UNIVERSITY OF CALIFORNIA

Santa Barbara

Caught Within the Family System:

An Examination of Emerging Adults' Dilemmas in Navigating Sibling Depression

A Thesis submitted in partial satisfaction of the

requirements for the degree Master of Arts

in Communication

by

Jade Salmon

Committee in charge:

Professor Tamara Afifi, Chair

Professor Andy Merolla

Professor Walid Afifi

June 2023

The thesis of Jade Salmon is approved.

_____

Andy Merolla

_____

Walid Afifi

_____

Tamara Afifi, Committee Chair

June 2023

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to my advisor, Tammy Afifi, for supporting me emotionally and professionally throughout my entire master's program. Her expertise and warmth have been invaluable to my growth and well-being. She has challenged me to think more critically and explore my research interests, which is how we came up with this thesis topic. Despite being one of the busiest people I know, she has always been there to chat about my sitcom of a life and remind me that my mental health matters. Tammy, thank you for accepting me as your advisee, giving me meaningful opportunities, and encouraging me even before I arrived in Santa Barbara.

I am thankful to Andy Merolla for being a member of my thesis committee, a fantastic instructor to work with, and an all-around role model of mine. He is one of the most compassionate professors I've met. Beyond patiently tending to my countless grading questions, he has always made himself a safe person to talk to about anxiety and imposter syndrome. I greatly admire that his scholarly passion does not overshadow his humanness in any way. Andy, I wish I could make clear just how much of an impact you've had on me.

I would also like to thank Walid Afifi for being a member of my thesis committee. His commitment to community engagement has helped me feel a greater sense of belonging in how I approach research. Walid, thank you for immediately responding to my thesis proposal a year ago by checking that the subject matter wouldn't harm my well-being.

I cannot begin to express how important my UCSB friends are to me; although I originally came here for academic reasons, these folks are by far the highlight of my program. I would like to give a special thank-you to my cohort-mates, friends, and colleagues

in the Department of Communication, including Chloe Gonzales, Laurent Wang, Kylie Woodman, Ceciley Zhang, Jacova Snyder, Qing Huang, Hannah Overbye, Kyungin Kim, Sovannie Len, Brittany Wheeler, Chris Otmar, Lindsay Miller, Nancy Molina-Rogers, Jesse King, and Nikki Truscelli, among others. I also have so much appreciation for my non-Comm friends, including Kristy Ali, Hind Al Ali, Nikola Klier, Hitomi Nakayama, Becky Martin, R Baker, Elena Mailander, and Stevie Sandy. And I am immensely grateful to Cole Airoso for becoming one of my best friends despite being neither a grad nor Comm student.

I feel like the luckiest person in the world to say that I have friends outside of UCSB who have been there for me through all the ups and downs of the past couple years. A huge shoutout to Stanley Wong, Kim Linh Nguyen, Rian K Patterson, Tyler DeMers, Bianca Lara, Kelsey Jarecki, David Gonzales, Emily Tran, Remy Matulewic, Lior Lisk, Len Truelsen, Michael Leong, Luis Espinoza, Adora Harvey, Ashlyn Patterson, and many more. Thank you for the jokes, game nights, body-doubling, and venting sessions. You mean the world to me.

This project would not have been nearly as meaningful, thoughtful, or successful without the work of my amazing research team: Eric Ching, Hannah O'Connell, Sabrin Elmoussaid, Lauryn Smith, Angelina Sam, Helen Tao, and Tiffany Yun. You are all highly driven, caring, and fun individuals. I am so excited to see you pursue your passions. Thank you endlessly for your flexibility and commitment as we took on this project.

If I could detail all my gratitude here, then this section would be a whole thesis itself. With that, I'd like to thank my mom for her love and open-mindedness as we've grown together while navigating mental health and intergenerational chaos in our own family. And finally, the coziest thank-you to Taro, who has always been there to snuggle, sit on my laptop keyboard, and comfort me even when my anxiety has triggered his own.

ABSTRACT

Caught Within the Family System:

An Examination of Emerging Adults' Dilemmas in Navigating Sibling Depression

by

Jade Salmon

As one of the most common mental health disorders in the world, depression represents a major concern for those who have the condition and their close relational partners. Extant literature has prioritized depression in romantic and parent-child relationships. The sibling bond is underexamined, despite the uniqueness of the relationship and siblings' positive role in mental health. Family systems theory frames the family as a complex system of interdependent individuals and relationships (or subsystems). Because system-level patterns are transmitted intergenerationally, family systems theory argues that depression is not solely a contributor to negative family outcomes, but also the result of maladaptive system patterns developed over the family's history. Family communication research has traditionally centered on a given dyad or triad in a singular interaction or set of interactions. This neglects the influence of other family members, interacting subsystems, and previous experiences. That is, the sibling's navigation of depression is not merely a dyadic issue, as the sibling subsystem is situated within the larger family system. Therefore, the present study seeks to describe the family system-related dilemmas faced by emerging adults who take on the supporting sibling (SS) role for their sibling with depression (SWD).

Inconsistent nurturing as control (INC) theory posits that close relational partners of individuals who display undesirable behavior have conflicting goals to nurture and control. Consequently, unafflicted partners respond to afflicted partners' undesirable behavior in inconsistent ways that unintentionally reinforce the behavior. Although INC theory was originally created to describe the maintenance of problematic substance use in romantic couples, it has been applied to a variety of health disorders and family relationships. Sibling depression represents an intersection unexamined through an INC lens. As such, the present study investigates SSs' communicative management of their family system-related dilemmas pertaining to their SWD's condition, with the objectives of better understanding the SS's experience and gauging the applicability of INC theory to siblings and depression.

Fifty emerging adults who grew up with at least one sibling, and one or both of the siblings having chronic depression, participated in individual semi-structured interviews about sibling management of depression in the family system. A thematic analysis revealed several interrelated themes demonstrating the relevance of the larger family system in all parts of the navigation of sibling depression. Insufficient support from older generations, combined with care for their SWD, contributed to emerging adults' felt obligation to upholding the SS role. They grappled with internal tension as they struggled to balance their family relationships, SWD's needs, and their own well-being and autonomy. Findings are elaborated upon, and implications for family systems research, INC theory, and practice are discussed.

TABLE OF CONTENTS

Rationale

Mental health challenges represent a major concern for those who experience them, at psychological and interpersonal levels. In particular, depression is associated with negative communication and poor social skills, which, in turn, can have harmful consequences for close relationships in which one member has depression (Afifi et al., 2018; Du Rocher Schudlich et al., 2019, 2015). Family systems theory argues that the family is a complex system of interdependent, mutually influential relational partners (P. Minuchin, 1985; S. Minuchin, 1974). Through this lens, depression is not only a contributor to negative family outcomes, but also the result of dysfunctional family system-level patterns (Minuchin, 1985).

Inconsistent nurturing as control (INC) theory describes how one's behavior can influence another's depression. It argues that in response to undesirable dysfunctional behavior, unafflicted relational partners struggle to balance two opposing goals: (1) their desire to nurture their depressed (or otherwise afflicted) loved one through hard times and (2) their drive to control and eliminate the behavior that renders life so challenging for both parties (Le Poire, 1995). The typical result is the unafflicted relational partner's inconsistent pattern of reinforcing and punishing the behavior, which unintentionally encourages the unhealthy behavior in the long-term (Le Poire, 1995). INC behaviors surrounding depression may be especially common in families, where one member's mental health affects the other members and relationships within the system (Minuchin, 1974). Whereas relevant research has examined the romantic partner and parent as unafflicted partners (e.g., Duggan, 2007; Duggan & Le Poire, 2006), one central role that has yet to be examined is that of the sibling of a person with chronic depression.

The sibling relationship is a uniquely close one. Siblings tend to serve as mutual confidants and role models, exchanging support and informing one another's behavior (Duggan et al., 2021; Feinberg et al., 2012). They tend to share similar experiences, peer-like camaraderie, and mutual closeness (Duggan et al., 2021; McHale et al., 2012), which extend across the lifespan (Milevsky, 2020; Stocker et al., 2020). Moreover, the sibling relationship promotes positive mental health and protection against threats to well-being (Davies et al., 2019; Gass et al., 2007). Taking these characteristics into account, siblings might see each other as a safe space to disclose their mental health challenges, as well as feel motivated to help one another navigate their mental health. One might take on the role of the supporting sibling (SS) who attempts to care for their sibling with depression (SWD). Exploring how the SS contributes to the management of sibling depression may thus provide a clearer, more nuanced understanding of mental health communication within the family. Mental health professionals and families alike could benefit from understanding the role of the larger family system in addressing one member's depression, as well as from grasping the experience of siblings who have a SWD.

Of interest to the present study is the lived experience of the emerging adult SS. Emerging adulthood (i.e., ages 18-29 years) represents an unstable time defined by identity exploration as individuals experiment with what adulthood will look like for them. Having recently found more independence from their family, emerging adults tend to demonstrate heightened self-focus while pursuing a firm identity (Arnett et al., 2014). To take on the SS role for their SWD could interfere with this developmental process. As such, the present study examines the unique family system-related challenges that emerging adults face when they have a SWD. This advances family systems theory, and especially INC theory, in at

least three ways. First, the study gives greater attention to the sibling relationship, whereas theory and research traditionally prioritize romantic couples (e.g., Dewes, 2013; Duggan, 2007). This emphasis also expands mental health research, where siblings are similarly understudied (Krzeczkowski et al., 2022; Whiteman et al., 2011). Second, this study challenges the INC theory's assumption that its predictions apply in a comparable fashion to depressive symptoms as they do to substance use disorders, which is the primary undesirable set of behaviors examined in the INC literature (Le Poire, 1995). Third, this study pushes past the immediate sibling relationship, considering the larger family system and history in which the relationship is embedded. This choice effectively advances INC and family communication research beyond the traditional dyadic scope, providing a deeper look into the inner workings of mental health communication in the family.

The investigation begins with a review of the family systems literature in the context of mental health, with an emphasis on the sibling relationship. This is followed by an evaluation of INC theory and possible behaviors that may occur when the SS tries to help their SWD. The influence of the entire family system is considered. Finally, a qualitative interview study is detailed to describe the experience of the SS—particularly which challenges they face and how they manage these tensions—in navigating this complicated context.

Mental Health in the Family System

Depression is one of the most common mental health disorders in the world (National Alliance on Mental Illness [NAMI], 2023). The term *depression* refers to any condition in the classification of depressive disorders, with the most classic form being major depressive disorder (MDD; American Psychiatric Association [APA], 2022). Characterized by persistent

feelings of sadness, worthlessness, and hopelessness, depression renders thoughts, feelings, and daily activities difficult for those who experience it. Behaviorally, people with depression may develop unhealthy sleeping and eating habits or stay in bed rather than engage in hobbies (National Institute of Mental Health [NIMH], 2023). However, this condition affects more than just the individual who exhibits symptoms. Interpersonally, depression is associated with deficits in social skills (i.e., the enactment of effective and appropriate communication; Segrin et al., 2007; Ward et al., 2010). For example, individuals with depression tend to engage in less supportive, more avoidant communication, which can adversely impact their relational partners and subsequently prompt negative feedback (Achterbergh et al., 2020; Du Rocher Schudlich et al., 2015). At the same time, those with depression tend to actively seek out negative feedback as well as excessive reassurance, which can harm their relationships and, in turn, worsen their mental health (Joiner & Timmons, 2009).

Depression research typically focuses on processes and outcomes in romantic (e.g., Duggan, 2007; Duggan & Le Poire, 2006) and parent-child relationships (e.g., Dewes, 2013; Prescott & Le Poire, 2002), at the expense of other close relationships like the sibling dyad. Siblings have a uniquely long-lasting, perceptibly involuntary familial bond. They tend to maintain fairly egalitarian roles and share life experiences due to their relative closeness in age, familial relationships, and peer groups (Duggan et al., 2021; Feinberg et al., 2012). Sibling relationship quality contributes to the development of emotional regulation skills early in life (McHale et al., 2012) and positive mental health across the lifespan (Waldinger et al., 2007). Additionally, sibling affection and support protect against the influence of stressful life events on internalizing symptomatology (Gass et al., 2007; Milevsky, 2005).

Given that siblings tend to play a meaningful role in mental health, it is surprising that the particular alliance between adult siblings with and without depression is underexamined. Faced with their *sibling with depression's (SWD's)* symptoms, one might take on the role of the *supporting sibling (SS)* who attempts to help their SWD. Siblings often serve as socializing agents who promote topics that the family may otherwise deem "taboo" (e.g., mental health; Reynolds et al., 2011), which suggests that the SS may provide a comfortable space for their SWD to talk about mental health. Consequently, the SS may possess relevant knowledge of, and sympathy for, their SWD's challenges. They may feel easily inclined to enact their role for the sake of their close other's needs. Alternatively, or perhaps simultaneously, the SS might feel strained by their SWD's condition, giving them pause. Because the SS could play a uniquely impactful part in their sibling's mental health, it would be relevant to learn the nuances of this role.

When considering the role of the sibling in depression, it is necessary to recognize that the SWD-SS dyad exists within a larger family system. *Family systems theory* examines the family as a complex whole that is greater than the sum of its individual members (P. Minuchin, 1985; S. Minuchin, 1974). The family system is conceptualized as interdependent, such that each member's behavior influences the other individuals and relationships (or *subsystems*) within the system, even shaping the system's functioning as a whole. At the same time, the family system's beliefs, values, and behavioral patterns shape individual family members. In this way, family system patterns are cyclical (Minuchin, 1985). Thus, it is not simply that the SWD's condition may impact the family. Rather, interactions and expectations enacted within the family play a part in the SWD's mental health challenges as well. Families with a member with depression have been found to have less cohesion,

support, and effective communication than those without members with depression (Sharabi et al., 2016; Yoo et al., 2016). They demonstrate greater marital distress, hostility, and negative conflict styles (Afifi et al., 2018; Du Rocher Schudlich et al., 2019). Altogether, their family functioning has been reported as low compared to unafflicted families (Weinstock et al., 2006). Although the directionality of these findings is unclear, family systems theory makes it apparent that the system environment impacts the SWD.

What is less known is the system's implications for the *adult SS's navigation* of their sibling's depression. The sibling relationship represents the most relevant dyadic subsystem here. Concurrently, the SS maintains other subsystems (namely the parent-child relationship), and their subsystems interact with one another. Family systems theory emphasizes the importance of the triad, which forms when an individual is triangulated into others' dyadic conflicts in the family (Bowen, 1978; Minuchin, 1974). The vast majority of intrafamilial triangulation research centers on the parent-parent-child triad, specifically when a child is brought in to manage their parents' conflict (e.g., Fosco & Bray, 2016; Schrodt & LaFreniere, 2022). In the present context, a possible equivalent could be the SS's triangulation into mental health-related conflict between their SWD and their parent. Indeed, parents of adolescents with depression tend to demonstrate heightened criticism and hostility and lower support in parent-child communication (Johnco & Rapee, 2018; Puig-Antich et al., 1985). The SWD may call upon the SS's support based on SWD-SS subsystem's history of unique closeness (Duggan et al., 2021; Feinberg et al., 2012). The parent may exercise their power over the SS, as traditionally established in the parent-child subsystem, by pulling the triangulated child into a mediator role. Triangulation into interparental conflict is associated with adolescents' feeling caught between their parents (Schrodt & Afifi, 2018; Schrodt &

LaFreniere, 2022). Similarly, the SS might feel caught between their afflicted sibling and parent, both whom they care about. Involved in both subsystems and their respective behavioral expectations, the SS could find themselves in a difficult position within the family because of their mutual loyalties to both people.

The extant literature on family systems and mental health suggests that the SS's experience may be a stressful one. Unafflicted siblings of people with mental health disorders have been found to fall into the role of the lost child who is neglected or overlooked by the family in favor of the SWD (Sanders et al., 2014; Zagefka et al., 2021). Others in this position have served as caregivers to their sibling and sources of practical support to their parents who have difficulty navigating the afflicted sibling's symptoms and medical treatment (Fox et al., 2017). These unafflicted siblings have often arisen as mediators in parent-afflicted sibling conflict, which researchers have attributed to the close, egalitarian sibling bond and/or the unafflicted sibling's concern for all their family members (Dimitropoulos et al., 2009; Jungbauer et al., 2016). The expectation to uphold any of these roles has resulted in the unafflicted sibling's ambivalence, resentment, and even fear of outside stigma for their family situation (Maon et al., 2020).

The literature has highlighted connotatively more severe mental health conditions than depression (e.g., eating disorders, psychosis). The more "commonplace" nature of depression could contribute to differences in the siblings' experiences. For example, parents may not be as careful or worried about depressive symptoms (which can resemble oversleeping or failing to complete chores) as they would be about psychotic episodes (which tend to be more visibly drastic and require hospitalization). This could lead to the SS to take on additional caregiving burden, but this could also come with reduced concern for stigma.

Similarly, the literature focuses on the "unafflicted" sibling's experience with these severe disorders. Research has recognized that siblings of people with mental health challenges are at risk of depressive symptoms themselves (Krzeczkowski et al., 2022; Maon et al., 2020), but the interplay of their own mental health and the simultaneous supporting role for their sibling has yet to be thoughtfully fleshed out. If a SS were to have depression themselves, that might limit the amount of sibling caregiving they could do, or perhaps give them insight to more productively support their SWD.

Another major gap in family systems and mental health research, especially in the communication discipline, is that the empirical spotlight is placed solely on dyads and triads rather than the family as a whole. The literature emphasizes current or recent triadic interactions, framing the family as a collection of individuals and subsystems (e.g., Schrodt & LaFreniere, 2022). Of course, the triad is a substantial part of the family systems approach (Bowen, 1978; Minuchin, 1974) and may arise in sibling depression. However, the concept of *the family system as its own entity* is empirically overlooked in general, let alone in the present context. The family system has its own history in which subsystems are embedded. This history involves the multi-generational transmission of family projection, in which parents pass down their emotional and communicative problems to their children, who do so to their children, and so on (Bowen, 1978). According to family systems theory, maladaptive patterns develop over generations of the family system's unsuccessful responses to stressors that occur internally (e.g., domestic abuse, death in the family) and externally (e.g., discrimination from the outside community; Glick et al., 2016; Minuchin, 1974). Despite being unproductive, they become foundational to maintaining the family's *homeostasis*, or consistent state of being (Jackson, 1957, 1965). Such patterns set the stage for family

dysfunction, which gives way to mental health challenges in the family (Glick et al., 2016; Zagefka et al., 2021).

As the family members with more power, parents may impair their children's mental health by enacting unhealthy parenting behaviors. Similarly, parents may view children's symptomatology as a deviation from the system's homeostasis, prompting negative parental reactions (Jackson, 1965). Even when doing their best to navigate stress (including facing their child's depression), parents may only know how to engage in maladaptive coping behaviors that they were taught by earlier generations of the family. This could be compounded by the parents' own difficulties (e.g., past trauma, interparental conflict, mental health challenges) that transfer into how they treat their children (Bowen, 1978). It is likely that children cannot avoid this exposure because they depend on their parents for resources when they are young. The family system's ineffective patterns are therefore enacted and reinforced over lifetimes. Through this lens, the family system's larger history provides context for the SWD's condition and relevant communicative processes in the family (e.g., triangulation).

In the same way, then, family system patterns may be central to understanding the SS's experience of their SWD's depression. The SS may wish to help their SWD as patterned in their sibling relationship. However, they may grapple with this urge due to being constrained by larger system patterns. To productively support their sibling might mean breaking the unproductive patterns foundational to the family's homeostasis. The SS might feel bound to these patterns as part of their family identity. Older family members are more likely to hold on to homeostasis (Fingerman & Bermann, 2000) and parents have greater power in the family hierarchy to reinforce these patterns. This could potentially be

problematic, given that older generations have a tendency to avoid talking about mental health and seeking mental health care (Picco et al., 2016). Consequently, the SS might struggle to support their SWD who is struggling with their mental health, while honoring their parents' authority and their own position as a child.

The sibling's experience navigating their fellow sibling's depression, as well as potentially their own depression, is missing in the extant literature. Confronted with their SWD's condition, their multiple family relationships, and their family system's lasting patterns, the SS may find themselves in a complicated position. Their experience may be especially difficult as they simultaneously navigate their identity and autonomy as an emerging adult (Arnett et al., 2014). In an effort to expand family systems-related research, give greater empirical attention to adult sibling relationships (Katz et al., 2023), and understand the particular struggles of emerging adults in the SS role, the first research question is posed:

> **RQ1:** What are the family system-related dilemmas that emerging adult children experience when they have a sibling with chronic depression?

Inconsistent Nurturing as Control

Family systems theory reasoning suggests that the SS's behavior has implications for the SWD and the entire family. For this reason, it would be valuable to know not only *which* challenges the SS faces, but also *how* the SS manages them. Le Poire's (1992, 1995) *inconsistent nurturing as control (INC) theory* considers the role of family involvement in individuals' behavioral management, making it potentially applicable to the present context. INC theory posits that close relational partners of individuals who display undesirable behavior tend to respond to this behavior in inconsistent ways that unintentionally reinforce

it. The inconsistency develops from the unafflicted (originally "functional") partner's competing goals of nurturing and controlling the afflicted partner's behavior. *Nurture* describes the desire to accommodate an afflicted individual when they enact a given unhealthy behavior (Le Poire, 1995). For instance, in the case of a child with depression, their unafflicted parent might take on their chores to lessen the afflicted individual's distress. *Control* is the goal of bringing a given undesirable behavior to an end (Le Poire, 1995). Nurturing contributes to the maintenance of a rewarding, mutually reliant relationship in which the afflicted partner has their needs fulfilled and the unafflicted partner feels needed. Simultaneously, however, this encourages the afflicted partner to continue their undesirable behavior. Nurturing actions are thus labelled *reinforcement.* On the other hand, controlling seeks to curtail the behavior, at the cost of the codependent relationship (Duggan et al., 2021; Le Poire, 1992). Controlling actions are referred to as *punishment.* While struggling with these opposing goals, unafflicted partners may resort to intermittent communication patterns that are both reinforcing and punishing the behavior. Corresponding with learning theory (Burgoon et al., 1981; Skinner, 1974), INC theory argues that this inconsistency is likely to further sustain the afflicted partner's undesirable behavior. Furthermore, the unafflicted partner's inconsistency could worsen their own mental health, as they fail to maintain control over their afflicted partner (Le Poire, 1995).

INC theory was originally developed with a focus on substance dependence, or addiction, as the undesirable behavior under study (Duggan et al., 2006; Le Poire, 1995). As such, the majority of INC research concerns this context (e.g., Duggan et al., 2008; Glowacki & Donovan, 2018). These studies have supported the theory's claim that an unafflicted partner's intermittent nurturing increases the likelihood of afflicted individuals' relapse into

problematic substance use (Duggan et al., 2006; Le Poire et al., 2000). In a similar vein, Kearns (2020) found that unafflicted romantic partners' inconsistency towards substance-abusive behavior predicted lower relationship quality.

Beyond addiction, it has been suggested that INC theory can be applied to depression as well (Duggan et al., 2006). Indeed, substance use disorders (SUDs) and depression share similar outcomes for those afflicted (e.g., fatigue, irritability; APA, 2022) and their relationships (e.g., social withdrawal; NIMH, 2023; Volkow, 2020). Likewise, it is common for SUDs and depression to co-occur (Marmorstein, 2009; McHugh & Weiss, 2019). There have been efforts to empirically test INC theory in the context of depression, though the literature is scarce. Duggan et al. (2006) identified parallel themes between the influence strategies of unafflicted partners of individuals with a SUD and those of individuals with depression: Unafflicted partners started off negatively reinforcing the undesirable behavior (via nurture), then actively attempted to help curtail the behavior (via control), then ultimately resorted to inconsistent strategies once their initial efforts proved insufficient (Duggan et al., 2006). These findings, which reflect the behavioral patterns predicted by INC theory, have been replicated in other works on INC and depression (Duggan, 2007; Duggan & Le Poire, 2006). In fact, Duggan and Le Poire (2006) pondered if these patterns were the result of unafflicted partners' conflicting views of depression as a serious medical condition and as a psychosocial reaction to stressful life events.

With that, it is necessary to acknowledge that depression differs from SUDs in at least two ways, which raises questions about INC theory's applicability to depression. First, the two conditions differ in the tangibility of their nature. Behavioral symptoms of SUDs are always linked to alcohol and/or drugs (APA, 2022). This addiction is catalyzed by a

substance(s), so treatment centers on ceasing substance use and avoiding relapse (National Institute on Drug Abuse [NIDA], 2020). On the other hand, depression is not forcibly coupled with an external catalyst (NIMH, 2023). Whereas a person with a SUD is likely to withdraw from social interactions to engage in substance use (NIDA, 2020), a person with depression is likely to do so due to feeling so worthless that they cannot leave their bed (NIMH, 2023). In cases of chronic depression, symptoms may be seen more as a state of being than a set of problematic behaviors. As such, tending to this primarily internal condition may not be a question of curtailing, but of managing. Processes related to managing depressive symptoms may thus differ from weaning someone off alcohol or drugs.

This issue lends itself to a second difference between SUDs and depression: the social stigma toward them. Although SUDs are characterized by a lack of control over substance use (APA, 2022), people are often inclined to view depression as much less controllable because there is no physical substance to stop using. Likewise, it is easier to blame those with SUDs because they may have initially used the substance(s) voluntarily (which eventually led to changes to their brain circuits; NIDA, 2020). Contrary to this, depression is rarely perceived as a choice. This may inherently influence how relational partners confront each condition's associated behaviors. The INC literature has found that an unafflicted partner's consistent punishment decreases the likelihood of relapse in individuals with a SUD (Duggan et al., 2008; Le Poire et al., 2000). In romantic relationships, punishment here can manifest as threatening, withholding resources from, and inflicting legal and relational penalties against partners with a SUD (Duggan et al., 2006). Such behaviors may not be deemed appropriate in the context of depression, as direct punishment could worsen depressive symptoms and even risk suicidality. This would defy INC theory's *control* goal of curtailing depressive behavior.

Duggan et al. (2006) attempted to resolve this discontinuity by suggesting that unafflicted romantic partners punish depressive *behaviors* rather than afflicted partners themselves. Through this lens, they identified "punishment" as providing social support and encouraging proactive solutions, while also encouraging partners with depression to take responsibility for their mental health care (Duggan et al., 2006). It appears that close others tend to treat SUDs as something their partners *do,* and depression as something that *happens to* their partners. Accordingly, it is important to be thoughtful of how INC theory, in its intended form, might or might not be appropriate for the context of depression. Given that Duggan et al.'s (2006) study was one of very few to make this application (and it required conceptual modification), further investigation is warranted.

Another aspect of INC theory to be brought into question is its applicability to the family, particularly the sibling relationship. The theory has its roots in family systems theorizing, highlighting the role of family members in sustaining and diminishing undesirable behavior (Le Poire, 1992). INC research has historically prioritized examining romantic partners (e.g., Duggan et al., 2008; Glowacki & Donovan, 2018). To the author's knowledge, the preexisting works connecting INC theory and depression have looked solely at this relationship (see Duggan, 2007; Duggan & Le Poire, 2006; Duggan et al., 2006). This research meaningfully supports INC theory's claims, yet the lack of consideration for other family relationships presents a gap in empirical knowledge. For example, withholding sex from an individual with depression may be a punishment strategy in romantic couples (Duggan, 2007), but this would assumedly *not* be the case in the sibling relationship. Rather, if INC patterns were to occur between the SS and their SWD, the behaviors would likely be more familial in nature. This has been the case in INC research on the parent-child

relationship, where parents punished their children's eating disorders by "grounding" them until they ate (Prescott & Le Poire, 2002; Duggan & Kilmartin, 2016) and punished their young adult children's problematic drinking by nagging or guilting them (Glowacki, 2016). Again, these findings did not concern depression, so it would not be wise to extrapolate from them for the present context. Moreover, the sibling relationship is inherently different from the bond between parent and child, which has prompted calls for sibling-INC research (Duggan et al., 2021).

The sibling is in a unique, and potentially compromising, position to help their SWD manage their depressive symptoms. For example, the potential for the SS to understand their sibling's needs (due to their shared life experiences; Duggan et al., 2021) may produce consistently beneficial or supportive behavior toward their SWD. On the other hand, the SS could engage in INC behaviors due to feeling strained by their afflicted sibling. When considering the SS as an emerging adult, inconsistency could result from their concurrent need to negotiate their pursuit of adulthood (e.g., romance, career; Arnett et al., 2014). In the only known study to apply INC theory to siblings (albeit regarding alcohol misuse), Glowacki (2017) found that unafflicted siblings enacted less severe forms of inconsistent reinforcement and punishment (e.g., topic avoidance, confrontational language) when addressing their sibling's problematic behavior. This suggests that INC behaviors occur in the sibling relationship, but with a lower degree of intensity and codependence than in other relationships. In fact, some participants in Glowacki's (2017) study eventually gave up on tending to their sibling, which the researcher attributed to the perceptibly involuntary nature of the sibling relationship (i.e., the relationship would continue regardless). And yet, this behavioral pattern might not be the case in the context of sibling depression, where the SS

could perceive their SWD as the disorder's victim in desperate need of strong support. Because the intersection of depressive behavior and the sibling relationship is lacking in INC research, researchers simply do not know if INC theory would even apply in this context and with this relationship.

A final, related concern is that INC theory has yet to make sense of its communicative processes as they exist within the larger family system. Not only is the role of the sibling understudied in this literature, but all known INC studies to date have only examined dyads in isolation (i.e., solely in the context of the given behavior and the given relationship). This is perplexing, as relevant researchers have incorporated family systems theory into the rationale for their work (e.g., Prescott & Le Poire, 2002). As elaborated upon previously, family interactions occur amid a long history of interaction patterns, role expectations, and shared beliefs (P. Minuchin, 1985; S. Minuchin, 1974). The unafflicted-afflicted relationship should be no exception, especially in the case of siblings and depression. INC theory does not appear to address system-related complexity, such as whole family dynamics and the inter-related nature of multiple family relationships and their shared history. Therefore, the theory lacks consideration of the long-term family history that would contextualize the SS's (in)consistent behavioral patterns. The family system's homeostatic patterns could limit the types, consistency, and/or effectiveness of certain behaviors the SS attempts to enact toward their SWD. For instance, due to their lower status in the family power hierarchy, the SS might find their efforts halted or countered by their parents. Alternatively, this sibling might model the unproductive interaction patterns that have come to characterize the family system over generations (Bowen, 1978). This could arise out of being conditioned with these patterns or seeking to honor the parent-child power dynamic. Indeed, adult children have

been found to revert back to system patterns when issues concern the family, even if they have previously developed more adaptive skills elsewhere (Fingerman & Bermann, 2000).

If the emerging adult SS experience is to come with unique family system-related dilemmas, it is worth knowing how the SS manages these dilemmas in order to support their SWD's mental health. It is possible that the SS's behaviors correspond to those predicted by INC theory, but it is also possible that characteristics of depression, the sibling relationship, and/or the family system contribute to more nuanced behavioral patterns. The extant literature does not make this clear. By examining the SS's communicative navigation of their complicated role, the present study has the potential to further grasp the emerging adult SS experience and extend INC theory. In particular, it is important to understand how emerging adult children communicatively manage the family-system related dilemmas they might face when they have a sibling with chronic depression. With this information in mind, the second research question is presented:

> **RQ2:** How do emerging adult children communicatively manage family system-related dilemmas when they have a sibling with chronic depression?

Methods

Recruitment

In order to participate, individuals had to be emerging adults (i.e., 18 to 29 years of age), be proficient in spoken English, and have grown up with at least one sibling. Emerging adults were selected as the target population because this age group experiences the greatest frequency of depressive symptoms (Villarroel & Terlizzi, 2020) and more intimate sibling relationships on average (Jensen et al., 2018).

Participants also had to meet at least one of the following criteria to be included in the study: (a) they demonstrated current, ongoing depressive symptoms, and/or (b) their sibling demonstrated such symptoms. Only one individual could participate from the same family. Originally, the goal was to only recruit participants without depression who had a SWD, as this would directly get at the research questions highlighting the SS's experience. The recruitment criteria were expanded to include individuals who *were* the SWD in their family, as their perspective on their SS's efforts would produce a more fully rounded picture of SWD-SS communication. The final recruitment decision, described above, was made to include participants who both were a SWD *and* had a SWD. This is because the occurrence of multiple siblings having depression is fairly common. Indeed, individuals who have a sibling or parent with depression are two-to-three times more likely to have depression than the average person (Havinga et al., 2017). One reason for this is that depression is genetically heritable, meaning that the disorder can be passed down the biological family to multiple children. Secondly, environmental factors (e.g., major life changes, experiences of trauma) can contribute to the condition (APA, 2022). Because siblings often grow up together and share many experiences in their upbringing, one sibling's exposure to environmental causes of depression often means the other's same exposure. Therefore, it follows that emerging adults with depression may have a SWD(s).

A clinical diagnosis for depression was not required in the recruitment criteria, with the goal of letting as many voices as possible be heard. That is, many depressed individuals do not have access to a formal diagnosis for a number of reasons. For example, psychiatric evaluations are time-consuming and expensive. Additionally, one's family may have negative or avoidant attitudes toward mental health. From a gender perspective, men may

feel shame for being vulnerable (and thus "unmanly") in admitting they might have depression (Möller-Leimkühler, 2002). Finally, with regard to biological sex, individuals assigned female at birth frequently go un- or mis-diagnosed for their mental health challenges (Smith, 2011). Therefore, the study sought diversity in the sample by validating participants' reports of their own and/or their sibling's depressive symptoms, regardless of clinical evidence.

After obtaining approval from the institutional review board, the eight-person research team engaged in purposive and snowball sampling to recruit participants. Physical recruitment flyers were posted around university campuses, community centers, and other public spaces (e.g., cafés, grocery stores) in two cities in the Western United States. Virtual recruitment flyers were posted on the research team's personal social media accounts, as well as sent to professors and academic discussion forums at a university on the West Coast. Finally, the study was made available to eligible undergraduate college students in communication via a department-level research participation platform. The project was promoted as an interview study of "communication in families in which at least one sibling has depression." Although the focus was on the sibling's experience within the family system, the investigation was framed in this broad way to (1) facilitate recruitment and (2) provide an opportunity for other themes to emerge. Of 53 emerging adults who expressed interest in the study, two were siblings from the same family. One of these siblings was randomly selected to participate, reducing the initial sample size to 52.

Pre-screening

Prior to participation, potential participants were pre-screened for current, ongoing depressive symptoms by responding to questions surrounding their own and/or their sibling's

mental health. If they reported having multiple SWDs, they were asked to select one to discuss for the screener. Participants who reported having depression responded to a modified version of Radloff's (1977) Center for Epidemiologic Studies Depression Scale (CES-D). Those who reported having a SWD responded to the CES-D with respect to their selected sibling's depression. The original 20-item CES-D measures the frequency of self-reported depressive feelings and behaviors over the past week. Because the present study used this measure to refine the sample (rather than for a clinical purpose), the CES-D was modified to measure "recent" symptoms of depression, as defined by the participant. The four-point Likert response scale (0 = *rarely/never,* 3 = *most/all of the time*) reflected this. When reporting on their sibling, participants were instructed to respond based on their own observation and knowledge, rather than attempt to guess how their sibling would respond. See Appendix A for the pre-screening measure. Participants whose own and/or sibling's CES-D scores met or exceeded the accepted cutoff score of 16 (Weissman et al., 1977) were eligible for the interview. Of the 52 individuals pre-screened, two did not pass the screener for themselves or their sibling. They were permitted to participate out of courtesy, but their data were not used.

Participants

The final sample was comprised of 50 young adults spanning the age range of emerging adulthood (range = 18 to 29 years), with a mean age of 22.98 years. Although 35 participants would conventionally suffice to achieve theoretical saturation in emergent qualitative themes (Glaser & Strauss, 1967), a larger sample was more likely to include emerging adults of diverse identities and backgrounds (e.g., gender, race, family composition). This sampling decision had the potential to provide a more comprehensive

understanding of the phenomenon under study by allowing more unique voices and experiences to be captured.

At the time of data collection, almost all participants (*n* = 46, 92%) resided in the Western and Southwestern regions of the United States, followed by two living on the East Coast (4%), one living in a non-contiguous US territory (2%), and one alternating between the US and a Southeast Asian country (2%). Most participants were assigned female at birth (*n* = 39, 78%) and 11 (22%) were assigned male at birth. A majority identified as women (*n* = 32, 64%), followed by men (*n* = 9, 18%), non-binary/genderqueer (*n* = 6, 12%), and other (*n* = 5, 10%). Of these, two participants identified with multiple gender identities. The sample was diverse in sexual orientation, including having attraction to two or more genders (e.g., bisexual, pansexual; *n* = 18, 36%), heterosexual (*n* =14, 28%), queer (*n* = 7, 14%), homosexual (*n* = 6, 12%), questioning (*n* = 4, 6%), asexual (*n* = 2, 4%), and other (*n* = 1, 2%). Of these, two participants identified with multiple sexual orientations. Most participants identified as White or Caucasian (*n* = 31, 62%), followed by Latina/o/x (*n* = 8, 16%), Arab or Middle Eastern or North African (MENA; *n* = 5, 10%), Asian (*n* = 4, 8%), Black or African American (*n* = 3, 6%), and other (*n* = 1; 2%). Of these, five identified with multiple racial identities.

Participants had an average of 2.32 siblings (range = 1 to 7) and reported keeping in contact with an average of two siblings (range = 0 to 7; one participant's sibling had passed away). All but one had lived in the same household as their sibling(s) during at least part of their childhood. When considering their entire family, most participants had biological siblings (*n* = 46, 92%), followed by half-siblings (*n* = 12, 24%), step-siblings (*n* = 6, 12%), and adopted siblings (*n* = 1, 2%). Of these, one-quarter (*n* = 13, 26%) of the sample came

from families with multiple sibling types. Although they were asked to focus on one sibling if relevant, participants had an average of 1.19 siblings with depression in their family (range = 0 to 4). Parent/guardian composition varied across participants' families: Although most participants grew up with cross-sex biological parents who were still in a romantic relationship (*n* = 28, 56%), 16 (32%) experienced parental divorce or separation, 11 (22%) had one or more stepparents, and six (12%) had a parent who had passed away. Only two (4%) participants had same-sex (step)parents.

Participants With Depression

Over half of the participants (*n* = 28, 56%) reported that both they and their sibling had depression, whereas 12 (24%) participants reported to be the only child in their family with depression, and 10 (20%) reported not having depression but a sibling who did. Of the 40 participants with depression, the average duration of ongoing symptoms was 8.59 years (range = 4 months to 16 years). The average CES-D score was 34.78 (range = 18 to 51). Most of these participants (*n* = 29, 72.5%) had a formal depression diagnosis, 10 (25%) did not, and one (2.5%) did not report their diagnosis status. Almost half (*n* = 18, 45%) of the participants with depression reported having comorbid mental health conditions, spanning symptoms and diagnoses of attention-deficit/hyperactivity disorder (ADHD), anxiety disorders (e.g., generalized anxiety disorder, panic disorder), trauma-related disorders (e.g., post-traumatic stress disorder), bipolar disorder (BD), borderline personality disorder (BPD), and obsessive-compulsive disorder (OCD).

Non-Participant Siblings with Depression

The 38 participants who reported having an SWD provided descriptive data about their respective sibling (i.e., the one they discussed in the pre-screener). As such, certain data

may be inaccurate to the siblings' lived experience. Most of these participants (*n* = 23, 60.53%) reported on an older sibling, 14 (36.84%) reported on a younger sibling, and one did not indicate birth order. Non-participant siblings primarily lived in various cities in the Western and Southwestern US (*n* = 31, 81.58%), with six (15.79%) living in other parts of the US and one (2.63%) in a Middle Eastern country. They had a mean age of 23.87 years (range = 7 to 35 years), and most were assigned female at birth (*n* = 23, 60.53%; male: *n* = 15, 39.47%). They identified as women (*n* = 23, 60.53%), followed by men (*n* = 14, 36.84%), and non-binary/genderqueer (*n* = 2, 5.26%). Of these, one non-participant sibling identified with multiple gender identities. Most (*n* = 26, 68.42%) were reported to identify as heterosexual, followed by having attraction to two or more genders (*n* = 5, 13.16%), unsure (*n* = 6, 15.79%), asexual (*n* = 1, 2.63%), and questioning (*n* = 1, 2.63%). Of these, one non-participant sibling identified with multiple sexual orientations. Although not all participant-sibling pairs were fully biologically related, the racial distribution of non-participant siblings was similar to that of the larger participant sample: over half were White or Caucasian (*n* = 25, 65.79%), followed by Latina/o/x (*n* = 6, 15.79%), Arab or MENA (*n* = 4, 10.53%), Asian (*n* = 4, 10.53%), and Black or African American (*n* = 3, 7.89%). Of these, four non-participant siblings identified with multiple racial identities.

Concerning the non-participant siblings' mental health, the average perceived duration of ongoing symptoms was 7.48 years (range = 3 months to 21 years). The average CES-D score was 33.39 (range = 15 to 52). The plurality of non-participant siblings (*n* = 22, 57.89%) were not formally diagnosed with depression, one-third (*n* = 12, 31.58%) were formally diagnosed, three (7.89%) were reported as unsure, and one (2.63%) sibling's diagnosis status was not reported. Almost half (*n* = 16, 42.11%) of them were reported as

having comorbid mental health conditions, spanning symptoms and diagnoses of ADHD, anxiety disorders, BD, OCD, trauma-related disorders, schizoaffective disorder, narcissistic personality disorder (NPD), and autism spectrum disorder.

Procedure

Prior to data collection, the eight-person research team (i.e., the principal investigator and seven undergraduate research assistants) underwent three weeks of training in which they reviewed the interview protocol in depth, conducted mock interviews with one another, and discussed their strengths and weaknesses from the practice sessions to prepare for successful interviews. Reviewing the protocol involved familiarizing themselves with the pre-screener, consent process, and interview questions, as well as learning how to probe for more information and foster a comfortable environment for participants in light of the potentially sensitive subject matter. Diversity was valued in putting together the research team, as each interviewer would be able to approach interviews with a unique perspective influenced by their identities and experiences. This intentionality served to counter the predominantly White, male, heteronormative, and cis-normative lenses through which mental health research is traditionally conducted. Therefore, all but one interviewer was assigned female at birth, two identified as non-binary, and the team's racial identities spanned Asian, White or Caucasian, Black or African American, Latina/o/x, and MENA. The team also demonstrated diversity in mental health experiences, varying in whether they, their sibling(s), and/or their parent(s) had depression (diagnosed or otherwise). All eight interviewers were emerging adults.

Interviews were conducted from early August to early December 2022. The principal investigator carried out 18 (36%) of the valid interviews. Pre-screened participants completed

the consent form prior to participation, then met with one of eight trained interviewers in either a private meeting space (e.g., private office, interaction laboratory) or on the video-conferencing application Zoom. After providing demographic information about themselves—and if relevant, their sibling—participants engaged in an in-depth, semi-structured interview. They were reminded that their participation was completely voluntary and that they could pause or end the interview at any time. The interviewers were trained to attend to participants' nonverbal cues during the interview, offering to pause if participants appeared sad or distressed. Participants were also assured that their information would be confidential, with the sole exception that if current crisis situations were mentioned, the interviewers were mandated reporters. No such exceptions occurred. To ensure confidentiality, the names of participants and their family members are replaced with pseudonyms in the present study's findings. All but one participant consented to being audio- or video-recorded. Interviews lasted an average of 55 minutes (range = 27 to 97 minutes). All participants were given a copy of the consent form and a sheet of US-, California-, and Arizona-based mental health resources (as these locations comprised the residences of almost all participants). Compensation was given to participants who enrolled in the study for course credit.

The interviewers asked questions from one of three interview scripts. The three near-identical scripts differed only in the focus of certain questions based on which child(ren) had depression. In other words, questions for participants with depression centered on their experience as the SWD and their relationship with their SS; questions for participants with a SWD centered on their experience as the SS; and questions for participants who fit both categories explored how their sibling sought to support them as the SWD, how they served as

the SS to their sibling, and how both siblings navigated the SWD and SS roles (see Appendix B). The interview questions were structured as a funnel, beginning by asking about participants' family of origin broadly, then narrowing into mental health communication in the family, and finally experiences of tension and feeling caught or torn in this context. In other words, the interview protocol got at the research questions by investigating participants' navigation of mental health within their roles and relationships in the family system, with an emphasis on sibling communication. Although each interview script emphasized participants' experiences regarding the relevant SWD(s) (i.e., themselves and/or their selected sibling), the semi-structured format permitted participants to discuss any family relationships and mental health experiences they deemed relevant. That is, the interviewers were trained to treat the script as a guide in order to probe for further information, as well as to focus the interview while allowing for the emergence of unexpected themes. Indeed, among the participants who reported only one child with depression in their family, most of them came to describe another child's depressive symptoms without explicitly labeling them as such. For this reason, it is likely that the descriptive data above underrepresent the true proportion of participants and non-participant siblings with depressive symptoms.

Following each interview, interviewers reflected on what went well, what they needed to improve upon, and questions or concerns they had. The research team met weekly during data collection in order to share their reflections and address any uncertainty. Early on, the principal investigator reviewed one interview per interviewer and provided feedback about probing and framing questions, with the goal of catering training to each member of the team.

Data Analysis

Recordings were transcribed with a speech-to-text transcription software, then interviewers ensured that the transcription was accurate, added in nonverbal cues, replaced names with pseudonyms, and added content warnings to each transcript. In the case of the participant who did not consent to being recorded, the interviewer's notes took the place of a transcript.

Data analysis was conducted by the principal investigator and three research assistants from the original research team. As with the larger interviewer team, they demonstrated diversity in sex, gender, race, and personal experience with depression (i.e., insider and outsider status relative to the sample). Although all four researchers were from the US, the intent was that their unique perspectives would inform as thorough and well-rounded an analysis as possible. A phronetic iterative approach was used, which is an abductive method highlighting the interaction between emergent data and extant theory and research (Tracy, 2018). The analysis comprised three phases largely following Tracy's (2018) process for qualitative data analysis, which is grounded in the work of Glaser (1978, 1992) and Strauss and Corbin (1990). In the first phase, *primary cycle (or open) coding,* the researchers independently read half of the transcripts and took extensive notes on emerging patterns related to intrafamilial alliances and the navigation of mental health in the family system. This stage encouraged free-flowing ideas driven by the data (Glaser, 1992; Tracy, 2018). Coding was done by hand and using qualitative data analysis software (Atlas). The team met to discuss their notes and begin narrowing the focus of the analysis. Following this, the research team studied extant INC research and proceeded to code the second half of the

transcripts, keeping an open mind while being informed by theory, research, and the previously coded data.

The team met once again to discuss their observations and transition into *secondary cycle (or axial) coding*, that is, examining how the preliminary codes interacted and grouped together as theoretical themes and sub-themes. (Glaser, 1978; Strauss & Corbin, 1990). The principal investigator categorized these themes into a comprehensive codebook that focused on the SS's challenges in navigating the family system. From there, the four-person research team returned to the dataset with the codebook in mind. Each week for four weeks, the researchers independently reread one-quarter of the transcripts, wrote analytic memos about if and how the themes reflected the data (Tracy, 2018), and coded standout quotes for each theme. The primary investigator kept voice and text memos as they made sense of the data and themes. The team came together to refine the themes based on patterns, new insights, and discrepant cases found in that portion of the data. Themes and sub-themes were continually compared and contrasted to fit the data more precisely (Glaser, 1978; Strauss & Corbin, 1990). The updated codebook served as the guide for the following week's coding. The process was complete once all fifty transcripts had been coded in this manner and all themes had been appropriately refined (Tracy, 2018). See Appendix C for the final version of the codebook. Finally, the principal investigator regularly focused on *selective coding* or the larger overarching "story" connecting the data (Glaser, 1978).

Along with surpassing theoretical saturation in sampling (Glaser & Strauss, 1967) and having a diverse team of researchers involved in data collection and analysis, three further measures were taken to establish validity. First, the primary investigator kept detailed notes about the data analysis process to demonstrate dependability (Lincoln & Guba, 1985).

Additionally, when the codebook was almost finalized, the primary investigator randomly selected and emailed approximately 25% (n = 13) of the study's participants to engage in member-checking. That is, they requested that the sub-sample read through the codebook to determine if (a) at least a portion of the themes captured their lived experiences and (b) any of the themes appeared incorrect or misleading. This process allowed participants themselves to verify the accuracy of the findings (Lincoln & Guba, 1985). No changes needed to be made to the findings.

Findings

Overall, the results revealed that for the vast majority of the adult children in this sample, the SS held a valuable yet difficult role while navigating their sibling's depression. Their experiences were rooted in intergenerational chaos and dysfunction in the family system. Older generations' maladaptive behaviors had set the stage for many parents' mental health disorders, destructive behavior, and inappropriate reactions to SWDs' symptoms. Adult SSs (who often had depression themselves) recognized these patterns as exacerbating their sibling's depression-related behavior. Faced with the family system's maladjustment, and out of worry for their SWD's well-being, they felt an obligation and desire to enact a supporting sibling role. However, they could not easily act on this due to their simultaneous dual positions as sibling and child in the family. Their prior development of behavioral patterns within their family subsystems led them to feel caught between family members at odds about mental health, and they experienced cognitive dissonance about the potential consequences of their behavior. SSs found themselves in a *double bind* in which any behavior they pursued could cause harm to their SWD, family relationships, and/or their own mental health.

SSs ultimately attempted to resolve their discordant state by prioritizing their SWDs' mental health. They were motivated by felt obligation to their sibling as a close ally and a part of the family system they sought to improve and sustain. SSs' support behaviors varied based on their respective SWD's behaviors and their own ability and knowledge. Regardless, they all struggled to maintain agency over the management of their SWD's mental health challenges. Family- and depression-related barriers challenged their SS role. Because their support efforts were not consistently successful, SSs remained emotionally connected to their SWD at the expense of their own autonomy and mental health. Siblings' commitment persisted into family mental health communication, where parents were the out-group and the siblings were the in-group. Siblings leaned on each other, and SSs actively resisted their parents' maladaptive behavior. Thus, this family dynamic and the SS role were forged into the family system's ongoing history (see Figure 1). These findings are explained in relation to the research questions below.

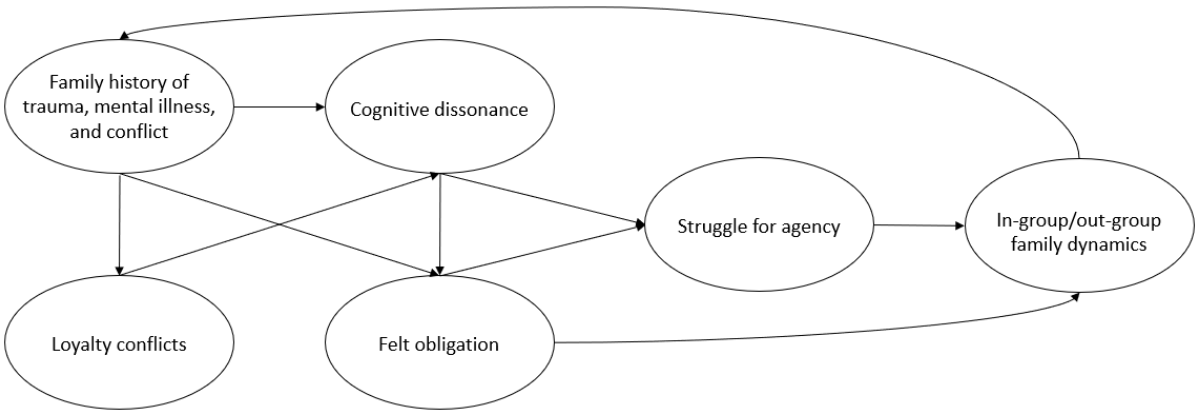

Figure 1. Themes encapsulating emerging adult siblings' navigation of depression.

Dilemmas Related to the Family System

The first research question inquired about the family system-related dilemmas faced by adult children who have a sibling with chronic depression. Results indicated that emerging adult SSs had difficulty approaching their SWD's challenges due to being caught within a historically chaotic family system that prompted conflicting loyalties and cognitive dissonance about how to behave. They were paralyzed by the possible effects of their behavior on their SWDs, themselves, the sibling relationship, and the family system at large.

Family History of Trauma, Mental Illness, and Conflict

A commonality among the adult children was a family history of trauma, mental illness, and conflict that set the stage for SWDs' symptomatology and maladaptive mental health-related communication processes in the family, all of which influenced SSs' experiences. While growing up, these now-adult children experienced *chaos in their home lives* in the form of dysfunctional and otherwise undesirable family experiences. Such experiences often concerned their parents' problematic behavior, which the children had been forced to witness. For example, Ruby mentioned the time her "mom came home covered in cocaine" (p. 5), and Fred recalled finding their mother "in the living room passed out drunk. My little brother was snuggled up next to her because he didn't know what was going on" (p. 9). Multiple emerging adults reported that their and/or their siblings' depressive symptoms began when they were "dragged into our parents' custody drama" (Paula, p. 9). When their parents separated, these children faced a dramatic shift in their family structure, as well as their parents' negative management of this shift. Some parents did not separate, revealing their destructive interaction patterns to the children more regularly. Mattie recalled, "I saw a lot of fighting in my parents, and I think it made me very anxious as a child and very unsure

of how to talk to my parents" (pp. 3-4). For these SWDs, parental misconduct had created a tense environment that impaired their mental health and ability to communicate about it for years to come.

Moreover, negative patterns in the parent-child relationship had worsened siblings' mental health during childhood. Kelsey described of her father, "He was oftentimes very abusive, very emotionally and verbally abusive… He took a lot of his anger, and he projected a lot of his own insecurities onto all three of us. Mainly, my sister" (p. 2). In their youth, these emerging adults and their siblings were at the mercy of their parents' traumatic "abuse and neglect" (Lyla, p. 5). They recognized that their parents' behavior had stemmed from the older generation's own ineffectively regulated mental health challenges. For instance, Heidi stated, "My dad was extremely mentally ill. He wasn't managing it well, but he was functional. My dad had a lot of paranoia, so me and my sister grew up thinking everybody was going to kidnap us" (p. 3). The participants identified parental mental health disorders, including depression, anxiety, PTSD, NPD, and BD. This had not only contributed to the adult children's depression, but also rendered the parents ill-equipped to support SWDs. In addition, most parents had historically reacted poorly to the children's depressive symptoms, if their children were to talk about mental health at all. SWDs had become familiar with invalidating phrases like "it's just a phase" (Lucas, p. 14) and "you had a perfect childhood… so just choose to be happy" (Lyla, p. 3). Many SWDs were unable to make sense of their challenges. Those who could were unable to seek mental health care if their parents were against it. When teenaged Ruby had initially requested to go to therapy, her mother responded that "seeing a therapist is about as effective as talking to a brick wall" (p. 3). Growing aware of all these layered issues (and many experiencing the effects themselves),

siblings sought to take on the responsibility of helping their SWD. Unfortunately, young SSs had been stuck in the same position in the family, holding less power than their parents. They struggled to navigate their own mental health, let alone their SWD's, amid their parents' problematic behavior.

The root of emerging adults' and their siblings' depression rarely stopped at their parents' generation. Rather, there was a deeper family history of *intergenerational antecedents* that indirectly contributed to their condition. Seth identified the vast occurrence of mental health disorders across his family: "There's a lot that goes really far back. Like, they [my parents] have mental health issues, their family members have mental health issues and their siblings. We have a history of schizophrenia, and I don't know what other things" (p. 3). Just as many participants experienced parental mistreatment and crisis in the household, so too had their parents. As such, parents' past negative experiences, shaped by *their* parents, had paved the way for how they treated their children (i.e., the participants and their siblings). In explaining the aggressive interactions between her SWD and father, Rebecca shared, "My dad was an alcoholic and he was raised by the meanest person in the world who beat the shit out of him a few times. So, I think a lot of it comes from trauma throughout the generations" (p. 2). That is, Rebecca's brother's aggressive behavior mirrored his father's and grandfather's aggression, all of which reflected their trauma. The intergenerational component increased adult SSs' concerns for their sibling. Sunny outlined his worries for his SWD:

> They're just very deeply depressed. And it scares me just because of my mom's side of addiction and depression, because her brother ended up taking his own life. So,

> there's just a lot of uncertainty with what my family will look like within five years (p. 7).

Mental health crises in older generations served as a reference point for SSs' perception of their SWD's (and own) depression, which had worsened into adulthood while going unchecked in the family. SSs had a stronger sense of the importance and urgency of tending to their SWD than their parents did.

Parents' past negative reactions to children's depression also appeared to be informed by transmission of intergenerational trauma. Many parents' explicit displays of anti-mental health values reflected the family's history. Adult children from Latina/o/x, Asian, and MENA families frequently mentioned that their cultures deemed it "very, very taboo in general to talk about mental health" (Victoria, p. 7), such that "it's not real, you just need to snap out of it" (Judy, p. 4). This was similar for participants from highly religious Christian and Muslim families, such as Holly, who said, "Our family has a long line of mental health issues and they tried to kind of write it off with religion" (p. 10). For children in these families, generations of anti-mental health values had contributed to their parents' unmanaged symptoms and harmful values, and in turn, their own unmanaged depression. Additionally, parents' experiences of crisis sometimes played a direct role in their mishandling of their children's depression. This was exemplified by Claudia:

> My mom, especially, is very afraid of the idea of poor mental health because her mom had bipolar. She committed suicide when my mom was eight. I think my mom has this fear, that she brings up a lot actually, that it might be sort of a hereditary thing. And we, as kids, might have something that might affect us. I think that her

fear of that is partially what led her to be anti-us-going-to-therapy because she didn't want to find out that we could possibly have the same kind of thing as her mom. (p. 7)

Claudia's mother's means of coping with her own mother's mental health-related death was to avoid addressing her children's mental health, which had left Claudia's SWD to continue experiencing worsening symptoms. For most of the emerging adults and their siblings, multiple generations of mishandled depression and related symptomatology made for a family system where parents had hurt, not helped, SWDs' condition. Because this was patterned, most parents' negative attitudes towards mental health persisted as the children matured. That is, few emerging adults had parents who presently supported their mental health, and most of those only developed this attitude after witnessing drastic suicidal behavior in the SWD(s). As children grew into emerging adults, they became more fully aware of their family's role in their sibling's and/or their own mental health. Lucas, whose father had narcissistic tendencies, disclosed, "I was very unhappy at home, but I didn't know what was going on until years later. My junior year of college, I was like 'Oh, okay, I see'" (p. 2). As adults, they felt better able to serve as mental health advocates. And yet, the SSs still had to navigate their SWDs' mental health against an interfering backdrop of a chaotic family history and pre-existing interaction patterns.

Loyalty Conflicts

SSs' co-occurring, conflicting family loyalties hindered their decision to actively tend to their sibling in need. Emerging adults felt caught between their SWD and parents, whose mental health-related goals and desires were frequently at odds. They sought to appease both loyalties, which produced internal tension. This was most explicit when their SWD and parent were in conflict surrounding the SWD's depression-related behavior (and often, the

parent's inappropriate reaction to this behavior). Lyla shared about her mother, "She'll try to convince me to take sides with her, which is really annoying. And then also, if I talk to my sister, she kind of feels like I should take her side… I do not like that feeling" (p. 8). SSs felt stressed when their conflicting family members triangulated them into conflict, as they were expected to simultaneously support each alliance. Many SSs, such as Maya, struggled to make up their minds out of fear of hurting either individual: "It's a little tough to manage because I don't want to create more conflict than there already is" (p. 21). These SSs often feared not only fanning the dyad's fire, but also negatively contributing to each family member's well-being. Despite wanting to self-triangulate into conflict between their SWD and parents, Kas was anxious about how to proceed:

> I want to defend Aylen. But that means that my mom has to do an extra thing to make sure that Aylen is okay. So, I don't want to yell at my mom to do this thing. But I do want to yell at her to do this thing. And I'm like, what if I yelled at my dad, because he's just adding more things? And like, no, he feels really useless right now. And he just feels like he needs to get control of something, so I can't yell at him. (p. 12)

Kas perceived that their parents were worsening their SWD's symptoms, but to be protective of their sibling would mean adding more responsibility to their already-overworked mother and enabling their father's insecurity, neither of which they wanted for their parents whom they loved. SSs like Kas were stuck, recognizing that their actions would affect their family system. As Maya summarized the triangulated SS's experience of loyalty conflicts, "You have to play the game of who you want to make angry" (p. 13).

SSs found themselves experiencing this tension outside of active SWD-parent conflict settings, as well. Many SSs played the role of messenger, obeying their parents' requests for

information about their SWD. Ophelia shared that when her SWD would not reach out to their mother during his depressive episodes, their mother relied on her: “She's always like, ‘Kenneth’s on edge, really bad. Can you please contact him?’ So, I'll call him and then he doesn't open up, so I'm not gonna pry it out. I can't really probe him” (p. 9). Ophelia, among other SSs, attempted to appease her parent while also honoring her SWD’s desire for privacy from the parent. This stalemate was the best-case scenario for SSs who felt caught, though they were regularly put into this conflicting situation. Some SSs had previously been punished by one family member for honoring the other, which heightened their internal tension about how to behave. Seth recalled his unfortunate experience trying to obey his SWD’s wishes:

> At one point, he had bought a gun and he had planned to shoot himself in his car, but he ended up returning it. He told me about it, and he said, ‘I haven't told mom and dad yet, but I don't want you to tell them about it because I want to do it myself. So please don't tell them that I did this.’ And so, I said, ‘Okay.’ And he did tell them. But then they were kind of like, ‘Did you know about this?’ And I said, ‘Yeah, he had told me before.’ And they were like, ‘Why didn't you tell us?’ I was like, ‘Because he said he was going to tell you?’ And he did. They're like, ‘Well, you should be telling us about these things. Like that's super serious.’ I'm like, ‘I know, but I also trusted him to tell you and I didn't want him to be mad at me and he didn't have the gun anymore.’ It just kind of came down on me. I was like, ‘Well, what's the right thing to do?’ I don't know. I still don't know. (p. 7)

Seth’s SWD was attempting to develop autonomy in his mental health journey. Seth chose not to defy his sibling’s efforts, which led his parents to look down on him, explicitly

reinforcing his loyalty conflicts. For most SSs, the expectations of the SS-SWD and SS-parent subsystems were directly at odds. In cases like this, SSs could not figure out the "right" course of action because they saw none that would simultaneously appease all the family loyalties pulling at them.

Cognitive Dissonance

Weighed down by concern for their sibling's condition, their family system's patterns, and their own well-being, SSs experienced cognitive dissonance about if and how they could address their SWD's symptoms. They did not want to be inactive bystanders, as that would leave the SWD struggling and violate the closeness that most of these siblings shared. However, addressing their SWD's symptoms, in the ways they knew how to, would have risks as well. This generated conflicting thoughts about the potential consequences of their behavior. SSs worried that their *support could enable their sibling's depression-related behavior.* Victoria shared, "We're trying to help her, but also we're trying to get her to understand how important it is that she does things on her own as well" (p. 4). Many SSs sought to help their SWD, but they anticipated that their efforts would promote their SWD's continued reliance on them (and therefore the SWD's sustained behavioral symptoms). This countered the SS's desire for both siblings to be autonomous and proactive in their mental health journey. This was most often the case in SSs who had grown up learning *nurturing* behaviors (e.g., comforting). Zack explained their family's typical reaction to their SWD's depression-related behavior: "If she does something poorly that we're mad at her about, I think because we're all very empathetic or very sympathetic to her emotions, we say, 'It's okay, it's okay'" (p. 11). Although this support would provide short-term relief for the SWD, there was an ongoing concern that the ailing sibling would not undergo any positive

behavioral changes. SSs who were used to *controlling* behaviors (e.g., confronting) worried that they would perpetuate their SWD's depressive symptoms, as well. Discussing her desire for her SWD to undergo rehabilitation for alcohol misuse, Alice said, "If I told her, 'You need to go, you need to do this. Like, it's getting bad. I don't even want to be around you currently,' that would only guilt her… which is not going to help her heal" (p. 5). Here, the SS worried that her passionate suggestions of solutions would add to her sister's dangerous symptoms.

In several cases, SSs feared that the damage might extend beyond the individual level, that is, their *support could threaten the sibling alliance.* Again, these SSs were caught in a troubling situation in which neither inaction nor the relational threat were desirable. Jennifer outlined her thought process surrounding her SWD's unhealthy coping mechanisms:

> She started making bad friends and getting involved with drug use, which I was not approving of. And that made it difficult because I wanted to have an open dialogue with her, but I still didn't want to encourage it. So, it was like, if I discourage it too much, she'll just stop telling me. And if I don't discourage it, then she'll keep doing it. (p. 5)

SSs like Jennifer feared that their support would cause relational distance between the siblings, such that their SWD would no longer confide in them. The interacting relationships within the larger family system served as additional obstacles for some SSs. Kas, whose parents regularly mishandled their SWD's symptoms, expressed, "I don't know if she wants me to help honestly, because it seems like every time I try to, I just make things worse" (p. 9). This emerging adult sought to support their sister by intervening in the family

environment that was worsening her depression. However, Kas' past efforts had exacerbated the turbulent system, thus threatening their SWD's perception of them as truly supportive.

Further contradictory cognitions and behaviors within SSs concerned their own needs and position in the family system. Participants commonly described the SS(s) of the family (whether themselves and/or their sibling) as "parentified." That is, addressing the SWD's mental health often involved caregiving, which SSs had come to view as well beyond their responsibility. Despite wanting to be supportive, SSs felt that *being parentified challenged their child role* (and vice-versa). In particular, SSs who were the eldest sibling had become accustomed to acting as their sibling's parent due to their actual parents' past (and often ongoing) caregiving deficiency. Ruby recalled struggling in the parentified role as early as her pre-adolescent years:

> I was kind of becoming more of a parental figure in the household, and also trying to shield my brother from a lot of what was happening. I never told my brother that I had to save my mom from a suicide attempt. Even though it happened just on the other side of the house from him. So those kinds of things. But I was also becoming a teenager and felt very alone. (p. 10)

She had sacrificed her well-being and childhood in order to protect her sibling's mental health in the past, rendering *herself* an unprotected SWD doing her parent's job. For many SSs like Ruby, this role had become patterned despite being undesirable, harmful, and sometimes even thankless. Maria described being parentified as "I basically raised you but get none of the credit for it" (p. 5). After undesirably serving as child-parents, adult SSs had difficulty deciding if they should, yet again, reinforce the parentified role (and relinquish the child role) for the sake of their SWD. In addition, given that most SWDs' challenges were

related to their parents' mental health, engaging in the family risked further parentification. Victoria expressed, "I want to be able to help them with anything I can because I want to support my family. But I don't want to be a second parent to my younger sister, or a parent to even my mom" (p. 2). These emerging adults sought to finally have the reduced caregiving expectations of a child, but this conflicted with their desire to support their SWD.

The decision to act as SSs many times risked not only their position as a child of the family, but also their well-being. This demonstrated a fourth, related form of cognitive dissonance among SSs: *prioritizing their family's needs challenged prioritizing their own needs* (and vice-versa). Having a painful history as SSs (and often concurrently as SWDs) had hurt their own well-being. Consequently, they sought to take care of themselves. Yet, they still did not want their SWD to hurt either. The tight link between SWDs' and parents' mental health disorders suggested that some SSs' dissonance concerned additional family needs where multiple other family members were experiencing or had experienced significant mental health problems, as in Victoria's case above. Therefore, SSs were confronted with the difficult decision of putting their SWD (and family) or themselves first. Supporting their SWD meant sacrificing their own mental health. Lisa, who had depression, became overwhelmed whenever her SWD confided in her: "When she tells me all those negative things and I feel them too, it's kind of like, 'Why are you telling me this? I can't handle this.' It's hard" (p. 8). She was unsure of how to approach the SS role because her sister's symptoms catalyzed her own challenges as a SWD. Kobi was also affected by his SWD's needs:

> Depression doesn't just affect one person, but everyone around them because you do want to take care of them and support them. But then, at the same time, you kind of push your own feelings to the side to do so. (p. 17)

He had mixed feelings about helping his SWD because it would require neglecting his own well-being. Despite this, SSs could not simply prioritize themselves because they were also inclined to honor their family, as they had done in the past. When asked if she tended to her family's or her own needs first, Victoria shared, "I want to prioritize mine. And I have a lot of boundaries to be able to do that. But I think because of this cycle… I have a tendency to worry about them more than I do myself" (p. 10). For Victoria and many others, prioritizing themselves would imply neglecting their distressed sibling, and more largely, their family. SSs' complex double bind crippled them with uncertainty about how to navigate their SWD's challenges. Eventually, they would have to cope with their predicament.

Communicative Management of Dilemmas

The second research question investigated the ways in which adult children with a sibling with depression communicatively manage their family system-related dilemmas. Results suggested that SSs grappled with their complicated position by attempting to support their SWD due to their innate sense of duty to their sibling and even their larger family system. From there, SSs struggled to maintain agency over their SWD's mental health management, which kept them tied to their family. Their desire to support their SWD, coupled with their ongoing family system-related challenges, produced an in-group/out-group (children-versus-parents) family dynamic concerning mental health.

Felt Obligation

Ultimately, all but a few SSs attempted to resolve their psychological and relational tension by being involved in their SWD's mental health journey. Despite the potentially worrisome consequences for their SWD and themselves, they took action. Their sibling's needs took precedence over their other concerns because they had *felt obligation* to their SWD. One piece of most SSs' felt obligation was their motivation to *compensate for family chaos,* or assist their SWD in healing from the undesirable experiences in their family system that contributed to their SWD's (and even their own) depressive symptoms. This drive was especially strong in older SSs who had moved out but whose younger SWD still lived in the family home. Kas claimed, "I just need to protect my sister from my parents" (p. 10). In the same way, Lucas was determined to help his SWD who had become bed-bound: "When he started feeling sick, I felt—not an obligation, but I was like, 'I really want him to have an outlet for someone to trust,' because I know how horrible it can be in the house" (p. 10). He did not view his motivation as obligation because he valued his SWD so dearly. Kas, Lucas, and many other SSs felt that they were responsible for their SWD's well-being due to their own knowledge and experiences of their parents' destructive behavior. In fact, Maria explained of her family, "I don't owe them anything, but I still want to be there for my brother because I would have wanted someone to be there for me" (p. 5). After growing up heavily neglected and parentified, she was devoted to giving her SWD the support that she had never received. Because her parents had not properly tended to her mental health, she sought to correct this for her sibling. Among SSs who were the younger sibling, a common goal was to return the favor to their SWD who had protected them from such dysfunction during childhood. This was the case for Sunny, who expressed:

> They did so much for me, like [they] shielded me from so much during living with my mom and always advocated for me through everything in my parents' divorce and both living situations. And they've always been there for me for support. I feel like it's just the duty of what I'm supposed to do. (p. 9)

Because his older brother had enacted the SS role for so many years and suffered the consequences of severe depression, Sunny concluded that the right course of action was to now take on the SS role himself. Finally, some SSs aspired to compensate for the part they, themselves, had played in the development of their SWD's symptoms. Holly shared, "I ignored her a lot when I was younger… I feel bad… because I think she looks up to me a lot. I wish I would have treated her better" (p. 11). Similarly, Michelle admitted, "I think I take up a lot of the emotional bandwidth of the family" (p. 11). Because these SSs felt guilty for being part of the harmful family system, they felt that they owed their SWD mental health support.

The other major aspect of SSs' felt obligation was their commitment to *being the "glue" of the family.* SSs chose to support their SWD's needs as part of their innate sense of duty to their family system's well-being and functioning. To them, fulfilling the SS role was "just what you must do for somebody you care about" (Judy, p. 6). This value was central to their family and was instilled in them. Sunny described why he kept deciding to put his SWD first despite the negative effect it was having on his own mental health:

> I think for me, it's a lot easier to continue, always going forward, especially when it's something important like family. I don't know how to describe it. It's just an innate thing that's in me… like an energy that I get that's like, "You have to deal with this.

> You have to keep dealing with it. Keep dealing with it ‘til it's gone,” which is also kind of frustrating because mental illness doesn't really go away. (p. 13)

To Sunny, his sibling’s depression was an unwinnable battle, yet his persistent involvement was the only acceptable option. This value had become deeply ingrained in these emerging adults, even defining their go-to role in the family system. In general, SSs had become accustomed to holding such roles as “moderator,” “fixer,” “mediator,” “therapist,” and “peacemaker” in the family. Managing conflict about their SWD’s challenges was no exception. Vicky stated of SWD-parent conflict, “I kind of like being a moderator…because I feel like I'm de-escalating things. And I feel helpful. Because otherwise they're just going nowhere” (p. 12). For her, mediating these conflicts was indeed a way to protect her SWD from her parents (as compensation). At a deeper level, however, this was how she could maintain the smooth functioning of her family whose other members would not break their maladaptive conflict patterns. Deciding to support her SWD meant actively working to better the entire system. Many SSs shared this mindset even if they harbored resentment towards their family. They “felt responsible to… smooth things over and find that path of least resistance that was going to get all of us [the family] where we needed to go” (Ruby, p. 8). To these emerging adults, “nobody else had the emotional skills” (Joe, p. 12) to recognize, let alone address, the system-level problems that hurt their SWD and even the rest of the family. Their internalized obligation to the family took priority.

Struggle for Agency

Although SSs appeared to have resolved their cognitive dissonance by deciding to address their SWD’s needs, their pursuit to give support proved challenging. These emerging adults fought to maintain agency over their SS role, and autonomy as individuals, amid their

SWD and family system. They primarily found agency as SSs by *regulating information and privacy* surrounding mental health in the family. In other words, they exercised control over the frequency and type of mental health communication and with whom it was shared. In its simplest form, this occurred when SSs chose to "consistently communicate" (Judy, p. 9) with their SWD, ensuring themselves as a core agent in their SWD's mental health journey. Selected communication strategies varied across participants and their siblings, depending on the SWDs' challenges and the SSs' support skills. Certain SSs, like Sunny, regularly *nurtured* their SWD: "I just resort to bringing them food, helping them clean up their house, doing stuff like that. And trying to get stuff going on with our friend group" (p. 10). Sunny made himself available as the primary caregiver for his SWD who did not care for themselves. Other SSs, like Nellie, regularly engaged in *control* behaviors like confrontation: "I tell him all the time, 'If you're not going to stop drinking for yourself, which should be first and foremost what you do because it's your life, just do it for Isla [your daughter]'" (p. 17). A similar behavior was advice giving, as John Michael did: "I was like, 'What if you go talk to a doctor… about this issue?' It was me driving the conversation to get her to start" (p. 9). These latter SSs exerted power by directly pushing their SWD to manage their symptoms. Outside of sibling interactions, SSs would advise their parents who had not been properly handling the SWD's situation. For example, Katalina explained of her father:

> I would hear him have conversations with my mom, and then I would chime in and just be like, "Again, I think he [my SWD] really needs you in his life as a figure. Not just as a coach, [but] as his dad. I think you need to have a conversation with him." (p. 9)

Katalina involved herself in parental exchanges about her SWD to counsel her father, based on what she knew of her SWD's needs and her family's history. Guiding relevant mental health information towards their parents was a popular strategy among SSs.

Interestingly, one of the most common ways SSs exercised agency was through the *lack* of information they let flow through the family. They did this primarily by withholding disclosure about their own mental health. Seth revealed, "I already knew that Jordan… was depressed and I knew my parents were stressed about knowing what to do with his depression, so I was trying to not really express it" (p. 2). Likewise, Kobi said, "I didn't want to make it about me… I kind of refrained from talking about my issues because they never seemed as big of a deal as what my sister and my dad were going through" (pp. 8-9). Starting as early as childhood, these SSs learned to suppress their own struggles because they believed their SWD was in greater need of support than themselves. Because parents already had difficulty managing the SWD's needs (as in Seth's case) or their own depression (as in Kobi's case), SSs' self-silencing served to push the family's limited support resources toward the SWD. This behavior persisted in SS-SWD dyadic interactions, as well. Lyla's strategy to manage her own depression involved "continuing to be open with her [sister], when I feel like she can handle it. I don't feel like she could handle it right now, so I just try to just not talk about it too much" (p. 6). Lyla refrained from discussing her own challenges so as not to burden her SWD by forcing her into the SS role. Jennifer reported actively self-monitoring in conversations with her SWD: "I was very intentional about not… letting my emotions impact how I reacted. Because she's my little sister, it's a priority to make sure she's doing well. I didn't want to be make it about me" (p. 9). Even though hearing about her SWD's difficulties caused her stress and worry, Jennifer kept the spotlight on her sister as the one in need.

Finally, albeit less commonly, some SSs found agency in creating distance between themselves and their SWD. Despite wanting to be more directly involved in her SWD's mental health, Kelsey said, "Her personality is very much that she has to figure things out on her own. So, it's more like, she knows that… I'll talk to her if she needs to. But I also know not to push it" (p. 10). By setting this boundary, Kelsey and other SSs felt that they were both honoring their SWD's privacy and giving their SWD autonomy over their mental health journey.

Despite their best efforts, however, adult SSs often faced barriers that left them *lacking agency* and success in supporting their SWD. The largest family-related barrier was their parents, who continued to see them as children. Maria recalled her disappointing attempt to advise her parents:

> I honestly tried to help my parents out the most I could by telling them… "I think you should tell him this" or like, "I think you should help him by doing this," or whatever it was. But most of the time, they wouldn't listen. (p. 4)

As much as she tried to get her SWD more support, her attempts were unsuccessful. Some SSs were left feeling like helpless outsiders, especially when their SWD still lived with their parents. This was the case for Kas, who shared, "I do feel like a witness because… I have no idea what I could even possibly do, because my parents just won't listen to me" (p. 10). Although they could support their SWD one on one, Kas could not conquer the larger challenge of addressing the family environment that continued to hurt their SWD's well-being. SSs felt powerless in the face of their parents who carried on with their unhelpful patterned values. As Lisa also expressed, "I wish I would have more of an influence to push them into taking mental health seriously" (p. 5).

Without their parents' help, most SSs tried to help their SWD fully on their own. With this came additional challenges. Specifically, SSs had a limited repertoire of appropriate techniques to support their SWD. Michelle reported that her SS "just didn't know what to do or say" (p. 3) in response to Michelle's depression. Those who attempted to exercise agency as SSs were riddled with uncertainty about whether they were truly making a difference. For example, Victoria shared, "I'm just very worried for her mental health and her well-being in general. So, I always hope that these kinds of conversations that we have can help her, but I don't know if they will" (p. 5). It was difficult for SSs like Victoria to feel helpful to their SWD, which left them worrying even more. Some SSs saw the fruits of their labor, but the results were often short-lived. Sunny explained:

> There have been times where my brother has been having a panic attack, really freaking out about something. And I've been able to talk them down from it. But for actual progress… The most painful part is that there hasn't really been any, and I don't really know what to do to make progress happen. (p. 10)

Like Sunny, many SSs could not sustain their sense of control over their SWD's mental health. Their successful support attempts were short-lived, making them feel even more helpless. They ultimately perceived lasting recovery impossible because the nature of depression limited their authority. SSs expressed such sentiments as "with the issues he's facing, there's only so much I can do" (Takuya, p. 10) and "you want to be able to do something about it but at the same time, it's out of your control" (Maya, p. 16). SSs also felt that they had limited power over their SWD's actions. As Victoria explained, "We can't tell her what to do because she's going to decide what she wants to decide" (p. 9). When the burden was too much to bear, a small minority of SSs attempted to create distance in the

sibling relationship. This was an apparent indication of switching to the other side of their cognitive dissonance out of (self-)preservation. When Alice's support attempts clashed with her SWD's mental health-related behavior, she distanced herself because "I feel it's healthier than constantly bickering" (p. 8).

Overall, SSs were pulled back and forth between their moments of agency and lack thereof, and their successes and failures, in supporting their SWD. Navigating their SWD's mental health became an experience that negatively impacted them but that they could not abandon. Consequently, emerging adults demonstrated an *inability to separate* from their SWD. Sunny spoke of his SWD's condition, "I don't know how to *not* think about it… It kind of just bleeds into my everyday life" (p. 7). SSs struggled to maintain autonomy in their own lives while still supporting their SWD. They appeared to be emotionally tied to their sibling, always ready to rush to their SWD's side to keep the depression at bay. For example, Judy revealed, "Whenever I get her texts, I make sure to respond within like 30 minutes just to make sure she knows I'm there for her and I'm there to talk to her" (p. 3). Victoria reported behaving similarly:

> I worry for her, and I care for her. So, I'll be there for her with whatever. But I think she ends up taking advantage still of the fear that I have to make sure that she's okay. She ends up kind of being able to do whatever she wants, because she can. She knows that I'll bail her out. So, there's a bit of an issue. (p. 10)

Even though she was unhappy with the patterns resulting from her own behavior, Victoria continued to be at the beck and call of her SWD. For many SSs, this inability to separate applied to both their SWD and larger family system. This arose when multiple family members had mental health challenges, and when the connection between the family system

and the SWD's symptoms were more explicit. For example, Sunny's brother's depression caused distress for their father who was also grieving his late wife. As such, Sunny was frequently at the mercy of both individuals:

> I've had to drop plans with my girlfriend quite a few times this year to go either deal with my dad when he was going through his shit or go and deal with my brother whenever they're having an episode, and it feels shitty to have to do that… When there's time that I put aside to have that part of myself, it just kind of sucks when it's taken away. (p. 10)

SSs like Sunny regularly sacrificed their independent adult lives to tend to their family system, as a function of their felt obligation and constant worry. That is, they did not want to take on a full-time caregiving role (nor could they due to their limited agency), however they would not fully relinquish their agency in the SS role. This pattern occurred even in the handful of SSs who claimed to have separated from their family for their own well-being. Kelsey, who had stepped away from being the family peacemaker, disclosed, "I think the expectation is that I'm still in that role and I don't love that… but I do love knowing what's going on, the way that the information channels are going with how the situation is now" (p. 15). Despite taking space for herself, Kelsey eased back into her peacemaking role whenever her family called on her to help with SWD-parent conflict. Not only that, but she still wanted to be informed of her family's undesirable functioning that had hurt her SWD and herself. Altogether then, these emerging adults were always tied to their SWD and family system.

In-group/Out-group Family Dynamics

Emerging adults' desperate commitment to the SS role, coupled with their being tied to a family with a turbulent intergenerational history that made their role necessary,

influenced the family system at large. The result was a family dynamic in which the siblings represented an in-group, and their parents were their out-group, in mental health-related matters. In particular, *parents' low mental health literacy,* or inaccurate understanding of depression, prompted adverse reactions in emerging adult children. For example, Dakota spoke on their mental health communication in the family: "It's mostly between me and my sibling. Yeah, I mean… I tried to bring it [depression] up to my parents and they were not very receptive to the idea that I might have mental health issues" (p. 5). Similarly, Maya explained of her SWD, "She stopped turning to them [our parents] for as much advice because… she's just not getting the response she wants from them… So, I think she started turning to [her therapist] or her friends or me" (p. 12). SWDs found their parents' past reactions unproductive and even negligent to their needs. As such, they gave up trying to seek support from the older generation. Instead, they limited mental health communication to the sibling relationship. In fact, Joe revealed that he informed his brothers that he was starting therapy and "told them not to tell my parents" (p. 7). Thus, parents were othered and children were allied.

SSs had unique characteristics that promoted the sibling mental health alliance. For one, SSs had *compassion for their SWD*. Sunny, whose adult life had been consumed by caregiving for his SWD, expressed, "I don't resent my brother for it or anything… I know that my brother isn't doing it to make my life worse or anything like that. It's just a really shitty situation" (p. 9). Like most SSs, Sunny demonstrated patience and understanding for his SWD's behavior despite its impact on his own mental health. SSs' compassion also involved attributing their SWD's condition to factors outside of the SWD's personality or choice. Their attribution was most frequently directed toward their parents. Joe stated

strongly, “He gets a lot of shit from our mom that he doesn’t deserve, and she blames him for everything… She fucked up a perfectly good kid” (p. 6). Amari felt similarly about her SWD’s social environment:

> She's stuck with them [our parents]. And she's like, “I have to get out…” And then she's dealing with friends and they're her way of getting validation and support, but they're not the right friends, either. So, I've seen her just become more mean and cold with the world as a reaction of how the world has been treating her. (pp. 5-6)

SSs like Amari sympathized with their SWD because they saw other people, especially their parents, as the real problem. In other words, they perceived that depression was an inevitable outcome for their sibling who was the target of hurtful actions. SSs more easily sided with their sibling despite the SWD’s undesirable mental health-related behavior. Another, related factor that brought siblings together as a team was their *shared understanding* of their chaotic family history and mental health challenges. Siblings could connect and support each other with a point of view that only they shared. Heidi said, “We kind of do self-therapy… We talk about the shit that's going on with my mom currently or dad in the past. We compare notes on stuff” (p. 13). For many of these emerging adults, their similar knowledge of their childhood allowed them to bond while making sense of their troubling experiences. SWDs benefited especially from their SS’s shared understanding of depressive symptoms. John Michael sought mental health support from his sisters because “they get that feeling. And they understand more of, it's not that I need to fix something, which is my parents’ approach to mental illness. My sisters are more understanding of, you just need to be there.” Because most SSs had similar mental health experiences, they could relate to their SWD’s struggles. In the few cases where the sibling bond was lacking (typically due to circumstance, e.g.,

large age gap, split custody, death), emerging adults wished for closeness *because* of the shared understanding it would entail. Ruby, who rarely saw her brother, revealed that the two siblings would talk about mental health when they were "completely separated from the rest of the family, only when just the two of us were alone… I would take any opportunity to just have a couple of minutes alone with him so that we could talk freely" (p.5). Because these moments were hard to come by, Ruby desperately pursued one-on-one conversations that would allow them to connect over their shared experiences. Meanwhile, Heidi yearned for the ability to have her late SWD's perspective:

> The biggest issue that I struggle with now and then after his passing is, he is the only person who knows what the dynamic was like in that house, from the standpoint of a child. My mom's gonna have a different viewpoint, and my dad's gonna have a different viewpoint, but his and my experience are going to be more similar… I can't remember a lot of growing up. And so, I wonder if he would, and if he would be able to help me navigate this shit with our parents. (p. 22)

Heidi mourned the impossibility of her and her brother collaboratively making sense of their background. In this way, siblings preferred to discuss mental health (and the role of family history) with each other.

Outside of dyadic interactions, the in-group/out-group dynamics further came to light when *children acted as a team against their parents* during mental health-related conflict. The vast majority of SSs enacted behaviors that supported, defended, or otherwise prioritized their SWD's mental health. Concerning his father's tendency to worsen his SWD's mental state by belittling her, Sol claimed, "A lot of times even I'll get involved in the fight, but I'll take my sister's side regardless of what my dad is saying" (p. 10). SSs like Sol self-

triangulated to provide strength for their SWD who was otherwise powerless to their parents' mistreatment. This was certainly the case when parents failed to understand the SWD's depression-related behavior. Lyla shared, "If I'm unable to do things… like a vegetable in bed all day… my mom gets really mad sometimes. And my sister will [say], 'You need to be more understanding'" (p. 9). Lyla's SS showed disapproval of and attempted to educate her mother. Furthermore, several SSs defended their SWD not only to help someone they loved, but also to honor the SWD's child role in the family system. Of course, this was most common when the SWD was a minor, as when Amari stood up to her mother who triangulated her into SWD-parent conflict: "'Whether Justice is in the right or wrong, you are an adult and you have to act so… You need to leave room for the child to be the child,' is what I tell her every single time" (p. 11). SSs also sought to protect their sibling's child role when the SWD was an emerging adult. Kas reflected on a time when their mother had shamed, not nurtured, their distressed adult SWD: "I called my mom, and I was like, 'You are the absolute worst.' I was really mean to my mom, and I still don't feel bad about it… You can't do that to your daughter" (p. 6). Although not all SSs were as passionate as Kas, they were empowered to stand up to their parents in defense of the sibling team. Siblings came to rely on this alliance. For example, Takuya struggled to independently confront his parents about the impact of their inappropriate mental health advice:

> I got my sister involved… because I just needed someone to help me just interpret or express what was going on my mind, because at the time that was just—I had a lot of emotions going on at that time and I couldn't exactly articulate them in a way that they would understand. (p. 12)

Even when SSs did not take the initiative in defending their SWD (and some wished not to be involved, for their own sake), they tended to pull through for their SWD when called upon. For some emerging adults, the power of the sibling alliance had been building since childhood, as a safe space in the household. For others, the team was only able to form in adulthood, when siblings developed a clearer understanding of their family. Regardless, both the family dynamic and SS role contributed to the family system's lasting history of mental health-related interaction patterns.

Discussion

Despite the prevalence of depressive disorders (NAMI, 2023; Villarroel & Terlizzi, 2020), little research has investigated the role of the sibling in navigating depression within the complexity of the family system. Specifically, the family communication literature fails to situate the sibling relationship within the larger family system, as well as histories of trauma. Thus, by taking a family systems theory approach (Minuchin, 1985) and considering the applicability of INC theory (Le Poire, 1995), the present study sought to describe the dilemmas faced by emerging adult children serving as the supporting sibling (SS) role for their sibling with depression (SWD). A thematic analysis of 50 semi-structured interviews revealed the family system as central to sibling depression. Family histories of trauma and mental illness contributed to the development and exacerbation of depressive symptoms. Because their parents played a negative role in mental health, SSs developed an innate sense of duty to caring for their SWD. This felt obligation called for SSs' management of mental health communication in the larger family, which manifested as SSs' protecting their SWD against their parents and withholding their own mental health challenges. These findings highlight not only the need for further study of the role of the sibling in depression, but also

the importance of considering the impact of the family system, including past experiences that every family member brings to a given interaction.

Additionally, this study revealed the double binds that plagued emerging adult siblings' experiences. Feeling deeply responsible for the well-being of their family system, SSs were caught between their loyalties to their SWD and parents, as appeasing one subsystem would risk harming the other. Moreover, SSs struggled to balance their duty to care for their sibling and their own needs for mental health care and autonomy. Ultimately, their behavior favored their SWD, yet their internal tensions remained as they sacrificed themselves to play the part of SS. These findings bring attention to the sibling's unique experience in navigating depression, including the potential ramifications for their well-being and development into adulthood.

Altogether, the present findings lend themselves to a multi-faceted critique of INC theory (Le Poire, 1995). For one, the theory fails to consider third-party influences on an afflicted partner's undesirable behavior. When examining behavioral patterns toward the SWD, inconsistency arose only when looking at the *combination* of SS's and parents' conflicting responses to depression and each other. The conflicting goals that form the basis of INC theory were not reflected in the findings either. SSs did not seek to *control* their SWD, but to curtail their parents' maladaptive behaviors while helping their SWD to cope (Duggan et al., 2006). Similarly, they did not seek to *nurture* their SWD as part of needing to feel needed, rather they took on the SS role out of perceived necessity due to the high stakes of depression and their felt obligation to their sibling. Finally, most SSs had depression themselves, thus both siblings were "afflicted," which has rarely been studied in INC research (Le Poire et al., 1998). These factors collectively suggest that INC theory should be

modified to incorporate the role of the family system's history, as well as further applied to the afflicted-afflicted relationship, but that it might not be applicable to depression or siblings.

The Importance of Family Systems and History in Understanding Sibling Depression

The current findings revealed the ubiquity of the family system's influence throughout emerging adult siblings' navigation of depression. Adopting the role of SS did not simply involve supporting the SWD one-on-one. Rather, SSs' support-related motivations and behaviors all revolved around the larger family system. It appears that this was largely due to the history of intergenerational chaos and trauma in the family, which initially transferred into the siblings' lives in the form of parents' inherited symptomatology and anti-mental health attitudes. In turn, parents' negative behaviors contributed to siblings' depression. This corresponds with family systems theorizing, which frames the multigenerational transmission of dysfunctional patterns as the source of mental health challenges in the family (Bowen, 1978; Glick et al., 2016). Indeed, research has identified parental depression and impaired family functioning as predictors of children's depression (Barnett & Hunter, 2012; Loechner et al., 2018).

Parents' lack of appropriate support for the SWD led SSs to adopt that role instead. It appears that these siblings assumed the caregiving role when those higher in the family power hierarchy (i.e., parents) failed to do so. The compensation hypothesis posits that negative parenting patterns promote siblings' tendency to take care of one another to make up for their parents' deficiency (Cox et al., 2001; Milevsky, 2005, 2022). Although support for this hypothesis is generally mixed (Dirks et al., 2015), the most consistent support comes from studies of disharmonious, abusive families (Graham, 2018; Katz et al., 2023). Almost

all of the siblings in the present study grew up in such families, further supporting this notion. Emerging adults internalized their drive to support their sibling, such that they felt it was their duty to adopt and uphold the SS role. The sense of *felt obligation* is commonly examined in the context of adults who feel responsible for caregiving for their aging parents (e.g., Petrowski & Stein, 2016). Felt obligation is rarely studied in the sibling context, although it has been found in adult siblings of people with autism spectrum disorder (Atkin & Tozer, 2014). The present findings suggest that sibling-oriented felt obligation can arise in cases of depression as well. Moreover, some SSs' felt obligation was directed toward their larger family system, that is, they felt a need to support their SWD as a means of facilitating and maintaining peaceful interactions within the entire family. These findings of the sibling's felt obligation have implications for the interdependence of the family system. It appears that emerging adult siblings' responsibility for the family had become patterned (Fox et al., 2017), setting the role expectation for siblings to continue doing so. A crucial component of future research is to determine how siblings can get out of these negative patterns when they are firmly embedded in larger family systems that make it nearly impossible for them to do so, while still supporting their sibling with depression.

Behaviorally, SSs chose to support their SWD by engaging with the family as a whole. Seeing the older generations as the catalyst—if not also the source—of their sibling's depression, almost all the SSs chose to ally with their SWD against their parents. The strengthening of the sibling alliance has been found in siblings who have lived through parental divorce (Jacobs & Sillars, 2012; Roth et al., 2014) and child maltreatment (Katz et al., 2023), with the conclusion being that siblings can bond through their distressing experience. It seems that this was the case in the present findings as well. In the family

counseling discipline, Williams et al.'s (2016) typology of sibling subsystems, which emerged in abusive family systems, includes two adaptive types: the *ally* subsystem, wherein siblings engage in mutual support and cooperation; and the *defensive* subsystem, wherein one sibling protects the other. Siblings' understanding of and compassion for mental health challenges are associated with greater involvement in sibling caregiving (Seeman, 2013). SSs in the present sample empathized with their sibling's family-related mental health difficulties because they had a shared understanding of their family's destructive patterns. This likely encouraged their development of unified subsystem patterns.

What is interesting is that almost none of the participants had any of Williams et al.'s (2016) remaining three sibling subsystem types, which were deemed maladaptive: *estranged* (i.e., emotionally distant), *enemy* (i.e., hostile), nor *sibling abusive.* These latter types support the spillover hypothesis, which argues that negative family (sub-)system patterns spill over into the sibling relationship (Cox et al., 2001; Jensen et al., 2021). For example, harsh parenting and parental differential treatment toward children are associated with sibling hostility and victimization (Tucker et al., 2020; Witte et al., 2020). It might be that the siblings in the present study had formed or strengthened their alliance while maturing into emerging adults. Sibling relationships become less tied to parent-child relationships in emerging adulthood (Milevsky & Heerwagen, 2013; Scharf et al., 2005), suggesting that these siblings were able to develop a bond that was relatively autonomous from the family's dysfunctional patterns. Likewise, emerging adulthood comes with changes in the parent-child relationship, such that children are less reliant on their parents for resources (Lindell & Campione-Barr, 2017). The reduced power differential may have contributed to SSs' self-efficacy in standing up to their parents for their SWD's sake. Indeed, Williams et al. (2016)

frame the sibling relationship as dynamic, shifting among the subsystem types with developmental changes. The present findings highlight the importance of the emerging adult sibling alliance in navigating depression within the family. Adult children may remain tied to their family system's role expectations, but the increased power and sustained sibling support of emerging adulthood (Guan & Fuligni, 2015; Lindell & Campione-Barr, 2017) may be crucial to shifting the behavioral manifestations of these expectations. In turn, this alliance could potentially resist the system and effect change in parental behavior (Kramer, 2014).

A primary way in which SSs enacted support was by controlling the flow of mental health-related information in the family. Most notably, they would refrain from discussing their own depression or related symptoms with their parents. Their goal was to *protectively buffer* their other family members (see also Carter et al., 2020), that is, minimize the amount of strain put on their family system by not positioning themselves as another stressor. This behavior has been found in children whose sibling had an eating disorder (Fox et al., 2017; Withers et al., 2014) or committed suicide (Dyregrov & Dyregrov, 2005). These children felt that their parents were struggling enough with the current situation, so taking any additional attention would be a burden. Where the present sample differs from this research is that SSs did not simply seek to prevent their parents' stress. Rather, many emerging adults had the goal of giving their SWD the "spotlight" in terms of receiving attention. It appears that they internally conducted a needs assessment, determining that their SWD's needs were more important than theirs. Thus, they advised their parents on how to support their sibling but refrained from discussing their own mental health. Some SSs intentionally monitored how much they would bring up their own symptoms when talking to their SWD. They gauged that their role as the SS was more necessary than their need to seek support as a SWD themselves.

According to communication privacy management theory, this self-silencing would be a means of preventing the rest of the family's redirected attention, which could otherwise result from co-owning the SS's mental health information (Petronio, 2010; Petronio et al., 2021). The risks of revealing one's own mental health difficulties on the rest of the family system when one's sibling already had depression was greater than the potential rewards. The sibling's self-silencing in this context could have ramifications for their own mental health, thus this phenomenon warrants further empirical attention.

The persisting relevance of the family system in emerging adult siblings' motivations and supportive behavior have important implications for INC theory. The theory centers on the role of one relational partner in influencing the undesirable behavior of another (Le Poire, 1995). When examining sibling behavior in the present study, SSs were fairly consistent in how they each addressed their SWD's symptoms. This contradicts previous INC research on siblings (Glowacki, 2017) and on depression (Duggan et al., 2006; Duggan & Le Poire, 2006). It might be that INC theory does not hold for the particular intersection of siblings and depression. That said, the pattern of inconsistent nurture and control behaviors *was* evident when looking at the family system altogether. SSs were consistently helpful, whereas parents were consistently unhelpful in managing SWDs' depression.

Family members' behaviors were reactive to one another in ways not reflected in INC theory. Parents reacted negatively to SWDs' symptoms, which prompted SSs' reacting against their parents and in alliance with their sibling. SSs did not seek to curtail their SWD's depression, but to help their sibling *manage* or *cope with* the symptoms. If anything, SSs had the goal of curtailing *their parents'* harmful homeostatic patterns. INC theory (Le Poire, 1995) does not account for family members or others outside the dyad that might affect the

individuals within the subsystem or the subsystem itself. Evidently, siblings tend to be less judgmental and punishing of one another, which could be attributed to their unique understanding and desire to maintain their lifelong bond (Glowacki, 2017). On a large scale, the continuous clashing of the SSs' and parents' approaches demonstrated system-wide inconsistency. These findings suggest the need to modify INC theory's scope. Prior research has argued that the *control/punishment* language in INC theory is not applicable to depression (Duggan et al., 2006), as is the case here. The theory may be better reserved solely for studying addiction, as it was initially intended (Le Poire, 1995). Beyond this, the present study demonstrates that the identification of INC patterning in the family requires looking beyond the dyad. Examining larger system-level influences would create a more complete picture of which behaviors occur and why. To expand INC theory in this way could give it greater utility, as no close dyadic relationship exists in isolation. The current study challenges INC theory by encouraging the examination of the broader family system rather than simply the dyad and by questioning its applicability to depression.

The Sibling's Double Bind

A second major contribution of the present study is its nuanced attention to the emerging adult sibling who seeks to support their sibling with depression. The SS's experience was found to be complicated, characterized by family system-related tensions that left them in a double bind. One primary tension concerned their fear of hurting their family members. Not only did emerging adult siblings fear further triggering their SWD, but they also struggled to choose between honoring the desires and goals of their SWD or those of their parents. Obeying their parents would often involve violating the privacy boundary pre-established with their sibling (Petronio, 2010; Petronio et al., 2021), but obeying their sibling

would mean withholding important mental health information from their parents. Such loyalty conflicts have been found in individuals caught between their sibling with an eating disorder or other potentially negatively-valenced information and their parents (Fox et al., 2017). The present findings indicate that loyalty conflicts also exist in the context of depression. This further demonstrates that the emerging adult sibling's role in depression is not straightforward. Just as they felt responsible for supporting their SWD, so too did they feel responsible for the potential negative outcomes of their behavior on their family members.

The other primary tension felt among SSs had to do with the risk of neglecting their own needs by supporting their sibling, and vice-versa. They wished to prioritize themselves aligns with the self-focus that characterizes emerging adulthood (Arnett et al., 2014). This was especially the case for SSs who had family-influenced depression themselves, as they needed to tend to their own symptoms too. However, fulfilling their felt obligation to their family overpowered their need for self-care. Indeed, siblings of people with severe mental health conditions have expressed guilt related to the idea of putting themselves first (Leith et al., 2018; Schmid et al., 2009). It appears that emerging adult siblings in the present sample adopted the SS role due to the severity and urgency of their SWD's needs, as well as their own need to honor their family system. Unfortunately, their strong felt obligation did not eliminate their internal tension, and they struggled to balance their family's and their own needs. This mirrors Kovacs et al.'s (2019) finding that adult siblings of people with prolonged mental health conditions experience dialectical tensions of *connection* (i.e., involvement versus distance in sibling caregiving) and *role* (i.e., positioning as a peer versus parent in the sibling relationship). Consequently, siblings in the present study were

negatively affected by taking on the SS role. They left their own needs insufficiently addressed, took on the stress of managing their SWD's challenges, and navigated the destructive family system to do so.

This self-sacrificing of their own mental health needs took a toll on SSs' well-being, which corresponds with research associating sibling-focused parentification with stress and caregiver burden (Leith et al., 2018; Tomeny et al., 2017). SSs' daily lives were consumed by stressful caregiving and family involvement, which may have implications for siblings' maturity into young adults. Their inability to separate from their family system is indicative of codependency, which hinders the development of a clear sense of self (Bacon et al., 2020). Similarly, juggling family expectations is associated with difficulty individuating (Bridge, 2019; Schmid et al., 2009). Therefore, it is likely that emerging adults' tension surrounding the SS role could restrict their well-being and their personal growth. Because emerging adulthood is the time for exploring one's identity and autonomy (Arnett et al., 2014), the negative impact of navigating depression in the family system could have lasting consequences for siblings as they progress through the lifespan. Future research should examine the long-term effects of these findings.

The nuances of the SS's experience raise concerns for the applicability of INC theory to siblings and depression. Although emerging adult siblings experienced conflicting goals and subsequent negative mental health (Le Poire, 1992, 1995), these were of a different nature than those proposed by INC theory. As previously discussed, the *control* goal does not appear to map onto the present context due to the nature of depression and the family system. In a similar way, the theory's *nurture* goal (including its corresponding reinforcing behavior) was not represented in the findings. INC theory posits that the unafflicted partner has a need

to feel needed, which is why they continue to care for their afflicted partner (Le Poire, 1995). Emerging adult SSs did not indicate such a need. In fact, they wished to maintain autonomy, with many wishing to have distance from their family of origin. Despite this, they sought to "keep their SWD going" because of the risks of depression and mistreatment from their parents. In this way, SSs were not torn between nurturing and controlling their sibling's depressive behavior. Instead, they were torn between staying involved in their family for the sake of their sibling and pursuing their own needs—and they almost always put their sibling first. Glowacki (2017), who identified INC patterns in siblings, suggested that emerging adult siblings may resign themselves to nurturing problematic drinking behavior because the sibling relationship is viewed as involuntary, bound to continue no matter how they act.

The present findings suggest that the lifelong sibling bond is still prominent, yet functions in the opposite direction, when the undesirable behavior is depression. SSs had one sibling-oriented goal: keep their SWD alive and well. Whereas emerging adults may see drinking as a "low-stakes" activity (likely due to the heavy drinking culture of college campuses), the common association between depression and suicide (NAMI, 2023) may raise the stakes. Consequently, SSs did not make sacrifices to maintain their nurture goal (Duggan et al., 2008), but to sustain the lasting sibling relationship's existence. INC theory frames the unafflicted partner's behavioral patterns as volitional (Le Poire, 1995). On the contrary, SSs saw caring for their SWD to be their only choice, as a function of felt obligation and the risky consequences of depression. The higher perceived stakes of depression, as compared to other undesirable behaviors, further the argument against applying INC theory to depression. Moreover, Glowacki (2017) previously called for modified boundary conditions when applying INC theory to the sibling relationship. The present study goes one step further in

arguing that INC theory should not be used with siblings at all. The sibling relationship is less voluntary and temporary than the romantic relationship. Likewise, the power dynamics and ties to the family system are different, as both siblings are generally deeply connected to their family system's patterns. As there is only one other known INC study on siblings in the literature (Glowacki, 2017), further research on this relationship is warranted to sufficiently gauge INC theory's relevance in that relationship.

A final point on INC theory- and family systems theory-based research is that it prioritizes the unafflicted-afflicted relationship. As evidenced in the present study, it is common for both relational partners to exhibit similar undesirable behavior. This is especially true for siblings, who are likely to share depressive symptoms due to their shared biology and/or family environment (APA, 2022). There is little research on INC patterning in the afflicted-afflicted relationship, providing mixed results. Glowacki (2017) found that siblings would often drink together, reinforcing problematic substance use by co-using. On the other hand, Le Poire et al. (1998) determined that "unafflicted" romantic partners with prior SUD experience were the most persuasive in directing their partner to alternatives to substance use. On a larger scale, there is a plethora of family systems research demonstrating the likelihood of depression in individuals whose siblings have mental health symptomatology (e.g., Havinga et al., 2017; Kovacs et al., 2019). Where the present study differs is in its deeper exploration of the sibling's experience as simultaneously a supporting partner and an afflicted partner themselves. Not only did navigating system-related internal tensions harm SSs' well-being, but their sibling-favoring behavior left their own depression unchecked and vulnerable. If their SWD were to take on the SS role for them, then both siblings would face these consequences. This finding informs family therapy on the

complexity of the sibling's challenges in navigating mental health in the family system. Furthermore, the present research justifies the insufficiency of INC theory in describing siblings and depression, as well as the need for greater family systems research considering the several roles the sibling plays.

Limitations and Future Directions

Although this study contributes an in-depth systems-based understanding of the emerging adult sibling's role in depression, the findings require careful consideration. Because a clinical diagnosis for depression was not required for participation, the extent to which depression was the mental health disorder under study may be questioned. Likewise, pre-screener data for non-participant siblings were collected via observer report, which may not have been completely accurate given the internalizing nature of depression. However, the pre-screener was utilized to capture evident depressive symptoms. That is, regardless of whether or not emerging adults technically had clinical depression, they identified with and/or demonstrated relevant symptoms. That participants perceived visible depressive symptoms in their sibling gives more certainty to the sibling having the condition, likely in more severe forms. Many participants reported diagnoses or symptoms of other mental health disorders (e.g., anxiety, ADHD) that share symptoms and frequently co-occur with depression (APA, 2022; Katzman et al., 2017). Because depression-related *behaviors* are what mattered most to the present study, the findings are relevant to mental health communication. The benefits of highlighting diverse emerging adults' experiences outweighed the costs of not requiring a diagnosis, which is inaccessible to many. Future research should continue to use pre-screening measures alternative to clinical diagnosis in order to gain a more developed understanding of mental health communication in the family,

beyond the White, cis-heteronormative, male perspective that is traditionally prioritized. Closer attention to the severity of depression is advised, as observer-reported data may not be able to capture milder symptomatology.

A second limitation to consider when interpreting this study is that there were inherent characteristics of the sample that may constrain the applicability of the findings. The recruitment materials called for emerging adults who grew up with at least one sibling, and one or both children had to demonstrate current, ongoing depressive symptoms. This may have generated a self-selection bias for participation. Emerging adults with a close, positive sibling relationship may have been more likely to volunteer for the study. Other would-be participants may not have identified with having a sibling due to estrangement, or relatedly, may not have wished to talk about their family if their sibling was a primary source of abuse and trauma in their life. Similarly, the language used in the recruitment flyer required participants to recognize depressive symptoms in their sibling's and/or their own behavior. Whereas the participants had come to engage in mental health communication by emerging adulthood, many individuals may continue to lack knowledge about depression today if their family never mentioned the term "mental health" in their upbringing. This may have limited the potential sample. It is possible that culture played a role in this, as Asian and Arab cultures are among those less likely to talk about mental health, due to stigma (Zhang et al., 2020; Zolezzi et al., 2018). The vast majority of the present sample resided in the US, so even if they had grown up elsewhere, they may have been acculturated to talk more openly about depression by the time of the study. Future research should be intentional in recruitment language to target individuals with depression who might not have the medical jargon to describe it.

Despite its limitations, the present study makes meaningful contributions to theory and practice. The findings highlight the importance of truly considering the entire family system's history in the experience of depression, which is otherwise uncommon in relevant literatures. Examining family interactions beyond the dyad and present day will foster more comprehensive theorizing and empirical research on mental health communication in the family, in line with family systems theory (Minuchin, 1985). Future research should also pay attention to subsystems of more than two siblings, in order to investigate the interplay of siblings, subsystems, and the larger family system in more complex ways. Similarly, this study provides a deeper understanding of not only the traditionally understudied sibling relationship, but also the complex challenges navigated by the emerging adult sibling supporting their sibling with depression. Mental health professionals and parents would be productive in recognizing the sibling's double bind and subsequent risks for well-being and development. Clinical practice should give greater attention to emerging adult siblings' felt obligation, giving them effective strategies to engage in self-care without carrying all responsibility over the family. The above implications cultivate the present study's critical contributions to INC theory. In particular, the findings demonstrate that INC theory would be best suited for SUDs and romantic partners, as initially intended (Le Poire, 1992, 1995). Additional research on siblings' navigation of depression within the family system is necessary to generate more appropriate theorizing on this context and relationship. The present study serves as a strong starting point for such inquiry.

References

Achterbergh, L., Pitman, A., Birken, M., Pearce, E., Sno, H., & Johnson, S. (2020). The experience of loneliness among young people with depression: a qualitative meta-synthesis of the literature. *BMC Psychiatry*, *20*(1), 1-23. https://doi.org/10.1186/s12888-020-02818-3

Afifi, T. D., Davis, S., Merrill, A. F., Coveleski, S., Denes, A., & Shahnazi, A. F. (2018). Couples' communication about financial uncertainty following the great recession and its association with stress, mental health and divorce proneness. *Journal of Family and Economic Issues*, *39*(2), 205-219. https://doi.org/10.1007/s10834-017-9560-5

Amato, P. & Afifi, T. D. (2006). Feeling caught between parents: Adult children's relations with parents and subjective well-being. *Journal of Marriage and Family*, *68*(1), 222-236. https://doi.org/10.1111/j.1741-3737.2006.00243.x

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Arnett, J. J., Žukauskienė, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18–29 years: Implications for mental health. *The Lancet Psychiatry*, *1*(7), 569-576. https://doi.org/10.1016/S2215-0366(14)00080-7

Atkin, K., & Tozer, R. (2014). Personalisation, family relationships and autism: Conceptualising the role of adult siblings. *Journal of Social Work*, *14*(3), 225-242. https://doi.org/10.1177/1468017313476453

Bacon, I., McKay, E., Reynolds, F., & McIntyre, A. (2020). The lived experience of codependency: An interpretative phenomenological analysis. *International Journal of Mental Health and Addiction*, *18*(1), 754-771. https://doi.org/10.1007/s11469-018-9983-8

Baker, A. J., & Chambers, J. (2011). Adult recall of childhood exposure to parental conflict: Unpacking the black box of parental alienation. *Journal of Divorce & Remarriage*, *52*(1), 55-76. https://doi.org/10.1080/10502556.2011.534396

Barnett, R. A., & Hunter, M. (2012). Adjustment of siblings of children with mental health problems: Behaviour, self-concept, quality of life and family functioning. *Journal of Child and Family Studies*, *21*(1), 262-272. https://doi.org/10.1007/s10826-011-9471-2

Bowen, M. (1978). *Family therapy in clinical practice.* Aronson.

Braithwaite, D. O., Suter, E. A., & Floyd, K. (2018). Introduction: The landscape of meta-theory and theory in family communication research. In D. O. Braithwaite, E. A. Suter, & K. Floyd (ESWD.), *Engaging theories in family communication: Multiple perspectives* (2nd ed., pp. 1–16). Routledge.

Bridge, E. N. (2019). Review of a case study in light of Bowen theory: Differentiation of self. *Life Skills Journal of Psychology*, *3*(5), 65-72. https://doi.org/10.31461/ybpd.556080

Burgoon, J. K., Burgoon, M., Miller, G. R., & Sunnafrank, M. (1981). Learning theory approaches to persuasion. *Human Communication Research*, *7*(2), 161-179. https://doi.org/10.1111/j.1468-2958.1981.tb00567.x

Carter, S. P., Renshaw, K. D., Allen, E. S., Markman, H. J., & Stanley, S. M. (2020). Everything here is fine: Protective buffering by military spouses during a deployment. *Family Process*, *59*(3), 1261-1274. https://doi.org/10.1111/famp.12457

Cox, M. J., Paley, B., & Harter, K. (2001). Interparental conflict and parent-child relationships. In J. Grych & F. Fincham (Eds.), *Interparental conflict and child development: Theory, research, and applications* (pp. 249–272). Cambridge University Press. https://doi.org/10.1017/CBO9780511527838.011

Davies, P. T., Parry, L. Q., Bascoe, S. M., Martin, M. J., & Cummings, E. M. (2019). Children's vulnerability to interparental conflict: The protective role of sibling relationship quality. *Child Development*, *90*(6), 2118–2134. https://doi.org/10.1111/cdev.13078

Dewes, A. A. (2013). *Children's experiences in memorable interactions with depressed parents* (Publication No. 1541107) [Master's thesis, Saint Louis University]. ProQuest Dissertations Publishing.

Dimitropoulos, G., Klopfer, K., Lazar, L., & Schacter, R. (2009). Caring for a sibling with anorexia nervosa: A qualitative study. *European Eating Disorders Review*, *17*(5), 350–365. https://doi.org/10.1002/erv.937

Dirks, M. A., Persram, R., Recchia, H. E., & Howe, N. (2015). Sibling relationships as sources of risk and resilience in the development and maintenance of internalizing and externalizing problems during childhood and adolescence. *Clinical Psychology Review*, *42*(1), 145-155. https://doi.org/10.1016/j.cpr.2015.07.003

Du Rocher Schudlich, T. D., Jessica, N. W., Erwin, S. E., & Rishor, A. (2019). Infants' emotional security: The confluence of parental depression, Interparental conflict, and parenting. *Journal of Applied Developmental Psychology, 63*(1), 42-53. https://doi.org/10.1016/j.appdev.2019.05.006

Du Rocher Schudlich, T. D., Norman, J., Du Nann, B., Wharton, A., Block, M., Nicol, H., Dachenhausen, M., Gleason, A., & Pendergast, K. (2015). Interparental conflicts in dyadic and triadic contexts: Parental depression symptoms and conflict history predict differences. *Journal of Child and Family Studies, 24*(4), 1047-1059. https://doi.org/10.1007/s10826-014-9914-7

Duggan, A. (2007). Sex differences in communicative attempts to curtail depression: An inconsistent nurturing as control perspective. *Western Journal of Communication, 71*(2), 114-135. https://doi.org/10.1080/10570310701354492

Duggan, A. P., & Kilmartin, B. (2016). Parental and sibling behaviors that encourage daughters' continued eating disorders: An inconsistent nurturing as control perspective. In *The darker side of family communication: The harmful, the morally suspect, and the socially inappropriate* (pp. 49-68). Peter Lang.

Duggan, A. P., & Kilmartin, B. (2016). Parental and sibling behaviors that encourage daughters' continued eating disorders: An inconsistent nurturing as control perspective. In *The darker side of family communication: The harmful, the morally suspect, and the socially inappropriate* (pp. 49-68). Peter Lang.

Duggan, A. P., & Le Poire, B. A. (2006). One down, two involved: An application and extension of inconsistent nurturing as control theory to couples including one depressed individual. *Communication Monographs*, *73*(4), 379-405. https://doi.org/10.1080/03637750601024149

Duggan, A. P., Dailey, R. M., & Le Poire, B. A. (2008). Reinforcement and punishment of substance abuse during ongoing interactions: A conversational test of inconsistent nurturing as control theory. *Journal of Health Communication*, *13*(5), 417-433. https://doi.org/10.1080/10810730802198722

Duggan, A. P., Glowacki, E. M., & Molineux, B. L. P. (2021). The reciprocal influence of substance use disorders and family members' communication. In A. L. Vangelisti (Ed.), *The Routledge handbook of family communication* (3rd ed., pp. 436-448). Routledge.

Duggan, A., Le Poire, B. A., & Addis, K. J. (2006). A qualitative analysis of communicative strategies used by partners of substance abusers and depressed individuals during recovery: Implications for inconsistent nurturing as control theory. In R. M. Dailey & B. A. Le Poire (Eds.), *Applied interpersonal communication matters: Family, health, and community relations* (pp. 150-174). Peter Lang.

Dyregrov, K., & Dyregrov, A. (2005). Siblings after suicide—"The forgotten bereaved". *Suicide and Life-Threatening Behavior*, *35*(6), 714-724. https://doi.org/10.1521/suli.2005.35.6.714

Feinberg, M. E., Solmeyer, A. R., & McHale, S. M. (2012). The third rail of family systems: Sibling relationships, mental and behavioral health, and preventive intervention in childhood and adolescence. *Clinical Child and Family Psychology Review*, *15*(1), 43-57. https://doi.org/10.1007/s10567-011-0104-5

Fingerman, K. L., & Bermann, E. (2000). Applications of family systems theory to the study of adulthood. *The International Journal of Aging and Human Development*, *51*(1), 5-29. https://doi.org/10.2190/7TF8-WB3F-TMWG-TT3K

Fosco, G. M., & Bray, B. C. (2016). Profiles of cognitive appraisals and triangulation into interparental conflict: Implications for adolescent adjustment. *Journal of Family Psychology*, *30*(5), 533. https://doi.org/10.1037/fam0000192

Fox, J. R., Dean, M., & Whittlesea, A. (2017). The experience of caring for or living with an individual with an eating disorder: A meta-synthesis of qualitative studies. *Clinical Psychology & Psychotherapy*, *24*(1), 103-125. https://doi.org/10.1002/cpp.1984

Garber, B. D. (2011). Parental alienation and the dynamics of the enmeshed parent–child dyad: Adultification, parentification, and infantilization. *Family Court Review*, *49*(2), 322-335. https://doi.org/10.1111/j.1744-1617.2011.01374.x

Gass, K., Jenkins, J., & Dunn, J. (2007). Are sibling relationships protective? A longitudinal study. *Journal of Child Psychology and Psychiatry*, *48*(2), 167-175. https://doi.org/10.1111/j.1469-7610.2006.01699.x

Gibson, C. (2016). *Examining support (in)adequacy in interpersonal relationship with adults with bipolar disorder: Support providers' perspectives* (Publication No. 10140784) [Doctoral dissertation, Saint Louis University]. ProQuest Dissertations Publishing.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis.* Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *Discovery of grounded theory: Strategies for qualitative research.* Aldine.

Glick, I. D., Rait, D. S., Heru, A. M., & Ascher, M. (2016). Problems and dysfunction from an integrated family systems perspective. In *Couples and family therapy in clinical practice* (5th ed., pp. 75-90). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118897218

Glowacki, E. M. (2016). Communication about problematic drinking between young adults and their parents: An application of inconsistent nurturing as control theory. *Health Communication*, *31*(9), 1135-1144. https://doi.org/10.1080/10410236.2015.1045578

Glowacki, E. M. (2017). Examining sibling communication about problematic drinking: An application of inconsistent nurturing as control theory. *Journal of Family Communication*, *17*(1), 65-87. https://doi.org/10.1080/15267431.2016.1251919

Glowacki, E. M., & Donovan, E. E. (2018). Predicting reinforcement and punishment behaviors in college students coping with substance misuse: An application of inconsistent nurturing as control theory. *Communication Quarterly*, *66*(5), 541-556. https://doi.org/10.1080/01463373.2018.1466345

Goldner, L., Jakobi, C. D., Schorr, S., Dakak, S., & Shawahne, N. (2022). Keep it quiet: Mother–daughter parentification and difficulties in separation–individuation shaping daughters' authentic/true self and self-silencing: A mediation model. *Psychoanalytic Psychology*, *39*(2), 165-174. https://doi.org/10.1037/pap0000352

Graham, T. L. (2018). *Parental alcoholism, triangulation, and self-differentiation in the sibling relationship.* (Publication No. 10792531) [Doctoral Dissertation, Walden University]. ProQuest Dissertations & Theses Global.

Guan, S. S. A., & Fuligni, A. J. (2016). Changes in parent, sibling, and peer support during the transition to young adulthood. *Journal of Research on Adolescence*, *26*(2), 286-299. https://doi.org/10.1111/jora.12191

Havinga, P. J., Boschloo, L., Bloemen, A. J. P., Nauta, M. H., de Vries, S. O., Penninx, B. W. J. H., & Hartman, C. A. (2017). Doomed for disorder? High incidence of mood and anxiety disorders in offspring of depressed and anxious patients: A prospective cohort study. *The Journal of Clinical Psychiatry, 78*(1), e8–e17. https://doi.org/10.4088/JCP.15m09936

Jackson, D. D. (1957). The question of family homeostasis. *Psychiatric Quarterly Supplement*, *31*(1, Suppl.) 79-90.

Jackson, D. D. (1965). Family homeostasis and the physician. *California Medicine*, *103*(4), 239-242.

Jacobs, K., & Sillars, A. (2012). Sibling support during post-divorce adjustment: An idiographic analysis of support forms, functions, and relationship types. *Journal of Family Communication*, *12*(2), 167-187. https://doi.org/10.1080/15267431.2011.584056

Jensen, A. C., Jorgensen-Wells, M. K. A., Pickett, J. M., Andrus, L. E., Leiter, V. K., Graver, H., Pollard, B. M., Kroff, S. L., Russo, R. B., & Hanna-Walker, V. R. (2021). Marital relationships spillover and parental differential treatment of siblings: A multilevel meta-analysis. *Journal of Family Theory & Review*, *13*(3), 347-365. https://doi.org/10.1111/jftr.12425

Jensen, A. C., Whiteman, S. D., & Fingerman, K. L. (2018). "Can't live with or without them:" Transitions and young adults' perceptions of sibling relationships. *Journal of Family Psychology*, *32*(3), 385–395. https://doi.org/10.1037/fam0000361

Johnco, C., & Rapee, R. M. (2018). Depression literacy and stigma influence how parents perceive and respond to adolescent depressive symptoms. *Journal of Affective Disorders*, *241*(1), 599-607. https://doi.org/10.1016/j.jad.2018.08.062

Joiner, T. E., & Timmons, K. A. (2009). Depression in its interpersonal context. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of depression* (2nd ed., pp. 322-339). Guilford Press.

Katz, C., Cohen, N., Tener, D., & Sharabi, O. Y. (2023). Sibling coalitions in the context of parental child maltreatment. *Child & Family Social Work*, *28*(1), 279-290. https://doi.org/10.1111/cfs.12960

Katzman, M. A., Bilkey, T. S., Chokka, P. R., Fallu, A., & Klassen, L. J. (2017). Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. *BMC Psychiatry*, *17*(302), 1-15. https://doi.org/10.1186/s12888-017-1463-3

Lam, C. B., Solmeyer, A. R., & McHale, S. M. (2012). Sibling differences in parent–child conflict and risky behavior: A three-wave longitudinal study. *Journal of Family Psychology*, *26*(4), 523-531. https://doi.org/10.1037/a0029083

Le Poire, B. A. (1992). Does the codependent encourage substance-dependent behavior? Paradoxical injunctions in the codependent relationship. *International Journal of the Addictions*, *27*(12), 1465-1474. https://doi.org/10.3109/10826089209047363

Le Poire, B. A. (1995). Inconsistent nurturing as control theory: Implications for communication-based treatment research and treatment programs. *Journal of Applied Communication Research*, *23*(1), 60–74. https://doi.org/10.1080/00909889509365414

Le Poire, B. A., Hallett, J. S., & Erlandson, K. T. (2000). An initial test of inconsistent nurturing as control theory: How partners of drug abusers assist their partners' sobriety. *Human Communication Research*, *26*(3), 432-457. https://doi.org/10.1111/j.1468-2958.2000.tb00764.x

Leith, J. E., Jewell, T. C., & Stein, C. H. (2018). Caregiving attitudes, personal loss, and stress-related growth among siblings of adults with mental illness. *Journal of Child and Family Studies*, *27*(1), 1193-1206. https://doi.org/10.1007/s10826-017-0965-4

Lincoln, Y. S. , Guba, E. G. (1985). *Naturalistic inquiry.* Sage.

Lindell, A. K., & Campione-Barr, N. (2017). Continuity and change in the family system across the transition from adolescence to emerging adulthood. *Marriage & Family Review*, *53*(4), 388-416. https://doi.org/10.1080/01494929.2016.1184212

Loechner, J., Starman, K., Galuschka, K., Tamm, J., Schulte-Körne, G., Rubel, J., & Platt, B. (2018). Preventing depression in the offspring of parents with depression: A systematic review and meta-analysis of randomized controlled trials. *Clinical Psychology Review*, *60*(1), 1-14. https://doi.org/10.1016/j.cpr.2017.11.009

Marmorstein, N. R. (2009). Longitudinal associations between alcohol problems and depressive symptoms: Early adolescence through early adulthood. *Alcoholism: Clinical and Experimental Research*, *33*(1), 49-59. https://doi.org/10.1111/j.1530-0277.2008.00810.x

McHale, S. M., Updegraff, K. A., & Whiteman, S. D. (2012). Sibling relationships and influences in childhood and adolescence. *Journal of Marriage and Family*, *74*(5), 913-930. https://doi.org/10.1111/j.1741-3737.2012.01011.x

McHugh, R. K., & Weiss, R. D. (2019). Alcohol use disorder and depressive disorders. *Alcohol Research: Current Reviews*, *40*(1), 3-10. https://doi.org/10.35946/arcr.v40.1.01

Milevsky, A. (2005). Compensatory patterns of sibling support in emerging adulthood: Variations in loneliness, self-esteem, depression, and life satisfaction. *Journal of Social and Personal Relationships*, *22*(6), 743–755. https://doi.org/10.1177/0265407505056447

Milevsky, A. (2020). Sibling dynamics in adulthood: A qualitative analysis. *Marriage & Family Review*, *56*(2), 91-108. https://doi.org/10.1080/01494929.2019.1655127

Milevsky, A. (2022). Relationships in transition: maternal and paternal parenting styles and change in sibling dynamics during adolescence. *European Journal of Developmental Psychology*, *19*(1), 89-109. https://doi.org/10.1080/17405629.2020.1865144

Milevsky, A., & Heerwagen, M. (2013). A phenomenological examination of sibling relationships in emerging adulthood. *Marriage & Family Review*, *49*(3), 251-263. https://doi.org/10.1080/01494929.2012.762444

Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. *Child Development, 56*(2), 289-302. https://doi.org/10.2307/1129720

Minuchin, S. (1974). *Families and family therapy.* Harvard University Press. https://doi.org/10.4324/9780203111673

Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders*, *71*(1-3), 1-9. https://doi.org/10.1016/S0165-0327(01)00379-2

National Alliance on Mental Illness (2023, April). *Mental health by the numbers.* https://www.nami.org/mhstats

National Institute of Drug Abuse (2020, July). *Drugs, brain, and behavior: The science of addiction.* https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/

National Institute of Mental Health (2023, April). *Depression.* https://www.nimh.nih.gov/health/topics/depression

Petronio, S. (2010). Communication privacy management theory: What do we know about family privacy regulation? *Journal of Family Theory & Review*, *2*(3), 175-196. https://doi.org/10.1111/j.1756-2589.2010.00052.x

Petronio, S., Child, J. T., & Hall, R. D. (2021). Communication privacy management theory: Significance for interpersonal communication. In *Engaging theories in interpersonal communication* (pp. 314-327). Routledge. https://doi.org/10.4324/9781003195511-28

Petrowski, C. E., & Stein, C. H. (2016). Young women's accounts of caregiving, family relationships, and personal growth when mother has mental illness. *Journal of Child and Family Studies*, *25*(1), 2873-2884. https://doi.org/10.1007/s10826-016-0441-6

Picco, L., Abdin, E., Chong, S. A., Pang, S., Shafie, S., Chua, B. Y., Vaingankar, J. A., Ong, L. P., Tay, J., & Subramaniam, M. (2016). Attitudes toward seeking professional psychological help: Factor structure and socio-demographic predictors. *Frontiers in Psychology*, *7*, 547. https://doi.org/10.3389/fpsyg.2016.00547

Prescott, M. E., & Le Poire, B. A. (2002). Eating disorders and mother-daughter communication: A test of inconsistent nurturing as control theory. *The Journal of Family Communication*, *2*(2), 59-78. https://doi.org/10.1207/S15327698JFC0202_01

Puig-Antich, J., Lukens, E., Davies, M., Goetz, D., Brennan-Quattrock, J., & Todak, G. (1985). Psychosocial functioning in prepubertal major depressive disorder: I. Interpersonal relationships during the depressive episode. *Archives of General Psychiatry*, *42*(5), 500-507. https://doi.org/10.1001/archpsyc.1985.01790280082008

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, *1*(3), 385-401. https://doi.org/10.1177/014662167700100306

Reynolds, J. F., Dorner, L. M., & Orellana, M. F. (2011). Siblings as cultural educators and socializing agents. In J. Caspi (Ed.), *Sibling development: Implications for mental health practitioners* (pp. 107–121). Springer.

Richmond, M. K., Stocker, C. M., & Rienks, S. L. (2005). Longitudinal associations between sibling relationship quality, parental differential treatment, and children's adjustment. *Journal of Family Psychology, 19*(4), 550–559. https://doi.org/10.1037/0893-3200.19.4.550

Roth, K. E., Harkins, D. A., & Eng, L. A. (2014). Parental conflict during divorce as an indicator of adjustment and future relationships: A retrospective sibling study. *Journal of Divorce & Remarriage, 55*(2), 117-138. https://doi.org/10.1080/10502556.2013.871951

Sanders, A., Szymanski, K., & Fiori, K. (2014). The family roles of siblings of people diagnosed with a mental disorder: Heroes and lost children. *International Journal of Psychology, 49*(4), 257–262. https://doi.org/10.1002/ijop.12020

Scharf, M., Shulman, S., & Avigad-Spitz, L. (2005). Sibling relationships in emerging adulthood and in adolescence. *Journal of Adolescent Research, 20*(1), 64-90. https://doi.org/10.1177/0743558404271133

Schmid, R., Schielein, T., Binder, H., Hajak, G., & Spiessl, H. (2009). The forgotten caregivers: Siblings of schizophrenic patients. *International Journal of Psychiatry in Clinical Practice, 13*(4), 326-337. https://doi.org/10.3109/13651500903141400

Schrodt, P., & Afifi, T. D. (2018). Untying the ties that bind: Dispositional and relational patterns of negative relational disclosures and family members' feelings of being caught. *Journal of Family Issues, 39*(7), 1962-1983. https://doi.org/10.1177/0192513X17739050

Schrodt, P., & LaFreniere, J. R. (2022). Witnessing interparental conflict, feeling caught, and mental health: A conditional process analysis involving parental confirmation and divorce status. *Journal of Social and Personal Relationships, 39*(2), 303-324. https://doi.org/10.1177/02654075211036508

Seeman, M. V. (2013). Spotlight on sibling involvement in schizophrenia treatment. *Psychiatry, 76*(4), 311-322. https://doi.org/10.1521/psyc.2013.76.4.311

Segrin, C., Hanzal, A., Donnerstein, C., Taylor, M., & Domschke, T. J. (2007). Social skills, psychological well-being, and the mediating role of perceived stress. *Anxiety, Stress, and Coping, 20*(3), 321-329. https://doi.org/10.1080/10615800701282252

Sharabi, L. L., Delaney, A. L., & Knobloch, L. K. (2016). In their own words: How clinical depression affects romantic relationships. *Journal of Social and Personal Relationships, 33*(4), 421-448. https://doi.org/10.1177/0265407515578820

Skinner, B. F. (1974). *About behaviorism.* Alfred A. Knopf.

Smith, E. C. (2011). Gender-biased diagnosing, the consequences of psychosomatic misdiagnosis and 'doing credibility' [Undergraduate honors thesis]. Occidental College. OxyScholar.

Stocker, C. M., Gilligan, M., Klopack, E. T., Conger, K. J., Lanthier, R. P., Neppl, T. K., O'Neal, C. W., & Wickrama, K. A. S. (2020). Sibling relationships in older adulthood: Links with loneliness and well-being. *Journal of Family Psychology, 34*(2), 175-185. https://doi.org/10.1037/fam0000586

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Sage.

Tomeny, T. S., Barry, T. D., Fair, E. C., & Riley, R. (2017). Parentification of adult siblings of individuals with autism spectrum disorder. *Journal of Child and Family Studies*, *26*(1), 1056-1067. https://doi.org/10.1007/s10826-016-0627-y

Tracy, S. J. (2018). A phronetic iterative approach to data analysis in qualitative research. *Journal of Qualitative Research, 19*(2), 61-76. https://doi.org/10.22284/qr.2018.19.2.61

Tucker, C. J., Finkelhor, D., & Turner, H. (2020). Family predictors of sibling versus peer victimization. *Journal of Family Psychology*, *34*(2), 186-195. https://doi.org/10.1037/fam0000592

Villarroel, M. A., & Terlizzi, E. P. (2020, September). *Symptoms of depression among adults: United States, 2019* (NCHS Brief, No. 347). Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/databriefs/db379-H.pdf

Volkow, N. D. (2020). Personalizing the treatment of substance use disorders. *American Journal of Psychiatry*, *177*(2), 113-116. https://doi.org/10.1176/appi.ajp.2019.19121284

Waldinger, R. J., Vaillant, G. E., & Orav, E. J. (2007). Childhood sibling relationships as a predictor of major depression in adulthood: A 30-year prospective study. *American Journal of Psychiatry*, *164*(6), 949–954. https://doi.org/10.1176/ajp.2007.164.6.949

Ward, S., Sylva, J., & Gresham, F. M. (2010). School based predictors of early adolescent depression. *School Mental Health*, *2*(3), 125–131. https://doi.org/10.1007/s12310-010-9028-3

Weinstock, L. M., Keitner, G. I., Ryan, C. E., Solomon, D. A., & Miller, I. W. (2006). Family functioning and mood disorders: A comparison between patients with major depressive disorder and bipolar I disorder. *Journal of Consulting and Clinical Psychology, 74*(6), 1192–1202. https://doi.org/10.1037/0022- 006X.74.6.1192

Weissman, M. M., Sholomskas, D., Pottenger, M., Prusoff, B. A., & Locke, B. Z. (1977). Assessing depressive symptoms in five psychiatric populations: A validation study. *American Journal of Epidemiology, 106*(3), 203-214. https://doi.org/10.1093/oxfordjournals.aje.a112455

Whiteman, S. D., Bernard, J. M., & Jensen, A. C. (2011). Sibling influence in human development. In *Sibling development: Implications for mental health practitioners* (pp. 1–15). Springer.

Withers, A., Mullan, B., Madden, S., Kohn, M., Clarke, S., Thornton, C., Rhodes, P., & Touyz, S. (2014). Anorexia nervosa in the family: a sibling's perspective. *Advances in Eating Disorders: Theory, Research and Practice*, *2*(1), 53-64. https://doi.org/10.1080/21662630.2013.839187

Witte, S., Fegert, J. M., & Walper, S. (2020). Sibling relationship pattern in the context of abuse and neglect: Results from a sample of adult siblings. *Child Abuse & Neglect*, *106*(1), Article 104528. https://doi.org/10.1016/j.chiabu.2020.104528

Yoo, S. H., Kwon, H. J., Kim, S. H., Lee, J. A., Sunwoo, S., Kim, Y. S., Kim, B. S., Oh, H. J., Kim, C. M., Choi, H. J, Hwang, H. J., & Ok, S. W. (2016). The impact of a spouse's depression on family functioning and communication. *Korean Journal of Health Promotion*, *16*(1), 11-19. https://doi.org/10.15384/kjhp.2016.16.1.11

Zagefka, H., Jones, J., Caglar, A., Girish, R., & Matos, C. (2021). Family roles, family dysfunction, and depressive symptoms. *The Family Journal*, *29*(3), 346-353. https://doi.org/10.1177/1066480720973418

Zhang, Z., Sun, K., Jatchavala, C., Koh, J., Chia, Y., Bose, J., Li, Z., Tan, W., Wang, S., Chu, W., Wang, J., Tran, B., & Ho, R. (2020). Overview of stigma against psychiatric illnesses and advancements of anti-stigma activities in six Asian societies. *International Journal of Environmental Research and Public Health*, *17*(1), 280. https://doi.org/10.3390/ijerph17010280

Zolezzi, M., Alamri, M., Shaar, S., & Rainkie, D. (2018). Stigma associated with mental illness and its treatment in the Arab culture: a systematic review. *International Journal of Social Psychiatry*, *64*(6), 597-609. https://doi.org/10.1177/0020764018789200

Appendix A

Pre-screening Measures

Prior to recording the semi-structured interview, potential subjects will be screened about their sibling's and their own mental health situation. Depending on the subject's responses to General Questions #1 and #2, **please have them respond to the respective version(s) of Radloff's (1977) Center for Epidemiologic Studies Depression Scale (CES-D).** A subject may be eligible to respond to both. Those who meet the **CES-D cutoff score of 16+** (Weissman et al., 1977*) qualify for use of that particular script (i.e., sibling-only if only the sibling meets 16+, participant-only if only the participant, or mixed if both the sibling and participant). Additionally, **collect demographic data for those who meet the cutoff.**

Further information: Relevant indicators of depression include responses and behaviors that demonstrate **telltale signs of the depressive symptoms' being ongoing, significant, a struggle, overwhelming, and/or difficult to cope with.** Signs that are NOT indicative of ongoing chronic depression include descriptions of depressive symptoms as one-off experiences, temporary emotions, and/or challenges that have already been resolved. Additionally, potential subjects should **have some sort of maintained contact or relationship with their sibling(s).** The siblings do not need to be close to each other.

*If the participant cannot come up with an item response for their sibling, or if they're not comfortable responding to a given item(s), they can skip the item(s). This may adjust the cutoff score to qualify:

19 items (1 missing) --> 16+ (same as original)
18 items (2 missing) --> 15+
17 items (3 missing) --> 14+
16 items (4 missing) --> 13+
15 items (5 missing) --> 12+

General Questions

1. Do you demonstrate depressive symptoms? If yes, how long have you exhibited such feelings and behaviors? Please respond in months and years to the best of your ability. **[If "yes," they can respond to the CES-D for themself.]**
2. Do any of your sibling(s) demonstrate depressive symptoms? If yes, please identify one you'd be comfortable talking about in this interview. How long has this sibling exhibited such feelings and behaviors? Please respond in months and years to the best of your ability. **[If "yes," they can respond to the CES-D for their sibling.]**

CES-D (Modified)

Participant's Own Mental Health

Thinking about your own recent feelings and behaviors, please tell me how often you have demonstrated the following:

Response set: 0 = *rarely or none of the time,* 1 = *some or a little of the time,* 2 = *a moderate amount of time,* 3 = *most or all of the time*

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends
4. I felt I was just as good as other people.*
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.*
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.*
13. I talked less than usual.
14. I felt lonely.
15. People were unfriendly (to me).
16. I enjoyed life.*
17. I had crying spells.
18. I felt sad.
19. I felt that people dislike me.
20. I could not get "going."

(Items denoted with * measure a lack of depressive symptoms. **Reverse-code these as follows:** 0→1; 1→2; 2→1; 3→0)

Participant's Sibling's Mental Health

Thinking about your sibling's recent behavior, please tell me how often you have observed them demonstrating the following:

Response set: 0 = *rarely or none of the time,* 1 = *some or a little of the time,* 2 = *a moderate amount of time,* 3 = *most or all of the time*

1. They were bothered by things that usually don't bother them.
2. They did not feel like eating; their appetite was poor.
3. They felt that they could not shake off the blues even with help from their family or friends.
4. They felt they were just as good as other people.*
5. They had trouble keeping their mind on what they were doing.
6. They felt depressed.
7. They felt that everything they did was an effort.
8. They felt hopeful about the future.*
9. They thought their life had been a failure.
10. They felt fearful.
11. Their sleep was restless.
12. They were happy.*
13. They talked less than usual.
14. They felt lonely.
15. People were unfriendly to them.

16. They enjoyed life.*
17. They had crying spells.
18. They felt sad.
19. They felt that people dislike them.
20. They could not get "going."

(Items denoted with * measure a lack of depressive symptoms. **Reverse-code these as follows:** 0→1; 1→2; 2→1; 3→0)

Demographic Questions

Participant

Note: Allow participants to respond with the language that best fits their experience.

1. What is your sex assigned at birth?
2. What is your gender identity?
3. What are your personal pronouns? (for the sake of referring to them in the writeup)
4. What is your sexual orientation(s)?
5. With which racial group(s) do you identify?
6. With regards to ethnicity, do you identify as Hispanic?
7. How old are you?
8. What city and state do you live in (or country, if out of US)?
9. What did your parent/guardian situation look like growing up (e.g., number of parents, sex composition of parents, parents' marital status, whether the family is blended)?
10. How many siblings do you have? What is your formal relationship to them (e.g., biological, half-, step-, adopted sibling)?

Participant's Sibling

Note: Alert participants that it is okay if they do not know their sibling's identity markers. We are already taking this into account as a feature of observer-reported data.

1. What is their sex assigned at birth?
2. What is their gender identity?
3. What are their personal pronouns? (for the sake of referring to them in the writeup)
4. What is their sexual orientation(s)?
5. With which racial group(s) do they identify?
6. With regards to ethnicity, do they identify as Hispanic?
7. How old are they?
8. What city and state do they live in (or country, if out of US)?

Appendix B

Sample Interview Script

1) **Tell me about your family of origin, that is, the family you've grown up with.**

    - Which individuals make up your family? What are they like?
    - How would you describe your relationships with your family members? What roles do you play for each other? How do you feel about each of these relationships?
    - How would you describe your family members' relationships with one another?
    - Regarding your mental health challenge(s)…
        - When were you diagnosed with depression? If you don't have a formal diagnosis, when did the symptoms first become evident? When did they become concerning?
        - Which of your behaviors stand out as being linked to your mental health? How do you feel about them?
        - How, if at all, did learning about your condition change your relationship with your family?
        - How, if at all, did the dynamics of your family change with the news of the diagnosis (or the recognition of the symptoms)?
    - Regarding your sibling's mental health challenge(s)…
        - When was your sibling diagnosed with depression? If they don't have a formal diagnosis, when did the symptoms first become evident? When did they become concerning?
        - Which of your sibling's behaviors stand out as being linked to their mental health? How do you feel about them?
        - How, if at all, did learning about your sibling's condition change your relationship with your sibling?
        - How, if at all, did the dynamics of your family change with the news of the diagnosis (or the recognition of the symptoms)?
    - What mental health challenges, if any, do your parent(s) experience? (What about your other siblings?)

2) **How does your family approach the topic of mental health?**

    - In what ways is the topic comfortable and/or taboo within your family?
    - How frequently does mental health come up in your family? Who tends to talk about it, and in what ways?
    - How does your family communicate about your mental health? Your sibling's (siblings') mental health? Your parent's (parents') mental health?
    - What is it about your family that has made conversations surrounding mental health operate in this way? For example, are there any aspects of family history, trauma, or life events that you feel play a role?

- In what ways do you wish that your family would approach the topic of mental health differently, if any?

3) Tell me about tensions within your family surrounding mental health problems.

- Has mental health ever become a point of contention in your family? How so?
- How have you reaffirmed and/or challenged the ways that your family tends to cope?
- How has your sibling(s) followed and/or countered these coping behaviors? How effective do you find this to be in addressing your condition? Their conditions? What role, if any, do you feel your sibling's mental health challenges play in this?
- What does conflict concerning mental health between you and your parent(s) look like, in general? What about conflicts concerning *your* mental health, specifically? Please provide examples.
- What does conflict concerning mental health between your sibling and your parent(s) look like, in general? What about conflicts concerning *your sibling's* mental health, specifically? Please provide examples.
- (How do these differ from mental health-related conflicts between your parents and your other sibling(s), if at all? What about between your parents?)
- How does you and your sibling communicate about mental health, whether broadly or with regards to their or your condition? If you have conflict with them about it, please elaborate. (What role, if any, do you feel your sibling's/siblings' mental health challenges play in this?)
- How does your family demonstrate their perspective on mental health in their daily talk and behavior? What about regarding your mental health? Your sibling's mental health? What about regarding other family members' mental health?

4) Do you ever feel "caught" or "torn" between members of your family? What about as it relates to mental health?

- Do you ever feel torn between your family members when it comes to addressing your depressive symptoms? How about specifically between your sibling(s) and one or both of your parents? Please provide examples.
    i. If you feel torn, how do you manage this tension? Which roles and/or goals do you prioritize?
- Do you ever feel torn between your family members when it comes to addressing your sibling's depressive symptoms? How about specifically between your sibling and one or both of your parents? Please provide examples.
    i. If you feel torn, how do you manage this tension? Which roles and/or goals do you prioritize?
- How do your parents talk about mental health with you and your sibling(s)? For instance, in what ways, if any, do they treat you and your sibling(s) differently when it comes to addressing depression-related challenges?

- Do either of your parents go to your sibling(s) to talk about you and especially your mental health? If so, how does this affect you individually? How does this affect your family relationships?
- Do either of your parents go to you to talk about your sibling and especially your sibling's mental health? If so, how does this affect you individually? How does this affect your family relationships?
- Do you wish that you held a different role(s) when it comes to conflict about your mental health in your family? In what ways? What about in regard to your family members' mental health?
- How do your family members react to your attempts to manage your mental health challenges? Are you rewarded, punished, ignored? Please elaborate.
- How do your family members react to your attempts to manage your multiple roles and/or goals in the context of conflict related to your sibling's mental health? Are you rewarded, punished, ignored? Please elaborate.
- How do you feel about these conflicts? Did you do anything about them, whether towards one or all of your family members? Please provide examples.

5) Final questions

- What else has been challenging regarding your mental health? Your sibling's mental health?
- What else has been challenging regarding mental health within your family?
- What positive and/or surprising personal outcomes have emerged from your and/or your sibling's mental health challenges, if any? What about outcomes for your family relationships? How about your relationship with your sibling, in particular?
- What do you wish you'd known before you'd learned about your condition? Your sibling's condition?
- What do you wish your family had known before learning about your condition? Your sibling's condition?
- What do you want people to know about living in a family in which one or more children have depressive symptoms?
- Is there anything else you'd like me to know?

Appendix C

Final Codebook

Abbreviations:

- **MH(C)** = mental health (challenge), generally depressive symptoms
- **Support** = to help, tend to, or otherwise address a given person's (MH) needs, regardless of how (i.e., nurture and/or control)
- **SWD** = depressed sibling; the child who the SS is supporting
- **SS** = supportive sibling; the child who wants/tries to support their SWD; oftentimes (but not necessarily) the participant
    - *Note:* The SWD and SS roles are a matter of the situation. That is, one child could have depressive symptoms but primarily serve as the SS to their SWD in need at a given moment. These role labels are for sake of ease, but siblings can hold both roles. In fact, serving as a SS could contribute to a child's own MHCs (and therefore position as a SWD).
- **Older generations** = parents & older; most often before the children's time

Note: In theme definitions, the word "includes" prompts examples, *not* an exhaustive list of manifestations of a given theme.

Theme	Sub-theme	Definition
Family history of trauma, mental illness, and conflict [FH] Intergenerational contributors to family chaos & dysfunction that set the stage for children's depressive symptoms & MH-related family communication processes.	**Intergenerational antecedents [FH-InterAnt]**	Older generations' experiences of abuse, risky behavior, crisis, and named MHCs. Can be related to the family's cultural identities. Includes explicitly stated anti-MH values.
	Home life chaos [FH-HomeChaos]	Dysfunctional or otherwise undesirable experiences and behaviors in the family that contribute to the child's/children's MHCs. Includes interparental conflict, parental abuse toward children, and parents' past negative reactions to the SWD's MHCs.
Loyalty conflicts [LC] The SS's navigation of intrafamilial alliances, especially those in opposition of each other.		The SS's internal tension due to wanting to appease family members with conflicting goals or desires. Indications of internal tension can be attitudinal (e.g., feeling torn about how to help both sides) or

Theme	Sub-theme	Definition
		behavioral (e.g., mediating conflict, playing messenger, giving advice about the SWD to the parent). Behavior may be initiated by the SS or another family member (e.g., the parent).
Cognitive dissonance [CD] Co-occurring, conflicting cognitions and actions within the SS, regarding their SWD's MH and/or the family system.	**Parentified vs child role [CD-ParChild]**	Dissonance between the SS's desire/efforts to support their SWD/family system (e.g., by caregiving for their SWD) and their desire/efforts to maintain their position as child (i.e., by having less responsibility for the family system).
	Support vs enable SWD [CD-SuppEnable]	Dissonance between the SS's desire/efforts to tend to their SWD's MH and their desire for the SWD to take care of themself, such that supporting the SWD could reinforce the SWD's MHC-related behavior (e.g., dependence on the SS). Support here often resembles nurturing (e.g., comforting, taking on SWD's responsibilities), but it does not have to take this form.
	Support SWD vs threaten alliance [CD-SuppThreat]	Dissonance between the SS's desire/efforts to tend to their SWD's MH and their desire/efforts to maintain relational closeness with their SWD, such that supporting the SWD could threaten the sibling alliance. Support here often resembles labeling and controlling (e.g., naming the MHC, confronting/punishing the SWD), but it does not have to.
	Others' vs own needs [CD-OtherOwn]	Dissonance between the SS's desire/efforts to prioritize their

Theme	Sub-theme	Definition
		SWD's/family system's needs and their desire/efforts to prioritize their own MH, such that (1) prioritizing the family puts weight on the SS and/or (2) prioritizing themself could have negative consequences for the family system.
Felt obligation [FG] Family-related motivations that drive the SS to tend to their SWD's MH in some way.	**Compensating for family chaos [FG-Compensate]**	The SS's drive to help their SWD heal from the unhealthy family life that had heightened the SWD's MHCs. Includes making up for their parents' dysfunctional behavior, differential treatment, and past negative reactions to the SWD's MHCs. May be related to self-blame or guilt for own actions that may have hurt the SWD.
	Glue of the family [FG-Glue]	The SS's commitment to maintaining and upholding their family system's well-being and functioning, whether as a consistent mediator, therapist, protector, or otherwise self-sacrificing role. Involves putting the SWD/family system above all.
Struggle for agency [SFA] The SS's pursuit of agency over their role as SS in tending to their SWD's MH and the family system (and perhaps their own MH). Includes cognitions and actions, as well as reasons for them.	**Information and privacy regulation [SFA-InfoReg]**	The SS's exercise of control over the flow of information about MHCs. Includes suppressing their own MHCs to allow the SWD more attention, offering advice to their parent(s) on their own terms, and choosing to enact consistent behavior and/or boundaries with their SWD.
	Lacking agency [SFA-Lacking]	The SS's inability to exercise agency. Includes feeling helpless or otherwise negatively in their limited ability to help their SWD,

Theme	Sub-theme	Definition
		ceasing support efforts with their SWD, not being listened to by their family, and being forced to mediate.
	Inability to separate [SFA-NoSep]	The SS's struggle to maintain autonomy while maintaining a consistently supportive role for their SWD. This is often due to being emotionally tied to their SWD and/or family system, and demonstrated primarily via inconsistency. Includes falling back into putting their SWD first when claiming to separate, or being at the will of their SWD/family system.
In-group/out-group dynamics [IO] Family dynamics, especially in the MH context, in which the siblings (children) are a team against their parents.	**Children as a team [IO-ChildTeam]**	The SS's behaviors that support, defend, or otherwise prioritize their SWD's (and possibly their own) MH. Includes taking the SWD's side in SWD-parent conflict, confronting their parents about parental treatment of either child, and saving MH communication for the sibling alliance *only.* Motives may be honoring the child as an individual or for their position as a child in the family system.
	Shared understanding [IO-SharedUnd]	Closeness, communication, and bonding between siblings due to their shared knowledge of family chaos, MHCs, and relevant experiences. When closeness is lacking, this includes a desire for more closeness and/or MH communication between siblings.
	Parents' MH language barrier [IO-ParBarrier]	The children's negative attitudes about and reactions to their parent's/parents' low MH literacy.

Theme	Sub-theme	Definition
		Such literacy is indicated by a lack of understanding or an undesirable reaction to the SWD's MHCs. Includes one or more children actively avoiding MH communication with their parents.
	Compassion for SWD [IO-Compassion]	The SS's attribution of their SWD's MHCs to outside of the SWD's personality or choice, as well as patience or understanding for the SWD's behavior. Includes explicitly not blaming the SWD, instead blaming their parents' abusive tendencies and/or the SWD's social environment, and seeing the SWD beyond their MHCs.