SIBLING SET CONFIGURATION, FAMILY DYNAMICS AND CHILDHOOD PSYCHOPATHOLOGY

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ABSTRACT

The study attempts to explore those characteristics which make it possible for a given child in a family to emerge with psychological dysfunction. As the starting point, Fishbein's (1981) research study on the effects of sex and birth order of sibling set on the selection of an identified patient is replicated in part. Also, the effects of the overinvolvement of one of the parents, the presence of a grandparent in the household and the sibling rivalry felt by the child upon psychological dysfunction in the identified patient are examined. The theoretical framework of this study rests on family systems theory (Bowen, 1974 ; Minuchin, 1974), which investigates the relationship between family members; and Adler's theory of birth order.

There are six hypotheses in this study, three of them are taken from Fishbein, and three are constructed for this study. The first hypothesis of this investigation claims that psychological dysfunction in the family unit is related to the sex and birth order of siblings in the family. The second hypothesis assumes that among all the identified patients there are more boys than girls, and the third hypothesis assumes that among all the identified patients there are more first borns than later borns. Hypothesis four claims that psychological dysfunction increases when one parent is overinvolved with the identified patient. The fifth hypothesis assumes that if there is a grandparent living in the household, the likelihood of psychological dysfunction increases. Finally, the sixth hypothesis assumes that the sibling rivalry is more intensely felt among identified patients than among their siblings. Besides these hypotheses, the relationship between the parents' ordinal positions and sibling set configurations in their families of origin and those of the children's are investigated.

The data were collected by examining the official records of AŞAM, which is a private mental health center in İstanbul. The cases between the ages of four and eighteen who do not have an organically based problem, and member of intact families were selected. Thus, 84 cases were selected for this study. The usual statistical techniques could not be applied in this study, since the subjects did not come from the general population but were a self selected group of people. So, the results were presented in a descriptive manner.

The results confirmed five of the hypotheses with the exception of the fifth one, which indicates that the presence of the grandparent in the household does not increase the psychological dysfunction in identified patient. These results may be taken as supporting the belief of most family system theorists that the transactional styles and patterns of functioning developed in the families of origin will influence how the parents relate to each other and to their children in their family. In spite of the limitations of

sample size, non-statistical handling of the data and a restriction in the socio-economic levels of the families, the results of this exploratory study appear to fit theoretical expectations. So, it is expected that further investigations along these lines will enrich the field.

CHAPTER I

INTRODUCTION

Recent research in childhood psychopathology has increasingly focused on the relationship between the child's difficulties and dysfunction in his family as a whole. These studies assume that psychological difficulties involving varying degrees of impaired emotional functioning or symptom production in the child are strongly related to certain dysfunctions in his/her family and that the child reflects the dysfunctions of his/her parents in different ways.

This study accepts the above assumption and tries to identify some characteristics of the child who develops psychological difficulties as a reflection of his family's dysfunction. In other words, the purpose of the study is to explore those

characteristics which make it possible for a given child to emerge as the identified patient. The starting point of this study was to replicate in part a study done by Fishbein (1981) on the effects of sex and birth order of the sibling set on the selection of an identified patient.

When speaking of the family, that refers to father, mother and children. However, many families live and/or function as extended families, usually including a grandparent in the household. Some authors (Guerin, 1976 ; Haley 1978) believe that the presence of a member of an older generation in the household creates a potential for intrafamilial conflict. Therefore, this study also attempts to explore the relationship between the presence of a grandparent in the household and childhood pathology.

In this chapter, relevant aspects of the literature on family structure and functions, the role of sex and ordinal positions, and the literature on intrafamilial relations and child rearing

in Turkey will be covered. The chapter will end with a description of Fishbein's study and the presentation of the hypotheses.

1. REVIEW OF THE LITERATURE ON FAMILY SYSTEMS

A. Family Structure

The concept of Family Structure refers to the "invisible set of functional demands that organizes the way in which family members interact" (Minuchin, 1974, p.51). That is, the unwritten rules which define who the members of the family are, their positions vis-a-vis each other, who can interact with whom are all included in the concept of family structure.

While dealing with family structure the family should be defined as a system always in transformation; that is, it constantly takes in information from the extrafamilial environment, and

after processing and acting upon it sends it back. So the family adapts to the different demands of the developmental stages it faces, in order to maintain some kind of balance and continuity in reaction to changes either in one member or in the environment.

The family system is made up of subsystems and their boundaries (Minuchin, 1974). The family system differentiates and carries out its functions through subsystems which are made up of group of family members; each individual belongs to the number of subsystems. For example, the husband belongs to the spouse subsystem, male subsystem and parental subsystem in the family. The individual will exercise different interpersonal skills in different subsystems (Minuchin, 1974). The number of seperately functioning subsystems in the family reflects the family system's differentiation, and such a division of subsystems encourages the family in carrying out its functions.

Subsystems are differentiated from each other by boundaries

which are rules defining who participates in a subsystem and how (Minuchin, 1974). They function to protect the differentiation of the system, that is, allow the functioning of one subsystem without interference from other subsystems. If under stress, there is an increment of communication and concern among family members, the differentiation of the family system diffuses, and the system may become deprived of resources necessary to adapt and change under stressfull circumstances. Members of such fused families may lack autonomy due to the heightened sense of concern and involvement, that is the lack of subsystem differentiation discourages autonomous exploration and mastery of problems.

On the other hand, and if the communication across subsystems becomes difficult under stress, this would be due to increased rigidity of the boundaries seperating subsystems. This would also potentially lead to lack of adaptation. Members of disengaged families may function autonomously but have a skewed sense of independence and lack feelings of belonging, loyalty, the capacity

for interdependence and for requesting support when needed. Thus both types of family structure indicate how psychological problems can occur if the boundaries of subsystems are not clear yet flexible (Minuchin, 1974).

The sex and generation boundaries are accepted to be important for the fulfillment of the functions and tasks of the family. For example, the generation boundary separates the parents from the children. This boundary has to be flexible enough so that, the children are not burdened by having to make decisions beyond their capacities and parents can fulfill their roles of nurturing as well as disciplining.

Lack of clear sex and generation boundaries can also lead to problems. For example, a highly fused subsystem of mother and son, who are close to each other can exclude the father who would become disengaged in the extreme. Such a situation is stressfull and can lead to development of symptoms. Also, when the father is unavailable

for some reason, the oldest son may take parts of the father role and participate in the parental subsystem. If this role is too rigid, and does not allow him also to be a child, he may develop symptoms.

The individual family member is also a special subsystem. The individual's sense of self or identity is shaped by the family during the individual's early socialization and consists of a sense of belonging and separateness (Minuchin, 1974). The sense of belonging develops while the child is accommodating to the family's patterns of functioning and the sense of separateness develops while the child is participating in different subsystems in different contexts. By the interplay of these two forces, the child's self is differentiated as an autonomous subsystem which is neverthless rooted in the family system. The self also has a boundary which consists of "how people define themselves and their personal space in relation to others" (Guerin, 1976).

The sibling subsystem is considered to be the first social

laboratory in which children support, isolate, scapegoat and learn from each other. They learn how to cooperate, negotiate, and when they contact the world of extrafamilial peers, they try to operate along the lines of the sibling world. The significance of the sibling subsystem is seen clearly in its absence. Only children may manifest difficulty in the development of autonomy and the ability to share, cooperate and compete with others. At the same time, they may develop in early patterns accommadation to the adult world, which may be manifested in precocious development (Guerin, 1976).

In summary, family structures provide the rules of how people define themselves and their relationship to other family members. It also helps family members learn where everyone's rights and responsibilities begin and end. Clear yet flexible boundaries allow families to adapt to stress. Diffuse or rigid boundaries create difficulties in dealing with stress, which may lead to problems in one or more family members.

B. Ordinal Position and Sex

Adler was one of the first famous theorists who constructed a theory about birth order. He claimed that ordinal position in the family had a special significance and that children derive impressions of their place in the family, the world at the time by comparing themselves with whomever was closest to them (Adler, 1975). The oldest child who generally develops socially acceptable ways of coping with life tasks may strive for perfection as a goal, whereas the middle child, proceeding in ways opposite to the oldest child can strive to be the number one. But then he/she may acquire an added condition to his existence, a younger child, and feel squeezed in his position. The youngest child enjoys a position which he perceives as being the center of attention and he can choose to use his charm in manipulative ways to enjoy life's pleasures or try to achieve everything in order to make his place within the family.

According to Satir (1967) the ordinal position of the child may

stimulate conflict in the mates which in turn influences the child since a child learns about people and about himself by interacting with his parents and watching them interact. One parent may have had problems as the middle child in his/her own family and now focuses on his middle child in a special way involving the child in the marital relationship. Satir assume that the first child has got the highest probability of becoming an identified patient because of his availability for the first time as the first alternative to the mates once marital disappointment set in. It can also be stated that first borns may suffer from the inexperience of the parents and interference from their in laws (La Perriere et. al., 1980).

Besides the ordinal position of the child, the sex of the child is considered as an important factor when dealing with the characteristics of the identified patient (Satir, 1967). Because of the child's being either male or female, he/she already looks like one parent and identified with one parent. Even though the mates

may at first respond to the child as a relatively sexless, third member of a triangle, the child doesn't remain sexless as the parents both respond to the fear of being the left out member of triangle. The same sex parent may see the child potentially as belonging more to him or her since they both carry the same sex characteristics, which may lead to a feeling of being excluded in the other sex parent and a fear of the child's turning against him or her so that parent may work harder to get the child to his/her own side to make up for deficiencies in the marital relationship, to balance up the situation. As a result of this struggle, the same sex parent may tend to see the child as a potential competitor for the same reason. So, if there is an existent disharmonous marital relationship between the mates, the sex of the child may become a factor in increasing the disharmony within the family.

C. Functions of the Family

The family as a unit has certain functions, which are the

parental colition, nurturant tasks, enculturation of the younger generation, emancipation of the offspring from the family and handling of family crises (Guerin, 1976). These functions are interrelated and overlap.

The "marital coalition" may be defined as those interactional patterns which the spouses evolve at first for their mutual needs and satisfaction. Later this coalition serves the age-appropriate needs of the children but still maintains an area of exclusive relationship and mutuality between the parents. When children are born, parents must establish triangular relationship, which are to be flexible as each child is born. The child at first must be very close to the mother and absorbs a great deal of attention and energy to which the older family members must adapt. The older child must give up this primary closeness with his/her mother and learn to tolerate his replacement by a younger sibling. Throughout such developmental phases of the family, the family coalition must be strong to provide a mutual support base for the parents, so that

they can carry out their other tasks.

"Nurturant tasks" are primarily assigned to the mother but must be supported tangibly and emotionally by the father. Nurturant functions encompass more than food and the psychological aspects of feeding, especially the establishment of basic trust (Fleck, 1972). The early nurturance of the child includes helping him/her how to manage and control his body and how to observe, distinguish and communicate about inner and external experiences. Weaning as a part of nurturance leads to the acquisition of ego boundaries and a sense of separateness that must be experienced without losing faith and trust in the continuity of the relationship and sense of security.

Coming to the "enculturation tasks", the child should not only have mastered body control with gender awareness but he should also communicate to each parent comfortably without the feelings which carry a sexual meaning (Fleck, 1972). That is, he must learn to respect the gender and generation boundaries. At this time, the family

must facilitate peer relationships to allow the child a certain distance from the family circle as well as teaching him within the family norms and values of the culture in which he/she lives. While enculturating the younger generation, the family should also teach the sociocultural norms of relationships, social and communicative skills, by the help of shared works and games, which should be carried out through giving explanations and examples rather than through giving orders (Fleck, 1972).

The final separation, that is "emancipation" must occur physically as well as psychologically and socially but this can not be sudden, rather it must be step by step. The parental coalition is on trial during the emancipation phases because the parents must be prepared and able to live again as a dyad. So all of these functions can be viewed as evolutionary family "crises". Moving from the parental dyad to a triad is one of these important crises. The parents may at this time establish a generation boundary or remain overly dependent to each other, thereby competing

with the child for the spouse's parental nurturance. Also, if one of the parents is overinvolved with the child and doesn't allow the child to feel a sense of separateness, the family may become unable to or unwilling to accomodate the demands of the school or peer group of their children while enculturating the child which also creates crises within the family.

When the family is dysfunctional in its tasks of parental coalition, nurturance, socialization of younger generation, emancipation of them from the family emotional, psychosomatic, and antisocial symptoms may show up in families (Fleck, 1972).

D. The Extended Family

While we are examining family functions, the families of origin of each spouse should also be considered since it is accepted that the spouses learn to develop a preference for a particular transactional style in their own families and whatever the previously existing

patterns of emotional functioning were in their families, they tend to be replicated (Bowen, 1974 : Minuchin, 1974). Thus, when the spouse come together in marriage, they bring behaviors, expectations and attitudes developed in their own families of origin. One of the functions of the spouse subsystem or the marital coalition is to develop a new "transactional style" for the new family, that is a new set of behaviors, expectations and attitudes. When problems arise in a marriage, they are often due to the conflicting expectations the spouses brought from their families of origin which they did not adapt to fit the demands of the new family. The marital conflict then may be assumed to relate to a blurring of the boundary between the spouse subsystem and in-law subsystem.

Given the above description, it is possible that the positions and relationships of the parents in their families of origin may influence their unwitting focus on a particular one of their children as the identified patient.

It can be seen from the above literature, that a given child may emerge as the identified patient for the number of reasons. In fact, there is the description of a particular type of family constellation in the literature which attempts to deal with this issue.

Guerin (1976) claims that there are specific types of families which maintain the survival of the totally dependent child even though this trait must have decreased as children grow and their need becomes less. Such families are called child-centered families and are dysfunctional structures since such a child-focusing mechanism leads to developmental difficulties with varying degrees of impaired emotional functioning. In such families the child is more important than either parent. As for the siblings, such child-centeredness also fosters a fierce competition between them which produces an atmoshpere of hostility. Three factors are influential in producing such families. First, the families of origin of the parents with their cultural traditions and idiosyncracies have a decisive negative influence

on the independence of a young couple. Second, the individual histories of each of the parents is such that the way their personalities were shaped by different interpersonal experiences with their families and life circumstances may lead them centering on their children in an attempt to provide them with what they themselves lacked but wished to have. Third, the process of mutual accommodation shared by the couple before the arrival of children may not have been a satisfying situation helping them to establish some barriers between themselves and their children. In such families, the children's symptoms can be viewed as having a double function. One is that the symptoms are a protest against being focused on which creates a stressful atmosphere in everyday life, the other is that symptoms serve as targets for the maintenance and perpetuation of the dysfunctional marital patterns. Symptom choice is determined by two factors. The first is the form with which the parents express their child centeredness, the other is the way in which the child becomes involved in the parental conflict. In child centered families when the instrumental functions

of parenting are more emphasized which cover limit setting, reinforcement of rules, the children with passive types of symptoms such as shyness, over sensitiveness, fears tend to be raised. But, if the parents emphasize more the expressive functions which cover care-taking, nurturance, warmth, affection expression, the child tends to exhibit active types of behaviors, aggressiveness rebelliousness and various types of undesirable behavior disorders (Guerin, 1976).

Guerin assumes that whenever there is a child-focused family there are four potential family triangles to be considered. They are:

1. The central nuclear family triangle, consisting of mother, father and the child who is symptomatic.
2. The auxiliary nuclear family triangle of parent, symptomatic child and the unsymptomatic child.
3. Intersibling triangle among three children.
4. The triangle over three generations involving the child, a parent and a grandparent.

E. SUMMARY

In sum, the literature review of this study yields the following points:

1. The family is a system composed of subsystems and their boundaries. These boundaries, especially the sex and generation boundary are important in helping the members of each subsystem fulfill their tasks. If the boundaries protecting the subsystems are not clear, the members may fail at their tasks with potential pathological results.
2. The ordinal positions of the children in the family and their sexes are important elements of family structure. Each position and each sex has its own special problems.
3. The tasks and functions within the family fall mainly on the parents. Each task involves a different developmental crisis and may lead to difficulties.
4. The presence of the grandparent in an extended family household can create additional difficulties in the fulfillment of the family tasks.

5. Finally, the child-centered family is a special type of family which often leads to the child's becoming an identified patient.

2. INTRAFAMILY RELATIONSHIPS AND CHILD REARING IN TURKEY

In this section it will be considered that the intrafamily relationships as seen between husband and wife, and between parents and children in Turkey. Sex is considered as a very important factor in determining the status hierarchy within the family (Fişek, 1982). In spite of social change, women's status is still lower than men which also is seen in clearly defined sex roles and customs of physical and social segregation (Kandiyoti, 1977). The woman deals with the home and child care and the man with the external world. So, the relationship between the spouses are defined in terms of their role sharing and allocation of responsibilities which are regulated by social and cultural norms. But, such a strict differentiation of roles and responsibilities may lead to lack of communication between

the spouses because they do not have much to share and negotiate about.

In the relationship between parents and children, the children are considered as an important part of the family, even though they are still expected to provide economic support and security in the future, and promote the family name, more than providing psychological fulfillment for the family (Kağıtçıbaşı, 1981). Such an evaluation of the children insures that boys will be more important for the family and occupy a higher status than girls due to the definition of sex roles, with the expectation that the boys will promote the family name, provide economic support and security for the parents in the future. So, families in Turkey, prefer to have a son for such cultural and pragmatic reasons, but only prefer to have a daughter for the single reason of friendship which carries psychological meaning (Kağıtçıbaşı, 1981).

Even while there is a clear status differentiation between

sexes and generations, this differentiation is sometimes diffused in parent-child relationships. It is claimed that this is most likely to happen in close mother-son relationships (Köknel, 1970). Since the husband and wife are not expected to have much mutual communication and expression of emotional closeness due to the cultural norms, the wife may seek such closeness with her children and especially with the son, in order to compensate for the emotional closeness which she has lacked in her relationships with the husband (Fişek, 1982). Also, as the son grows to be a man he will have a higher status than the mother in traditional families (Fişek, 1982). That is, when the son is married and has a new family, his value will be increased and occupy a higher status than his mother. This also may lead to reinforce and strengthen the close and diffuse relationship already existing between them. Because in contrast to the closeness between mother and son, the father-son relationship is formal, distant and authoritarian, as reinforced and required by cultural norms (Kağitçıbaşı, 1981). Such a relationship between the son and parents lasts until the circumcision ritual which is

seen as initiation into manhood, and as increasing the value of the boy ensures the gradual separation between mother and son. But this separation may evoke oedipal conflicts which later may lead to the psychological disorders in the boy (Kağitçıbaşı, 1981). These situations show the significant emphasis put on sex as a determinant of status in intrafamilial relationships.

Upon these findings, related to the intrafamily relationships in Turkey, it may be claimed that the traditional family structure provides the male child more protection in terms of his physical and psychological needs, that is the families emphasize his needs for nurturance, education and success. This may be influenced by the socio-cultural norms of the society which expects the male child to support his parents both socially and financially when the parents are in need, and when they get old. It seems that even when he is overly protected, he is later expected to protect his parents which may lead to his feeling a lot of pressure. This mixture of high value and high expectation may lead to difficulties for the son.

However, the socialization of the female may be easier than male in Turkey, in terms of their involvement in family tradition, and being trained to strengthen the family norms. The female child is not faced with expectations of the parents related to their own security due to the cultural norms, but rather expected to cope with the moral codes of the culture, which encourages her being engaged in a feminine role. So, she is not faced with variant alternatives but reinforced to strengthen her sexual and social identification with her same sex parent. Therefore, one would expect girls to feel less pressure and stress.

3. FISHBEIN'S RESEARCH

In the research of Fishbein (1981), the relationship between sex and birth order of the sibling set in the primary family unit and family dysfunctions were examined. For the purpose of this research, family dysfunction in the area of offspring socialization is assumed to occur if the parents seek and receive psychological treatment for one or more of their children, and the sex and birth order of sibling set of which the child was a member have been noted. In Fishbein's

study, only two-child and three-child families all of school age, and all living with one or two natural parents were taken as a sample. Also, the extended families were excluded from the sample. The starting point for the research, was the conception that the family can influence and be influenced by the extrafamilial environment, members of a family are interconnected, there is a generational hierarchy within the family, and outside of it and the family members have shared rules and beliefs that at least partially control their behaviors within and outside of family.

It is assumed that when the families can not accommodate the tensions coming from within or outside the family, they become dysfunctional. The causes of dysfunction can be various. The parents may have disagreements about child-rearing, the family may be unable to or unwilling to accommodate to the demands from the environment, or the family may not be able to accommodate to the influences on their children by their peer groups. When the family is dysfunctional

in socializing their children, the dysfunction often manifests itself in terms of emotional or psychosomatic symptoms or as children's antisocial behavior (Fishbein, 1981).

Fishbein studied the effects of sex and birth order configuration on family dysfunction for the following reason: He assumed that structure and function are interrelated. That is, certain types of family structures allow certain family tasks to be accomplished more competently than others. For example, a family structure with an only child will impose different demands for the socialization tasks of the parents from a family structure of multiple children. The structural variables that Fishbein considered in his study as being important were sex and birth order configuration as stated above.

In terms of the sex and birth order configurations, Fishbein considered four possible sex/birth order configurations of the sibling set for two-child families and eight possible sex/birth

order configurations of the sibling set for three-child families. It was found that across all family types, families with all-girl sibling sets were the least dysfuntional, whereas the families with all-boy sibling sets were at an intermediate level of dysfunction. It was also found that, mixed gender sibling set has an increasing effect on family dysfunction for both the two-child and three-child families. But, this dysfunction also depended on birth order in that, if at least one boy precedes one girl there will be the highest degree of family dysfunction, but if there are sets of boys or girls before boys intermediate levels of dysfunction will be obtained.

It is assumed by Fishbein that there are two factors which lead to such findings. The first one is that the male and female children are different in terms of their relative commitment to the supporting norms of the family. Such norms as explained by Boszormenyi-Nagy, Spak and Minuchin (1973) in terms of the "parentification" of the child, usually the oldest one.

Parentification of the child involves the acquisition of parental roles in a family, and it is claimed that female children are more likely than males to support family tradition. Also, norms such as staying in close proximity to mother, helping her and caring for younger sibling are easier for the female child in terms of her sexual and socio-cultural roles, and lead to the strengthening of and commitment of family norms.

The second factor is the development of a family culture. The children of the same gender are accepted to be more similar to one another than children of different genders. It is accepted that when the parents succeed in socializing boys or girls, this would have been influenced by their previous experiences. Thus, each succeeding same sex child in a family strengthens the culture of the family, such as the beliefs concerning child behavior and child socialization. However, if the genders are mixed, then the family culture will be challenged. Since the different genders require different ways of socialization, the parents must be able

to consider the sexual characteristics of their children as well as cultural norms in order to adapt themselves to this situation.

4. HYPOTHESES

The specific purpose of this study, is to replicate Fishbein's (1981) research study, so the hypotheses that will be stated in the following are taken from Fishbein.

Hypthesis 1. Psychological Dysfunction is related to the sex and order of sibling in the family. Specifically, it is anticipated that all female sibling sets will have the lowest rate of dysfunction, followed by all male sibling sets. The case of mixed gender sibling sets will yield higher rates of psychological dysfunction if there are sets of boys or girls before boys and, in particular, the case of the oldest sibling being a boy is hypothesized to yield the highest rate of dysfunction.

Hypothesis 2. Among the all identified patients there are more boys than girls.

Hypothesis 3. Among the all identified patients there are more first borns than later borns.

Additional to the Fishbein's hypotheses, three more hypotheses are constructed in this study, as will be stated in the following.

Hypothesis 4. Psychological Dysfunction increases when one parent is overinvolved with the identified patient and decreases when both parents are equally involved with the identified patient.

Hypothesis 5. If there is a grandparent living in the household, the likelihood of psychological dysfunction increases.

Hypothesis 6. Sibling rivalry is more intensely felt among identified patients than among their siblings.

In this research study, we also wanted to investigate the relationship between the parent's ordinal positions and sibling set

configurations in their families of origin, and the children's. However, no hypotheses were made on this topic.

CHAPTER II

METHOD

The data were collected by examining the official records of AŞAM, which is a private Mental Health Center operating since 1979, in İstanbul. Also, the records at Çapa Child Psychiatry Clinic were examined, but due to the lack of appropriate information in them for the needs of this study, they were not taken into consideration.

In this study, certain criteria were set to help in deciding which case records to include or exclude from our analyses. These criteria were:

1. The identified patient could not be under four years of age, because it was suspected that the problems of very young children may actually have more to do with the parents than

the child as an identified patient.

2. The identified patient could not have organically based problems since such problems may not be directly caused by psychological factors and intrafamilial relationships.

3. The identified patient must come from intact families since it is attempted to investigate the intrafamilial relationships from various aspects as important factor upon psychological dysfunction in the child.

With these limits, 84 children of whom 59 were male and 25 were female between the ages of 4-18 were selected. Even though the actual number of cases in AŞAM consisted of 192 children, 119 of them male and 73 of them female, 47 of these cases were excluded due to organic problems such as mental retardation and being below 4 years of age. 71 of the 192 cases also are excluded from the sample due to the lack of adequate information in their files, which was necessary for this research study.

In order to make a comparison and bring a new dimension to this study, the sample was split into two groups as two and three child families and only child families resulting in 43 two and three child families and 41 only child families. Among two and three child families, there were 30 male and 13 female children, and among only child families, there were 29 male and 12 female children.

An examination of the records at ÇAPA Child Psychiatry Clinic revealed that the information in their files were quite in appropriate for the needs of this study. In addition the majority of the cases seen there appeared to have organic origins. Since only 5 out of 246 cases fit our criteria, it was decided to exclude these and examine only the AŞAM data.

5. PROCEDURE

In this study, the necessary information in the files were found and placed in the charts which were prepared by the examiner and this process took place over six months. These families were

considered to be middle class because of the fact that they could afford to apply to a Private Mental Health Center which requires 1500 TL per interview.

Before actual data collection, typed charts were prepared for the each child which outlined all the factors to be examined. These factors were as follows:

1. Sex and ordinal position of the child (identified patient).
2. Sibling set configuration within the family.
3. Overinvolvement of one of the parents (which of the parents deal most with the child's problems in terms of his/her worries complaints, overprotection).
4. If present, the involvement of the grandparent with the existing problem.
5. If there is a sibling rivalry, which of the children is concerned with such a feeling in terms of his/her sex and ordinal position.

Also, it is attempted to examine the relationship between the parent's ordinal positions and sibling set configurations and children's, so the ordinal position, sibling set configuration of each of the parent in their families of origin were taken as necessary information. However, no hypotheses were made on this topic.

CHAPTER III

RESULTS

Since the subjects of this study did not come from a random sample selected from the general population, but a self selected group of people, the usual statistical techniques could not be applied. Since the purpose of the study was a preliminary investigation in any case, the results will be presented in a descriptive manner.

Before explaining the results, it will be appropriate to restate the hypotheses constructed in this study. Now, each hypothesis will be taken in turn, and the results will be examined.

Hypothesis 1 stated that Psychological Dysfunction is related to the sex and order of siblings in the family. Specifically,

it is anticipated that all female siblings sets will have the lowest rate of dysfunction, followed by all male sibling sets. The case of mixed gender sibling sets will yield higher rates of psychological dysfunction if there are sets of boys before girls or girls before boys. In particular, the case of the oldest sibling being a boy is hypothesized to yield the highest rate of dysfunction. The results indicate that among two and three children families 39.5% of them have at least one boy who is older than one girl, 30.3% of them have mixed sibling sets and the sets of boys or girls precedes the boys, 18.6% of them have all boy sibling sets, and 11.6% of them have all girl sibling sets. Thus, the results are in line with the first hypothesis and family dysfunctions are seen the least in all girl sibling sets and start to increase with all boy sibling sets, mixed gender sibling sets where the sets of boys or girls precedes the boys, and reaches to the highest degree in families where at least one boy is older than one girl. Table I shows these results.

TABLE 1

Number & Percentage of Different Sibling Set Configurations in the Sample

All girl s.s.	All boy s.s.	Mixed gender s.s. (first born girl later born boy)	Mixed gender s.s. (first born boy later born girl)
5 (11.6%)	8 (18.6%)	13 (30.3%)	17 (39.5%)

The second hypothesis stated that there will be more boys among the identified patients than girls. Our results show that 70.2% of the sample were males (35.7% of them are from two and three child families and 34.5% of them are from only child families) whereas, 29.8% of the sample are females. Thus the second hypothesis is also supported and there are more boys than girls among the identified patients. Table 2 shows these results.

The third hypothesis stated that there would be more first borns than later borns among the identified patients. The results on Table 3 indicate that among the identified patients, 55.8% of them are first borns, and 25.5% are second borns, 16.2% are third borns and 1.19% are fourth borns. Thus, the results are in line with the third hypothesis and there are more first borns than the later borns among the identified patients.

The fourth hypothesis stated that psychological dysfunction increases when one parent is overinvolved with the identified patient

TABLE 2

Number & Percentage of Males & Females among the Identified Patients

	Males	Females
Only child families	29 (34.5%)	12 (14.3%)
Two-three child families	30 (35,7%)	13 (15.5%)
Total	59 (70.2%)	25 (29.8%)

TABLE 3

Number & Percentage of Identified Patients in Different Ordinal Positions

First born	Second born	Third born	Fourth born
24 (55.8%)	11 (25.5%)	7 (16.2%)	1 (1.19%)

and decreases when both parents are equally involved with the identified patient. In order to analyze this question/issue, it is divided into four categories as follows:

1. Who brought the identified patient.
2. Who speaks most for the identified patient.
3. Who is more concerned with the identified patient's problem.
4. Who disciplines the identified patient.

The results for the first category indicate that among the families who brought their children to ASAM, 56% of the identified patients were brought by both of the parents, 40.45% were brought by the mothers, and 3.57% were brought by the fathers. At this point, it should be mentioned that even though the clinic required that both of the parents must come to the initial interview, only 56% of the parents acted accordingly, but 44% of the parents did not.

The second category analyzed which of the parents was speaking most for the child. The results for this category show that, 88.7% of the parents are mothers who speaks the most for the child, 5.95% of the parents are fathers, and 2.38% are either granparents or a close relative, that are the other people in relation with the identified patient.

The third category was about the overconcern of the parents. The results indicate, in this category that among all the families, 93.27% of the parents are the mothers who are more concerned with the identified patient's problem, 4.76% are the fathers, and 2.38% are the other people either grandparents or close relatives who are more concerned with the identified patient's problem.

The fourth category was about the disciplining of the identified patient, and it was found that, 80.94% of the identified patients were disciplined by their mothers, 8.33% of them were by their fathers

3.5% of them were by both parents and 7.14% of them were by other people, either grandparents or close relatives. Thus, the overall results are in line with the fourth hypothesis that four of the categories show that the overinvolvement of one of the parents especially the mother, increase the psychological dysfunction in identified patient instead of the overinvolvement of both parents. Table 4 shows the results.

Hypothesis 5 stated that if there was a grandparent living in the household, the rate of psychological dysfunction would increase. The results indicate that among all the families 64.28% of them have no grandparents (either maternal or paternal grandparents) living in the household. Only, 21.42% of the families have paternal grandmothers living in the household, and 14.19% of them have maternal grandmothers living in the household. Also, while considering the maternal and paternal grandparents, 89.2% of the families have no maternal or paternal grandparents living in the household. But, 10.7% of them have paternal grandfathers living

TABLE 4

Number & Percentage of Parents Involved with the Identified Patient

		Two-three child families	Only child families	Total
"Who brought the child"	together	27 (32.14%)	20 (23.8%)	47 (56%)
	mother	15 (17.85%)	19 (22.6%)	34 (40.45%)
	father	1 (1.19%)	2 (2.38%)	3 (3.57%)
"Who speaks for the child	mother	40 (47.6%)	37 (40.47%)	77 (88.7%)
	father	3 (3.57%)	2 (2.38%)	5 (5.95%)
	other	0	2 (2.38%)	2 (2.38%)
"Overconcern of the parents"	mother	41 (48.8%)	37 (40.47%)	78 (93.27%)
	father	2 (2.38%)	2 (2.38%)	4 (4.76%)
	other	0	2 (2.38%)	2 (2.38%)
"Disciplining the child"	mother	34 (40.47%)	34 (40.47%)	68 (80.94%)
	father	4 (4.76%)	3 (3.57%)	7 (8.33%)
	both	1 (1.19%)	2 (2.38%)	3 (3.5%)
	other	4 (4.76%)	2 (2.38%)	6 (7.14%)

in the household, and none of the families have the maternal grandparents living in the household. Among all the grandparents 21.42% of the families have paternal grandmothers, 14.19% of them have maternal grandmothers, and 10.7% of them have paternal grandfathers living in the household. But, there were no maternal grandfathers living in the household in this sample. Thus, the results indicate that the fifth hypothesis is not confirmed, since 64.28% of the families have no grandparents living in the household. Table 5 shows the results.

Hypothesis six stated that among two and three children families sibling rivalry is more intensely felt among identified patients than among their siblings. The results for this hypothesis show that, among two and three child families 65% of them have identified patients who intensely feel sibling rivalry, but none of their siblings are concerned with such a feeling. Among the identified patients only 35% of them are then not experiencing this feeling. Thus, the results are in line with the sixth hypothesis that sibling

TABLE 5

Number & Percentage of Grandparents Living in the Household

		Two-three child families	Only child families	Total
aternal grandparents"	None	27(32.14%)	27 (32.14%)	54 (64.28%)
	paternal g. mother	5 (5.95%)	13 (15.47%)	18 (21.42%)
	maternal g. mother	11 (13%)	1 (1.19%)	12 (14.19%)
aternal grandparents"	None	39 (46.4%)	36 (42.8%)	75 (89.2%)
	paternal g. father	4 (4.76%)	5 (5.95%)	9 (10.7%)
	maternal g. father	0	0	

rivalry is more intensely felt among identified patients than among their siblings. Table 6 shows the results.

ADDITIONAL RESULTS

In this study, additional to the analysis of the results related to the hypotheses, certain other findings have shown themselves, in relation to the questions investigated in this study, so it may be meaningful to mention them.

One of these findings concerns the ordinal position of the parents. Among all the families, 65.54% of the fathers are first children, whereas 31.88% of the fathers are second children, 10.7% of them are third children, 3.57% of them are fourth children, 4.76% of them are fifth children and 3.57% of them are sixth children in their families of origin. Also, among all the families, 41.58% of the mothers are first children, 23.8% are second children, and the percentage is same for third, fourth, fifth children as 7.14%. Thus, the results indicate that most of

TABLE 6

Number & Percentage of Identified Patients' and those who do not have Feeling of Sibling Rivalry

Yes	No
28 (65%)	15 (35%)

the mothers and fathers are first children in their families of origin. Table 7 shows these results.

Also, while considering the number of siblings in the parents' families of origin, it is seen that 38% of the mothers come from four and five child families, 36% of them come from one and two child families, 26% of them are from three child families. Among all the fathers, 49% of them come from one and two child families, 29% of them come from three child families and 22% of them are from four and five child families. Thus, The results show that fathers come from smaller families than mothers. Table 8 shows these results.

While investigating the parent's ordinal sibling set configurations, certain interesting findings have manifested themselves as follows. 53% of the mothers have a mixed sibling set in their families of origin, 33% of them have the same gender

TABLE 7

Number & Percentage of Ordinal Position of the Parents

Mothers			Fathers		
wo-three hildren	Only children	Total	Two-three children	Only children	Total
23 (27.3%)	12 (14.28%)	35 (41.58%)	20 (46.5%)	16 (19%)	36 (65.54%)
12 (14.28%)	8 (9.52%)	20 (23.8%)	12 (14.28%)	6 (17.6%)	18 (31.88%)
3 (3.57%)	3 (3.57%)	6 (7.14%)	5 (5.95%)	4 (4.76%)	9 (10.7%)
4 (4.76%)	2 (2.38%)	6 (7.14%)	1 (1.19%)	2 (2.38%)	3 (4.76%)
1 (1.19%)	5 (5.95%)	10 (7.14%)	2 (2.38%)	2 (2.38%)	4 (4.76%)
			3 (3.57%)		3 (3.57%)

TABLE 8

Number & Percentage of Number of Siblings in Father's and Mother's Families of Origin

	Mothers	Fathers	Total
and two ildren	26 (36%)	32 (49%)	58 (34%)
hree ildren	19 (26%)	19 (29%)	38 (27.6%)
r and five ildren	28 (38%)	14 (22%)	42 (30.4%)
	73 (52.9%)	65 (47.1%)	

sibling set, and 14% of them are only children. 60.5% of the fathers come from the families with mixed gender sibling sets, 14% of them come from the families with the same gender sibling sets and 26.5% of them are only children.

Here only 73 of the cases had the full data about father's sibling set configurations in the files, so the calculations were made for 73 cases. The results of this investigation indicate that since 53% of the mothers and 60.5% of the fathers come from families with mixed gender sibling sets, there may be a relationship between parent's and children's (IP'S) sibling set configurations. The results of this analysis is shown in Table 9.

We also attempted to investigate the relationship between the identified patient's birth order and the parent's birth order. The following findings have emerged as can be seen on Table 10. Out of 84 cases, 14 of them did not have the parent's birth order in their files, so the calculations could be made upon 70 cases.

TABLE 9

Number & Percentage of Parent's Sibling Set Configuration

	Mixed gender sibling set config.	Same sex sibling set config.	Only children
thers	45 (53%)	28 (33%)	11 (14%)
thers	43 (60.5%)	10 (14%)	20 (26.5%)

TABLE 10

Number & Percentage of Children's Birth Orders Related to Their Parents

	Same with both parents	Same with mothers'	Same with fathers'	Different from both
Children	16 (22.8%)	9 (12.8%)	20 (28.6%)	25 (35.7%)
First Child	15	1	16	13
Second "	1	2	3	5
Third "			1	6
Fourth "				4

The results indicate that, 22.8% of the children have the same birth order as both parents, and 12.8% of them have the same birth order as their mothers but not as their fathers, and 28.6% of them have the same birth order as their fathers but not as their mothers. Also, 35.7% of the children have different birth orders from both parents. Another finding about the relationship between children's and parent's birth order is that, if their birth order is the same, most of them are first children.

Among the 16 cases where the childrens' and both parents' birth order is the same, 15 of these cases are both first children and one case is second children, Among the 20 children who have the same birth order as their fathers, 16 of them are first children, 3 of them are second children and one of them is a third child. Among the 9 children who have the same birth order as their mothers, 7 of them are first children, and 2 of them are second children. Also, if we consider the cases whose birth orders are different from both parents, 13 of them are first children, 5 of them are second children, 6 of them are third children and one of them is

fourth child. Table 10 shows these results.

In summary, the results having to do with the parents show that, most of the parents of this sample were first borns; while most mothers come from four and five child families, most fathers are only children; most of the parents come from families with mixed gender sibling sets, and most of the identified patients have the same birth order as their parents, that is they are both first borns.

CHAPTER IV

DISCUSSION

In this study, there were six hypotheses as follows:

Hypothesis 1: Psychological dysfunction is related to the sex and order of siblings in the family. Specifically, it is anticipated that all female sibling sets will have the lowest rate of dysfunction, followed by all male sibling sets. The case of mixed gender sibling sets will yield higher rates of psychological dysfunction if there are sets of boys or girls before boys, and in particular, the case of the oldest sibling being a boy is hypothesized to yield the highest rate of dysfunction.

Hypothesis 2: Among all the identified patients there are more boys than girls.

Hypothesis 3: Among all the identified patients there are more first borns than later borns.

Hypothesis 4: Psychological dysfunction increases when one parent is overinvolved with the identified patient and decreases when both parents are equally involved with the identified patient.

Hypothesis 5: If there is a grandparent living in the household, the rate of psychological dysfunction increases.

Hypothesis 6: Sibling rivalry is more intensely felt among identified patients than among their siblings.

We also attempted to investigate the relationship between the parent's ordinal positions and sibling set configurations in their families of origin, and the children's. But, no hypotheses were constructed on this topic.

The hypotheses described above, were confirmed in this research study with the exception of the fifth one, and the findings related to these hypotheses were explained in the results section. Additional findings about the relationship between the parent's and children's

birth orders and sibling set configurations were also given in the results section. We can summarize these results as follows. The results of hypothesis one indicate that family dysfunctions are seen the least in all girl sibling sets, and start to increase with all boy sibling sets, mixed gender sibling sets where the sets of boys or girls precedes the boys, and reach the highest degree in families where at least one boy is older than one girl. The second hypothesis was also supported by the results that we have obtained in that there are more boys than girls among the identified patients. The results of the third hypothesis show that there are more first borns than later borns among the identified patients. The fourth hypothesis was analyzed in four categories, and the overall results are found to be in line with this hypothesis that overinvolvement of one of the parents especially the mother, increase the likelihood of psychological dysfunction in the identified patient instead of overinvolvement of both parents. The results of the fifth hypothesis indicate that it is not confirmed and the presence of the grandparent in the household does not increase the likelihood of psychological

dysfunction in the identified patient. However, the sixth hypothesis is confirmed by our results that sibling rivalry is more intensely felt among the identified patients than among their siblings.

Since this study attempted to replicate Fishbein's research study, it may be meaningful to compare the two studies in terms of their results. The first three hypotheses of this study are the same as Fishbein's hypotheses thus, we can state the rules that Fishbein derives from his results as being relevant for us. The first rule may be stated as "Sets of boys before girls are associated with high levels of dysfunction" (Fishbein, 1981). Also, since intermediate levels of family dysfunction are associated with sibling sets in which girls precede boys or boys precede boys, the rule here may be stated as "Sets of boys or girls before boys are associated with intermediate levels of dysfunction" (Fishbein, 1981).

This agreement stands despite the fact that, there were dissimilarities between Fishbein's and our selection criteria.

In Fishbein's research study, both two-parent and single-parent families were selected, but in this study only two-parent families were used in order to examine the intrafamily relationships as an important factor bearing the psychological dysfunction of children. In Fishbein's study only the children who were enrolled in school were selected, but in this study the children of kindergarden age were also selected. In the study of Fishbein, families had no one else living at home except mother, her children and if married the fathers of these children, but in this study families with an existent grandparent living in the household were also selected. In Fishbein's study all families with stepparents, step-children and foster children were excluded from the sample as was the case in this study. Also, in this study, the identified patient with organically based problems were excluded since such problems may not be directly caused by psychological factors and intrafamily relationships. Such a criterion had not been set in Fishbein's study. Since the results are in agreement in spite of these differences between the two samples, it may be fair to say that

these findings appear to have considerable generality.

Another interesting point is that these findings seem to have cross-cultural generality, at least across two cultures as diverse as American and Turkish cultures. The obvious implication to be made at this point is that the explanations proposed by Fishbein must have validity for Turkish culture also. Let us now examine Fishbein's explanations.

While explaining his findings, Fishbein considers the factors of parentification of a child and development of a family culture. Parentification involves the acquisition of parental roles in a family and the acceptance of social norms. Female children are more likely than males to be involved with and support family traditions in terms of learning and carrying out household chores, helping mother and caring for younger siblings, and these activities involve strengthening of commitments to family norms. Thus, the parents will have an easier time socializing an oldest daughter.

In the second factor, the development of a family culture is emphasized and, each succeeding same sex child in a family is accepted to strengthen the culture of the family, beliefs concerning child behavior and child socialization. Thus families should face less stress in socializing same sex siblings. This study also accepts these explanations of Fishbein about the findings.

In addition, it is felt that intrafamily relationships in Turkey would serve to emphasize these factors, as follows: It may be claimed that, the traditional family structure provides the male child more protection in terms of his physical and psychological needs, that is the families emphasize the facts of his nurturance, education economical security more than those of the female child. This was one of the facts emerging from our literature review. However, it seems that even when he is overly protected, he is expected eventually to protect his parents which may lead to his feeling a lot of pressure. However, the socialization of the females may be easier than males in Turkey, in terms of their involvement in family tradition, therefore being trained to strengthen the family norms. The female child is not

faced with expectations of the parents related to their own security due to the cultural norms but rather expected to cope with the moral codes of the culture which encourage her being engaged in a feminine role. Therefore, one would expect girls to feel less pressure and stress. Also, while considering the ordinal position of the child, the oldest son is faced with the strongest expectations of the parents, since he is the first alternative for them to carry out their expectations and for the mother, the first chance to compensate for any dissatisfaction in her marriage, if present.

Hypotheses four, five and six were not a part of the replication of Fishbein's results and need explanation on their own. The results relating to the fourth hypothesis indicate that in the majority of the cases, there was overinvolvement on the part of one parent, typically the mother. These results can be explained by referring to the literature on family therapy. In fact the concept of the child-centered family indicates that triangulation

is an important element in childhood dysfunctioning. The fact that the mother is mostly the overinvolved parent is to be expected from an examination of Turkish family structure. In most cultures, the mother has a more closely involved relationship with her children, and in Turkish culture this relationship is more emphasized. As mentioned in the literature review, the mother's role is in part defined by child care, as opposed to the father. Further her lower status in the family brings her closer in status to her children, especially her high status son. This status similarity, coupled with a relative lack of intimacy with her husband can easily lead to a blurring of boundaries between her and her children. Under stress it would be only too easy for a mother to form an alliance with her child or children and distance the father in a dysfunctional triangle.

It was mentioned at the beginning of this section that hypothesis five was not confirmed. It was found that the grandparent's existence in the household does not appear to be an influencing factor upon the child's psychological dysfunction. But, if we

consider the relationship between generations in Turkish society we may not rely on this finding. In Turkey, the relationship between generations are determined by a clear cut status differentiation that reinforces obedience to the older generation. So, one may suspect an interference on the part of the older generation in the intrafamilial interactions of the nuclear families. Since male children are expected to provide social and economic support to their parents when they are in need, living in the same house may not be the only condition for grandparents to be influential upon their children's life, and living in seperate houses may not mean that they are independent from each other.

Hypothesis six was confirmed, indicating that the identified patients are more concerned with feelings of sibling rivalry than their siblings. These results can be explained by referring to the notion of child-centered families. Guerin (1976) states that child-centeredness produces intense competition among the siblings. The child chosen as the identified patient in such families has

a special position. He may receive more attention than his siblings but much of that attention is bound to be negative. Moreover, the child is bound to feel more stressed, conflicted and restricted. Thus, he may envy his siblings, who while they may not receive as much attention, may be more autonomous from the parents. This may lead to a heightening of jealousy. In addition the identified patient may be especially sensitive to the nuances in the intrafamilial relationships and more ready to respond with jealousy.

In addition to the findings relating to the hypotheses, some further results having to do with the parents emerged from this study. In summary, it was found that, most of the parents of this sample were first borns; while most mothers came from three-child families, most fathers were only children; most parents came from families with mixed gender sibling sets; most identified patients had the same birth order as their parents, i.e., they were both first borns. Since the relevant data were not

available for all cases, the sample size was quite small here and thus it was difficult to make meaningful generalizations. However, the trend that emerged appears to indicate that there are some parallels between the birth order, positions of identified patients and their parents. This trend may be taken as a support of Guerin's contention that the selection of the identified patients in a child-centered family depends in part on the parent's lives in their families of origin (1976). These results may also be taken as supporting the belief of most family system theorists that the transactional styles and patterns of functioning developed in the families of origin will influence how the parents relate to each other and to their children in their family (Bowen, 1974 ; Minuchin, 1974). A further implication is that a through understanding of the dysfunctioning in one identified patient, may necessitate an investigation of more than one generation in the family (Guerin, 1976).

Overall, this study has provided some very interesting results despite the limitations of sample size, non-statistical handling of

the data, and a restriction in the socio-economic levels of the families. It is especially interesting that the empirical results appear to have cross-cultural generality. From the point of view of Family Systems Theory, it is encouraging that even the results of such an exploratory study, appear to fit theoretical expectations. It is expected that further investigations along these lines will enrich the field.

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APPENDIX A

MÜRACAATÇI

1. Doğum tarihi
2. Yaşı
3. Cinsiyeti
4. Kardeş sayısı 1 2 3 4 5 6
5. Yaşları
6. Cinsiyetleri
7. Kaçıncı cocuk
8. Kardeş kiskançligi var mı ?
9. Varsa hangi kardeşle var?
10. Aile ile birlikte yaşayan anneanne/babaanne var mi?
11. Varsa hangisi?
12. Çocuk kimin tarafından getirildi?
13. Çocuk için kim daha çok konuşuyor?
14. Çocuk için kim daha çok kaygi/üzüntü besliyor?
15. Çocuğun en çok kim üstüne düşüyor? (ders çalişma, kontrol, disiplin)
16. Anne Baba

    Yaş

    Kardeş sayisı 1 2 3 4 5 1 2 3 4 5 6 7

    Kardeş cinsiyeti

    Kardeş yaş