Autism Spectrum Disorders Effect on Siblings Psychosocial Adjustment: Explained Using
Alfred Adler’s Theory of Birth Order Personality

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Abstract

Autism spectrum disorders (ASD) are a group of developmental disorders that are defined by social interaction deficiencies, communication delays, and restricted, repetitive behavior patterns. Moreover, it is the fastest growing developmental disability. This unique pattern of symptoms cultivates challenges for the family unit. Often a child’s diagnosis of autism tests the family structure and/or relationships, therefore, creating a new and atypical family system. Siblings are affected most, especially when their older brother or sister is the one diagnosed with autism. Generally, older siblings often serve as examples to younger siblings regarding how to behave and relate to the community in which they live in. However, due to the characteristics of autism, older siblings diagnosed with an ASD are often incapable to lead by example. Therefore, due to the circumstances of being a younger sibling of a child with autism can result in poor psychological development. The paper uses Alfred Adler’s theory of birth order in an attempt to explain how having older sibling diagnosed with an autism can have such a profound effect on the personality and psychological development of a younger and typically developing sibling. In addition to Adler’s birth order philosophy, expanding on his idea of social interest may be a solution in order to alleviate the challenges faced by younger siblings of children with an ASD. It is important to note, the more severe the characteristics of the child with autism, the higher the likelihood of even poorer sibling adjustment. However, high functioning autism is the primary catalyst regarding these scenarios.
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Autism Spectrum Disorders Effect on Siblings Psychosocial Adjustment: Explained Using Alfred Adler’s Theory of Birth Order Personality

**Introduction**

Autism spectrum disorder (ASD) is considered a neurodevelopmental disorder by the American Psychiatric Association (American Psychiatric Association, 2013). Diagnostic criteria include: continual impairment in reciprocal social communication and social interaction and restricted, repetitive patterns of behavior, interests, or activities. Typically, symptoms are present in the early development of a child, and the symptoms may not become apparent until the child can no longer meet typical social demands or behavior challenges cannot be hidden behind learned strategies for behavior as demonstrated later in life (American Psychiatric Association, 2013). The age and pattern of onset should be noted as the symptoms of autism are usually recognized during the second year of life, but behavioral indicators may be seen earlier than twelve months depending on the severity of the developmental delays.

There may be a genetic component to ASD, meaning family members of people with an ASD diagnosis demonstrate similar personality features such as inflexibility to change, increased relationship withdrawal, and hypersensitivity to criticism which increase difficulty for the individual to interpret or understand the importance of social norms (Altiere & von Kluge, 2009). In addition, these interpersonal variables reduce the number of friendships and the quality of friendships for individuals with ASD in large part due to reduced expression of empathy, which makes acquiring and maintaining friendships difficult (American Psychiatric Association, 2013). Cognitive deficits such as impaired executive functioning, weak coherence, and pragmatic language deficits further complicate communication between the individual with autism and those around them. Furthermore, the research developed by Mohammadi and Zaraflsh in 2014
suggests there is a Broader Autism Phenotype (BAP); another indication ASD may be a genetic disorder.

A diagnosis of autism is permanent; an individual does not simply grow out of ASD (Hall, 2012). However, identifying the pattern of onset and gathering an accurate description of onset helps clinicians get valuable information about early developmental delays, the loss of social language skills, and regression in developmental milestones (American Psychiatric Association, 2013). Particularly in cases involving loss of skills, some parents or caregivers may report the loss of skills as gradual. Conversely, other parents or caregivers might describe a rapid deterioration in social behaviors or language skills (American Psychiatric Association, 2013). Typically, most reports of skill reduction occur between twelve and twenty-four months of age.

**Prevalence**

ASD affects approximately 1% of the world population and the Center for Disease Control (CDC) estimate the prevalence at 1 in 68 births (Autism Society, 2016). Research gathered by Buescher, Cidadv, Knapp, and Mandell (2014) estimates more than 3.5 million Americans live with autism. The predominance of autism in children in the United States has grown 119.4% since 2000 and has since become the fastest-growing developmental disability (Autism Society, 2016). Consequently, due to the number of children diagnosed with an autism spectrum disorder, parents and caregivers look to make additional accommodations than parents and caregivers of neurotypical children.

**Cost**

On average, the cost to the conventional American family raising a neurotypical child is $241,080 (Buescher, et al., 2014). However, due to the characteristics of ASD, supplementary
services are required for the child with autism to be equally successful in their lifetime, when compared with their neurotypical peers. Therefore, the cost for a family raising a child diagnosed with autism increases significantly. Annually, Buescher et al. suggested autism services cost U.S. citizens between $236-262 billion dollars per year (Buescher, Cidav, Knapp, & Mandell, 2014). Furthermore, the cost of ASD during the lifespan of one person diagnosed with autism is estimated to be $1.4 million (Autism Society, 2016).

**Educational cost.** In addition to the cost to the American family, there are additional services and expenses required when providing educational services to children diagnosed with autism. Lavelle, Weinstein, Newhouse, Munir, Kuhlthau, and Prosser (2014) estimate the annual cost of educating a child with an ASD diagnosis to be more than $8,600 on top of the $12,000 spent for educating a neurotypical child (2014). In addition, costs for special programs, appropriate before and after-school care, day care or childcare, weekend programs, summer school programs are often not covered by school district funding, requiring parents to pay out of pocket for necessary education related services (Autism Society, 2016).

**Medical costs.** In addition, medical services, including: typical well-child visits, emergency room services, inpatient, outpatient, other health care professionals, pharmacy, home health care, and out of pocket expenses also bare a financial burden (Buescher et al., 2014). Likewise, non-medical services, such as family respite care or other overnight services, travel to medical appointments, modifications to the family’s home, and damage replacement related to behavior are other examples of additional expenses incurred by parents and caregivers to assist their child with autism (Autism Society, 2016).

The educational and medical costs for accommodating a child with autism can be substantial. However, there are additional costs that go beyond monetary value in which families
can accrue. For example, the cost of the family’s social lifestyle can be taken away or significantly reduced due to the characteristics of autism (Lickenbrock, Ekas, & Whitman, 2011).

**ASD and the Individual**

To be diagnosed with ASD, an individual must meet specific criteria for diagnosis, as identified in the *Diagnostic and Statistical Manual of Mental Health, 5th edition* (American Psychiatric Association, 2013). The diagnostic criteria include: “deficits in social communication and social interaction across multiple tests” and “restrictive, repetitive behaviors interests, or activities” (American Psychiatric Association, 2013, p. 50). In addition, “symptoms must be present in the early developmental period” and the symptoms must “… cause clinically significant impairment in social, occupational, or other important areas of current functioning” (American Psychiatric Association, 2013, p. 50).

Individuals with ASD are also often diagnosed with co-morbid disorders (American Psychiatric Association, 2013). For example, it is common for a child with ASD to be diagnosed with an intellectual disorder or language impairment. Children with an autism diagnosis and average or high intelligence have unique characteristics of abilities (Winter-Messiers, 2007). For example, children with high functioning autism can be extremely detailed oriented. Interestingly, the distance between intellectual capability and common sense is often large (Winter-Messiers, 2007). Motor deficits are also often present, contributing to increased self-injury due to poor motor coordination (American Psychiatric Association, 2013). Disruptive or challenging behaviors are more common in autism diagnoses than any other neurodevelopmental disorder. Moreover, it is not uncommon to observe symptoms of depression and anxiety in adolescents and children with autism (American Psychiatric Association, 2013).
The Social Impact of Autism

Symptoms of ASD will cause significant impairment in social, occupational, or other important areas of current functioning (American Psychiatric Association, 2013). These difficulties are particularly evident in young children, in whom there is often a lack of shared social play and imagination and, later, insistence on playing by very fixed rules. Older individuals may struggle to understand the subtleties of social behavior (Ross & Cuskelly, 2006). For example, laughter is considered appropriate at a family gathering, but not when the family is attending a funeral or other somber event. Furthermore, an adult or adolescent with ASD may not understand the different ways that language may be used to communicate. For example, sarcasm may be difficult to understand (Hastings, 2003a).

Communication Impairment and the Social Impairments

Communication impairments and social interaction impairments are prevalent in ASD and is a part of the child for life. Deficits in non-verbal communicative behaviors used for social interaction are manifested by absent, reduced, or atypical use of eye contact, gestures, facial expressions, body orientation, or speech inflection (American Psychiatric Association, 2013). The characteristics of ASD may be relatively slight within the condition of the individual but apparent in application of eye contact, body language, body posture, rhythm, and facial expression for social communication. When determining the possible deficit in developing, maintaining, and understanding relationships, children with an ASD diagnosis should be compared with the social norms for age, gender, and culture of typically developing peers (Smith & Elder, 2010). There may be absent, reduced, or atypical social interest, materialized by the rejection of others, passivity, or inappropriate approaches that seem aggressive or disruptive.
Autism spectrum disorder is further defined by restricted, repetitive patterns of behavior, interests, or activities which show a range of manifestations per age and ability, intervention, and the availability of current support services (American Psychiatric Association, 2013). Stereotyped or repetitive behaviors include simple motor stereotypies, repetitive use of objects, and repetitive speech also known as echolalia. Strong adherence to routines and limited patterns of behavior may result in resistance to change or ritualized patterns of verbal or nonverbal behavior (Johnson & Simpson, 2013). Highly fastened, fixated interests in ASD tend to be abnormal in intensity or focus. Strong interests and routines may relate to plausible hyper or hyperactivity to sensory input, manifested through an abnormal reaction to specific sounds or textures, a heightened sense of smell or touching objects, an attraction with lights or spinning objects (including themselves), and sometimes indifference in pain, heat, or cold (Hall, 2012).

**Limited Public Knowledge**

The general population remains uninformed about ASD, autism, and its effects on the children, their families, and society. Children with autism usually have no outward appearance of a disorder that allows the public, parents, or professionals to identify its presence (Hall, 2012). In addition, the child’s disruptive behaviors that are symptoms of autism are different from those of other children. These behavioral differences cause problems among family and community members, and parents often find themselves blamed for their children’s disruptive behavior. Furthermore, parents find themselves either defending their parenting skills and are often embarrassed as they try to explain why the child with autism appears to be physically normal but behaves in an unruly manner (Hall, 2012). Siblings of children with autism could find themselves in the position of explaining obviously inappropriate behaviors to surrounding peers,
making it awkward to justify behaviors that go against the social norm (Diener, Anderson, Wright, & Dunn, 2015).

Many children with ASD demonstrate extraordinary special interest area(s) (SIA), which are a defining characteristic of individuals with autism (Winter-Messiers, 2007)). Frequently, members of society view SIAs as annoying, socially inhibiting, even harmful activities, and students’ involvement in them as behaviors to end (Winter-Messiers, 2007). Informing those unfamiliar with SIAs might reframe SIA and assist people to see past the quirkiness of the child’s behavior and potentially view their unusual interests (SIAs) as extraordinary abilities capable of attaining a high level of performance or achievement in a certain area (Winter-Messiers, 2007).

People outside of the immediate family do not understand the symptoms of ASD and may not understand why the children behave the way that they do (Lock & Finstein, 2009). Enlightening not only families, but also society, about autism and its effects is important. Therefore, educating the public concerning the consequences of autism and behaviors of children with autism and their families is significant (Hall, 2012). Community support and resources provided for families and others interested in learning more about autism could prove beneficial to the public regarding understanding the families of children on the autism spectrum (Hall, 2012).

**Support Services and Community Resources**

Seeking support from outside sources, such as in the community, when not available from the immediate family, is an effective strategy for dealing with stress and is an indication of healthy family functioning (Johnson & Simpson, 2013). Social support also appears to be a
protective factor that alleviates stress and improves personal well-being and positive attitudes towards the child (Pozo, Sarriá, & Brioso, 2014).

There are a number of support services and community resources to support the child diagnosed with ASD (Granat, Nordgren, Rein, & Sonander, 2012). There are, however, limited support services and community services for parents and caregivers (Granat et al., 2012). Relatively little attention has been directed towards the support services and community resource needs of siblings of children with disabilities. Arguably these siblings experience the same type and amount of stress as the parents and caregivers (Macks & Reeve, 2007). Unlike parents or caregivers, however, sibling responses are often linked to the level of parental acceptance and the success the family experiences when adapting to a child with autism. Thus, it is reasonable to believe that siblings of children with an ASD diagnosis may experience embarrassment or higher levels of anxiety when their sibling displays ASD behaviors (Pollard, McNamara Barry, Freedman, Kotchick, 2013). Siblings may react differently to life in a family of all neurotypical children than in a family system with a child with autism. Research suggested that support groups for siblings of children with ASD may provide encouragement for the siblings (Lock & Finstein, 2009). Furthermore, siblings of children with ASD may benefit from the opportunity to engage in group activities with other individuals sharing a similar family experience.

Group or individual support offered to siblings by health care professionals is limited or non-existent because all support efforts are entirely concentrated on the sibling with autism or on his or her parents (Granat et al., 2012). The needs of siblings are often neglected by parents because the parents, striving to meet the needs of the child with autism, are distracted or too exhausted to meet the needs of the additional children as well (Macks & Reeve, 2007). Yet, supporting siblings has been recognized in recent years by health care professionals and desired
by parents, who believe that their neurotypical children need something in addition to what the parents or caregivers can provide alone (Pollard et al., 2013).

**ASD and the Impact to Families**

The apparent increase in the prevalence of ASD has raised awareness to the needs of the child, parents or caregivers, and their families (Trembath, Balandin, & Rossi, 2005). Just like parents with neurotypical children, parents’ interactions and expectations of their child who is diagnosed with ASD are likely to be influenced by differing culturally bound childbearing practices and attitudes towards disability (Trembath et al., 2005). Because of the nature of the disorder, raising a child with an ASD often exerts substantial pressure on the family (Lickenbrock et al., 2011). In addition to the struggles of typical family function, families with an ASD member must cope with the initial diagnosis, engage in the search for treatment and intervention services, modify their parenting practices, reorganize the family dynamics, and manage the significant financial burden of paying for services.

**Coping with the Initial Diagnosis**

Once the diagnosis of autism has been verified, families can be overwhelmed with emotions (Nealy, O’Hare, Powers & Swick, 2012). Some of the common early stressors include posttraumatic stress, hostility, self-consciousness, and depression (Zhou & Yi, 2014) as well as grief, confusion, loss, sadness, denial, isolation, and guilt (Nealy et al., 2012). Furthermore, parents of children with ASD are at greater risk for stress and poor mental health than parents of children without autism (Zhou & Yi, 2014). Parents begin to feel a deep sense of loss as they are forced to abandon previous dreams and expectations for the future and develop new expectations that take having a child with autism into consideration.
Search for Treatment and Intervention Services

The variety of treatments and the decision about day-to-day care of children with ASD is a responsibility to be shared by both parents (Johnson & Simpson, 2013). An autism diagnosis forges a relationship between parents and professionals working in the field of ASD (Stoner & Angell, 2006). Teachers, pediatricians, psychologists, and caregivers work alongside parents of children with autism to find services and treatment. However, the process of finding assistance can be a lengthy one.

Modify Parenting Practices

Families of children with chronic developmental conditions such as autism face many stressors but often adapt well in their situations (Altiere & von Kluge, 2009). In accordance with family systems theory, behavioral adaptation is an ongoing, dynamic process that occurs across the lifespan which involves shaping the world, as well as adjusting to and being influenced by the world (King, Zwaigenbaum, King, Baxter, Rosenbaum, & Bates, 2006). Like individuals, families adapt and change over time. There is no greater change for a family than a child diagnosed with autism. This diagnosis challenges the family belief system, increases parenting stressors, and creates the need for family re-organization.

Family Belief System

The family belief system is among the most important factors affecting adaptation and the resiliency of families. The family belief system is comprised of the family world view, values, and priorities (King et al., 2006). The family establishes their world view based on assumptions about the social and cultural environment. Establishing family beliefs often leads to developing family values, and creating rules about how people conduct their lives and organize the lives of their families (Trembath et al., 2005).
Family belief systems are thought to constitute the core of a family’s overall resilience (King et al., 2006). Family beliefs provide anchorage and stability; a shared sense of meaning that helps the family pull together and face the future with a sense of strength. A wide range of positive changes or transformational outcomes may occur. For example, finding resources for a family with a child with autism as well as for the child with autism could provide relief to the family unit. Typical behaviors develop and have been reported by parents of children with autism, including: the development of personal qualities such as patience, love, compassion, and tolerance; improved relationships with family members and others; stronger spiritual or religious beliefs; and a greater appreciation of the small and simple things in life (King et al., 2006).

Parents of children with autism will regain a sense of control over their circumstances and a sense of meaning in life by seeing the positive contributions of their children with respect to personal growth and learning what is important to life (King et al., 2006).

Experiencing a child’s diagnosis of ASD may cause parents to re-examine their family beliefs in ways not encountered by neurotypical families (King et al., 2006). Changes in family priorities, refocusing on the needs of the other family members, and focusing on the child’s needs and strengths are a few reframing strategies that involve transcending events, devaluing the importance of goals. And, refocusing priorities can assist families to establish a sense of coherence and control (King et al., 2006).

Parenting Stressors

Following an ASD diagnosis, parents often report feeling grief, confusion, loss, sadness, denial, isolation, guilt, and even clinical depression (Nealy et al., 2012). Parents begin to learn and attempt to use a variety of techniques to cope with the stress brought about by the new diagnosis. Lack of knowledge or the resources to fully comprehend, endure, and manage ASD
may perpetuate feelings of loss and depression and lead to a breakdown in communication between family members as parents become less responsive to each other’s needs (Hastings, 2003b). Therefore, social support is an integral piece of the coping milieu in families with a child with autism. Social support appears to be a protective factor that alleviates parental stress and improves personal well-being and positive attitudes towards the child (Pozo et al., 2014). Thus, when a family can draw upon adequate resources while perceiving the family situation as manageable, the stress of raising a child with autism may never lead to a crisis. Seeking support from outside sources, such as in the community, when support is not available from the immediate family, can be an effective strategy for dealing with stress and could be an indication of healthy family functioning (Mohammadi & Zarafshan, 2014).

Reorganizing Family Dynamics After the ASD Diagnosis

A well-functioning family has a good balance of cohesion and adaptability (Altiere & von Kluge, 2009). Cohesion, in family systems is the emotional bonding that family members have toward one another. Adaptability in family systems measures the family’s ability to change in response to a stressful situation (Altiere & von Kluge, 2009).

In establishing a healthy family framework, inclusive of cohesion and adaptability, the relationship between mothers and fathers is important (Johnson & Simpson, 2013). The family atmosphere is established by the parents and based on the parents’ connection with one another. Gender roles, which are established in direct reflection of our parents, play an important part in family systems because gender roles are socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women (World Health Organization, 2016).
Family therapist and other mental health professionals are challenged by changing societal expectations and the impact of societal influence on the social construction of gender norms (Hartley, Mihaila, Otalora-Fadner, & Bussanich, 2014). Furthermore, the family framework is impacted by the role of parenting styles (Zhou & Yi, 2014). Parenting styles are influenced directly by the bond between parents as an example of healthy communication for children implement in their own family interactions (Zhou & Yi, 2014).

**Changes in family atmosphere.** Family atmosphere is established from the relationship between the parents (Stein, 2014). Family atmosphere may be understood as the *climate* of the household as the person remembers perceiving and experiencing it when he or she was a child and may be described in meteorological analogies such as sunny, warm, stormy, calm, foggy (BehaveNet, 2017). The family atmosphere has interactional components such as: encouraging, hostile, and cooperative to name a few. The subjective evaluations concerning family atmosphere are judgements made about life in early childhood at a time when the individual’s basic convictions about self, others, and the world were being formed (Stein, 2014). Therefore, these valuations become significant elements in his and her biased apperceptions and expectations about what life both provides and requires.

There are instances where parenting styles or the family atmosphere overlap, however, only the authoritative parenting style prepares a child for cooperation (Stein, 2014). Authoritarian or permissive parenting styles may provoke a lack of trust, eliminate the child’s courage, and emphasize the mistaken value of superiority over others. Furthermore, authoritarian and permissive styles may also breed self-centeredness, emotional distance, and inhibit the empathy for others. Changing the family atmosphere may require parents to change their fundamental views of life, attitudes towards other people, and feelings (Stein, 2014).
In establishing a healthy family framework, the relationship between mothers and fathers is important (Mohammadi & Zarafshan, 2014). As stated previously, the family atmosphere is established by the parents and based on the parents’ ability to connect with one another. Furthermore, the role of parenting styles as directly connected to the bond between parents as an example of healthy communication for children to implement in their own family interactions. Gender roles play an important part in family systems as they are socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women (World Health Organization, 2016). There is much debate as to what extent gender and its roles are socially constructed. Often, gender roles are centered on opposing conceptions of femininity and masculinity, though there are countless exceptions and variations.

Parenting Style

Mohammadi and Zarafshan (2014) established parenting styles as influential to children’s behavior and psychosocial adjustment. In alignment with family systems theory, the functioning of the parent affects the child, the development of the child affects the functioning of the family (Zhou & Yi, 2014). Parenting styles are the representation of how parents respond to and command their children; it is the emotional climate in which parents raise their children (Mohammadi & Zarafshan, 2014). The approach a parent chooses when interacting and correcting their child is as unique as the parent themselves (Zhou & Yi, 2014). Developing a parenting style includes the personality of the parent, the influence of their family-of-origin and culture, and the established family beliefs, values, and priorities. While each parent will find their unique parenting style, research on parenting styles posits there are three major categories regarding parenting styles: permissive parenting style, authoritarian parenting style, and authoritative parenting style (Zhou & Yi, 2014).
**Permissive parenting style.** Permissive parenting is a type of parenting characterized by low parental demands and high responsiveness (Mohammadi & Zarafshan, 2014). Permissive parents tend to be loving, yet provide few guidelines and rules for their children. Typically, permissive parents do not expect mature behavior from their children and often behave more like a friend than a parent. Permissive parenting is also known as indulgent parenting. Permissive parents are more responsive than they are demanding. Furthermore, they are non-traditional and lenient while avoiding any confrontation. Because there are few rules, expectations, and demands, children raised by permissive parents tend to struggle with self-regulation and self-control. Children who have permissive parents demonstrate higher levels of impulsivity and aggressiveness and lack self-control and independence (Mohammadi & Zarafshan, 2014).

Highly enmeshed families, such as permissive parent families, are overly involved with and protective of their children’s lives (Altiere & von Kluge, 2009). This over involvement can have detrimental effects on the child because there may not be a promotion of growth and independence (Altiere & von Kluge, 2009). A permissive parent of a child with ASD might mistakenly believe their child is not capable of achieving a task, therefore the parent will not demand that the child even try. Although ASD does make some things more difficult, most children with autism can learn to accomplish tasks if they are asked and encouraged to do so. When expectations are low, or the child is with autism is offered to little discipline or consequences, parents are making it more difficult for the child to understand or achieve typical expectations.

**Authoritarian parenting style.** The authoritarian parenting style is described as parents who have high demands and low responsiveness (Mohammadi & Zarafshan, 2014). Parents with an authoritarian style have very high expectations of their children, yet provide very little in the
way of feedback and nurturance. Mistakes tend to be punished harshly and if feedback does occur it is often negative (Mohammadi & Zarafshan, 2014). Yelling and corporal punishment are also commonly associated with the authoritarian style. Authoritarian parents have high expectations of their children and have very strict rules they expect to be followed unconditionally (Stein, 2014). These parents want obedience and are status-oriented, meaning the authoritarian parent expects the orders to be obeyed without explanation. Furthermore, authoritarian parents often utilize punishment, rather than discipline, but are not willing or able to explain the reasoning behind their expectations or rules (Mohammadi & Zarafshan, 2014). Authoritarian parenting has shown that a high level of behavioral control is related to low levels of externalizing problems, such as antisocial behavior and conduct disorders (Mohammadi & Zarafshan, 2014). The authoritarian parenting style often creates disengaged families that establish rigid boundaries surrounding their family roles and are under-involved because involvement causes anxiety (Altiere & von Kluge, 2009). In addition, disengaged and under-involved parenting correlates to poor child behavior outcomes (Mohammadi & Zarafshan, 2014). A child with ASD experiencing authoritarian parenting may develop independence, but may not receive the attention and protection they need to learn coping strategies for their disorder (Mohammadi & Zarafshan, 2014).

**Authoritative parenting style.** The authoritative parenting style places reasonable demands on children and high responsiveness are distributed (Mohammadi & Zarafshan, 2014). While authoritative parents might have high expectations for their children, these parents also give their children the resources and support they need to succeed (Mohammadi & Zarafshan, 2014). Parents who exhibit authoritative parenting listen to their kids and provide love and warmth in addition to limits and fair discipline. The authoritative parenting style is usually
identified as the most effective, and a well-functioning family with a child with autism should be close-knit, able to express emotions, supportive of one another, and involved in outside recreational activities (Altire & von Kluge, 2009). Furthermore, the presence of warmth and positivity and the absence of criticism in the family environment are associated with fewer behavioral problems (Mohammadi & Zarafshan, 2014). Such a family may better adapt to the stresses of caring for a child with autism. Authoritative parents are also flexible; if there are extenuating circumstances, they allow for adjustment and respond accordingly (Mohammadi & Zarafshan, 2014).

Cooperative parenting. Once parenting styles have been established, it is important to cooperate and collaborate in decision making for the family (Wood Rivers & Stoneman, 2008). It takes collaborative effort to select appropriate treatment options and make decisions regarding the day-to-day care of children. Especially with ASD children. Typically, the extra time and attention needed to provide even basic care involves negotiation by both parents. However, the parents’ difference of opinion can be a source of stress for parents and a cause of unease and potential arguments (Johnson & Simpson, 2013).

In addition, raising a child with ASD provides daily reminders of the discrepancy between “what is” and “what should be” regarding family functioning (Johnson & Simpson, 2013). Stress is a typical response when expectations differ between spouses about how best to react to their child with autism’s behavior. Furthermore, the inconsistencies in mother-child and father-child treatment approaches can be confusing for the child with autism. The differences among parental treatment could be explained by mother’s traditional role of caregiver and doing most care. Fathers react differently to their children than mothers (Johnson & Simpson, 2013). Fathers tend to focus on the broader, practical implications of childrearing such as cost of care,
developmental milestones, and securing provisions for the child’s future. Mothers, in contrast, are more concerned about the child’s happiness and emotional hardships (Donaldson, Elder, Self, & Christie, 2011). However, when more than one person is responsible for caring for the children, teamwork and the ability to negotiate conflicting interests can be extremely valuable.

**ASD and Adlerian Basic Concepts**

Adlerian Psychology, also known as Individual Psychology, is a values-based, unified theory of personality, a model that is non-pathologizing, and a philosophy of learning (Ansbacher, & Ansbacher, 1956). The identified client is typically seen as an indivisible unit which needs to be understood in their totality (Mosak & Maniaci, 1999). Adler believed the total individual must be understood holistically while examining or observing the client’s behavior in the groups to which they belong (Mosak & Maniaci, 1999). An Adlerian trained family therapist joins with the family system with a goal of changing the family organization is such a way that the family members experience improved functioning (Ansbacher, 1991). Therefore, the common objective of treatment is to intervene with first order and second order change; impacting the individual behavior and the family system functioning (Ansbacher, 1991).

**Belonging**

The concept of belonging is a fundamental principle in Adlerian therapy (Stein, Mozdzierz, & Mozdzierz, 1998). Adlerian philosophical foundations assume that all of an individual’s movement in life is directed at securing (striving for) a place of belonging (1998). In Adlerian therapy, it is believed that the child’s sense of belonging is first established within the family unit (Ansbacher & Ansbacher, 1956). Each member of the family has their own place to belong within the family unit and therefore works collaboratively with other family members to fulfill the collective tasks and aspirations of a well-functioning family unit.
When an individual family member struggles to find belonging in the family unit, Individual Psychology perceives that person to be experiencing discouragement (Mosak & Maniacci, 1999). The child’s discouragement may stem from the perception that the child does not feel like a capable and contributing member of their family. Therefore, when the child strives to achieve a task and does not reach competency, the child perceives they are inferior, which in turn impacts belonging in the family unit. Adler believed that encouragement was the appropriate intervention to combat feelings of inferiority; which then reestablishes contribution and the child’s place of belonging in the family (Minuchin, 1982).

**Family Constellation and Birth Order**

Alfred Adler was one of the first theorists to incorporate the ideas of family constellation (i.e. birth order) along with additional information to understand the individual (Eckstein, Aycock, Sperber, McDonald, Van Wiesner, Watts, & Ginsburg, 2010). Adler speculated there were two definitions concerning birth order: ordinal position, which alludes to the actual order of birth of the siblings and psychological disposition (Eckstein et al., 2010).

Adler saw challenges that contradicted with the criteria of ordinal birth order as the sole influence on personality development (Eckstein & Kaufman, 2012). Adler insisted not only does the child’s ordinal position in successive births influence character development, but the situation into which that child was born (family atmosphere) and the child’s interpretation (perception and misperception) of the family play a role in personality development (Eckstein, et al., 2010). For example, children who have a physical or mental disability can change their psychological position because of a decrease in their abilities or perceived inadequacies, while younger siblings change their psychological position to accommodate the missed roles in the
family dynamic. Therefore, Adler described the psychological position, referring to the role the child adopts within his or her interactions with one another (Eckstein et al., 2010).

The birth order framework provides a model upon which generalities of personality develop may be understood within the interactional relationships between family members and the symptomatic child (Eckstein & Kaufman, 2012). Other variables, such as sibling gender and age spacing, also influence a child’s psychological position within their family structure. As a child is born into their status, they remain there, barring any situations such as death of a sibling or remarriage. Thus, parents and members of society can impose on children beliefs about different birth order characteristics which can affect expectations, rearing practices, and ultimately children’s outcomes in life (Zhou & Yi, 2014).

Children learn from their parents while growing up, and birth order can have substantial ramifications for sibling learning strategies as well (Eckstein & Kaufman, 2012). In addition to family constellation and atmosphere, birth order may affect the child’s perceived footing with their family while the development and encouragement of such roles embodies the person’s progress to fulfill the basic human needs to belong and to play a meaningful part in the family. The hierarchy in a family system often determines the roles and responsibilities of the children. Adler suggested four birth order related sibling positions: first-born child, middle child, youngest child, and only child. However, due to focus of this paper on children with ASD and the relationship with their neurotypical sibling the only child description has been left out.

**Birth Order Characteristics**

**First-born.** First-born children are typically more achievement-oriented, antagonistic, anxious, assertive, conforming, extraverted, fearful, identified with parents, jealous, neurotic, organized, responsible, self-confident, and traditional than their siblings (Eckstein et al., 2010).
First-born children tend to affiliate under stress and are more likely to assume leadership roles. The oldest role may gravitate toward family roles that involve authority and first-born children are sensitive to issues of protocol and hierarchy. First-born children generally demonstrate a desire for order, structure, and adherence to norms and rules. Lastly, the first-born child may fear being dethroned from their privileged position by the birth of a sibling (Eckstein et al., 2010).

**Middle child.** The middle child may perceive they are squeezed out of their families because they are not the oldest and most responsible, nor are they garnering the attention directed to the youngest child (Eckstein & Kaufman, 2012). Middle children tend to believe that there is nothing about them that make them special and thus often feel unworthy of their family’s attention or esteem (Eckstein & Kaufman, 2012). Additionally, children in the middle child role may become discouraged easily and feel less loved or perceive themes of rejection (Stewart, 2012). But, middle children who successfully overcome these perceptions may emerge with well-developed interpersonal skills and enhanced self-esteem (Stewart, 2012). Middle children evolve and become more independent. Middle children think outside the box, and are less likely to conform to norms of the family or society. In addition, middle children are often more compassionate (Eckstein & Kaufman, 2012).

Most people see first-born children as driven and ambitious but middle children are driven too. Adler believed that middle children often acted in opposition to the first-born child to establish their belonging (Stewart, 2012). Often the striving to overtake or find their own place can create a rift in the relationship between first-borns and middle children as the fear of dethronement enters the first-borns thought process (Eckstein et al., 2012). Therefore, middle
children are more oriented to principles and concepts, like justice, over earning power or prestige.

**Youngest children.** The person in the role of youngest child may feel disadvantaged compared to their older and more experienced siblings who have already established their roles (Eckstein & Kaufman, 2012). The youngest child develops a perception that they are the least capable and most inexperienced which may result in the child being provided for, indulged, or even spoiled (Stewart, 2012). When this opportunity is presented, some youngest children become skilled in coaxing or charming others to do tasks or provide things, establishing the youngest’s role as helpless within the family (Eckstein & Kaufman, 2012). Youngest children are generally more adventurous, altruistic, cooperative, easygoing, empathetic, open to experience, popular, rebellious, risk-taking, sociable, and unconventional (Eckstein et al., 2010). Some people who strive in the youngest role may meet the opportunities in their families that launch them into positions of considerable significance. On the other hand, some youngest children may become discouraged and may not establish a socially useful role among their siblings.

**Adlerian Theory Applied to ASD**

Though it is difficult to articulate how Adler would defend his theory regarding how to treat a child with ASD currently, the implication that people with autism must change to accommodate the typically developed world no longer applies. But, an important element that plays a key role in therapeutic interventions are the experiences of people with autism (Stein et al., 1998). However, that is not to say that children with autism choose to remain in conflict as Adler may have suggested. Autism is not a function of choice; it is a neurological disconnect. But, parents and or caregivers raising and growing with a child with autism can chose how to
function in their daily lives and family system. And, the socioemotional impact of raising a child with autism on the family is extensive, affecting all its members. For example, siblings of children with autism have been reported as having more extensive behavioral and emotional problems than siblings of typically developing children (Lickenbrock et al., 2011). Sibling relationships in families where one sibling has autism can be strained by the characteristics of the disorder. Another variable to consider is the amount of time and attention the child with autism takes away from the typically developing siblings’ relationship with the parents. Therefore, siblings of children with autism often go out in search for other ways to be recognized by their parents (Lickenbrock et al., 2011).

The Role of Misbehavior

As established previously, the concept of belonging is a fundamental principle in Adlerian family counseling (Stein et al., 1998). It is assumed that all of humans’ movement in life is directed at securing a place of belonging. Siblings in family counseling, the affected child, is discouraged rather than a misbehaved child. The child’s discouragement stems from the fact that he or she does not feel like an acceptable member of the household (Stein et al., 1998). Like any sibling, the child with ASD is also struggling to find his or her place to belong, but since he or she does not know how to fit in usefully, the child often chooses various useless or negative behaviors to secure their place.

Every member in a family system is influenced by the child’s striving to belong (Mosak & Maniacci, 1999). It comes with an accommodation in the sibling’s part to the family groups and with their assumption of transactional patterns in the family that are consistent throughout different life events. Minuchin believed there are groups and subgroups that make up the family
system (Minuchin, 1982). Part of the family accommodation may be the system’s way of establishing the parent group and the sibling group, with a subgroup of neurotypical siblings.

Per Rudolf Dreikurs, when children become discouraged in finding their place to belong usefully, they subconsciously attempt to pursue one of four goals of misbehavior: attention getting, power seeking, revenge taking, and displaying inadequacies (Mosak & Maniaci, 1999). Although in any single display of misbehavior a child may opt for any one of these goals, misbehaved or misbehaving children may characteristically select one goal as the most frequently pursued. Typically, short-term, these goals can be detected in three ways:

1. by observing what happens when the child misbehaves and observing the parent or caregiver’s response to the child;
2. by the parents checking on how the child’s misbehavior makes them feel. For example, if the parent feels annoyed, the child’s goal may be to obtain attention. If the parent feels angry, the child’s goal is to engage in a power struggle. If the parent feels hurt, the child’s goal is revenge; and
3. by observing what happens if the parent attempts to naively correct the child. For example, if a parent or caregiver offers the attention-seeking child attention, he or she will stop briefly, only to begin again when their goal has been achieved (Ansbacher, 1988).

Therefore, understanding of which goal children are striving for facilitates the handling of the situation in which these feelings arise (Ansbacher, 1988).

**ASD and Family Operation**

In families of children with an ASD diagnosis, one or more members of the family may need to switch ordinal birth order position and take on additional responsibilities of care within
the system (Minuchin, 1982). Hartley et al. (2014) studied role specialization in families with ASD. Hartley et al.’s research demonstrated a correlation between high levels of parenting stress and other indices of poor psychological well-being in both the parents and the siblings. The result of high parenting stress is an increase in tension within the family. Therefore, the dynamics within the family change and roles and personality traits that once made sense may no longer apply.

**Role Specialization**

Hartley et al. (2014) offered one explanation for the pronounced pattern of role specialization in families of children with autism as the *demand-response hypothesis*. The demand-response hypothesis predicts that role specialization within the family unit is a response to high levels of stress and the stressful nature of child care with an ASD diagnosis. But, when the role boundaries within the family system need to change due to unmet needs, members of the sibling subsystem become part of one or more subsystems. A subsystem is a group of two, three, or more whose members are linked by a special association (Minuchin, 1982). When a child joins the parenting subsystem, for example, the role of parent and the role of child become blurred creating an unbalanced family atmosphere.

**Impact of Parental Differential Treatment**

As siblings of children with ASD attempt to define their role in the family system, parental differential treatment is another obstacle they encounter (Feinberg, Solmeyer, & McHale, 2012). While relationships between siblings grow within an extensive family system, there are assignable associations between sibling dynamics and additional family subsystem relationships (Feinberg et al., 2012). Also, those transactional relations between siblings are partly pre-determined by the individual’s birth order.
Parental differential treatment is a key influence on the family dynamics (Feinberg et al., 2012). Parental differential treatment is the amount in which parents treat each child in the family differently (Brody, 2004). Therefore, when siblings’ perception of parents’ reasons for differential treatment and the individual interpretation of fairness may is important in creating healthy sibling relationships. The possibility of interpersonal sibling discord can be linked to greater levels of parental differential treatment that could manifest into several variables such as amplified parental stress, leading to scapegoating of a child, or the possibility for children to adopt different family roles, with one becoming most likely to be drawn into interparental animosity (Feinberg et al., 2012).

**Sibling Relationships in ASD**

As previously established, family atmosphere, parenting styles, gender roles and birth order all impact the family framework and give all family members a model for interaction. Other factors contributing to the interactive nature of sibling relationships are dependent on development of personal coping styles, availability of family resources, and individual sibling perceptions (Diener et al., 2015). Families with an ASD member are further challenged to develop health interactive patterns due to the social and emotional discrepancies linked to ASD (Macks & Reeve, 2007),

Unfortunately, research concerning the effects on children of having siblings with autism has been inconsistent (Brody, 2004). Some researchers found negative outcomes for siblings, including: increased loneliness and greater challenges in regard to their siblings’ behavior, amplified externalizing and internalizing behavior problems, increased depression, reduced self-esteem, augmented social competence, and frustration with sibling interactions that are less socially reciprocal (Wood Rivers & Stoneman, 2003).
Research has yet to uncover the impact of a sibling with ASD on typical development of other children in the family system. Furthermore, research has not yet addressed the increase in behavioral and emotional challenges for siblings in an ASD family system. Then next portion of this literature review will examine the importance of sibling relationships, the sibling relationship development that neurotypical siblings experience, and the role of gender in sibling relationships.

**Importance of Sibling Relationships**

Sibling relationships are typically the longest relationships for individuals and can provide important sources of support throughout the lifespan (Diener et al., 2015). Siblings are often perceived as providing companionship and a unique influence on one another’s development. In early childhood, close, everyday interaction combined with emotional acuteness promotes the development of social behavioral norms, and social support from siblings plays a part in adjustment starting in childhood (Feinberg et al., 2012). For example, sibling warmth and support can be linked to peer acceptance and social competence, academic engagement and educational attainment, and intimate relationships in adolescence and young adulthood. However, sibling relationships in families in which one sibling has an ASD diagnosis can be strained, simply by the characteristics of the disorder (Dempsey Llorens, Brewton, Mulchandi, & Goin-Kochel, 2012). The limited abilities regarding social communication is a unique challenge to developing the interpersonal relationship skills of the sibling subgroup (Diener et al., 2015).

**Reflecting on Neurotypical Sibling Relationships**

Sibling relationships are often argued to be one of the strongest relationships that humans develop, second only to the parent-child relationship, and are strongly related to psychosocial
development (Pollard et al., 2013). Simply put, children spend more of their free time with siblings than with anyone else (Feinberg et al., 2012). The relationships developed between siblings contribute to family harmony or discord; and also impact individual development (Smith & Elder, 2010). Furthermore, the sibling relationship influences a child’s sense of belonging to the family (Stein et al., 1998). The teaching and caregiving experiences provided by the first-born benefit cognitive, language, and psychosocial development in both older and younger siblings (Brody, 2004). Older siblings are expected to serve as models, sources of information, and caregivers for their younger siblings. Moreover, supportive, close, and amiable sibling relationships may safeguard the effect of negative influences on the child’s well-being in addition to the primary of sibling dynamics on mental health and adaptation (Feinberg et al., 2012). Positive sibling ties protect youth from the impact of stressful life events on internalizing problems.

Children, whose development is fostered by interaction with an older sibling, become more responsive to other people’s feelings (Feinberg et al., 2012). Sibling relationships that are defined by a balance of nurturance and opposition can be an exceptional opportunity for children to establish the comprehension of other people’s feelings and perspectives, develop skills to learn to manage anger and settle conflict, and skills to offer nurturance themselves and others (Brody, 2004). Younger siblings who encountered a balance in their livelihood have been able to construct social skills and obtain more positive peer relationships in comparison with children who miss this opportunity. In addition, younger siblings who whose older siblings provide them with emotional support during times of severe inter-parental hostility show less signs of social or emotional problems than do children whose older siblings are less supportive (Brody, 2004).
The close, everyday contact coupled with emotional intensity promote the growth of social understanding.

Social encouragement from siblings plays a part in adjustment originating in childhood (Feinberg et al., 2012). During early childhood, sibling interactions provide an arena for developing and practicing relationship skills. Therefore, close, supportive sibling relationships may promote the quality and skills needed for successful friend and romantic relationships. For example, sibling warmth and support may be linked to peer acceptance and competence. Therefore, close, supportive sibling relationships may promote the quality and skills needed for successful friend and romantic relationships (Feinberg et al., 2012). Otherwise, siblings may be more negative about their peer relationships than children with siblings with typically developing siblings (Diener et al., 2015).

Sibling relationships also have the likelihood to shape a child’s development in a negative manner (Brody, 2004). For example, experiencing life with a sibling diagnosed with autism is related to a wide range of negative psychosocial outcomes (Pollard et al., 2012). Because of the specific social and communication deficits that occur with autism, the sibling dynamic would regularly provide changes. Siblings of children with autism may have differing levels of anxiety depending on the specific behaviors their sibling exhibits (Feinberg et al., 2012). For instance, younger siblings growing up with aggressive older siblings, a common characteristic of autism, are at considerable risk for developing conduct problems, performing poorly in school, and have few positive experiences in their relationships with their peers (Brody, 2004).
Reflecting on Non-neurotypical Sibling Relationships

Siblings of children with ASD that include moderate to severe intellectual disability may sometimes feel unsafe in their own home (Diener et al., 2015). For example, if a child with autism and a co-occurring intellectual disorder may have trouble understanding the idea of sharing. When frustrated the child with ASD could become physically aggressive in acting out their frustration. If the acting out behavior is directed toward their sibling, the sibling could be hurt or scared by their brother or sister. These behaviors may leave the neurotypical child feeling unsafe.

The growing interest in sibling research reflects an increased understanding of the importance of the sibling relationship to families and to individual development, as well as an interest in understanding variability in the quality of sibling relationships across different pairs of children, including those affected by autism (Wood Rivers & Stoneman, 2008). Currently, researchers are unable to clearly answer the question as to why some sibling pairs experience warm, supportive relationships while other siblings experience conflict. Children with autism have a collection of behaviors that might be expected to affect the sibling relationship; they have limited range of play and social/affective behavior, typically have poor eye contact, demonstrate communication deficits, and may not be socially receptive. Troubling behaviors such as aggression, destroying of property, and tantrums may be present; and typically developing siblings of a child with autism can occasionally be disturbed by their siblings’ behavior. However, persistence was found to be an important predictor of the quality of relationships between children with ASD and their typically developing sibling (Wood Rivers & Stoneman, 2008).
The Impact of ASD to Younger Siblings

Due to the characteristics of autism, older siblings with autism are unable to provide appropriate emotional support to their younger, typical developing, siblings. Their impairment in reciprocal social communication inhibits the older sibling with autism the ability to explain to their typically developing sibling the inconsistencies of their family system. Several studies have reported that psychological and emotional adjustment of siblings of children with disabilities is largely dependent upon the number of siblings in the family, the socioeconomic status of the family, and the gender and birth order of the nondisabled sibling (Macks & Reeve, 2007). Furthermore, siblings of children with autism can have more internalizing and externalizing behavior problems when compared to siblings of non-disabled children (Macks & Reeve, 2007).

Younger siblings who are subjected to a balance of nurturance and opposition in their typical sibling relationships have been found to be more socially skilled and have more positive peer relationships in contrast with children who lack this experience (Brody, 2004). However, younger siblings who grow up with an aggressive older sibling can be at significant risk for developing conduct problems, performing poorly in school, and having few positive experiences in their relationships with their peers (Brody, 2004). In addition, younger siblings are more likely to influence children’s social behavior repertoires (Feinberg et al., 2012) and are expected to grow up faster (Macks & Reeve, 2007).

The Impact of ASD to Older Siblings

Older siblings who have a younger sibling with autism are often expected to do more household chores and physically care for the child with autism (Macks & Reeve, 2007). Furthermore, due to the increased responsibility and care taking duties, the older siblings’ social interaction styles may be better established (Feinberg et al., 2012) and develop a sense of balance.
of their self-concerns with other’s needs (Brody, 2004). In addition, older siblings of children with autism experience higher empathy and patience; and, older siblings will typically display a greater social competence (Diener et al., 2015).

Regardless of birth order, siblings of children with autism may be angry with the child with autism because of the resulting restrictions on family activities and the time and resources that must be expended on them. These siblings are often embarrassed by the child with autism for their inappropriate public behavior as well. Additionally, siblings can often resent not being able to invite friends to their home due to the possibility of the misbehavior of the child with autism. Perhaps the primary reason why siblings may be negatively affected is because a great deal of parental time, energy, attention, and resources that the child with autism requires (Macks & Reeve, 2007). Many siblings may feel that they do not receive the same amount of parental attention as the child with autism. Siblings of children with autism may be more likely to experience problem of psychological adjustment (Macks & Reeve, 2007) and have poorer emotional health (Diener et al., 2015).

**Shifting Attitudes in ASD Sibling Relationships**

Research involving sibling relationships in which one sibling has an ASD diagnosis indicates that relationships involve patterns of, or shifts between, positive and negative elements and emotions (Diener et al., 2014). Sibling pairs in which one child has autism identified experiences such as fun shared activities, pride, special intimacy, but also disruptive, aggressive behavior, prejudice and negative reactions from other people. Thus, in sibling pairs in which ASD is identified, experience dichotomous relational interactions that swing from positives, such as shared activities, pride, special intimacy to challenging interactions such as disruptive behavior, aggressive behavior, prejudice, and negative reactions from other people.
As the children age, siblings who are in middle childhood or adolescence may be especially influenced by the social difficulties of having a sibling with autism (Pollard et al., 2012). For instance, adolescents may be embarrassed by their sibling’s behavior and the stigma associated with inappropriate behavior which often accompanies autism spectrum disorders (Diener et al., 2015). An adolescent could begin isolating themselves to avoid their sibling with autism’s inappropriate behavior which in turn can lead to feelings of loneliness (Diener et al., 2015). Therefore, siblings within this specific age group have fewer interactions, experience less closeness and understanding, and further feel more isolated. Over time, researchers have determined an association between mental and behavioral health traits of typically developing sibling due to the contribution of the behavior from the child with autism (Feinberg et al., 2012). For example, one sibling’s negative behavior can be associated with the other’s depression. Therefore, the mental health of the sibling of a child with autism may be directly linked to the child with autism’s behavior.

**Parental Differential Behavior**

As sibling relationships change within a larger family system, there are operational associations between sibling dynamics and both other family members’ welfare and other family subsystem relationships (Feinberg et al., 2012). One crucial family dynamic that effects sibling relationships is known as parental differential behavior, where family members assess themselves based on comparison with others in their family, particularly those who are physically close and like themselves (Brody, 2004). Symbolically, siblings are the leading candidates for social comparison and are often directly associated to one another by others, such as parents. Parents acknowledge the disparities between their children in behavior, personality, and needs and often allude to the personal characteristics as incentive for treating their children.
in a different way (Wood Rivers & Stoneman, 2008). Siblings often describe feelings as though they are treated unfairly by their parents because the children with autism is held to a lower standard (Macks & Reeve, 2007) or experience low levels of self-esteem and have high amounts of conduct trouble (Brody, 2004). Children justify differential treatment by justifying ways in which they and their siblings differ in age, personality, and special needs (Brody, 2004).

Moreover, siblings’ perceptions of parents’ reasoning for differential treatment and whether they believe the differential treatment to be fair may be as more important for sibling relationship quality than the amount of parental differential treatment. Nevertheless, it is important that children understand why parents treat siblings differently from one another so that they will be protected from misapercception of the differences as evidence that they are not as valued or worthy of love.

**Gender and Sibling Relationships**

Gender can also be an important factor in the quality of the sibling relationship (Wood Rivers & Stoneman, 2008). Fathers react differently to situations (such as their child being diagnosed with autism) than mothers. For instance, while mothers are more concerned about the child’s future happiness and emotional hardships, fathers concentrate on the bigger picture of childrearing such as cost of care, developmental milestones, and obtaining the necessities for the child’s future (Donaldson et al., 2011). Moreover, in families of children with developmental disabilities, mothers tend to take on the majority of the child care responsibilities while fathers take on more paid employment (Hartley et al., 2014). Parents who have a child with autism are more likely than parents of neurotypical children to classify their roles within the family system more conventionally as masculine and feminine, as research has identified mothers are often taking on the primary role of caring for and coordinating treatment (Nealy et al., 2012) while
fathers go in search for additional income to cover the cost of treatment (Altiere & von Kluge, 2009).

Research on siblings who have a brother or sister with a disability indicates that sisters have more contact, do more of the caretaking, and benefit from their role in the family (Diener et al., 2014). These behaviors could be due to the mother’s constant presence in the home where mothers are the primary caretaker within the family system that has a child with autism. Therefore, through observing their mother’s example, daughters assume the same philosophy as they take on their special role as a sibling of a child with autism.

Fathers, who tend to have a lower sense of rationality, are more oriented to use coping strategies based in denial, self-blame, behavior disengagement or distraction (Pozo et al., 2013) and may use more withdrawal and avoidance behaviors (Altiere & von Kluge, 2009). In addition, fathers of children with autism can become withdrawn or absent. Therefore, without a male role model, brothers of children with autism are more likely to imitate the behavior exhibited by their older sibling with autism. However, maintaining positive paternal involvement can be associated with positive outcomes for children including better mental health in adulthood (Altiere & von Kluge, 2009).

Childhood disability can have a significant impact on families, on parents, and caregivers, and on siblings (Granat et al., 2012). Due to the high levels of stress, the family dynamics may become dysfunctional. Living with a brother or sister with autism can have detrimental consequences on some siblings (Granat et al., 2012). However, because of the increased attention directed at the child with autism and the parents who are raising them, many support groups focus on their needs rather than the needs of the additional members of the family – particularly siblings (Pollard et al., 2013). As of today, social support is being explored in
terms of its main effect on the sibling relationship and the adjustment process (Brody, 2004) and how it could function in two different ways. First, social support may mediate the relationship between child disability and sibling adjustment. Second, social support could be described as a compensatory factor (Hastings, 2003b) and siblings in families with higher levels of social support may have less negative and more positive adjustment.

Understanding the functioning of children and adolescents who have siblings with autism is important for a variety of reasons. A growing body of research is focusing on sibling-mediated intervention for children with ASD; therefore, understanding the psychological functioning of these typically developed siblings is important for shaping and individualizing future sibling-facilitated treatment programs (Dempsey et al, 2011). Any insight researchers and clinicians may provide to families regarding possible functional difficulties that their typically developed children may face and how to recognize and cope with them is valuable (Dempsey et al., 2011).

In addition to understanding the functioning of sibling adjustment, educating siblings about ASD is equally beneficial. Siblings who have greater knowledge of ASD have a more positive relationship with their sibling (Ross & Cusckelly, 2006), gaining understanding and patience for their sibling with autism. Family, friends, and peers who are uneducated about autism and its effects on families may cause additional stressors for siblings of children with autism (Ross & Cusckelly, 2006), such as judgement. Thus, the public needs to be educated concerning the different ways autism affects a person’s behaviors so children with autism and their families will not suffer from unjustified criticisms from people who have no understanding of autism. Moreover, Adler’s application of social interest can bridge the lack of understanding from society to the perception siblings of children with autism live with daily.
Applying Adlerian Social Interest to ASD

Adler spoke of social interest in terms of a striving for community, rather than only looking at one’s own achievements (Bickhard & Ford, 1991). In addition, Adler’s perception of social interest was the cardinal personality trait, with characteristics echoing the relationship of an individual to their environment. Furthermore, Adler equated his theory of social interest with identification and empathy, that is, with cognitive functions rather than innate forces (Ansbacher & Ansbacher, 1956), to experience what the other experiences. Therefore, identifying one’s usefulness within the environment is one aspect of social interest.

There are three main functions in which Adler attempts to make the concept of social interest serve: 1. Social interest is an anticipated ability for support and social livelihood which can be acquired through coaching, 2. These skills have manifested into the impartial capabilities of cooperating and contributing, as well as appreciating others and empathizing with them, and 3. Social interest is a personal choice process that establishes choices and thus maintaining the dynamics with the individual (Ansbacher & Ansbacher, 1956). Social interest tends to combine with general intelligence, changing the latter from without social interest to with social interest. Thus, the function of social interest is to direct the individual towards the socially useful side. To Adler, being useful was a sign of movement, striving to improve one’s self in the process of associating within the community. As a result, in the context of the Adlerian viewpoint, human growth is contingent on belonging (Ansbacher & Ansbacher, 1956). Social interest, as a cognitive function, influences the direction of the determined, regardless if it is socially useful or on socially useless. Eventually, social interest will turn out to be part of the objective, but will be in little opposition with the reality and the strength of goal setting as any other skill or significance.
Social Sense and Misbehavior

Adler spoke of the necessity of advancement of the social sense and described misbehaved children as showing lack of social sense. The social sense was a counterforce against selfish forces and the barometer of the child’s normality (Ansbacher & Ansbacher, 1956). The criterion which needs to be watched is the degree of social interest which the child manifests. Otherwise, the child will picture themselves in a world in which they are entitled to be the first in everything. Consequently, social interest, as an aptitude to be developed, implies that when developed it becomes an ability. It becomes the guidelines for social living, including contacting others and cooperating with them. Therefore, we are not interested in society as an existing object but in the interests or values of society while being interested in the aspirations of society, an ideal, better society of the future.

Social Interest and Family Programming

Previous research on sibling relationships of children with ASD do not include a program in which siblings engage in joint activities (Winter-Messiers, 2007). Family based programs should focus not just on reducing sibling conflict or useless behavior, but also focus on facilitating positive engagement. Shared activity is a critical component of successful sibling relationships. There are benefits to a sibling relationship when the child with ASD is involved in a strength-based program that promotes their skills and abilities and involves siblings (Diener et al., 2015). If shared activities were included, it would teach all siblings, ASD impacted and neurotypical children, the notion of social interest thereby impacting their feelings of belonging and significance.

Friendship building. It has been established that ASD impacted siblings struggle to build friendships (Hall, 2012). If the shared activities with neurotypical siblings included SIA’s,
will not only will individual progress increase, so will the quality of life of both the neurotypical sibling and their sibling with autism (Winter-Messiers, 2007).

**Family focused programming.** Also, family-focused programs for youth with autism may want to help parents identify their stereotypes of sibling relationships and focus on the positive dimensions of these relationships versus aspects that are more challenging to encourage the siblings to engage in such an activity. Positive engagement in a shared activity is a critical component of successful sibling relationships.

**Sibling-based interventions.** Creating a sibling-based intervention in order to decrease the conflict and antagonism within the sibling relationship may potentially decrease the self-reported anxiety in typically-developing siblings (Pollard et al., 2012). Involving siblings in strength-based, family focused program to demonstrate the skills of the child with autism is an important approach. Not only does it enable siblings to feel pride in their brother or sister with autism, it may also provide an avenue of common engagement and interest for sibling pairs. Positive engagement in a shared activity is a critical component of successful sibling relationships (Diener et al., 2014). Another benefit is that including siblings of children with autism may provide an opportunity for typically developing to meet other youth with siblings with ASD. Developing relationships with other children with siblings with autism may provide opportunities for additional social support and the identification of coping strategies. Strength-based, family centered programs should involve siblings and provide peer support for those with a sibling with autism.

Siblings who report more negative interchanges and rate their overall sibling relationship quality to be lower may have more psychosocial maladjustment (Pollard et al., 2012). Thus, the importance of shared understanding of family circumstances and supportive sibling relationships
often provides enhanced coping skills to typically-developing siblings. Furthermore, this framework leads to the view that siblings in childhood should be directed at improving the sibling-relationship in order to decrease the effects of sibling coercion on each child’s behavioral repertoire as well as remove stress on other parts of the family system. Thus, those children in families with higher levels of social support may have less negative and/or more positive adjustment.

**Summary**

Adler’s social interest would be this principle as it applies to human interaction specifically. Rather than a typically-developing sibling conforming to society’s perception of autism, they join their sibling diagnosed with autism and expand on the child with autism’s SIA and bring it to the public – educating society on the gifts autism could offer. Once a sibling of a child with autism begins to cooperate and contribute to the sibling with autism, their mental health status improves and their behavior may be more useful for society. And, as their behavior improves, the sibling of a child with autism is now capable of cooperating for a better future while gaining independence and courage to continue to supporting the education of the community.

**Conclusion**

Autism is a developmental disorder with disadvantages in social communication and interaction and restricted and repetitive behaviors which presents a particularly difficult challenge in the family unit. Parents of children with autism confront daunting challenges and multiple demands in their life compared with parents of typically developing children. One challenge a child with autism presents is their unpredictable behavior and how parents should go about reacting to their conduct. Parents’ belief systems and values are tested as they determine
whether their parenting style is adequate enough to provide the support their child with autism needs. Therefore, the structure of the family adapts. Roles change, boundaries blur, the atmosphere of the household shifts, and gender specific characteristics become even more pronounced and clearly defined.

Siblings of children with autism have their own stressors that they may experience, which includes changes in family roles, restructuring of the family’s functioning and activities, loss or absence of parental attention, feelings of guilt, a sensation of shame usually brought on by negative valuation within their peer group, and bewilderment at peculiar behaviors that children with autism may display. Hence, it is not difficult to presume that younger siblings of children with autism can undergo negative psychosocial maladjustment. The everyday interaction of siblings in the early years and the enduring nature of sibling relationships, combined with the strong emotional personality of siblings’ interactions, produce a subsystem within the family relationship in and of itself. Therefore, the sibling relationship is accountable for the expansion of social understanding.

Children who are nurtured by their older siblings become more mindful of other people’s feelings and beliefs. Older siblings who shoulder the responsibility of teaching and caregiving learn more quickly to offset their self-interests with other’s necessities while offering younger siblings with emotional help. Therefore, younger siblings demonstrate an understanding of appropriate social behavior and emotions. However, when an older sibling is diagnosed with autism, the ideal sibling developmental relationship seems to collapse. Because of the characteristics of autism, the younger siblings no longer have an example to lean on, thus making them susceptible to behavior problems. Alfred Adler’s insight on birth order personality seems to explain how such disconnects can occur. First-borns are natural leaders, educating their
younger siblings about social norms. Though, when an older sibling has autism and cannot provide guidance, younger siblings are often left scrambling to figure it out on their own,

Indeed, typically-developing siblings receive support from other members of the family, but it also would be beneficial to develop therapies in which the sibling diagnosed with an ASD and the typically-developing sibling can work together to learn how to resolve conflict in order to reduce anxiety. And participating in a strength-based activity is an excellent starting point. Having something that is of interest to both the child with autism and their typically-developing sibling can lead to a more positive relationship, better coping skills, and understanding. Furthermore, when the child with autism and their neurotypical sibling combine forces and become a new and improved subunit, their interests will begin to benefit those in their community while transcending one another’s mental health.
References


