a quantitative manner as the focus of the research is on gaining knowledge into a certain phenomenon and not on trying to prove or disprove a hypothesis. To ensure trustworthiness and a high quality of data, this research draws on the notions of transferability, triangulation, and binocularity. Transferability "refers to the extent to which results apply to other, similar, situations" (Bless et al, 2013, p. 236). Transferability was ensured by the researcher, through detailed descriptions of the data collection procedure, participant information (biographical details), the context in which data was collected, and the transference (participant's feelings towards the researcher) and countertransference (the researchers experience and feelings towards the participant). Additionally, triangulation was utilized which can be described as making multiple links across interviews and between interviews and field notes. This included collecting multiple forms of data (Two interviews and field notes). The researcher analysed the interview transcripts and identified links between the content and interpretation of data, and the researcher's experience of the participant in the research interview through detailed field notes. The researcher also included binocularity, which involved a combination of bottom-up (interview (talk), read transcripts, generate hypotheses and apply theory) and top-down (use theory, generate hypotheses, and interview (talk)) approaches in analysing and interpreting data (Frosh & Saville Young, 2008; Hollway & Jefferson, 2005). By combining both approaches, it reduces generating a heavy theoretical approach of a participant's transcript.

Reliability refers to the "consistency, stability, and repeatability of results" (Hollway and Jefferson, 2008, p. 74). Reliability is inappropriate in this context as each participant constructs his or her own meanings and these are related to a specific interpersonal encounter. However, as previously mentioned, reliability can be ensured by having evidence to substantiate claims.

Therefore, in reporting these findings, the researcher includes extensive extracts from the transcripts.

3.8 Ethical Considerations

Hollway and Jefferson (2008) discuss key ethical principals in relation to psychosocial research. They are as follows: firstly, they discuss payment and power as having an effect on the research relationship. Power is inevitable in the research interview as participants assume that researchers are immediately more powerful than them. Combined with payment, participants may feel as though they are obliged to disclose information or continue with the research interviews when actually wanting to withdraw. In this research, participants were given a R40.00 voucher to thank them for their time. This remuneration may have contributed to the power dynamic in the interview. Additionally, it was disclosed to participants that the researcher was a trainee counselling psychologist who reduced the power dynamics participants felt less intimidated. However, with the offer of remuneration, power dynamics also increased and participants may have felt pressured into attending both interviews. Although these power dynamics were present, I assured the participants that this research was completely voluntary and they could withdraw at any time.

Secondly, due to the nature of psychosocial research, informed consent needs to be discussed. This is due to the fact that psychosocial research and its questions are broad in nature and seek to gather information about participant's experiences (see appendix 4). They aim to elicit a free flowing narrative from the participant. The true nature of the research could not be fully described, as the first interview was unstructured so information that was disclosed by the participant may have been distressing for the participant. Participants were informed that if this did occur, the interview would be stopped, the participant would be comforted, and the researcher would show empathy and would refer on for further help if required.

Confidentiality is discussed by Hollway and Jefferson (2008) as a complicated issue. The more detailed and rich a narrative is the more chance that a participant (or others known to the participant) may be able to identify their narrative (even with the use of pseudonyms). Confidentiality was assured as only the researcher and supervisor had access to the interview transcripts. Additionally, pseudonyms and significant details that could result in the participant

being identified were changed in order to protect the participant's identity. Hollway and Jefferson argue that participants may feel uneasy discussing personal issues in a research interview; however, this does not mean that the surfacing of unconscious and hidden material causes any harm. I ensured that the research environment was containing so the participant felt as though they were heard and accepted therefore not threatened or harmed in any way.

In conclusion, power, informed consent, and confidentiality are three central principles in psychosocial research. Although Hollway and Jefferson discuss power, informed consent, and confidentiality to be complex principles to uphold in a psychosocial research context, I was honest, respectful, and sympathetic towards the participant's, ensured that they could leave at any stage, informed them of all procedures, and used pseudonyms to protect the participant's identity. This research has been through the Research Proposal and Ethics Review Committee, Department of Psychology and was granted ethical clearance (see appendix 5).

Chapter 4

Findings

4.1 Introduction

In the first part of this chapter, I make use of a social constructionist approach, in particular, discourse analysis to investigate the ways in which participants construct their experiences of having a sibling with a mental illness. In doing so, this chapter will also explore the subsequent subject positions that these discourses make available as well as the ideological dilemmas that participants have to negotiate as they draw on different and sometimes contradictory discourses. The way in which the sibling relationship is constructed within these experiences of having a mentally ill sibling, will also be discussed. As this research employs a psychosocial theoretical framework, it is interested in both the social and the psychic construction of experiences in relation to having a sibling with a mental illness. Therefore, in addition to a discursive reading, the second part of the findings utilizes a psychoanalytic approach alongside a discursive reading whereby the researcher is interested in *why* participants construct their sibling relationships with their mentally ill siblings in particular ways, exploring the unconscious and conscious 'reasons' for their emotional investments in particular discourses over others. While the discourse analysis is applied to all participants' transcripts, the psychosocial reading (combining both a discursive and psychoanalytic reading) is applied to one of the participants' interviews in a case study format. The reason for this is because the psychosocial approach is fine grained in its analysis and provides readers with a deeper understanding of the participant's narrative.

4.2 Constructions of siblings' mental illness

Participants drew on a variety of discourses in the construction of their sibling's mental illness. The following discourses were prominent throughout the interviews and will be explored further: a discourse of mental illness as a sickness, a discourse of mental illness as part of the person, a discourse of mental illness as bad behaviour, and a discourse of mental illness as a spiritual issue. Some participants drew on multiple discourses while others only drew on one in the construction of mental illness. When participants drew on multiple discourses, there were

varying constructions of the sibling relationship and the way in which they positioned their sibling. These will be discussed below.

4.3 A discourse of mental illness as a sickness

Ann draws on two contradictory discourses in constructing her experiences of her brother's depression. The first discourse that she draws on is a discourse of mental illness as a sickness. This discourse is employed in order to construct mental illness as a 'real' medical problem with her sibling. This is evident through the use of diagnostic labels and medical terminology. When Ann draws on this discourse, the sibling relationship is constructed as obligatory; in other words, she is obligated to provide her 'ill' siblings with love and acceptance.

Extract 1:

"*But just, I don't know what it was, just the idea of going to hospital because of a mental illness, because of depression, I was like "no, that was Jack". So, like I don't want to be associated, I think it was because I didn't want to be associated with Jack in that sense of, just thinking about it now, Jack was sick and I didn't know what was going on and people were like in hospital and I was little and he had medicines and he was doped up and I didn't know what was going on at that stage. I didn't want to go, I didn't want to go into hospital and be that unknown, surrounded by all this unknown*" (Ann, p. 25-26, 1. 1135-1142).

Extract 2:

"Um, I don't think so, because my mom was very supportive and encouraging of the fact of, yes, he's your brother and yes, he's sick, but it's not your problem, and it's not your fault, so, I just carried on living my life and I'm a kid, but my brother's sick and therefore I'm going to love him, but I'm not going to change who I am because with him I'm not, although I did change in just being more helpful of taking clothes upstairs, moving to the back seat, being quiet. But I think that was also just picking up on the vibes around me and that calmness was needed, and you just go out of your way to have calmness" (Ann, p. 20, 1. 876-883).

Extract one is Ann's response when she was questioned about her fears of being hospitalized because of a mental illness or psychological condition. When Ann refers to the

"depression", she is speaking about her own diagnosis. Ann was diagnosed after her brother, Jack, passed away in an accident and Ann's response after her mother suggested that she be hospitalized because of her depression. Extract two is Ann's response when she was questioned about her role expectations as a sibling in Jack's life. She explains what she thought was expected or required of her, as a sibling, in her mentally ill sibling's life. Both extracts are discussed interchangeably as they contain important and overlapping themes.

Ann draws on a discourse of mental illness as a sickness throughout her interview. In extract one, Ann refers to Jack as being medicated and *"doped up"* and in extract two, she refers to Jack as *"sick"*. When Ann draws on this discourse, she views mental illness as being a physical or medical problem as though Jack has something wrong within his body. The use of the words *"doped up"*, *"medicines"*, and *"sick"*, describes mental illness as solely requiring medical intervention as a form of treatment and that the person cannot function without it. When Ann draws on this discourse, she positions Jack as 'sick' or 'unwell'. In relation to Jack's subject position, Ann positions herself as a 'caregiver'. When Ann draws on this discourse and positions her brother in this way, she constructs the sibling relationship as obligatory. This means that Jack requires or depends on Ann's love and acceptance as a 'sick' person.

This discourse constructs mental illness as fearful and confusing. This is substantiated by Ann in extract one, when she refers to mental illness as being *"unknown"*. By using the word, *"unknown"*, mental illness is also viewed as contaminating, misunderstood, unexplained, and something to be wary of. All that accompanies or is related to mental illness is also referred to as the *"unknown"* by Ann. The word *"unknown"* carries connotations of uncertainty and as though it is something that people should fear. Ann's fear of mental illness is seen through her desire to not be admitted into hospital because of depression. Ann expresses that she *"changes"* when Jack is ill. In extract two, Ann assumes more caregiving roles and responsibilities for Jack such as *"taking clothes upstairs"*. She also becomes more accommodating whereby she moves to the back seat of the car and remains quiet as an attempt to keep Jack happy and maintain calm. By positioning Jack in this way, he is given priority and power. Thus, Jack requires more attention or focus because there is something medically wrong with him.

Ann treats Jack differently and positions him as 'sick' because of the *"unknown"*, which she refers to in extract one. Ann's uncertainty around mental illness results in her treating Jack

like a stranger who she fears. Ann and her younger brother would hide away and fear Jack when his mental illness presented in the form of aggressive outbursts: *"...we'd go and lock ourselves in my mom's bathroom because that was the only door that could lock. And, so from being able to feel safe in my room to the only safe place was in the bathroom... that was really scary":* (p. 21, 1. 952-954). Ann does not want the *"unknown"* that accompanies mental illness to surface thus she becomes more accommodating and sacrificial as an attempt to prevent or reduce Jack's outbursts. These outbursts are a trigger of the *"unknown"* and a reminder that Jack may be hospitalized again. This discourse takes away agency in that Jack's disorder is a result of external factors. In other words, when one gets physically sick it is not something that one really has control over and by constructing Jack's mental illness as a sickness, he is constructed in a similarly passive position. Ann does not blame Jack for his disorder however views him as someone who is strange and who has to have certain 'things' done to him (electrodes placed on him and needles stuck in him). This highlights the fact that he cannot function without these 'things' being done to him by other people, in particular, mental health care, and medical practitioners.

When Ann draws on a discourse of mental illness as a sickness, it also constructs the treatment of mental illness as fearful, uncertain, and unexplored. In extract one, Ann does not want to be admitted into hospital: "*I didn't want to go into hospital and be that unknown, surrounded by all this unknown*". This *"unknown"* refers to mental illness and the accompanying treatment and management. She also speaks about Jack's treatment in the following way: *"he had electrodes all over his body and like needles stuck in him" (p. 1, 1. 26).* The word, *"stuck"* connotes dehumanizing and forceful treatment of mentally ill patients in hospitals. The use of the words, *"unknown"* and *"stuck"*, constructs mental illness and the accompanying treatment as undesirable and fearful.

Ann does not want to be associated with Jack in relation to being hospitalized because of depression or a mental illness. In extract one Ann considers mental illness and hospitalization to be solely Jack's domain. When she says that: *"no, that was Jack"*, she positions Jack as the 'sick' sibling in the family who had to be hospitalized because of a mental illness. Ann does not relate to Jack in any way when she positions him as 'sick' even though she is diagnosed with a mental illness herself. The *"unknown"* and accompanying fear, which is discussed in extract one,

prevents Ann from relating to her brother. Additionally, hospitalization is constructed as a form of punishment when Ann's mother threatens Jack with hospitalization when he experiences outbursts: *"my mom was like "if you're* [Jack] *going to act this way, um, then you're going to have to be hospitalised" (p. 3, l. 121-122).*

In sum, Ann draws on a discourse of mental illness as a sickness and positions Jack as 'sick'. When Ann views Jack as a passive recipient of his sickness, it has a positive impact on the sibling relationship as the relationship is constructed by closeness and care, however, when Ann views Jack as the 'other', it impacts the sibling relationship in a negative way as Ann does not want to be associated or related to Jack in this way. As previously mentioned, Ann also draws on an alternative discourse, a discourse of mental illness as part of the person.

4.2 A discourse of mental illness as part of the person

This discourse is employed in order to construct mental illness as part of the sibling's personality. The participants who drew on this discourse view their sibling's mental illness as part of who they are. Ann and two other participants draw on this discourse, each with different effects. These will be discussed with reference to the following extracts.

Extract 3:

"...he [Jack] *was very artistic and they'd like, I want to say Kurt Cobain, but just that very other worldly, felt very oppressed by authoritative figures or authoritative places. He saw flaws in the world and wanted to fix them, didn't know how because he was battling with things himself. And, so very, like overboard like intelligent, just couldn't express himself because, and no one knew what was wrong with him so he was on lots of medication and he went and saw a counsellor for three years. And still, I used to walk into the kitchen and we always used to have our different medications because I'm ADD. So I used to have my little one pill and there was his seven pills and like he was, he went on to schizo pills just to see if it schizo, wasn't that. So I was always very confused about all the pills when I just had my one" (Ann, p. 2, l. 70-80).*

Extract 4:

"Um, there was also a bit of admiration of, he was very arty, so went the arty route. Um, hung out with the alternative people so he was always expressing himself in different ways which were different to my private school friends whose brothers all went out partying and wore the same pastel coloured clothing and so that was like, wow, you're different, that's really cool, I like that in my brother. Um, and, I think the main things were love and confusion" (Ann, p. 17-18, l. 770-775).

Extract three is Ann's description of Jack when she was asked to describe her sibling who had been diagnosed with a mental illness. Extract four is Ann's response to a question about her feelings towards her mentally ill brother.

When Ann draws on this discourse, Jack is positioned as 'alternative' or 'different'. In extract three Ann describes Jack as: *"artistic"*, *"Kurt Cobain"*, and *"worldly"*, and in extract four as *"arty"* and *"different"*. The use of these words constructs Jack as 'alternative' and someone that is different from the norm. Jack is referred to as being extremely clever: *"like overboard like intelligent"*, in extract three, and "*always expressing himself in different way"*, in extract four. Drawing on this discourse, Jack's aggressive outbursts, actions, or behaviours are constructed as his alternative way of being and not because he is 'sick'. Drawing on this discourse, Jack's mental illness is simply an expression of who he is. Jack is not 'sick', he is too clever and expresses himself too differently from the accepted ways of society. Thus, mental illness is viewed in a more positive manner as being part of who Jack is. When Ann positions Jack in this way, her relationship with Jack is constructed as one of admiration, in other words, Ann looks up to Jack and wants to be like him. Ann relates well to Jack when she positions him as 'alternative' or 'unique'. She admires him and wants to be like him in those ways. This is demonstrated by Ann when she uses the words *"cool"* and *"different"*, in extract four. She finds these qualities about Jack admirable and is attracted to the fact that he is 'different'.

In sum, Ann draws on this discourse in order to construct Jack as 'alternative' and 'unique'. When Ann draws on a discourse of mental illness as a sickness and a discourse of mental illness as part of the person, simultaneously (see extract 3 where Ann discusses Jack's pills and diagnosis), they contradict each other. This results in an ideological dilemma. In other words, Ann wants to be associated with Jack when she positions him as 'alternative' and 'different', however, she does not want to be associated with him when he is positioned as 'sick'.

Ann manages this ideological dilemma by drawing on these discourses in different contexts. When Ann relates to Jack in specific ways (such as being similarly creative, artistic and alternative), Ann draws on a discourse of mental illness as part of the person. When Jack is receiving treatment or acts in inappropriate ways (which are different to who she is), she draws on a discourse of mental illness as a sickness.

Sarah also draws on a discourse of mental illness as part of the person, however, with different effects compared to Ann, and these can be seen in the two extracts below. Extract five is Sarah's response when she was questioned about her feelings towards her mentally ill sister, Jessica. Extract six is Sarah's response when she is questioned about her role expectations as a sibling in Jessica's life.

Extract 5:

"I would resent it I would say, just like I resented her for being what she was in our lives 'cause I mean, she was the reason that like, we have never been on holiday as a family. No, I lie, we went um, in 2007, we went away together, we went to the UK. My dad's client, my dad's a businessman and his client, you know he won a case or whatever and we got to go to the UK, and we went with, it was our family and two kids and then the businessman and his wife and their two kids, they're family friends. We all went together and it was the same sort of, Jessica trying to gang up and be nasty, and it was just a disaster. So like I resent her, not so much her illness because they're hard to separate, but like you know, it was typical like very teenagy thing. We couldn't be normal because of her. And I know that if you know, she wasn't around something else would have happened, so no one has a normal childhood. Like my parents would have gotten divorced or something bad would have happened as well. But, it was just that she, you know, some people just have like a few negativities in their life, like maybe their parents relationship isn't so great, maybe they struggled, but Jessica was all the negativity, she took up all the space there was for bad things. So anything bad just was her fault." (Sarah, p. 11, l. 472-487)

Extract 6:

"Um, the sad thing with Jessica is that I've always felt some diagnosis that I'm going to feel responsible for her for the rest of her life. Like when my parents are gone, you know, I don't know if like Jessica will hold onto her current friends, her friends are a bit crazy as well. Um, there will come a time, I think, where I'm the only person left in Jessica's life. And I think that's why now I'm enjoying this freedom, because I won't always have it. You know, I don't have to go see her when I'm home because she doesn't need me right now, but in a few years, instead of my parents going to dinner every Wednesday, I'll be going, because, you know, it will eventually fall on me" (Sarah, p. 16, l. 723-730)

Sarah does not separate Jessica from her mental illness. She views them as one entity. She does not view Jessica as 'suffering' from a mental illness as we saw in the discourse of mental illness as sickness, instead she views it as part of who she is. This has the effect of constructing Jessica as 'bad'. Sarah expresses, in extract five that she resents Jessica and not just her illness because she finds it difficult to distinguish between the two: *"So like I resent her, not so much her, illness because they're hard to separate"*. By viewing Jessica's mental illness as part of who she is, results in Jessica being portrayed as having a 'bad' or 'negative' personality and constructs Jessica as a thoroughly bad person and someone who was always bad.

In extract five, Sarah also constructs Jessica as a normal teenager who is going through a *"typical teenagy"* stage in her life. When referring to Jessica in this way, Sarah further positions her as 'naughty' or 'bad' teenager whose behaviour is a result of a developmental crisis instead of a mental illness diagnosis. When Sarah draws on this discourse, agency is taken away from Jessica. This is evident when Sarah refers to Jessica as being *"all the negativity"* and that *"anything bad just was her fault"*. Blame is shifted onto Jessica and there is a lack of empathy and sympathy from Sarah towards her sister. By using the word *"negativity"*, and that the family *"couldn't be normal because of her"* implies that Jessica is the problem and that she has contributed to an unhappy and abnormal lifestyle for Sarah. Blame is placed onto Jessica and she is positioned as the 'bad' teenager who has a negative, the sibling relationship is a resentful one.

As Sarah does not view Jessica as 'sick', there is a lack of sympathy and empathy and heightened resentment. It seems as though Jessica took up all the space in the family, even the negative space: *"she took up all the space there was for bad things"*. This results in heightened levels of resentment between Sarah and Jessica. Anything 'bad' that occurred was because of

Jessica. Although Sarah resents Jessica and refers to her as all the *"negativity"* in the family, there is still a sense of duty or responsibility to care for her in the future.

Sarah positions herself as a future caregiver in relation to Jessica's mental illness. Although Sarah does not position Jessica as 'sick', she feels a certain level of responsibility to care for her sibling. This care differs in relation to Ann's care in that it is more of an imposed or forced responsibility that is expected of Sarah. In extract six, Sarah uses the word *"sad"* when describing her feelings of having to care for Jessica later on in life. Sarah feels that this is expected of her, as she is Jessica's sibling: *"I'm the only person left in Jessica's life"*. Sarah feels as though she is trapped and will be forced into caring for Jessica. In extract six, Sarah expresses that she feels free because she is currently uninvolved in her life: *"I'm enjoying this freedom, because I won't always have it"*.

In sum, Sarah positions Jessica whose personhood *is* her mental illness; her mental illness is part of who she is rather than a separate entity, as in the discourse of mental illness as a 'sickness'. When positioning her in this way, the sibling relationship is constructed as resentful. Agency is taken away from Jessica in that Jessica's personhood is her mental illness therefore she actually does not have much control over it. Sarah may blame Jessica for her behaviour however Sarah cannot blame Jessica for who she is as she was born that way. As previously mentioned, Sarah feels obliged to take care of Jessica later on in life, this obliging may be linked to the feeling that Jessica is the way she is which is not her fault, therefore Sarah should care for her. Ann and Sarah's constructions can be compared. For Ann, her brother's non-conformist self and his mentally ill self is something she admires whereas Sarah seems to wish that her sister was more conformist. In other words, Sarah wants a more 'normal' sister and childhood.

4.3 A discourse of mental illness as bad behaviour

Participants that draw on this discourse did not position their sibling as 'sick' or as the mental illness being part of their personhood, rather participants spoke about their sibling's mental illness diagnoses as an excuse for them to behave badly. This resulted in subject positions for their siblings as manipulative or deceptive. The use of this discourse is explored below using extracts eight, nine, and ten. Two participants drew on this discourse with similar effects.

Extract seven is Michelle, speaking about her younger sister, Kim. Kim reported that she was raped however Michelle is not convinced and does not fully believe this. The start of the extract: *"And I won't condone it"*, is Michelle's response to speaking about rape in general. She does not condone rape however she does not believe Kim when she discloses that she was raped. Extract eight is Michelle's response to her expectations of mental illness in relation to the sibling relationship. She discusses what she thought should have happened to the sibling relationship when Kim was diagnosed with a mental illness. Michelle is also referring to a suicide attempt when she refers to the words 'bandages'.

Extract 7:

"And I won't condone it but it's just ... I just couldn't believe that ... I've tried to empathise with her, but it just doesn't seem like she's the victim, or she's maybe a victim but a victim of rape, type thing (G: Hmm, yes)... Just to understand. And I was starting to get a bit worried about myself because I was like how can I not feel sympathetic for my sister who is in a psychiatric clinic? (G: Hmm, yes)... How can I ... I'd like to think I'm a pretty empathetic person and throughout my life I've always been like, mental illness is a real thing, guys. You can't just brush it aside, it's not cooky. It is not people. It's as serious as diabetes. It's a real, physical... (G: Hmm, yes)... medical problem. So I was starting to get a bit worried. I was like, how can I be this heartless; it's my sister, Jesus" (Michelle, p. 5, 1. 230-242).

In extract eight, Michelle speaks about Kim's mental illness and how she also does not believe or empathise with her because she views Kim's behaviour as an excuse to behave badly: *"...but it just doesn't seem like she's the victim*" (p. 5, 1. 231).

Extract 8:

"Ja, I think ... I certainly expected the dealing of a mental illness to bring people together and I also expected ... I would expect it of myself to become a little bit more nurturing than I did. But I found the fact that I was so confused and I was kind of disgusted with how she was pushing me away, or actively getting mad at me for something I didn't know what I was doing. I don't know what I did wrong and also the

fact how she acted in public, how she went about it, and how she flaunted her bandages almost. I found the fact that I was getting so irritated or disappointed at how she was portraying herself at home and in public, pushed me away of how I felt I would act. Thought I would be more kind of like a lot more hugs, like 'there- there's' and things like that. I thought I would've ... a sibling that's there for me would, especially an older sibling, as well. I thought that would bring us together but it's done the opposite, or maybe just it hasn't ... I don't think about how she has this illness, I think about how she treats other people. So, the fact ... the way she's gone about it, over shadows the fact that she's been clinically diagnosed. It's probably a problem, but yes, I would expect us to be the opposite of how it is now" (Michelle, p. 16, l. 866-878)

Therefore Michelle resists adopting the discourse of mental illness as a sickness to construct her sister. Michelle believes that mental illness is a *"real, physical, medical condition"* that is out of an individual's control, but she does not see this as being the case for Kim. Michelle feels that Kim uses her mental illness as an excuse to behave badly and avoid the repercussions of her behaviour. This is expressed in extract eight: *"I don't think about how she has this illness, I think about how she treats other people"*. Michelle does not view Kim as 'sick', she sees her, as being rude towards others constructing her behaviour is a choice and not a result of her illness. It is interesting to note that Michelle does draw on a discourse of mental illness as a sickness (as referred to in Ann's case), however, this differs in this context as Michelle refuses to draw on this discourse in relation to Kim's mental illness.

Michelle uses the word *"flaunted"* in extract eight which further highlights that Kim is positioned as manipulative or attention seeking. This word is used to describe Michelle's feelings towards Kim's cutting on her arms. Michelle's talk constructs Kim as someone who wanted people to know that she had attempted suicide by cutting her wrists. Michelle constructs this behaviour as an attempt for Kim to gain attention and not as a result of being 'sick' or mentally ill. Additionally, in extract eight, Michelle does not like the way Kim acts at home and in public: *"portraying herself at home and in public"*. Michelle's talk constructs Kim as irresponsible, careless, and reckless in the

way she conducts herself at home and in public and this is due to bad behaviour as opposed to mental illness.

When Kim is positioned as 'bad', the sibling relationship is constructed as full of rivalry and conflict. Within this discourse Michelle cannot adopt the subject position of sympathetic and empathic older sister for Kim, as evident in extract seven when she says she does not feel sympathetic towards Kim: *"I was like how can I not feel sympathetic for my sister who is in a psychiatric clinic?"* When Michelle draws on this discourse, she positions herself as a resentful sister who feels as though Kim does not deserve to be treated with empathy and sympathy. Michelle does not view Kim as the *"victim"* which is expressed in extract seven. The use of this word shifts the blame onto Kim and treats her as guilty of acting the way she does on purpose constructing her as someone who does not deserve sympathy.

Extract nine is Cara's response to her sister Pam's admittance into a psychiatric institution and her feelings about Pam's mental illness. Cara draws on a discourse of mental illness as an excuse for bad behaviour. Cara positions Pam as deceitful when she draws on this discourse. In extract nine, Cara uses diagnoses, such as *"bipolar"* and *"borderline personality disorder"*, to construct her sister however with different effects from a discourse of mental illness as a sickness. Cara constructs Pam as using the diagnosis in order to avoid taking responsibility.

Extract 9:

"Yes, and then I don't know if it's linked to the clinic but I feel that we weren't there in Durban to see the actual relapse, but I found that since she'd gone into the clinic; she then all of a sudden went downhill. After that she latched onto the idea that she has a problem and there's nothing she can do about it. She's in this whirlwind at the moment where she's bi-polar or she's got borderline personality disorder and she can't do anything about it. She can't get a job, she can't be responsible for her own decisions that she makes" (Cara, p. 3-4, 1. 160-166).

Within this discourse, Cara adopts the subject position of frustrated sibling and Pam is constructed as someone who does not want to do anything to help herself. The disorder has

rendered her helpless. The sibling relationship is affected as Cara becomes frustrated and blames Pam for using her diagnoses to escape life's responsibilities. Cara's construction of mental illness as bad behaviour shifts blame and agency onto Pam. Pam is positioned as the 'bad' sibling who uses her disorder as an excuse for everything. This is found in a statement by *Cara: "I do feel that she's [Pam] taking a bit for a ride this year and blames the disorder for everything" (p. 13, 1. 659-660)*. Cara constructs Pam as immature, irresponsible, and deceitful. Cara's talk suggests that Pam is not worthy of trust as she views Pam as 'bad' and constructs mental illness as bad behaviour.

When Cara refers to Pam as being *"bipolar"* or having *"borderline personality disorder"*, there is an understanding that there is something 'wrong' with her sister however Pam is constructed as using this to her own advantage and to escape certain responsibilities, this aspect of her behaviour is not seen as part of her mental illness, but rather as her being manipulative. Thus, Cara labels Pam in this way but does not fully engage with the discourse of mental illness as a sickness. She does not view Pam as 'sick', rather as using her diagnoses as an easy way out. Cara positions Pam as 'bad' and deceitful when she draws on this discourse. This positions Cara as someone who does not have to feel empathy; rather agency is placed on Pam. The diagnoses that Cara refers to are simply labels that Pam uses to her advantage.

In sum, the discourse of mental illness as bad behaviour positions ill siblings, as deceitful or manipulative individuals who are not 'sick' instead are 'naughty'. It is significant that even though Michelle draws on the discourse of mental illness as a sickness elsewhere in the interview, she does not draw on this when constructing Kim's mental illness. When Michelle draws on a discourse of mental illness as bad behaviour, she positions herself as lacking in empathy, however, she also constructs herself as being wrong for lacking empathy. She is presented with an ideological dilemma in that when she draws on the discourse of mental illness as bad behaviour, she justifies her subject position of an annoyed and resentful sister. However, in the light of the discourse of mental illness as a sickness, a discourse that Michelle draws on elsewhere, Michelle is positioned very negatively as a non-empathic sibling.

4.4 A discourse of mental illness as a spiritual issue

The last discourse to be discussed is a discourse of mental illness as a spiritual issue. Extract ten is Pumi's response when questioned about her mentally ill sibling, Thembi. Pumi was the only participant in the sample group who was black and isiXhosa speaking. Pumi describes what she felt happened to Thembi when she was first diagnosed. Extract eleven is Pumi's description of a fight that she and Thembi had post-diagnosis. Pumi draws on a discourse of mental illness as a spiritual issue.

Extract 10:

"Because, I had to believe she was bewitched. So, like, they took something from her and they left us with what she is now and that's not her and I, I don't know. It didn't feel like that was my sister and even now I'm not that close to her, because she doesn't seem like a proper human being" (Pumi, p. 6, l. 284-288).

Extract 11:

"Yoah! I went, I got angry, I slapped her; we got into a fist fight, I bit the crap, yoah, I really, I'm sorry about my language, yoah, I bit her up so badly and there was this one punch that I gave her on her face, she got like a blue eye, it was really bad" (Pumi, p. 15, l. 740-743).

In the above extracts, mental illness is constructed as fearful and as though it takes away or destroys a part of the person. Pumi views Thembi as bewitched. The word 'bewitched' indicates that there is a spiritual force or external higher power responsible for Thembi's mental illness. Pumi also states *"they took something from her and left us with what she is now"*. The word *"took"* indicates that Thembi was robbed of some part of herself. Additionally, Pumi refers to *"they"* who are the supernatural or spiritual forces that took the 'nice' human part of her sister away and left the family with a 'different' and contaminated object or 'thing'. Pumi language use in the above extracts is noteworthy: she says "*and they left us with **what** she is now*". Pumi's talk has the effect of dehumanizing Thembi in that Thembi no longer exists as a person or as Pumi's older sibling. When Pumi draws on this discourse, Thembi is no longer treated as a human

being. Pumi *"beat"* Thembi up and gave her a *"blue eye"* which highlights an extreme level of violence expressed in the sibling relationship. It is as though Pumi no longer views Thembi as a person who deserves to be shown any humane treatment. The human or sibling of Pumi has been consumed and replaced by a foreign and hated supernatural being. By drawing on this discourse, the sibling relationship is positioned as filled with conflict and resentment. Pumi expresses that she does not trust Thembi after she was bewitched: *"I don't trust her [Thembi] at all"* (p. 25, 1. 1246). Mental illness is thus constructed as something fearful, contaminating and consuming part of who you are.

In sum, Pumi positions Thembi as 'different' when she draws on the discourse of mental illness as a spiritual issue. This discourse positions those who are mentally ill as bewitched and being at the control of supernatural forces that consume a part of you and leave you as a 'thing'- foreign, different, and unknown. While a different discourse, there is some overlap in its effects to Ann's description of her brother's mental illness as a sickness. Ann expresses that she fears the treatment of mental illness and the *'unknown'* that accompanies mental illness.

Carlos, also draws on a discourse of mental illness as a spiritual issue however with different effects compared to Pumi. In extract twelve below, Carlos is speaking about his role as a sibling in his mentally ill brother's life. Carlos does not position Tom as 'sick' nor does he see him as being 'mentally ill'. Therefore he resists the discourse of mental illness as a sickness. Instead, Carlos constructs mental illness as a *'gift'*, which is something Tom is privileged to have. This *'gift'* allows Tom to be more insightful and look *'deeper into issues'*. This giftedness positions Tom as extraordinary and as someone who is privileged to have a mental illness, which allows him to see the world more creatively and differently. In other words, Tom's mental illness is a spiritual or God given gift. Therefore, Tom is positioned as 'unique' or 'special'.

Extract 12:

"But to me the illness is not, in times, if we're separated then that's my relationship but if we see him as a person with having an illness or not having an illness; having a great gift that helps him see more like, deeper into issues and that, which maybe is a way that I view it, so viewing it positively. I think our relationship in terms of sharing ideas, speaking about future ideas and that, is definitely part of how I interact with him and important in that way... that I think we share very similar interests and ideas on what's right" (p. 18-19, l. 900-907)

When Carlos constructs mental illness and Tom in the abovementioned ways, the sibling relationship is constructed by closeness. Carlos and Tom share current and future ideas with each other which Carlos considers to be an *'important'* part of relating to Tom. By using the word *'gift'* and referring to the sharing of similar ideas as *'important'*, there is a sense of admiration of Tom and a longing to be like him.

Carlos does not construct Tom's mental illness as a sickness, rather he sees him as possessing a special *'gift'* which is part of him as a person and which makes him 'unique' and better understood. This *'gift'* is constructed as being something that was given to him that he is privileged to have. Carlos relates closely to Tom when drawing on this discourse and wants to be associated with him and his *'gift'*. There is an underlying sense of admiration and wonder at this 'unique' being, who is his brother. By using the words, *'great gift'*, Tom is placed in a more deserving and superior position then Carlos. Ann and Carlos' constructions of their siblings are similar in that they both construct their sibling relationship as being one of admiration.

In sum, although Pumi and Carlos draw on the same discourse, they do so with differing effects. When Pumi draws on a discourse of mental illness as a spiritual issue, Thembi is constructed in a dehumanizing manner and the sibling relationship is impacted on in a negative manner as it is constructed by sibling rivalry and conflict. In contrast to this, Carlos, who also draws on this discourse, views Tom's mental illness as a *'gift'* which has a positive impact on the sibling relationship whereby it is constructed by closeness and care.

4.5 Investigating emotional investments in particular constructions of mental illness

Although, in the previous section, I identified the discourses that participants draw on to construct their experiences of having a mentally ill sibling, discourse analysis neglects to explain the conscious and unconscious 'reasons' for why participants invest in certain discourses over others. To investigate the emotional investments in particular discourses, a psychosocial reading will be conducted. This is a combination of a discursive and psychoanalytic reading which will be done using one participant's extract in a case study format. This approach argues that it is not helpful to separate out the social from the individual but rather to understand that each participant's talk is mediated by both the social world and the psychic world, intertwined with one another.

Michelle's extract below will be used to conduct a psychosocial reading. Michelle's extract was selected so as to explore the possible psychoemotional reasons for investing in the discourse of mental illness as bad behaviour when talking about her sister. In doing so, this research argues that it is not enough to identify dominant discourses and to analyse their effects but that it is also important to engage with the more personal, individual and emotionally inflected 'reasons' for participants investing in these discourses over others. Michelle was selected as a case because her interview was highly emotional, with Michelle laughing excessively during the interview. The particular extract from her interview was selected because there is a large presence of hesitations found in the extract which point to active meaning making on behalf of the participant, suggesting that emotional work is being done. These are referred to by Hollway and Jefferson (2005) as emotional breaches which are identified as a reflection of Michelle's internal world or unconscious conflicts and drives. It is with this internal world that this research now turns to in order to investigate the psychosocial experience of having a sibling with a mental illness.

Case study: Michelle

Before beginning the psychoanalytic reading, it is important to consider the relevant biographical details surrounding this participant in order to provide a rich context for the

interpretation of the case. The biographical information will contain information about Michelle, her sister, and her parents.

Michelle is a 19-year-old first year student. She is white, English speaking, and has one younger sister, Kim, who is 18 years old. Michelle's parents are married and are described by Michelle as having an average marriage. Michelle describes her mother as being overly involved in Kim's life and illness. Michelle feels that her mother gives Kim everything and anything and describes feeling less important and loved by her mother compared to Kim. Michelle describes her father as not tolerating Kim and her disorder. Michelle relates closely to her father in that they both feel Kim is not psychologically ill but rather acting inappropriately or badly and getting away with it. Michelle expresses having a better relationship with her father as opposed to her mother. Michelle's parents continue to see Kim, however, they understand that Michelle does not want to see Kim or have a relationship with her. Michelle expresses that her mother continues to 'baby' Kim and her father thinks Kim acts the way she does because she is spoilt and naughty. Kim was diagnosed with depression and has been hospitalized three times. The first time Kim was hospitalized was when she was 16 years old and the second time when she was 17 years old. Kim was also hospitalized a third time for three to four weeks because of self-harm (specifically cutting).

Michelle described her mother and father as having a passive-aggressive marriage and relationship. Michelle describes her mother as soft and easily influenced, giving her children anything they desired. Michelle describes her father as strict, less involved in their lives, and taking a different approach to parenting to his wife. According to Kim this was the root cause of their marital conflict. Michelle and Kim's parents have always struggled financially and work together in a time-consuming industry. Additionally, Kim was born one year after Michelle. Michelle did not have much time to be a 'baby' before her sister arrived. Michelle also describes her mother as always being sad implying that she has depression. It is possible that the above-mentioned factors contributed to inconsistent parenting or unavailable caregiving, which shape the way in which Michelle relates to others (Ainsworth & Bowlby, 1991). Michelle described her relationship with Kim as close when they were children, however, she described them now as strangers who are uninvolved in each other's lives. In the interview, Michelle described feeling that throughout her life Kim has been more successful than her. She described a part of herself

that longs for a good relationship with Kim; however, she also described feeling happier without Kim in her life.

The extract below begins with Michelle describing how she felt betrayed by Kim because Kim started dating Michelle's ex-boyfriend while being fully aware that he caused problems for the family when he and Michelle were dating. Although Michelle expresses that Kim and her have always had a bad relationship, this incident was the beginning of when their relationship broke down. From this point onwards, the resentment in their relationship grew and the lack of empathy increased. Michelle describes not being able to understand the way Kim acted and that dating Michelle's ex-boyfriend was due to her mental illness. Michelle felt as though Kim's mental illness was an excuse for Kim to escape the responsibility and repercussions of acting inappropriately and not apologizing for what she did.

4.5.1 Michelle's extract

M: *But I don't know, it's just (big sigh, tries not to cry) … even now, like I told my friends, I would love to have a good relationship with her but she needs to understand, like she needs to suffer first. And not suffer in like I hope the world smites you, but just understand what you did and be properly sorry for what you did because my parents … even the people I know, the most empathetic, the most forgiving people I know, are really like tired of her shit, you know what I mean? All they've done for her and she just … it's like mocking almost, the way she just doesn't give a … she doesn't say thank you or anything… She just uses them. My parents say that her grades have plummeted, she doesn't care about anyone else, but her friends (laughs) and their perception of her and that's been my experience of (laughs)… I would love to say that at the end I was all very … mental illness is real and we had a good serious marathon and all of that …(G: Hmm)… which is how I usually kind of … before all of this happened I would assumed that that's how it would go because I suppose there would be like some kind of understanding or, I don't know, 'big sister/younger sister' type thing but it's just been weird, it's … that's why I think she has sociopathy. She's a sociopath instead of … I'm sure she has depression as well but I think the mental illness is that she just can't empathise with other people (laughs). She cares foremost and only about herself type thing. But ja …*

G: *Can you tell me a bit more about how her illness per se and her diagnosis has affected your life?*

M: *Um (big sigh and pause)… In the beginning it was annoying and (long pause) …. well, it's kind of … because she's cut me out and subsequently I don't interact with her, um it's weird, like I almost don't feel her absence, which feels kind of telling as well, because I'm assuming you feel loss … (G: Hmm)… or missing of that person as well. And I look at pictures of when we were younger and everything and then I get nostalgic for that but I don't really… um … and I hear stories of all the gross things she does and it's not that I'm happy with her in my life, I just don't think about it because it doesn't… um … her presence is just not felt really; or the absence thereof is just not felt. I will say though it was really upsetting when… (pause)… just before I came to varsity, during the*

December as well, my parents were still very much focused on her and I had just gone through an abortion and my mom was only with my sister and I haven't even told my mom because she's just gone through so much with Kim that I couldn't deal with it with her. Also we come from a religious family so there's all of that kind of thing and, as supportive of as my ex-boyfriend was - and my friends as well, they were all really amazing - there was no like 'meh', he wasn't one of those guys who was there and then when all the shit went down, he just left. He was really, really great but nothing really compares to a maternal-type presence and it was upsetting that Kim was getting all the attention and I was just like I just really need my Mom right now. As I was leaving and my Mom wouldn't do 'us' things because she had to look after Kim and I was just like, I am literally not coming back until two months' time. You can't spend time ... I remember there was one time when we wanted to go to the movies, but Kim didn't want to go, so my mom didn't want to leave her at home alone so she stayed with Kim, and I flipped shit because I was just like I am always going to come second to Kim, no matter how proud ... like my parents were really proud that I got into this university and that I was doing something that I wanted to do and I was really stoked to go, and I was very ... still, I suppose, very career-driven ... (G: Hmm)... because I don't want to do some mediocre job, you know what I mean (becomes teary). I want to do something I can be proud of, and it's not like a doctor or anything, but it's something that I really enjoy doing and my parents are really proud of the ... even not just getting in or ... the willingness to leave home to pursue what I wanted to do. It's like independent and all that, and also just the mentality I have about studying. My parents are really proud of that. And despite that it was still very frustrating that my sister, who was just like ruining their marriage because obviously my mom had to solely look after her type thing, was getting all the attention. Also at holiday time, a lot of ... I don't think the whole family knew what was going on but still it was very ... she was getting praise for other things anyways and I was just ... it was just another time where I was coming second even though at home we know that I'm a lot more healthy than she is, like mentally and physically; I don't take the drugs that she does ...(G: Hmm)... or drink as much, or just have such like sex with so many people (laughs in disgust)... I'm emotionally way more mature than she is. Even though ... just the way I deal with crappy things that happen

with life, it's a lot more … like my Mom was like, you're actually a very mature person, and it was just very frustrating that…um… I have achieved more than she has even though it's always been the other way around. It's like yes; finally it's the opposite… (G: Hmm)… I was getting no recognition and it was … actually it wasn't even the fact that I wasn't getting recognition, it was the fact that she was getting recognition that I felt was not really deserving…

4.5.2 Discursive reading of Michelle's extract

In the above extract, Michelle positions Kim as manipulative whereby she takes advantage of people (*"she uses them"* 1.18) and as selfish *("she just can't empathise with other people"* 1.27). Michelle positions Kim in this way as she draws on a discourse of mental illness as bad behaviour.

Alongside this discourse of mental illness as bad behaviour, in the above extract a discourse of mental illness as a sickness is made available: this discourse constructs mental illness as a real, physical condition (*"I would love to say that at the end I was all very... mental illness is a real thing"* 1.21-22). Michelle also uses diagnoses when talking about Kim's mental illness stating that she is a *'sociopath'* and has *'depression'*. The use of these diagnoses indicates that the discourse of mental illness as a sickness is made available. Michelle wishes she could draw on this discourse of mental illness as a sickness; however, she cannot do so as she does not experience Kim's diagnosis as an illness but rather as manipulative or bad behaviour.

Therefore, Kim is not positioned as 'sick' and Michelle resists drawing on this discourse when constructing Kim's mental illness. Instead, Kim is positioned, as previously mentioned, as manipulative, and selfish. Michelle constructs Kim's mental illness as 'bad' or naughty behaviour in that she is excessively selfish (1.27-28), rude (1.18), and engages in unacceptable behaviour (1.68-69). From this perspective, Michelle constructs Kim's mental illness as an excuse for her to behave badly and as a means to gain parental attention.

Further, within the extract, Michelle positions herself as the 'ideal' older child as she describes herself using all 'good' qualities including *'career-driven'* (1. 56), *'independent'* (1.60), and emotionally mature (1.69-70). Michelle constructs her parents as being proud of her for being accepted into university: "*no matter how proud ... like my parents were really proud" (1. 54).* This construction serves to distinguish Michelle as being different to Kim in that she is the 'better' and better-behaved daughter. Thus, setting herself apart from her sister. In sum, Kim is positioned as the 'bad' child who

gets all the attention and Michelle positions herself as the 'good', neglected child. As such Michelle seems to be drawing on a broader developmental discourse of normal or appropriate early adulthood – significantly Michelle is constructed as aligning with this dominant discourse whereas Kim does not.

Finally, alongside the constructions above Michelle constructs mental illness as powerful. She constructs a difference between what is publicly said about Kim's mental illness and what is actually known at home: "*it was just another time where I was coming second even though at home we know that I'm a lot more healthy than she is*" (1. 57). In public, Kim receives a lot of attention and praise whereas at home she is seen as a 'troublemaker'. Mental illness is therefore powerful in setting up this divide in order for a public façade to be maintained. This façade results in different subject positions for Michelle and Kim and differing responses to these positions. Michelle constructs her family as needing to maintain a good impression, therefore responding strongly and quickly to bad behaviour (Kim's) rather than to distress (Michelle's).

When Michelle draws on this discourse of mental illness as bad behaviour, the sibling relationship is constructed as justifiably full of resentment (*"she needs to suffer first"* 1.13). Nevertheless, Michelle's talk also constructs this mental illness as bad behaviour as very powerful in preventing any shifts or changes in the family system, particularly because of the stigma of mental illness. We now move from a discursive reading to a psychoanalytic reading in order to explore Michelle's emotional investments in the discourse of mental illness as bad behaviour as opposed to others.

4.5.3 Psychoanalytic reading of Michelle's extract

In this section, the possible reasons for investment into the above discourse will be explored through a psychoanalytic reading. Why does Michelle construct her sister's mental illness in this way – as bad behaviour rather than a sickness? Why does she draw on very different discourses in describing herself in relation to her sister? In this section I will argue that Michelle constructs her experience in this specific way in order to defend against anxiety. Michelle's conscious and unconscious reasons for constructing her experience in this specific way are analysed using a combination of data sources. These data sources include psychoanalytic

theory, biographical information, a fine grained reading of the extract, and information from the interview context such as how the researcher experienced Michelle drawing on the concepts of transference and countertransference. From a psychoanalytic perspective, the researcher's subjective experience of Michelle is important information that can assist in the interpretation of the data. These multi-layered sources of information allow for triangulation thereby increasing the validity of interpretations. In other words, if interpretations are supported by multiple sources of data then they are more valid. Furthermore, this approach assists in thickening our understanding of Michelle's story.

Throughout the extract, Michelle expresses a feeling of frustration. Michelle's frustration is generated by her parents, because of the way in which they manage Kim's mental illness. Michelle feels that her parents maintain a façade that Kim is a 'normal' child who acts in socially acceptable ways. Michelle does not feel that Kim deserves attention because she is not the person that everyone thinks that she is. Michelle's frustration fuels her resentment towards Kim and subsequently, Michelle desires to spoil or ruin Kim's 'specialness' and reveal her sister as the badly behaved person that she really is. For example, Michelle says "*flip, where's the karma in this... like she doesn't do any work... you know what I mean... [Michelle must] suffer a little bit...*" *(p. 14, l. 746-747)*, However, Michelle experiences contradictory feelings as she also feels an underlying sense of guilt for wanting to 'harm' her sister. This is a difficult position for Michelle to manage because when she feels anger towards Kim, she may unconsciously experience anxiety, as she is being a 'bad' sibling. This anxiety is generated due to Michelle being aware of a dominant discourse of siblingship and mental illness as a sickness where siblings are supposed to support and be kind to one another. However, in Michelle's case, she manages her anxiety of not drawing on this discourse by projecting her feelings of being a 'bad' sibling onto her sister. I also argue that Michelle differentiates herself from Kim in order to distance herself from the 'threat' of mental illness. Michelle and Kim are siblings who have genetic similarities therefore Michelle may fear developing a mental illness of her own. This can possibly read into the following extract from Michelle's interview: *"I don't want to associate myself with malicious people, in a friend group, or a peer group, whatever. I don't really want to hang out with that and I'm also not going to force my friendship upon her now" (p. 15 l. 675-677)*. Michelle is less likely to experience mental illness or be labelled as

mentally ill if she is very different from her sister and doesn't associate with her sister. This links to Juliet Mitchell's theory on siblings, which I will return to shortly.

Michelle becomes teary during the extract (1. 47), which may indicate her hidden or unconscious feelings of 'not being good enough'. Michelle considers herself to be the ideal and well-behaved child who does most things the correct way (such as being ambitious, wanting to study, and choosing the right boyfriends), however, she does not receive the praise or reward that she expects. Michelle also has angry, resentful feelings towards her sister who is mentally ill which may, from an outsider perception, appear to be very negative. Michelle feels overwhelmed by this feeling of 'not being good enough' thus she attempts to keep it out of consciousness. Michelle manages this distressing feeling by both, holding onto her difference from her sister as a way of being different/good enough, but also experiencing her difference as a loss, as her sister tends to get the attention. Michelle's good behaviour is both wished for and feared – she wishes to be good in order to be loved by her parents but also fears that in her goodness she will be forgotten when compared to Kim.

It is useful to refer to the Kleinian notion of projection and splitting in understanding why Michelle invests in the discourse of mental illness as bad behaviour. According to Kleinian theory the infant needs to project bad impulses so as to protect the good object and self-representation (Fonagy & Target, 2003). As a result of these projections perhaps not being held by her mother when Michelle was an infant, this shaped the way in which she relates to others. Michelle tends to view herself as 'good' and others as 'bad', particularly when her anxiety is triggered. In relation to her current sororal relationship, we might understand that Michelle is unable to move from the paranoid-schizoid position to the depressive position because of the fear that her mother wouldn't survive her hate. Michelle internalised this and views Kim as all 'bad' and herself as all 'good'. Splitting and projection ensure that Michelle is different from Kim thus reducing her fear of being vulnerable of developing a mental illness as well as reducing her levels of guilt and anxiety of being a 'bad' sibling (more typical of the depressive position).

As discussed in chapter two, according to Mitchell (2003), the birth of a sibling is a traumatic event. The pre-existing sibling realizes that he or she will never be the infant or younger child again. This feeling of displacement renders feelings of hatred and violence towards the new sibling because the sibling represents what is the same – another baby to take

my place. In realising that someone who is the 'same' has replaced his or her position, the pre-existing sibling differentiates himself or herself from the new sibling. The new sibling is viewed as a threat to the pre-existing sibling's existence, which results in the generation of two contradicting internal feelings hate, due to their displacement, and love at the thought that the baby is a replica of oneself (Hollway, 2005). One way in which this violence or hatred towards one that is the same is managed by the pre-existing sibling is through asserting their difference.

By applying Mitchell's theory to Michelle's case, I am arguing that Michelle's view of herself as all 'good' and of Kim as all 'bad' is a way in which she accentuates her difference from Kim. By projecting her feelings of 'bad' onto Kim and asserting her difference, she protects her place as a sibling. Michelle's abortion could have been an opportunity for her to 'join' Kim in her distress but Michelle rejects this. Furthermore, if Michelle draws on the discourse of mental illness as a sickness, she may view Kim's behaviour as being a result of her psychological disorder and that the accompanying behaviour is out of her control. She could potentially view Kim as both 'good' and 'bad'. This would generate feelings of anxiety for Michelle as she views herself as all 'good'. By viewing herself as 'good' and Kim as 'good', Michelle's existence is again threatened; as she believes there is only space for one in her parents' minds. In order to protect her existence, Michelle would rather project her 'bad' self onto Kim to maintain her 'good' self, which is less anxiety provoking. In this way Michelle might be understood as protecting herself from feelings of rejection and being 'not good enough'. As such, her projections serve to reduce her levels of anxiety.

The feelings of anger directed towards Kim can be understood as being further exacerbated by the relationship between Kim and her mother. Throughout their lives, Michelle felt as though she had to compete for their mother's attention and was always loved less. Michelle refers to this extensively throughout the interview and in the above extract. This presents Michelle with a dilemma, as she wants to be different from Kim because of her unconscious fears of also being vulnerable to mental illness, however, finds this conflicting as she longs for and is jealous of the attention that Kim receives. In other words, Michelle wants to but does not want to be the same as Kim. Michelle manages this by constructing Kim's mental illness as bad behaviour so as to maintain her view of Kim as 'bad'. Thus by Michelle employing

defences such as splitting and projection, she maintains a view of herself as good and Kim as bad.

Following the application of psychoanalytic theory, I will now turn to examining the research relationship, in order to further substantiate the above-mentioned claims. This is done by referring to my field notes, which were recorded during the interview process. The way in which Michelle interacted with me can be understood as a reflection of her inner world and subsequently her external relationships. Throughout the interview, Michelle did not make eye contact, was restless, and fiddled with her hair. Michelle may have felt anxious or intimidated by the interview process as she expressed she had never spoken about her experience in this context.

Michelle frequently asked me, in a rhetorical manner: '*you know what I mean?'* (1. 57). I felt that Michelle longed for acknowledgement of her narrative and wanted me to agree with or support her story. I felt suspicious of her because it was as though she was trying too hard to convince me that her story was true. Michelle dominated the space in the interview room by gesturing excessively and speaking loudly which I believe was a demand for my attention. This demand may link back to her home life whereby she has to demand attention and acknowledgment from her parents. This was also referred to in my field notes, which stated the following: *'I feel as though she wants me to take her side desperately, like I don't believe her'*. This is interesting as Michelle also expresses that people outside their home do not know the truth about Kim. She may doubt that people will believe what she has to say about Kim as her parents maintain the 'normal' façade. Michelle's feelings of frustration were projected onto me, which made me question the truthfulness of her story. I felt as though there was a sibling transference experienced between Michelle and I, during the interview. I thought Michelle was being intolerant, overdramatic and lacked empathy towards Kim, however at the same time, I felt guilty for feeling this way because of the way Kim has treated Michelle. The same sibling dynamic between Kim and Michelle played out between Michelle and myself. It is possible to understand this as a result of Michelle projecting feelings of frustration and I subsequently identified with them. I experienced the feelings that Michelle is currently experiencing with her sister. I was conflicted because part of me felt frustrated but another part of me felt guilty, as I was being a 'bad' person by doubting the credibility of her narrative.

In sum, Michelle draws on a discourse of mental illness as bad behaviour when talking about her sister's experiences. In this psychoanalytic reading I have argued that Michelle draws on this discourse for two main reasons; firstly, Michelle projects her badness onto her sister in order to avoid feelings of guilt and anxiety about her own badness, and secondly, Michelle finds herself in a position she wants (the good girl) and the position she hates (the forgotten girl). Drawing on the discourse of mental illness as bad behaviour enables her to at least console herself with the idea that she is not also vulnerable to this mental illness because it is just naughtiness after all and she is very far from being naughty. In applying Mitchell's theory on siblings, I have argued that Michelle differentiates herself from Kim in doing this all 'good' and all 'bad' splitting so as to protect herself from feelings of nonexistence and in order to assert her position as a sibling. This particular psychosocial interpretation demonstrates some of the social and psychological processes that siblings of individuals with mental illness have to negotiate – in this case, the experience of sibling rivalry is exacerbated by her sister's mental illness which increases Michelle's need for her parent's attention. Investment in the discourse of bad behaviour, while meeting a number of psychic functions including managing anxiety that arises from feelings of sibling displacement and rivalry, also unfortunately increases the stigmatization of mental illness.

In conclusion, chapter four discusses four key discourses that participants drew on in constructing mental illness; a discourse of mental illness as a sickness, a discourse of mental illness as part of the person, a discourse of mental illness as bad behaviour, and a discourse of mental illness as a spiritual issue. Additionally, Michelle's extract was analysed in a case study format which explored the reasons for her investment into the discourse of mental illness as bad behaviour. Michelle draws on this discourse so as to avoid feelings of guilt and anxiety about her own badness, and to at console herself with the idea that she is also not vulnerable to this mental illness because it is a result of bad behaviour.

Chapter 5

Discussion and conclusion

5.1 Introduction

This section will briefly discuss the findings of this study in relation to existing literature on mental illness and sibling relationships, specifically well sibling's experiences of having a mentally ill sibling and the ways in which this has affected the relationship.

5.2 Discussion

This study found four main discourses that participant's drew on in talking about their experiences of their sibling's mental illness; a discourse of mental illness as a sickness, a discourse of mental illness as part of the person, a discourse of mental illness as bad behaviour, and a discourse of mental illness as a spiritual issue. Participants shared meanings about mental illness and spoke about and constructed mental illness in different ways with different effects (positive, negative, or both). This research confirmed the literature reviewed, however, added to it by demonstrating that the way people talk about mental illness affects the sibling relationship.

As previously mentioned, participants drew on different discourses to construct mental illness in relation to their siblings which led them to develop different subject positions for themselves and their siblings. Hatfield and Lefey (2005) found that well siblings were obliged to assume the role of a caregiver and provide emotional and social support for their ill sibling. They found that this forced responsibility generates feelings of frustration and anger towards their ill sibling. Additionally, it was found that caregiver expectations fall onto well siblings once parents were too old to do so. With regards to this research, some participants took on the subject position of caregiver for their ill sibling, which is consistent with the literature, however, not all participants did so, and some discourses did not call for this subject position at all. This research shows that when participants draw on a discourse of mental illness as a sickness (such as Ann's case), the well sibling assumes the role of a caregiver. Well siblings assume this position as a result of positioning their ill sibling as 'sick'. This construction of mental illness impacts on the sibling relationship in both a negative and positive way. The negative effect of this discourse is the fear

that is expressed with regards to the 'unknown' and medical aspect of mental illness (treatment and hospitalisation). This fear results in participants treating their siblings as strangers or someone who they should fear. This finding is consistent with Lukens, Thorning, and Lohrer (2002) who discovered that well siblings fear their ill siblings which includes the fear of the unpredictable nature of mental illness as well as the fear of becoming mentally ill themselves. The positive effect of drawing on this discourse is that well siblings provide care for their ill siblings and position themselves as caregivers.

This research also found descriptions of high levels of hostility between siblings when participants drew on the discourse of mental illness as part of the person and the discourse of mental illness as bad behaviour. By drawing on these discourses, the sibling relationship is affected negatively as the relationship is constructed as full of resentment and conflict. One participant draws on the discourse of mental illness as part of the person, which results in the ill sibling being positioned as 'a bad person'. The mental illness is considered to be part of who they are and always have been. It is interesting to note that when the well sibling draws on the discourse of mental illness as part of the person, there is an underlying sense of duty to be responsible or provide care for their ill sibling later on in life. This links in with the caregiving role discussed above. The participant may blame the ill sibling for their behaviour but feels responsible for them because the illness is something they were 'born' with; it is essentially not their fault.

Other participants who draw on the discourse of mental illness as bad behaviour do not consider their sibling to be 'sick'; they position ill siblings as manipulative, deceitful, or malicious. This also has a negative impact on the relationship as it results in higher levels of resentment and hostility experienced between siblings. These findings relate to subject positions described by Lukens, Thorning, and Lohrer (2002). They found that well siblings experienced anger and frustration towards their mentally ill sibling due to beliefs that ill siblings were purposefully deceiving and exploiting mental health care professionals. By drawing on these discourses, participants are able to express and feel frustrated at their ill sibling without experiencing guilt, as opposed to expressing anger at someone who is positioned or viewed as 'sick', as in Ann's case.

Nevertheless, for some participants who draw on a discourse of mental illness as part of the person, their construction led to the development of different subject positions, which have positive effects on the sibling relationship. It was discovered, which is not consistent with the literature reviewed, that when drawing on this discourse, ill siblings are positioned as 'alternative' or 'different'. This leads to higher levels of admiration and closeness as ill siblings are not viewed as 'sick', rather as being more worldly, creative, and different. Participants draw on this discourse so as to protect themselves from viewing their sibling as 'abnormal'. Participants may experience high levels of anxiety if they view their mentally ill sibling as 'strange' or 'odd'. Thus, it serves a protective function for Ann to continue drawing on this discourse.

Participants also draw on a discourse of mental illness as a spiritual issue. When drawing on this discourse, participants do so with both positive and negative effects. The ill sibling is positioned in two different ways, one being 'bewitched' and the other 'unique' or 'special'. When positioned as 'bewitched', the relationship is affected negatively and constructed by levels of conflict and hostility. This is consistent with a study conducted by Botha, Koen, and Niehaus (2006) who explored schizophrenic patients' perceptions of stigma in the South Africa population. It was found that in South Africa mental illness is considered to be a culture-bound syndrome or as a result of supernatural powers. Patients reported being physically and verbally abused. Furthermore, a study conducted by Mbanga, Niehaus, Mzamo, Wessels, Allen, Emsley, and Stein (2002) explored isiXhosa families' attitudes and beliefs of the causes of schizophrenia. They discovered that there was as strong belief that schizophrenia develops as a result of evil spirits and witchcraft. When ill siblings are positioned as 'unique' or 'special', the relationship is constructed by closeness and care. The 'unique' subject position contrasts a study conducted by Jones (2002) who found that well sibling experience 'complicated grief' due to changes in their ill sibling's personality or behaviour. These changes are viewed as negative as they long for the person their ill sibling used to be.

The psychoanalytic reading shows that multiple psychological processes play a role in participant's continuous drawing on of specific discourses over others. As psychologists we need to be mindful of the discourses that are made available to our clients. Nevertheless, we cannot simply introduce new discourses and expect clients to adopt or draw on these. We need to

consider the psychological investments clients are making in the discourses that they draw on. If clients position their ill siblings as 'bad' or 'manipulative', we need to be very careful of reinforcing this discourse. Psychologists need to explore and reinforce other discourses that are made available to clients that are more likely to strengthen the sibling relationship as well as explore the emotional reasons that clients invest in their chosen discourses as opposed to others. Additionally, psychologists need to be aware of the important role that siblings play in ill sibling's lives. The ways in which well siblings perceive or view their ill sibling's mental illness determines the effects it has on the sibling relationship. Psychologists also need to make sure that well siblings are receiving the parental attention that they require.

By utilizing discursive psychology and psychoanalytic theory, we are able to better understand the reasons that individuals continually invest in certain discourses over others. Additionally, it provides us with the understanding that we cannot simply introduce new discourses and expect individuals to draw on them as there are emotional investments and psychological processes that maintain the drawing on of certain discourses over others. Nevertheless, it is clear that as psychologists, perhaps there are certain discourses that should be undermined. As previously mentioned, when drawing on a discourse of mental illness as bad behaviour, we would need to undermine this discourse and the positioning of ill siblings as manipulative, deceitful, and bad. Psychologists would need to be aware of the discourses they make available to clients as the effects may vary. Discourses can be made available to clients and those that resonate and generate positive effects and subject positions should be reinforced.

5.3 Conclusion

The final section will include a reflection of the research process, strengths and limitations of the study, and directions for future research.

5.3.1 Reflection on research process

The research process proved to be more challenging than expected. Using Hollway and Jefferson's free association narrative interview (FANI) method assisted in generating in depth and meaningful data however I feel as though participants would have been more comfortable with a more structured interview process. In saying this, I was still able to collect rich and

meaningful data. While using the FANI method, I also continually tried to avoid asking 'why' questions, however, this proved to be difficult.

Most of my participants were either the same age or slightly younger than me. I feel as though the similarity in ages helped with establishing rapport and feeling more comfortable with regards to speaking about personal or private issues. All participant's disclosed private information and spoke openly and freely. In the second interview, it was evident that participants were even more comfortable as they disclosed information that they had reportedly not disclosed to many other people.

All participants reported that they felt relieved and psychologically 'lighter' after both their interviews. The interview process proved to be a therapeutic tool for participants even though the researcher did not perform any therapeutic intervention.

5.3.2 Strengths

This research provides insight into the difficulties that well siblings experiences by having a mentally ill sibling and the support that they require. This support is underrated by social services and families with regards to well siblings and the effect that this has on them. With the use of the psychosocial methodology, I was able to explore questions such as 'how' is mental illness constructed and 'why' is it constructed in this way. These two questions provide vital insight into the ways in which sibling relationships are affected by mental illness. Lastly, this research focuses on young adults who have been a previously neglected age category for mental illness and sibling relationships thus filling some of the gap in terms of this literature.

All participants attended both interviews and no participants dropped out of the study. This enabled the researcher to collect rich and detailed data from participants.

5.3.3 Limitations and directions for future research

From the outset of this research, I aimed to collect data from isiXhosa speaking young adults. There is an increased need for more information using black participants to explore differences among sibling roles from a cultural perspective as well as the indigenous knowledge behind mental illness and the available discourses. This proved to be a challenge as no participants volunteered for the research. It was then decided to open up the criteria for any race or language

group to participate. Although the data collected is rich, there is a lack of cultural knowledge of mental illness and sibling relationships from a black South African perspective.

There needs to be continued and increased research conducted on sibling relationships and mental illness. There needs to be more research in this area so as to provide mental health care professionals with a deeper understanding of why well siblings may invest in certain discourses over others. There needs to be a specific focus on more research on the less educated. This research only focused on University students and therefore the more educated portion of the population. Psychologists and mental health care professionals in South Africa typically deal with those who are less educated.

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Appendices

Appendix 1: Recruitment advertisement

Dear Students;

I, Gina Laurie, am studying my Master's in Counselling Psychology at Rhodes University and am seeking volunteers for my research. The title of my research is 'A Psychosocial Study of Mental Illness and Sibling Relationships' which will focus on young adults' subjective or personal experiences of having a mentally ill sibling. Lisa Saville Young part of the Rhodes Psychology Department will supervise this research.

There are specific criteria, which I am a seeking volunteer for. These include:

1. Rhodes University students (undergraduate and post graduate)
2. Between the ages of 18 and 25, who
3. Have a sibling with a diagnosed mental illness and who has been hospitalised due to this mental illness

The purpose of this study is to grasp a better understanding of young adults' subjective/personal experiences of having a mentally ill sibling. As family and siblings are highly involved in providing care to mentally ill relatives, especially in South Africa, a better understanding of experiences provides mental health care professionals with insight into the effects of mental illness on family members. The research will include participating in two in-depth unstructured interviews, one week apart. The interviews will be conducted in the Rhodes Psychology Clinic at a time convenient to the participant.

Participants will remain anonymous and information shared will be kept confidential. Only the researcher and supervisor will have access to the interview transcripts. Pseudonyms (false names and information) will be used to protect identities of participants. Participants can withdraw from the research at ANY time and must participate on a voluntary basis. This advertisement and research has been through the RPERC, Department of Psychology and been granted ethical clearance.

You will receive a meal voucher to the value of R40.00 to thank you for your participation. If you would like to contact me, with any questions or to volunteer for the study, you can find me at:

Email: g.laurie@ru.ac.za

Thank you for your time,

Gina Laurie

Appendix 2: Interview schedule

First Interview

1. Can you tell me a bit about yourself
2. Can you tell me a bit about your sibling

Appendix 3: Interview schedule

Second Interview

1. Can you tell me about your relationship with your sibling
2. Can you tell me a bit about your siblings' mental illness
3. Can you tell me what it was like for you/your experience of having a sibling with that specific mental illness
4. Can you tell me about your experience of mental health care professionals
5. Can you tell me a bit about your feelings towards your mentally ill sibling
6. Can you tell about your role as sibling in your mentally ill siblings' life
7. Can you tell me a bit about, if applicable, any specific role expectations of being a sibling in your mentally ill siblings' life

Appendix 4: Informed consent

Agreement between Student Researcher and Research Participant

I, _____ (participant's name) agree to participate in the research project of _____ (researcher's name) on a psychosocial study of mental illness and sibling relationships.

I understand that:

1. The researcher is conducting this research based on the requirements set for a Master's degree in Counselling Psychology at Rhodes University. The researcher can be contacted on 073 01 77 333 or g.laurie@ru.ac.za. Ethical clearance has been granted from the relevant committee, and is under the supervision of Dr Lisa Saville Young in the Psychology Department at Rhodes University, who may be contacted on 046 603 7212 or l.young@ru.ac.za.
2. My research is interested in young adults subjective experiences and meanings attributed to the experience of having a mentally ill sibling.
3. My participation will involve partaking in two in depth interviews, one week apart. The first interview is unstructured and the second interview is more structured as it is based on the information disclosed in the first. The length of the interview is unknown but should not last longer than an hour and a half depending on the amount of information disclosed. I may be asked to answer in depth personal questions, but I may choose whether to respond to these or not. As the researcher cannot guarantee the type of information disclosed, I may contact the Rhodes Counselling Centre on (046) 603 7070 if any psychological distress or embarrassment is caused.
4. I am invited to inform the researcher of any concerns that I have about my participation, or consequences that I may experience as a result of my participation, and to have these addressed to my satisfaction.
5. I am free to withdraw from this research at any given time as participation is fully voluntary. However I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.
6. I allow the researcher to use the information from the first interview if I decide not to continue the research or attend the second interview.
7. The report may contain personal information but this information will be protected by false names and details that will not be identifiable by in the public.

Signed on (date): _____

Participant: _____

Researcher: _____

Appendix 5: Ethical clearance

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RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

14 May 2014

Gina Laurie
Department of Psychology
RHODES UNIVERSITY
6140

Dear Gina

ETHICAL CLEARANCE OF PROJECT PSY2014/05

This letter confirms your research proposal with tracking number PSY2014/05 and title, 'A Psychosocial Study of Mental Illness and Sibling Relationships', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 14 May 2014. The project has been given ethics clearance.

Please ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

CHAIRPERSON OF THE RPERC