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Sibling Position: The Unique Case of Twins

By Devana Weiss, MA, RCC

Have you ever wondered how siblings can turn out so differently when they've been brought up in the same family, and raised by the same parents? How does sibling position come into play as children develop? Most parents attempt to foster a healthy separate identity in each of their children – this is a unique challenge with twins. A glimpse into Bowen family systems theory provides some insight into sibling behaviour and the factors influencing child development, as it relates to twins.

Everyone is born into a sibling position. Birth order plays a significant role in how family members behave toward and react to each other. This influences how each member defines him or herself and how each interacts within and outside the family system. Walter Toman, an Austrian psychologist, developed the concept of sibling position in the 1960s. He described characteristics of family members, their strengths and weaknesses, based on their chronological position in the family. Dr. Murray Bowen included sibling position as one of the 8 concepts in his theory and introduced the notion of a functional sibling position.

Each family member takes on functions associated with their birth position, and they are carried out in a predictable manner. Oldest children in general tend toward taking on responsibility and maintaining the status quo. As first-borns, parents tend to place higher expectations on them. Bowen family systems theory suggests that when one member performs a certain function, another member will not perform that function. For example, an oldest sister of sisters gravitates toward leadership, tends to be organized and independent-minded, while a younger sister of sisters is typically carefree, unconventional, and may often have trouble making decisions. Any change made by one member will have an effect on the other members. In other words, if the youngest sister of sisters begins to take more initiative in decision-making and not consult her older sister or others, the older sister may react by behaving coolly towards her sister and / or assert her strong opinions in another area of her life.

A first born can become an immature youngest in one family, and a youngest child can become a mature oldest in another family. How does this happen? The family system itself dictates how siblings function and what functions they perform. This occurs by way of the family projection process. When parents are unable to manage the tension within or outside of their relationship, they 'project' it onto one or more siblings with or without their knowing. It can be negative or overly positive attention, neglect or abuse. This child 'absorbs' some of the tension. He is the least differentiated from his parents, meaning he is less able to be emotionally separate and thus more sensitive to anxiety in the system. This process can occur with any sibling. Some siblings come into this functioning role around the time of birth, especially if the family was experiencing other stressful events at the time. Or, the sibling may have a disability or a serious accident that makes him more susceptible to becoming part of this process.

The family projection process results in compromising the child's normal development of a self. If, over time, one sibling continues to 'absorb' the family's anxiety, he or she will develop symptoms be it physical, emotional or social. As well, an unhealthy triangle may form between the parents and child resulting in one parent siding with the child in some way and alienating the other parent. The child learns to play their part early on in this process. This can be destructive to the child's own development as his or her energy is directed towards the triangle and/or the symptom, rather than developing a healthy self apart from and within his family.

Birth Order and Twins

Twins are unique in terms of sibling position. Their experiences are different from those of chronologically-spaced siblings. Twins co-exist from conception on. Their sibling dynamics begin before they enter the world, as does the triangle between mother and twins. Twins typically share characteristics of both an oldest and youngest. When they are the only children in the family, twins behave as any two siblings, but without age conflict. When there are other children, twins will both take on characteristics of the birth position they share. They may also take on characteristics of their same-sex parent's sibling position.

If parents are sensitive about differences in size between each child or about some defect within one child and there is enough tension in the system, the larger or "healthy" child may become a functioning oldest and the smaller or "unhealthy" child may become a functioning youngest. The latter child may become the focus of parents' anxiety, resulting in further impingement of that child's development.

Twins who tend to function well and adjust better to life are those who have been treated as individuals within the family unit, whose parents have downplayed their twin-ness and encouraged their individual interests and potential. Parents who pick up on and push certain traits in one twin may create a dynamic

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in which the other twin will gravitate to or avoid that trait, just to be different. This will influence how the twins relate to each other, to each parent, and to self.

Twins' development in-utero is influenced by how the parents felt about having them, whether they embraced the challenge or were chronically anxious. Other stress in the system plays a role as well, such as marital conflict, finances or work-related issues. Couples who learn early in the pregnancy that they are having twins tend to adjust better. The writer's aunt birthed twins unexpectedly several years ago, and recalled feeling completely shocked and overwhelmed for a long period post-birth. The surprise of a second infant creates additional stress in an already stressful time in the family unit.

Parents of twins can have added anxiety resulting from common complications in multiple births. The mother may feel pressure to ensure the healthy growth of two fetuses. Vanishing Twin Syndrome is common in one-third of twin pregnancies in which one fetus does not survive. The volume of medical appointments and monitoring in the 3rd trimester can also affect anxiety levels. This can become all consuming for the mother. Regarding birth, most twins are born earlier than singletons (average: 35 weeks gestation) and of lower birth weight (average: 5 pounds), and may be required to stay longer in hospital. Premature babies are generally less responsive socially and with eating which can also influence parent's stress levels and how they interact with the infant. These babies appear different than normal babies, which can trigger an anxious response within parents.

Case Study of Twins In-Utero and Infancy

Mr. and Mrs. B (41 and 38 years old respectively) learned they were expecting twins at 9 weeks gestation during a routine ultrasound (to determine delivery date). Conception efforts had been ongoing for 3 months. Twins were conceived naturally and run in both families. Both parents recall feeling shocked, overwhelmed and overjoyed, followed by anxiety about having two infants at the same time. Extended family members were excited and supportive. Mr. B recalls worrying about finances and Mrs. B about growing two healthy fetuses. Soon after the big news, Mrs. B began to have significant nausea which could last all day and into the evening. In the early weeks she sometimes felt anxious about losing one twin (her mother had had a few miscarriages; her cousin and grandmother each lost one twin); she kept the anxiety to herself and combated the feelings with positive thinking, prayer and focusing on other things. The pregnancy proceeded normally.

At 30 weeks Mrs. B began regular appointments with an obstetrician and a midwifery clinic. At this time she chose to discontinue her paid work. At 35 weeks it was discovered that one twin (Baby B) had a small abdomen for its gestational age and was smaller in general than Baby A. Parents were told this was somewhat common with twins. At this time, heart monitoring and stress-test sessions at the local hospital began and their frequency increased with each passing week. Mr. and Mrs. B had concern about Baby B. They frequently spoke about Baby B especially after each monitoring session, having had the opportunity to see and hear the twins. Results of the monitoring were normal. They made efforts to "stay grounded" through prayer and meditation, and Mrs. B focused on having a healthy pregnancy. Again, extended family stayed positive and were supportive.

At 36 weeks it was decided by professionals that a C-section would be performed since both babies were in breech positions. The babies were born at 39 weeks without complications. Baby A (a girl, hereafter "K") was born first, followed by Baby B (a boy, hereafter "E") born one minute later. E's appearance was like that of a premature infant whereas K had a more typical newborn look. The boy also had low blood sugar for three days following birth. Mr. and Mrs. B brought their twins home four days after birth. Mr. B returned to work after one week. Mrs. B's parents and mother-in-law assisted with household needs and baby-care.

K latched easily for breast-feeding. E had trouble latching though Mrs. B made significant efforts towards this for 6 weeks following birth. E's lack of weight gain was of concern to professionals who visited the household every few days for 3 weeks post-birth. E also had moderate colic symptoms for a month. After 6 weeks, both babies and parents settled into a normal schedule.

At 4 months post-birth parents noticed E did not display normal development such as rolling over. K's development coincided with the norms. At 6 months, E was referred to a pediatrician and was given two developmental assessments. He was diagnosed with global developmental delay (affecting cognitive, language, gross and fine motor skills). Parents were told he could eventually catch up to his sister or continue indefinitely to be slower in development by about 10 months. Parents tried to keep perspective that, in the long run, this number was quite insignificant. He was referred to a pediatric neurologist to determine if there was a neurological connection to his delay – to date, this is still unknown. He was also referred to a pediatric ophthalmologist who diagnosed E with strabismus (exotropia type) (misalignment in both eyes related to an eye muscle problem). Surgery will take place in 2012. At 8 months, he also began physiotherapy to assist E in his efforts to become mobile. This continues as present, as well as regular home visits by a child development specialist.

To date, E has made moderate progress. At 17 months he became mobile for the first time by bum-shuffling along the floor. He does not crawl, roll over, or self-feed, nor does he talk beyond 'momma'. K is walking and eating on her own; expressive language is also delayed.

After the assessments and opinions of professionals, Mr. and Mrs. B recall they were less concerned with E not meeting development norms than with ensuring he would have the opportunity to live to his potential, whatever that was. K is described as strong-willed, playful, curious, and physically active. Her build, height and weight is slightly larger than E and she is typically the leader in their play. E is described as laid-back, cheerful, cautious and curious. He sometimes likes to be the follower.

Recommendations

There are several things Mr. and Mrs. B can work on to promote a well-functioning family unit. It is critical that parents be aware of their anxiousness and not behave in an anxious manner around E. Mr. and Mrs. B should keep communication lines open in their relationship, talking regularly about stressors within and outside the family. Mr. and Mrs. B would also benefit by working on themselves. One aspect of this is being aware of each parent's own sibling position and how that affects their marriage and how they parent. In this case, both parents are first-borns, and thus more likely to overfunction for their "youngest" child. Also, Mr. and Mrs. B should be aware of the triangles that exist between them and their parents and/or siblings. Extended family members' projection of anxiousness or overly positive messages about E can have a big impact on the parents and how they relate to E.

It would be in E's best interests for his parents not to think of him as "special" in the sense that he is currently developmentally delayed. Keeping perspective when dealing with health professionals is important as they can fuel parent's anxiety about E. Further, Mr. and Mrs. B can work on not comparing their children – each child has their own strengths and weaknesses. Building a one-on-one relationship with each twin is critical. In their interactions with E, parents should restrain themselves from doing too much for him, especially when he can do many things for himself (as observed by others when parent(s) are not present). Watching him struggle will be difficult, but critical to his personal development. E's sister should be encouraged to develop an equal relationship with her brother as she has the potential to function for her brother if his delay continues.

Further reading on sibling position, and the sibling profiles, can be found in Birth Order and You by Richardson and Richardson.