HAIGAZIAN UNIVERSITY

The Impact of Parentification on Mental Health and Identity in a Sample of University Students in Lebanon

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DEDICATION

I would like to dedicate this thesis to all the burdened children, may you find your way. I would also like to dedicate this to my son, to whom I promise to do my very best to break the cycle of trauma.

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Abstract

Parentification is a role-reversal, or boundary dissolution, where a child is assigned roles and responsibilities that are typically performed by parents. In a convenience sample of 157 university students, the study investigated the effect of past and ongoing "destructive" levels of emotional parentification and perceived unfairness on mental health outcomes and identity development. Participants were recruited from 2 universities, Haigazian University (n=71) and Arab Open University (n=45), both located in Beirut, Lebanon. The remaining participants (n=41) were recruited online. All participants filled out the Demographic Questionnaire, Filial Responsibility Scale-Adult (FRS-A), Identity Distress Scale (IDS) and the Brief Symptoms Inventory- 18 (BSI-18). In a one-way Anova analysis, those who reported ongoing caregiving were found to have significantly more mental health symptoms and identity distress than those who reported low levels of parentification (i.e. No Caregiving Group). Past emotional caregiving and perceived unfairness were positively and significantly correlated to mental health symptoms and identity distress, but did not predict poor outcomes. Ongoing emotional caregiving was found to be positively and significantly correlated to mental health symptoms but not to identity distress, and did not predict poor outcomes. Meanwhile, ongoing perceived unfairness was positively and significantly correlated to mental health symptoms and identity distress, and it predicted mental health symptoms but not identity distress. The results of this study illustrated how in a Lebanese sample, specific caregiving dimensions, ongoing caregiving and perceived unfairness, may be more destructive than other dimensions that are typically associated to poor outcomes (i.e. past emotional caregiving).

Key words: Parentification, role-reversal, emotional parentification, filial responsibility, perceived fairness, duration, mental health, identity distress

The Impact of Parentification on Mental Health and Identity in a Sample of University Students in Lebanon

Childhood is generally thought of as a period of exploration and discovery, which is considered necessary for children to meet specific developmental milestones. In order to encourage exploration in children, primary caregivers foster a sense of security in children by providing them with their basic needs for food, shelter, safety, validation, love and support. What happens when there is a role-reversal between the parent and child, where the child has to be the caregiver and is expected to meet the needs of their parents, sometimes at the expense of their own needs? Parentification occurs when children are assigned roles and responsibilities that are typically performed by parents (Boszormenyi-Nagy & Spark, 1973). Parentification is also conceptualized as a type of boundary dissolution, or role-reversal, between the parental and child subsystems (Kerig, 2005; Sroufe, Jacobvitz, Mangelsdorf, DeAngelo & Ward, 1985).

Parentification is thought to be associated to poor outcomes when caregiving tasks: far exceed the child's developmental capacity, are developmentally inappropriate, are frequent enough to keep the child from exploration necessary for healthy development, are chronic and on-going (vs. time limited), are perceived by the child as unfair (i.e., their efforts are not recognized, rewarded or reciprocated by the parents) (Jurkovic, 1997). Over the last few decades, there has been some variability in parentification outcome studies. Some studies have reported on positive outcomes associated to parentification, such as coping skills (Stein, Rotheram-Borus & Lester, 2007), feelings of competence (Champion et al., 2009; Kuperminc et al., 2009) and problem solving (McMahon & Luthar, 2007). Meanwhile the majority of studies have reported on negative mental health outcomes

associated to parentification, these finding include: poor academic performance (Chase, Deming & Wells, 1998) internalizing disorders (Peris, Goeke-Morey, Cummings & Emery, 2008; Stein, Riedel & Rotheram-Borus, 1999; Van Loon, Van de Ven, Van Doesum, Hosman & Witteman, 2015), depressive symptoms (Carroll & Robinson, 2000; Champion et al., 2009; Hooper, Tomek, Bond & Reif, 2014; Hooper, Wallace, Doehler & Dantzler, 2012; Jankowski, Hooper, Sandage & Hannah, 2011; Katz, Petracca & Rabinowitz, 2009; Khafi, Yates & Luthar, 2014), externalizing disorders (Khafi, Yates & Luthar, 2014; Peris, Goeke-Morey, Cummings & Emery, 2008; Stein, Riedel & Rotheram-Borus, 1999), psychological/emotional distress (Hooper, Marotta & Lanthier, 2007; Jurkovic, Kuperminc, Sarac & Weisshaar, 2005; Kuperminc, Jurkovic & Casey, 2009;Tomeny, Barry, Fair & Riley, 2016), co-dependence (Wells, Glickauf-Hughes & Jones, 1999), Shame (Wells & Jones, 2000) masochism and narcissism (Jones & Wells, 1996),borderline personality disorder (Carlson, Egeland & Sroufe, 2009; Zanarini et al., 1997), eating disorder (Rowa, Kerig, & Geller, 2001), substance use (Carroll & Robinson, 2000; Godsall, Jurkovic, Emshoff, Anderson & Stanwyck, 2004), somatic symptoms (Earley & Cushway, 2002; Mechling, 2011) and problems with individuation (Perrin, Ehrenberg & Hunter, 2013)

Furthermore, parentification theory, informed by clinical experience, suggests that excessive caregiving has a negative effect on identity development (Jurkovic, 1997). While there are a few studies that found parentification to have a detrimental impact on identity related constructs (Castro, Jones & Mirsalimi, 2004; Fullinwinder-Bush & Jocobvitz, 1993; Mayseless & Scharf, 2009; Perrin, Ehrenberg & Hunter, 2013) there remains a scarcity of empirical knowledge in this domain. This study aimed to investigate

the impact of past and on-going emotional parentification, and past and on-going perceived unfairness on mental health and identity development on university students in Lebanon.

Background of the Study

Parentification

Parentification can manifest in different ways depending on the type of caregiving tasks the child is expected to fulfil. There are two main types of parentification, instrumental and emotional or expressive parentification. Instrumental role-reversal requires the child to perform functional tasks such as: cleaning, cooking, doing the laundry, providing physical assistant to an ill parent, or taking care of siblings (Hooper, 2007; Jurkovic, Jessee, & Goglia, 1991). Meanwhile, emotional or expressive parentification requires the child to provide a parent with emotional support, validation, reassurance and affection. In addition, the child may play the role of counsellor to a distressed parent, or mediator during parental conflict (Hooper, 2007; Jurkovic, Jessee, & Goglia, 1991).

Parentification can be found to varying degrees in most families. A certain amount of parentification or role-reversal is considered adaptive and necessary for development because it provides children with the opportunity to practice adult roles (Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997). Meanwhile, Jurkovic, (1997) described a pathological degree of parentification called “destructive parentification.” Parentification is considered to be harmful, or destructive if emotional and/or instrumental role-reversal: starts at a younger age, tasks are developmentally inappropriate, tasks are frequent,

caregiving is chronic (long duration vs. time limited), caregiving prohibit the child from adequate exploration considered necessary for healthy development, and the child perceives their caregiving role as unfair (i.e. child's needs are disregarded, and their efforts are nor recognized or appreciated) (Jurkovic, 1997).

In addition, theoretically, emotional parentification is thought to be more harmful because emotional role-reversal tasks are characteristically more vague and developmentally inappropriate, and therefore more difficult and overwhelming to the child (Boszormenyi-Nagy & Spark, 1973; Byng-Hall, 2002; Jurkovic, 1997). In addition, Kerig (2005) explains that emotional parentification may be disruptive to development and the child's well-being when the parent's emotional needs override, and are at the expense of the child's emotional needs. In families, this relational pattern is observed to pass down from generation to generation, as parents once parentified look to their children to fulfil an emotional deficit from their own childhood (Boszormenyi-Nagy & Spark, 1973)

Parentification and Mental Health Outcomes

For the purpose of this study and in line with the author's hypotheses, studies reporting on the detrimental psychological outcomes associated to parentification, as observed in adolescence, university students (i.e. young adults) and adults, will be elaborated on in the following section.

There has been some questions about the effect of past parentification on academic performance. In a sample of 360 undergraduate university students, Chase, Deming & Wells (1998) found that those with low academic performance were more likely to report a history of parentification than students with regular academic performance.

Past parentification has been associated to poor mental health outcomes, especially symptoms of depression and distress. Carroll & Robinson (2000), found that parentified undergraduate students scored significantly higher on measure of depression compared to a control group. Similarly, in a sample of 99 undergraduate students, Williams & Francis (2010) reported that childhood parentification was significantly associated to higher levels of depression and lower levels of happiness. Hooper, Marotta & Lanthier (2008) investigated the effect of past emotional parentification in a sample of 156 university students. They reported that past emotional parentification was a significant predictor of emotional distress. Abraham & Stein (2013) investigated the mediating effect of parent-child role-reversal between mothers with mental illness and mental health symptoms in their adult children (mean age: 19.79). They reported that role reversal was significantly associated to psychological symptoms in adult children who had mothers with mental illness.

Some studies have focused their investigation on emotional parentification and subsequent outcomes. Schier, Herke, Nickel, Egle & Hardt (2014) investigated the long-term consequences of childhood emotional parentification in a sample of 500 adults. They found that emotional parentification was a strong predictor of depression. They also found a positive associated between childhood emotional parentification and somatic symptoms. In addition, Katz, Petracca & Rabinowitz (2009) reported that in a sample of 161 female university students, past emotional role-reversal in mother-daughter relationships was found to predict depressive symptoms in daughters.

Past parentification has also been associated to pathological personality traits. A study by Jones & Wells (1996) investigated the long-term consequences of past parentification on developing masochistic/self-defeating, overt narcissistic and compulsive personality trait. In a sample of 360 undergraduate students, they found that past parentification significantly predicted masochistic/self-defeating and narcissistic traits, but not compulsive traits.

Other studies have explored the effect of childhood parentification on interpersonal related outcomes. In a sample of 200 university students, Wells, Glickauf-Hughes & Jones (1999) reported that past parentification was associated to co-dependent behaviour in interpersonal relationships. Another study suggested that past emotional role-reversal, within mother-daughter relationships, might lead to more reassurance seeking behaviour in daughters, in order to maintain a sense of self-value (Katz, Petracca & Rabinowitz, 2009). In a sample of 542 female university students, Baggett, Shaffer & Muetzefeld (2013) investigated the relationship between past paternal parentification and current romantic relationship satisfaction. Paternal parentification was found to be negatively associated to romantic relationship satisfaction and positively associated to romantic relationship insecurity.

Parentification and Identity Formation

There are numerous assertions throughout parentification theory on the detrimental impact of parentification on identity formation (Boszormenyi-Nagy & Spark, 1973; Byng-Hall, 2002; Jurkovic, 1997; West & Keller, 1991), yet there is little empirical evidence to support this. Theoretically, parent-child relationships characterized by boundary

dissolution, such as parentification or role-reversal, is thought to negatively interfere with the individuation process, which is considered to be prerequisite to healthy identity development (Kerig, 2005). Furthermore, involvement in frequent and chronic caregiving is thought to keep the child from adequate exploration and exposure to new experiences, which puts the adolescent at risk of prematurely committing to parental ideals, i.e., foreclosed identity (Fullinwider-Bush & Jacobvitz, 1993). On the other hand, inadequate exploration of different roles could results in internalizing and becoming committed to the caregiver role (Jurkovic, 1997; West & Keller, 1991). Jurkovic (1997), described how destructive parentification could result in a caregiver identity, whereby identity "revolves around the needs of family members and thus is other- directed, reactive, or undifferentiated."

The most relevant research assesses the effect of parent-child boundary dissolution on adolescence or young adult's level of individuation. In such research, inferences about identity development are made based on the participant's degree of individuation as individuation is thought to be a prerequisite to normal and healthy identity development. One such study is by Perrin, Ehrenberg & Hunter (2013) where they compared two groups of university students (divorced versus intact families) in terms of the presence and extent of boundary diffusion with their parents and current levels of individuation. For all participants, boundary diffusion was associated to lower levels of individuation. In addition, individuation was found to mediate the association between boundary diffusion and healthy adjustment in university students. Another study by Mayseless & Scharf

(2009), also suggested that boundary distortion between parent-daughter relationships interfered with separation-individuation processes in late adolescents.

Meanwhile, Fullinwinder-Bush & Jocobvitz (1993) reported that weak boundaries in child-parent relationships predicted problematic identity formation and identity styles in parentified individuals. They found that a father-daughter relationship characterized by weak boundaries was associated to daughters having a diffuse-identity orientation. While mother-daughter relationships characterized by having weak boundaries, was associated to having daughter with foreclosed identity status- i.e., committing to an identity or role provided by the parents, without exploration of alternative roles.

Other studies have investigated the effects of past parentification on outcomes related to how parentified people experience themselves. One such study by Castro, Jones & Mirsalimi, (2004), who investigated the association between childhood parentification and imposter phenomenon - a feeling of discord between how the person views themselves and how others perceive them. Also, described as an inability to attribute personal success to one's own ability, but rather attributing it to external factors such as good fortune. In a sample of 213 graduate students, past parentification was found to predict imposter phenomenon.

Identity Formation and Distress

According to Erikson's theory of psychosocial development, identity formation typically occurs during adolescence (Erikson, 1968). This developmental stage is conceptualized as a period of experimentation and exploration, whereby adolescents

engage in new and different roles and activities that include: academic interests, hobbies, sports, social and political activities, religion and different interpersonal relationships (Marcia, 1966). Typically, after a period of exploration, adolescents develop a sense of identity that is commitment to specific roles, goals and ideals that give a person a sense of internal stability and consistency across different contexts, and which provide them with a sense of direction and purpose (Erikson, 1968; Marcia, 1966).

While many are successful in acquiring a sense of identity, some individuals experience identity or role confusion (Erikson, 1968). Berman, Montgomery, & Kurtines (2004) suggested that identity distress, which is defined as a "severe subjective distress regarding the inability to reconcile aspects of the self into a relatively coherent and acceptable sense of self," (American Psychiatric Association 1980, p. 65) is an important indicator of problems related to identity formation. For the purpose of this study, identity distress was used as an indicator of problematic identity formation. The assumption was that those who have succeeded in developing a healthy, coherent and mature identity will report low levels of identity distress, and those who are experiencing problems in identity formation (i.e. role confusion) will report higher levels of identity related distress.

Statement of the Problem

Inspired by Jurkovic's (1997) conceptualization of destructive parentification, this study investigated the impact of specific, more pathological, dimensions of parentification (i.e., emotional caregiving and perceived unfairness, that either occurred in the past or that is on-going) on mental health and identity formation.

Therefore, based on the above-discussed literature, the author examined the following hypotheses:

Hypothesis 1: (1) Past Expressive Caregiving group and (2) Past Unfairness group are positively and significantly correlated to:

a) Identity distress
b) Mental health symptoms (i.e., GSI)

Hypothesis 2: (1) Past Expressive Caregiving group and (2) Past Unfairness group predict

a) Identity distress
b) Mental health symptoms (i.e., GSI)

Hypothesis 3: (1) On-going Caregiving group has significantly higher scores on

a) Identity distress than (i) Past Caregiving Only, (ii) Current Caregiving Only, (iii) No Caregiving groups.
b) Mental health symptoms (i.e., GSI) than (i) Past Caregiving Only, (ii) Current Caregiving Only, (iii) No Caregiving groups.

Hypothesis 4: (1) On-going Expressive Caregiving group and (2) On-going Unfairness are positively and significantly correlated to

a) Identity Distress
b) Mental Health Symptoms (i.e., GSI)

Hypothesis 5: (1) On-going Expressive Caregiving group and (2) On-going Unfairness group predicts

a) Identity distress

b) Mental health symptoms (i.e., GSI)

The Professional Significance of the Study

Variability in outcome studies indicates that there is still much to understand about the parentification construct. There has been some evidence that culture/ethnicity may play a role in explaining variability in mental health outcomes. There is a growing trend in parentification research to explore parentification outcomes in different cultures and ethnic groups to get a more comprehensive understanding of the effects of parentification (East, Weisner, & Slonim, 2009; Hooper, Tomek, Bond & Reif, 2014; Khafi, Yates & Luthar, 2014; Tsai, Gonzales & Fuligni, 2015). Although this study used a convenience sample, it gave us a glimpse into the effect of parentification on mental health and identity development related outcomes in a Lebanese sample.

In addition, while parentification is often thought to have a negative effect on identity formation, this assertion was mostly supported by clinical observation (Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997; West, & Keller, 1991). From what this author was able to determine, there is one published study that specifically investigated the association between parentification on identity outcomes (Fullinwinder-Bush & Jocobvitz, 1993), while a small handful of other studies investigated the impact of boundary distortion in families and its effect on identity related constructs (Castro, Jones & Mirsalimi, 2004; Godsall, Jurkovic, Emshoff, Anderson & Stanwyck, 2004; Mayseless & Scharf, 2009; Perrin, Ehrenberg & Hunter, 2013). The current study is the only study to investigate the relationship between parentification and identity development using the construct of identity distress to operationally define problematic identity formation.

If the results of this study show that parentification does have detrimental consequences on mental health and identity formation, then this information can be used to orient clinician's assessment and treatment of individuals presenting with an extensive history of parentification. Furthermore, this knowledge may be of particular importance for counsellors at university counselling centres. Individuals with a history of parentification may be prone to elevated stress during university as exposure to new experiences may trigger a desire for exploration. Exploration may be considered particularly stressful for people who have experienced parentification, as it may be at odds with their caregiving role and feelings of loyalty and commitment towards their families, which may lead to feelings of anxiety and guilt. With these students, it may be useful for counsellors to gear their intervention towards identity formation, following an in-depth assessment of current identity status, style and distress.

Overview of Methodology

The following quantitative study assessed the effect of past and on-going emotional caregiving and perceived unfairness related to caregiving experiences, on mental health and identity development. The sample was a convenience sample comprised of 157 university students, in Lebanon. The majority of participants were recruited from 2 different universities, Haigazian University (n=71) and Arab Open University (n=45). . The remaining participants (n=41) were recruited online. This study used four self-report instruments: a demographic questionnaire; Familial Responsibility Scale-Adult, to asses and measure parentification; Identity Distress Survey, to measure identity related distress; Brief Symptoms Inventory-18, to measure mental health symptoms.

Consent was acquired from the abovementioned universities in order to approach and recruit students from their campuses. Specific professors at each university were asked if they would allow the investigator to approach their students during the beginning of class in order to inform them about the study and collect data from those students who were interested in being participants. Participants were provided with a package containing an information form, a consent form, and the four questionnaires. They were provided 15-25 minutes to complete the questionnaires. They were asked to hand them back to the investigator upon completion. Online recruitment was conducted by posting a brief description about the study on social media. Individuals who were eligible (i.e. university students) and who were interested in participating, were provided a link which they could follow in order to learn more about the study and fill out the study's questionnaires.

Limitations of the Study

The current study is the first study in Lebanon to investigate the effect of parentification on mental health and identity development. There is a scarcity of research that explores the effects of parentification on identity formation; hence, this study is a valuable contribution to this specific domain of research. Also, it is the first study to empirically study the relationship between parentification and identity development using identity distress to capture problematic identity formation. Nonetheless, some limitations were considered.

The FRS-A assessment of past or retrospective caregiving required that the participant rely on their memory to recall previous experiences, which may have yielded

imprecise information due to inaccurate recalling of past events. Also, parentified individuals tend to have a strong sense of loyalty and identification with their parents and family system, which might make them reluctant or uncomfortable answering certain questions in the FRS-A, especially if they perceive questions as geared towards pathologizing their family dynamic.

There has been some questions about whether the IDS is measuring distress related to unresolved identity issues or if the distress captured by the IDS overlaps with distress related to having mental illness. While this issue is still being debated, the IDS is currently being used in research.

Definition of Key Terms

Boundary dissolution: Is a concept in family systems theory that refers to a loss of psychological separateness between parent and child subsystems. It can manifest as interpersonal boundaries that are distorted, reversed, diffused and enmeshed. Parent-child role-reversal, i.e. parentification, is a kind of boundary dissolution that manifests as a reversal of interpersonal roles between parent and child. (Kerig, 2005).

Childhood: A child is a human being below the age of 18 years old ("Convention on the Rights of the Child", 1989). In western cultures, childhood is typically a period from infancy to late adolescents. During this period, a typical child lives with and is mostly dependent on a primary caregiver.

Child development: Childhood is considered a period of systematic growth, where specific physical, cognitive, psychological and social milestones are acquired, and is the basis for

future growth and development throughout an individual's life span (Scharf, Scharf & Stroustrup, 2016)

Destructive parentification: This is the fourth stage of the parentification process. It is considered to be a pathological degree of parentification that is defined by: earlier onset of caregiving, developmentally inappropriate caregiving tasks, frequent caregiving responsibilities, caregiving is chronic/on-going (vs. time limited), and perceived unfairness in relation to caregiving (i.e. unsupported and unacknowledged) (Jurkovic, 1997).

Emotional parentification (i.e. expressive caregiving): This type of parentification or role-reversal occurs when children provide their parents with emotional support, comfort, validation and affection/love. Examples of this type of role-reversal include when a child plays the role of counsellor or confidant to a distress parent, or mediator in parental conflict (Hooper, 2007; Jurkovic, Jessee, & Goglia, 1991)

Identity formation: This developmental stage occurs during adolescence. It is a phase conceptualized as a period of exploration followed by commitment to specific roles, goals and ideals that give a person a sense of internal stability and consistency across different contexts, and which provide them with a sense of direction and purpose (Erikson, 1968; Marcia, 1966).

Identity distress: According to DSM-III, the term is defined as "severe subjective distress regarding the inability to reconcile aspects of the self into a relatively coherent and acceptable sense of self" (American Psychiatric Association 1980, p. 65)

Instrumental parentification (i.e. instrumental caregiving): This is a type of parentification, which involves providing parents with physical care (e.g. taking care of the physical needs of younger siblings or a sick parent) and/or logistical support (e.g. house chores, grocery shopping, paying bills, working to provide financial support, managing the household, etc.) (Hooper, 2007; Jurkovic, Jessee, & Goglia, 1991)

Parentification: This phenomenon occurs when children are assigned roles and responsibilities that are typically performed by parents. Parentification can manifest in different ways depending on the type of caregiving tasks the child is expected to fulfil. There are two main types of parentification, instrumental and emotional or expressive parentification (Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997)

Perceived Fairness: In parentification studies, perceived fairness refers to an experience of relational justice or injustice experienced in the family environment. Perception of fairness, as it relates to the parentification, is typically determined by assessing perception of reciprocity of support and needs fulfilment, and acknowledgement and appreciation of the support that is being provided. (Jurkovic, 1997; Jurkovic, Thirkield & Morrell, 2001)

Role-reversal: In the parentification literature, role-reversal is a term that is used interchangeably with the term parentification. Role-reversal is a type of boundary dissolution between parent and child (Kerig, 2005)

CHAPTER 2

Review of Literature

Parentification is a multifaceted construct that is present in most families to varying degrees. The following chapter will try to capture and define the parentification phenomenon and review factors that make certain individuals more susceptible to being parentified. Parentification studies assert that role-reversal can have a detrimental impact on mental health and healthy childhood development. The proceeding chapter will introduce specific theories in psychology that have been used to conceptualize parent-child role-reversal as a phenomenon that places parentified individuals at greater risk for poor mental health outcomes and identity development. Lastly, studies that explore the effect of parentification on mental health and identity development were also included in this chapter.

Types of Parentification

Boszormenyi-Nagy & Spark (1973) described parentification as relational process that can exist between any two individuals in a relationship, regardless of age, whereby one person seeks from another the kind of care and attention typically provided by a parent. Today, parentification research is more strictly defined as a reversal of roles between parent and child, whereby the child is expected to perform certain roles or take on certain responsibilities that are typically executed by a mother or father (i.e. primary caregiver) in a typical family system (Chase,1999; Hooper, 2007; Jurkovic, 1997; Kerig, 2005). Jurkovic, Thirkield & Morrell (2001) used the term filial responsibility, which is used interchangeably with the concept of parentification, as the term parentification has come to imply a pathological process.

Parentification is mainly organized into two subtypes based on the roles and responsibilities assigned to the child, instrumental tasks and/or emotional or expressive tasks (Hooper, 2007; Jurkovic 1997). When a child provides assistance in instrumental tasks, this usually involves responsibilities that may include home chores (cleaning, dishes, laundry, cooking), assisting in their families finances (e.g. working to provide additional income, overseeing or maintaining the family budget), taking care of and looking after siblings, and if a parent is unwell this may also involve providing care for a sick parent (providing assistance with medication, meals, hygiene, physical mobility) (Chase, 1999; Hooper, 2007; Jurkovic, 1997). Meanwhile, when a child is engaged in an emotional/expressive role reversal, their tasks and responsibilities may involve providing a parent with comfort, solace, validation and understanding during times of distress. Sometimes the child may appear as though they are the parent's counsellor, therapist and confidant. The child's role may be to emotionally regulate and stabilize the distressed parent. Emotional parentification may also involve being a mediator or peacemaker during parental conflicts (Chase, 1999; Hooper, 2007; Jurkovic, 1997)

It is important to note that in the parentification literature, similar terms from family system theory are commonly used interchangeably with parentification. Inconsistent is terminology is a methodological problem facing parentification research (Engelhardt, 2012). Examples of these terms are: role-reversal (e.g., Fullinwider-Bush & Jacobvitz, 1993; Katz et al., 2009; Mayseless et al., 2004), parentified child (Earley & Cushway, 2002), triangulation (Jacobvitz & Bush, 1996; Kerig, 1995), spousification (Brown & Kerig, 1999; Sroufe & Ward, 1980) diffuse boundaries (Fullinwinder-Bush and Jocobvitz, 1993; Perrin et al., 2013) and boundary distortion (Mayseless & Scharf, 2009).

These concepts overlap with parentification whereby they refer to a situation within the family system whereby the child's personal boundaries and drive towards individuation are disregarded by the parental subsystem, as the parent's needs take precedence over the child's needs.

Is Parentification Harmful?

Parentification should not be equated with pathology, as a certain degree of role-reversal is considered necessary for development because it provides children with the opportunity to explore, practice and prepare for adult roles (Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997). Parentification is thought to occur in most families at one time or another. When families encounter hardships they may enlist children to help alleviate strain on the parents and family system as a whole. Age appropriate and time-limited role-reversal may be an adaptive coping mechanism for the family system, and may protect parents from burnout (Boszormenyi-Nagy & Spark, 1973). Additionally, parentification has been found to be associated to positive outcomes, especially when their efforts were recognized, appreciated and they felt supported (Champion et al., 2009; Jurkovic and Casey, 2000; Kuperminc et al., 2009; McMahon & Luthar, 2007; Stein et. al., 2007).

Jurkovic (1997) conceptualized a multidimensional continuum of parentification that has four categories (infantlization, non-parentification, adaptive parentification, and destructive parentification). In order to determine which category of parentification an individual belongs to, specific aspects or dimensions of the experience must be ascertained. Specific dimensions or characteristics must be evaluated, such as: onset of caregiving role, frequency and duration of child involvement in parentification tasks,

developmental appropriateness of parentification tasks, and the child's perception of fairness related to their caregiving role (i.e. reciprocity in care/support, acknowledgement and appreciation for their support and efforts). In this study, we will focus on the category referred to as destructive parentification.

Destructive parentification is characterized by emotional or instrumental role-reversal, whereby a child is expected to frequently fulfil developmentally inappropriate caregiving task, for an unlimited period of time, while they are unsupported and their effort are unacknowledged (Jurkovic, 1997; Jurkovic et al., 1999). Destructive parentification is considered to be a type of maltreatment, neglect or trauma and is thought to have a detrimental impact on development and is associated poor mental health outcomes (Jurkovic et al., 1999).

Furthermore, theoretically and clinically emotional parentification has been thought to result in poorer outcomes; these assumptions have been empirically proven. Theoretically, the rational is that instrumental tasks are more definable, predictable, and therefore can be learned and adapted to (Chase, 1999). Whereas in emotional parentification, the requests made by the parents are more indirect and covert in their nature, and children are thought to lack the cognitive and emotional developmental capacity to fully grasp and provide what is required of them (Boszormenyi-Nagy & Spark, 1973; Chase, 1999). When parentis look to their children to perform or fulfil developmental inappropriate responsibilities, the child's failure to meet their parent's expectation is internalized, leading to feelings of self-blame, failure, low self-esteem and incompetence (Byng-Hall, 2002), which they may carry into adulthood.

The focus of this study was past or on-going (i.e. chronic) emotional role-reversal or caregiving that is perceived to be unfair. The specific dimensions that were explored are: type of caregiving, duration of caregiving and perceived fairness towards caregiving role.

Parentification and Perceived Fairness

The concept of perceived fairness is not a new or one that is specific to the study of parentification. In the social sciences it refers to one's perception of fairness or justice in relation to a component or aspect of one's environment. Fairness is typically determined or assessed according to the rules and customs of a particular group, context or environment (Peiró, Martínez-Tur & Moliner, 2014). In parentification studies, perceived fairness refers to an experience of relational justice or injustice experienced in the family environment. The perception of fairness, as it relates to the parentification process, is typically determined by assessing ones perception of reciprocity of support and needs fulfilment, and acknowledgement and appreciation of the support that is being provided. Furthermore, perception of fairness is also determined by differences in cultural expectations related to the caregiving role (Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997; Jurkovic et. al., 2001).

Parentification theory has often referred to the importance of perceived fairness or justice in relation to role-reversal as being an important dimension to consider when exploring the effect of parentification on mental health. The Parentification Questionnaire (PQ), is the first parentification instrument to investigate perceived fairness as a dimension of parentification or caregiving (Jurkovic et al., 2001). The current study used the Filial

Responsibilities Scale-Adult (FRS-A), which is considered to be an extension or updated version of the PQ. While the PQ included questions that explored feelings of justice related to caregiving, the FRS-A includes a perceived unfairness subscale.

Risk Factors for Parentification

Parentification is more likely to happen when the family system is dysfunctional or under strain. (Engelhardt, 2012). By enlisting a child's help during hardships or stressful periods, role-reversal serves to help parents and the family as a whole to function better. Parent-child role reversal serves to help parents and the family as a whole to function better. Research has found that certain individual characteristics and familial stressors and circumstances are more likely to put children at risk of being parentified. Being female (Aldridge, 2006; Chase, 1999; Jurkovic, 1997) and the eldest sibling (Burton, 2007; Stoneman, Brody, Davis, & Crapps, 1988) were linked to greater risk for parentification. Also, families that are experiencing economic strain, one-parent households (Burton, 2007; Jones & Wells, 1996), divorced (Jurkovic et al., 2001), or parents who are workaholics (Carroll & Robinson, 2000) are at greater risk of parentification. Greater risk for parentification has also been found in homes where parental figures may be suffering from physical illness (Lackey & Gates, 2001; Shifren & Kachorek, 2003; Stein et al., 1999), psychological illness (Aldridge, 2006; Shifren & Kachorek, 2003), and addiction (Carroll & Robinson, 2000; Godsall et al., 2004). Other risk factors include, parents who themselves experienced emotional parentification, who unconsciously look to their own children to fulfil unmet childhood needs (Chase, 1999).

Theoretical Background

There are numerous theories that have been used to understand and explain the parentification process, and the potentially detrimental impact of it has on mental health and identity development. The current study focused on three main theories, family systems, attachment and psychosocial development. The following section will provide a summary of how each theory conceptualizes parentification as a precursor to poor mental health and identity related outcomes.

Family systems theory. According to family systems theory, a normal family system is composed of subsystems, marital/spouses, parental, child and siblings subsystem. The parental subsystem engages the child subsystem in a horizontal manner, which is intended to convey authority and protection/security. As a result, children are thought to experience emotional and physical security, a basic need necessary for children to thrive. Parentification, is a deviation in this mode of interaction, and is known as generational boundary dissolution between the parental and child subsystems. As a result, children are thought to feel less emotionally and physical secure, as they no longer experience a sense of security associated with having parental authority and guidance. Children who don't feel secure are more prone to feeling anxiety and stress, making them more prone to negative psychological outcomes. (Hooper, 2007; Macfie, Brumariu & Lyons-Ruth, 2015; Shaffer & Sroufe, 2005).

Furthermore, family systems theory suggests that parent-child relationship characterized by boundary dissolution, such as parentification, could hinder the process of individuation in parentified individuals. Generally speaking, individuation is conceptualized as a process whereby children come to see themselves as emotionally and psychologically separate from their parents. Furthermore, in relation to identity formation,

individuation is considered to be an essential step towards healthy identity development. Therefore, a lack of individuation may negatively affect identity formation (Hooper, 2007; Macfie, Brumariu & Lyons-Ruth, 2015; Shaffer and Sroufe, 2005).

Attachment theory. Another integral theory to conceptualizing the negative consequences of parentification on mental health is attachment theory. Children are born with an inherent drive to form attachments to their primary caregivers in order to ensure their survival (i.e. emotional and physical security) and pathology in the child arises when attachment needs are not met by primary caregivers. The manner in which caregivers respond to a child's distress (i.e., with consistency and attunement to the child's needs) and the subsequent feeling that the child has in response (i.e., comfort or continued distress) will eventually define the kind of attachment the child will have towards their caregiver. A securely attached child has learned that they can rely on their parent for comfort and will turn to their parents during periods of distress. On the other hand, an insecurely attached child has come to learn that they cannot rely on the parent for comfort and may not seek the parent when they are in distress. The child's unmet innate need for safety and security, and inability to rely on their parents for comfort is thought to produce anxiety and fear in the child. As a result the child is forced to find alternative ways to cope with their anxiety and fulfil their needs. Within this context, parentification is thought to emerge when the insecurely attached child comes to inadvertently learn that by meeting their parent's emotional and/or instrumental needs, their parents are more likely to provide them with the attention and care they need (Hooper, 2007; Macfie, Brumariu & Lyons-Ruth, 2015).

According to attachment theory, a secure attachment to caregivers is a prerequisite for healthy development. Securely attached children are thought to engage the world with less anxiety and more openness to experience as they carry with them the knowledge and confidence that they have parental support to rely on. Thus insecurely attached children, such as those who experience destructive levels of parentification, experience elevated distress and anxiety, which is thought to makes parentified children more susceptible to poor psychological and developmental outcomes (e.g. problems with identity development). Attachment style is thought to affect exploratory behaviour during adolescence that is considered necessary for healthy identity development (Hooper, 2007; Macfie, Brumariu & Lyons-Ruth, 2015; Shaffer & Sroufe, 2005).

Stages of psychosocial ego development. According to Erikson's stages of psychosocial ego development, human psychological and social development occurs in eight stages, with each stage building on the growth or developmental gains made from the previous stage. Psychological gains, at every stage, especially during childhood, are accompanied with feelings of competence. Feelings of competence are thought to motivate action towards additional psychological growth. Failure to accomplish specific ego characteristics and strengths may results in feelings of incompetence and inadequacy (Erikson, 1968).

Destructive parentification can potentially interfere or hamper personal growth at every stage of childhood, especially the following stages: stage 3, initiative vs. guilt; stage 4, industry vs. inferiority; stage 5, identity vs. confusion. Preschool children (initiative vs. guilt) and school age children (industry vs. inferiority), who are given developmentally inappropriate tasks that they can't successfully accomplished may not develop specific

ego strengths (i.e. initiative and industry), instead they may acquire feelings of guilt and inferiority (e.g., inadequacy, low self-esteem) (Earley & Cushway, 2002). Therefore, destructive parentification could put children at risk for developing feelings of inferiority and guilt, which may put the individual at greater risk for mental health problems (e.g., Godsall et al., 2004).

Furthermore, according to Erikson (1968), identity development or formation is thought to occur during the stage called identity versus role confusion, which occurs during adolescence. This stage is characterized by exploration and experimentation in all aspects of life (e.g. academic interests, hobbies, sports, social and political activities, religion and different interpersonal relationships). Towards the end of adolescence, they will become committed to ideals, values, and interests that both feel right or make sense to the person, and that are supported and encouraged by key individuals (e.g., parents) in the person's life. Those with healthy identity development feel anchored; their commitments provide them with internal stability, and a sense of meaning and purpose in their daily lives. Meanwhile, failure to develop a coherent sense of self can lead to "role confusion" and is associated to feelings of distress, anxiety and despair (Erikson, 1968; Marcia, 1966).

When destructive parentification is conceptualized through Erikson's psychosocial developmental stages, identity development, is negatively affected because parentified adolescents are not allowed enough opportunity to engage in developmentally appropriate activities and exploration which is considered necessary for successful identity formation (Erikson, 1968; Marcia, 1966). Inadequate exploration and exposure to new experiences,

puts the adolescent at risk of prematurely committing to parental ideals, i.e., foreclosed identity (Fullinwider-Bush & Jacobvitz, 1993). Additionally, inadequate exploration of different roles could results in internalizing and becoming committed to the caregiver role (Jurkovic, 1997; West, & Keller, 1991).

Description of the literature and inclusion criteria. There is a plethora of research that explores the psychological consequences of child provided caregiving in the context of parental illness. Much of this research is qualitative, exploratory and does not conceptualize or make assertions about caregiving from the perspective of parentification theory. While the results of these studies are relevant to parentification research, they are not considered of primary relevance to the current study. This review will only include quantitative studies that investigate child caregiving from the theoretical framework of parentification theory.

One of the problems facing parentification research is related to inconsistencies in how the concept is operationalized. As previously noted, there is variability in the terminology used to refer to the parentification phenomenon and in how it is measured. This review will include parentification studies that use the following terminology: caregiving and filial responsibility (only when embedded in parentification theory), boundary dissolution/distortion, triangulation, enmeshment, parentification and role-reversal.

The effect of parentification on mental health has been explored in numerous groups. The bulk of parentification research falls under two categories: (1) the effect of current role-reversal in adolescent samples or (2) the long-term effects of past role-

reversal in adult samples. While the sample in this study is composed of university students, studies that explored the effects of parentification in adolescent sample were included in this review. Although our sample consists of university students, a group often referred to as adults, but they are also sometimes referred to as "emerging adults" (Abraham & Stein, 2013; Arnett, 2000; Mayseless & Scharf, 2009). Emerging adults are considered to be in transitional developmental period between adolescent and adulthood where they are still highly involved in issues pertaining to separation-individuation and identity (Arnett, 2000; Borchet, Lewandowska-Walter & Rostowska, 2018; Mayseless & Scharf, 2009).

Additionally, specific studies investigated the association between parentification and mental health in specific groups or samples defined by race or ethnicity, those possessing a specific mental health diagnosis (e.g. GAD), at risk groups (e.g. children who have parents with a medical or mental health condition) or those who experience specific caregiving experience such as language brokering in immigrant families. This review will include studies that explore parentification and mental health outcomes in at risk groups, except for studies that investigate the effect of language brokering in immigrant families.

Furthermore, there were studies that explored mental health outcome related to specific types of parentification (instrumental vs. emotional), while other studies do not make this differentiation and investigate parentification in general. This review will include studies that investigated specific types of caregiving, as well as general role-reversal. Some studies explored the difference between parent-focused and sibling-focused caregiving, while other studies do not elaborate on to whom the caregiving is provided

within the family. This review will include studies that explore parent and sibling focused caregiving as well as studies that do not differentiate to whom the caregiving is provided.

Theoretically, duration of caregiving is considered to be an important parameter in differentiating normal from destructive levels of caregiving. According to our knowledge, only one study directly investigates the effect of duration of caregiving on mental health (Shifren & Kachorek, 2003) and it was included in the review. Furthermore, although perceived fairness has been referred to as a significant facet of the caregiving experience, only recently has it been given more empirical attention. Therefore, many studies do not measure this dimension of the caregiving experience. This review will include studies that reported on perceived fairness associated to role-reversal and caregiving.

Published research on the effects of parentification on identity related constructs are scarce. Furthermore, published quantitative research that specifically explores the relationship between the term “parentification” and the term “identity distress” was not found. Only one study was found that investigated the effect of “parentification” on an identity related construct (i.e. imposter phenomenon). The literature reviewed below will include research that explores constructs that are similar or overlap with parentification (e.g., boundary dissolution, boundary diffusion and triangulation), and identity distress (e.g., identity style, self-concept, imposter phenomenon and individuation- considered to be a prerequisite for healthy identity development).

This review will include studies that explore the mental health consequences (e.g. depression, anxiety, somatization, psychological distress, internalizing symptoms and

externalizing symptoms) and identity related problems associated to current caregiving in adolescent samples, and past caregiving in adult samples (e.g. university student and older adults).

In the following section, the studies included will be organized according to the age of the study's sample (i.e. adolescents or university students/adults) and whether the parentification being investigated is current or past. Furthermore, additional subcategories will combine studies that investigate the psychological outcomes of parentification in specific groups or samples (e.g., having a parent with medical or mental illness, having a mental health diagnosis, etc.).

Parentification and Mental Health Outcomes

Current parentification in adolescent samples. The impact of current parentification is usually explored in toddlers, young children and adolescent age groups. This section will include studies that investigated the effects of existing or current parentification on mental health and adjustment in adolescents living with their parents. Many of these studies include parents as informants in the assessment of adolescent adjustment and mental health.

In a convenience sample of 145 adolescents (mean age: 13 years old) from Bosnia, Jurkovic, Kuperminc, Sarac & Weisshaar (2005) explored the impact of filial caregiving and perceived fairness on psychological wellbeing. Caregiving dimensions were measured using the Filial Responsibility Scale- Youth (FRS-Y), a self-report measure. Emotional distress was assessed using a self-report measure called the Weinberger Adjustment Inventory (WAI). They found that caregiving was negatively correlated to perceived

fairness, which implies that an increase in caregiving is associated to a decline in perceived fairness. Caregiving was positively correlated to psychological distress, but was not a predictor of distress. Perceived fairness was not found to moderate the relationship between caregiving and distress. Meanwhile, perceived fairness was found to be a predictor of psychological distress.

Meanwhile, Peris, Goeke-Morey, Cummings & Emery (2008) explored the consequences of emotional parentification on mental health in a sample of 83 adolescents (mean age: 15.26) and their parents. Emotional parentification was assessed using the Emotional Parentification Questionnaire (EPQ), a self-report measure. Adolescent's mental health, specifically the presence of internalizing and externalizing symptoms, was measured by having parents fill out The Child Behavioural Checklist (CBCL), while adolescents filled out the Youth Self-Report (YRS). They found that emotional parentification was significantly correlated to and predicted youth reported internalizing and externalizing problems.

Kuperminc, Jurkovic & Casey (2009) studied the impact of filial responsibility (i.e. caregiving) and perceived fairness in relation to caregiving, on psychological distress in a convenience sample of 129 Latino adolescents (mean age= 16.8). Filial responsibility and perceived fairness were measured using the Filial Responsibility Questionnaire-Youth (FRQ-Y), a self-report measure. Meanwhile, psychological distress was captured using the Weinberger Adjustment Inventory (WAI). They found that caregiving was not significantly associated to distress but had a negative and significant association to perceived fairness. This finding may imply that the more caregiving the child experiences

the less they perceived their caregiving experience to be fair. Perceived fairness as a dimension of caregiving was negatively and significantly correlated to psychological distress.

In a rural population, a convenience sample of 51 adolescents (mean age: 13.80) and their parents, Hooper, Doehler, Jankowski & Tomek (2012) investigated the impact of parentification on adolescent's physical, medical and mental health. Parentification was measured using the Parentification Questionnaire-Youth (PQ-Y), a self-report measure. The Becks Depression Inventory II (BDI-II), a self-report measure, was used to capture depressive symptoms. Among their findings, they reported that higher level of parentification was associated with higher levels of depressive symptomatology in adolescents.

In a convenience sample of 199 Latino adolescents (mean age= 13.8), Kuperminc, Wilkins, Jurkovic & Perilla (2013) explored the association between caregiving variables and psychological distress. Current caregiving and perceived fairness were measured using the Filial Responsibility Questionnaire—Youth (FRQ-Y), a self-report measure. Current psychological distress was assessed using the Weinberger Adjustment Inventory—Distress Scale. They found that the relationship between caregiving and distress was mediated by perceived fairness. This implies that when caregiving is associated to lower levels of perceived fairness, caregiving was found to be associated to psychological distress.

In a longitudinal study, Khafi, Yates & Luthar (2014) studied the impact of emotional and instrumental parentification on healthy adjustment and mental health in a sample of 143 racial diverse mother-child duos (White American: 42%; African American: 58%). The first wave of assessment, child participant's mean age was 10.17 years old, and at the second wave of assessment their mean age was 14.89 years old. The Child Caretaking Scale, a self-report measure, was used to capture experiences of emotional and instrumental parentification. Meanwhile, depressive symptoms in children were measured using a self-report instrument called the Children's Depression Inventory (CDI). Furthermore, mothers were asked to report on their child's externalizing symptoms (i.e., aggressive, disruptive, hyperactive, and antisocial behaviours) using the Behavioural Assessment System for Children and Adolescents (BASC). They reported that parentification was observed to be stable across the two time periods. Ethnic groups did not significantly differ in terms of reported emotional caregiving. Meanwhile, African American children reported higher levels of instrumental caregiving at both time periods. In the general sample, they found that emotional caregiving was associated to depressive symptoms and externalizing problems. When they compared ethnic groups based on this finding, they observed a significant increase in externalizing problems existed for white American children but not for black American children. Meanwhile, for both ethnic groups, instrumental parentification was not found to be significantly associated to children's depressive symptoms. The authors suggest that cultural differences in caregiving expectations may explain ethnic differences in outcomes related to emotional parentification.

Outcomes in at risk groups. Meanwhile, other studies focus on the effects of parentification on adolescents living with parents who suffer from a chronic medical condition. Stein, Riedel & Rotheram-Borus (1999) investigated the psychological impact of parentification in a sample of adolescents who have a mother diagnosed with AIDS. In the first phase, the sample consisted of 183 parent-adolescents duos (mean age= 14.8), and at follow up, 3 to 9 months later, the sample was reduced to 152 parent-adolescent duos. In the first phase, current parentification was assessed using the Parentification Scale (PS), a self-report measure. PS results were organized into three scales: Non-specific adult role taking, Spousal role vis-à-vis parent, and Parental role vis-à-vis parent. In the second phase, adolescent participant were assessed for internalizing problems using The Brief Symptoms Inventory (i.e., depression, anxiety, somatization) and externalizing problems as measured by the Conduct Disorder Scale (CDC) (i.e., aggression, criminal behaviour and rebellious behaviour, sexual behaviour and alcohol/marijuana use). They found that adult role taking predicted more internalizing symptoms, and parental role taking predicted externalizing symptoms (i.e., sexual behaviour, alcohol and marijuana use, and conduct problems).

Some studies explored the effect of parentification on mental health in adolescent who have a parent diagnosed with a mental illness. For example, Champion et al., (2009) investigated mental health outcomes of emotional and instrumental parentification in adolescents (n= 72; mean age: 12.2) who have mothers with or without a history of depression. Parent-child interactions were directly observed for the presence of parentification behaviours and observations were coded and quantified using the Iowa

Family Interaction Rating Scales (IFIRS). Symptoms of anxiety and depression in adolescents were assessed using The Child Behavioural Checklist (CBCL), which is based on the mother's observation of her child, and the Youth Self Report (YSR), which is an adolescent self-report measure. They found that having a parent with a mental illness did not put adolescents at a significantly greater risk of experiencing emotional and instrumental parentification. Meanwhile, emotional and instrumental parentification was significantly correlated with self-reported anxiety and depression symptoms, but only in adolescents who have mothers with a history of depression. Additionally, emotional parentification was found to be significant predictor of adolescent anxiety and depression, but only in adolescents who have mothers with a history of depression.

In a cross-sectional and longitudinal study, Van Loon, Van de Ven, Van Doesum, Hosman & Witteman (2015) also investigated the emotional and behavioural outcomes related to parentification in adolescents (n=118; mean age: 13.47) who live with a parent diagnosed with a mental illness, and who are currently symptomatic. Parentification was assessed using The Parentification Questionnaire-Youth (PQ-Y). The presence of mental health symptoms in adolescents was assessed using a self-report instrument called the Youth Self-Report (YSR), which assess Internalizing (i.e., anxiety, depression and somatic symptoms) and externalizing (aggressive and rule-breaking subscales) symptoms. At baseline, they found that parentification was associated to internalizing and externalizing symptoms. One year after the initial assessment, parentification only predicted internalizing symptoms.

Past parentification in adult samples. The effect of parentification, specifically past parentification on mental health is investigated in university students and adults. These studies use retrospective self-report measure to capture past parentification.

In a convenience sample of 156 university students (Mean age: 22.45), Hooper, Marotta & Lanthier (2007b) explored predictor of distress in those who experienced past parentification. Emotional and instrumental parentification was assessed using the Parentification Questionnaire (PQ). Psychological distress was measured using the Brief Symptoms Inventory (BSI). Emotional parentification was correlated to and a predictor of psychological distress, but instrumental parentification was not found to have any significant association with distress.

In a study by Katz, Petracca & Rabinowitz (2009) the effect of emotional role reversal during childhood on mental health was investigated in a sample of 163 undergraduate female students from families, where parents are not divorced, separated or widowed. Past emotional role reversal was measured using the Relationship with Parents Scale (RPS), a retrospective self-report instrument. Depressive symptoms were assessed using the Center for Epidemiological Studies Depression Scale (CES-D). They found that emotional role-reversal with the mother predicted depressive symptoms. Furthermore, they found that anxious attachment style was a mediator between emotional role-reversal and depressive symptoms.

Meanwhile, in a convenience sample of 143 university students, Hooper & Wallace (2009) explored the effect of past emotional and instrumental parentification, and perceived fairness in relation to parentification, on mental health. Past Parentification was

measured using the Parentification Questionnaire (PQ), and specific mental health symptoms (i.e. symptoms of anxiety, depression and somatization) were assessed using The Brief Symptoms Inventory (BSI). The BSI includes a Global Severity Index (GSI) to measure the overall level of psychological distress related to mental heath symptoms. They found that different parentification experiences resulted in different outcome. Past instrumental caregiving was not correlated to any specific mental health disorder, but it was positively and significantly correlated to GSI scores. Meanwhile, past emotional parentification and perceived fairness were positively and significantly correlated to symptoms of depression, anxiety, somatization and GSI. They concluded that in line with parentification theory, emotional parentification was associated to worse mental health outcomes compared to instrumental parentification. Nonetheless, in regression analyses, the only parentification dimension to predict mental health symptoms was perceived fairness, which was found to predict symptoms of somatization.

In a convenience sample of 314 university students, Hooper, Wallace, Doehler & Dantzler (2012) compared the prevalence of parentification and explored its effects on mental health (e.g., depression) in two groups, African American and White American. Past parentification was measured using the Parentification Inventory (PI), which measure 3 dimensions of parentification: parent-focused parentification (PFP), sibling-focused parentification (SFP) and perceived benefits of parentification (PBP). Depressive symptoms were measured using the Becks Depression Inventory (BDI). There was no significant difference in parentification scores based on race. They found that PFP and SFP were both positively correlated to depression scores; this applied for both African and

While American groups. In addition, for both groups, parentification predicted depressive symptoms.

In a convenience sample of 783 university students (mean age: 20.92 years), Jankowski, Hooper, Sandage & Hannah (2011) explored past emotional and instrumental parentification and perceived fairness using the Parentification Questionnaire (PQ). Mental health symptoms (i.e. depressive symptoms) were assessed using the Becks depression inventory (BDI). The BDI has a Global Severity Index (GSI) that was also used in the analysis. Higher GSI scores were associated to an increase in perceived unfairness. BDI and GSI were both positively and significantly correlated to emotional and instrumental caregiving, and perceived unfairness. Furthermore, perceived unfairness was a significant mediator between caregiving and depression.

In another study by Hooper, Tomek, Bond & Reif (2014) investigated the psychological effect of past parentification in a sample of racially diverse college students (N=977; mean age: 21. 39). Past parentification was measured using the Parentification Inventory (PI), which assesses parent-focused parentification (PFP) and sibling-focused parentification (SFP). The Becks Depression Inventory (BDI-II) was used to measure psychological distress (i.e., depressive symptomatology). They found that White Americans reported significantly less PFP and SFP than Black and Latino Americans. In general, parentification was found to have a positive association with depressive symptoms. Participants with higher PFP and SFP scores were significantly more likely to report depressive symptoms. The relationship between depression and parentification was significantly greater for White Americans compared to Black and Latino Americans.

The long-standing mental health consequences of past emotional parentification were explored in two online samples, an extraction group (n= 500; mean age: 45 years) and a cross validation group (n=500; 39 years old). Schier, Herke, Nickel, Egle & Hardt (2014) assessed past emotional parentification using the Childhood Questionnaire, a self-report measure that focuses on experiences that occurred during the first 14 years of life. Symptoms of depression and somatization were measured using The Symptoms Checklist-27-plus (SCL-27-plus). They reported that childhood emotional parentification was a strong predictor for current depressive symptoms.

Outcomes in at risk groups. Carroll & Robinson (2000) explored the prevalence and mental health consequences of past parentification in participants with parents who are workaholics and/or alcoholics. In a sample of 207 undergraduate students, the relationship between parentification and depression was assessed in four groups of participants, children of those who are workaholics, alcoholics, or both, and a control group. Past parentification was measured using the Parentification Questionnaire (PQ), a retrospective self-report measure, and depression was measured using Becks Depression Inventory (BDI). They found that participants with workaholic parents scored significantly higher in parentification and depression scores compared to the other groups. Children of alcoholics reported significantly more parentification than the control group. Children of those with a parent who are both an alcoholics and workaholics, reported significantly more parentification and depression than the children of alcoholics and the control group.

In a sample of 116 participants (mean age: 19.79), of whom almost half had a mother with a diagnosed mental illness (n= 52), Abraham & Stein (2013) looked into how

specific modes of parent-child interaction, such as reciprocity and past role-reversal, mediated the relationship between maternal mental illness and poor psychological outcomes in their adult children. Past role-reversal was assessed using The Relationship with Parents scale-mother version, and psychological symptoms were assessed using a self-report measure called The Brief Symptoms Inventory (BSI). The BSI includes The General Severity Index (GSI), which was used to represent range and severity of psychological symptoms experienced by participants in the last week. Maternal depression was positively and significantly associated with role- reversal, and negatively associated with reciprocity. They observed that role-reversal, but not reciprocity, was a mediator between maternal mental illness and mental health symptoms in young adults.

Another study explored the effect of past parent-focused versus sibling-focused parentification on current levels of distress, in a sample of 41 adults (mean age: 25.83) who care for their siblings diagnosed with autism. Tomeny, Barry, Fair & Riley (2016) assessed past parentification using the Parentification Inventory (PI). Current distress (i.e., symptoms of depression, anxiety, and stress) was measured using the retrospective self-report measure called the Depression, Anxiety and Stress Symptoms (DASS). They reported that parent-focused parentification was significantly related to stress and anxiety. Meanwhile, sibling focused parentification was significantly associated to stress only.

Furthermore, some studies looked at past parentification in adult sample with a specific mental health disorders. In a sample of 138 participants (mean age: 37 years), Cassidy, Lichtenstein-Phelps, Sibrava, Thomas & Borkovec (2009) compared two groups, participants with a GAD diagnosis (n-=69) and those without a GAD diagnosis (n=69),

based on self-report of past parental care-giving relationships. Past parentification was measured using the Perceptions of Adult Attachment Questionnaire (PAAQ), specifically the role-reversal/enmeshment subscale. Results showed that participants with a GAD diagnosis reported significantly greater past parentification (i.e. role-reversal) than the control group.

The consequences of early caregiving in adult children who provided primary care assistance (i.e. instrumental assistance) to ill parents was explored in a sample of 24 participants (average age: 36). Shifren & Kachorek (2003) collected data about early caregiving experiences using a semi-structured questionnaire, and current mental health was assessed using The Center for Epidemiologic Studies Depression Scale (CES-D). The reported that 42% of the participants had high depressive scores on the CES-D, and those who provided caregiving for longer periods reported more depressive symptoms.

Another study explored the relationship between past parentification and current mental health symptoms, including generalized anxiety disorder (GAD), in a sample of 119 non-clinical participants (mean age: 22.90 years). Tan, Moulding, Nedeljkovic & Kyrios (2010) captured past parentification using a roles reversal/enmeshment subscale form the Perception of Adult Attachment Questionnaire Short Form (PAAQRR-60). Depression and Anxiety symptoms were measured using the Depression and Anxiety Stress Scale Short Form (DASS-21), and GAD symptoms were measured using the Generalized Anxiety Disorder Questionnaire for DSM IV (GAD-Q-IV). They reported a weak positive significant correlation between parentification and GAD. Yet, in a regression analysis, once depression was controlled for, parentification was no longer a

predictor for GAD. The author suggests that the relationship between parentification and GAD might be due to depression.

Parentification and Identity Related Outcomes

When children are consistently given developmentally inappropriate tasks that they are unable to master, as in the context of destructive parentification, they may internalize these experiences, which may lead them to believe that they are somehow deficient and inadequate. Theoretically, imposter feelings or imposter phenomenon, are thought to arise from a repeated sense of failure in the context of parentification. For people with imposter feelings, there is a marked discrepancy between how they see themselves and how others perceive them. Regardless of their actual success and the praise they receive, they constantly feel less capable than others. In order to provide empirical evidence for this assertion, Castro, Jones & Mirsalimi (2004) explored the relationship between early parentification and imposter phenomenon in a sample of 213 graduate students (mean age: 31 years). Past parentification was measured using The Parentification Questionnaire (PQ), a retrospective self-report measure. Current imposter feelings were measured using Chance's Imposter Phenomenon Scale (CIPS). They found that past parentification was positively and significantly correlated to current imposter feelings in participants.

In another study, Perrin, Ehrenberg & Hunter (2013) examined if psychological individuation had a significant role in the relationship between diffuse boundaries in the family (i.e. parentification and triangulation) and later psychological outcomes. A sample of 404 young adults (mean age: 19.4 years) was assessed for past emotional parentification using an instrument that the investigators devised for the purpose of this

study. The retrospective self-report parentification scale used in the study took items from other commonly used parentification measures (Parent-Child Boundaries Scale-III (PBS-III), Filial Responsibility Scale-Adult (FRS-A), Family Structure Survey (FSS), and Parentification scale. Similarly, the investigators devised a retrospective self-report instrument to measure triangulation using established questionnaires that already measure triangulation (e.g. Caught in the Middle [CIM]; Children's Perception of Interparental Conflict Questionnaire [CPIC]). Furthermore, to measure psychological individuation, the investigators devised an instrument that consisted of items taken from the Psychological Connectedness subscale of the Multigenerational Interconnectedness Scale (MIS) and the Conflictual Independence subscale of the Psychological Separation Inventory (PSI). Current psychological adjustment and symptomatology was measured using the self-administered Mood and Anxiety Symptoms Questionnaire (MASQ) which assessed mood and anxiety symptoms. The investigators reported that past maternal parentification and triangulation predicted poor mental health outcomes. Furthermore, the relationship between past maternal parentification or triangulation and poor mental health outcomes was mediated by psychological individuation.

In a sample of 45 undergraduate female participants (mean age: 20 years), Fullinwider-Bush & Jacobvitz (1993) explored the association between parent-child boundary dissolution and identity development in young women. Participants were organized into 3 groups bases on their relationship with their parents: balanced (i.e., close relationship that support and inspire individuation), boundary dissolution between mother-daughter, and boundary dissolution between father-daughter. Boundary dissolution (i.e.

parents' reliance on the daughter for emotional support) was measured using two subscales from the Family Relationship Questionnaire (Father-Daughter Boundary Dissolution scale (FDBD) and Mother Daughter Boundary Dissolution scale (MDBD). Participant's identity style was assessed using the Identity Style Inventory which places participants into 1 of 3 identity problem solving styles: The Information orientation, The Norm orientation, and The Diffuse orientation. Participants who had a balanced relationship with their parents, reported more over all exploration. The authors found that mother-daughter boundary dissolution was more likely to make identity commitments without exploration, i.e., the Norm Orientation identity style. Meanwhile, those with a father-daughter boundary diffusion were less likely to explore and to make identity related commitments, i.e., the Diffuse Orientation identity style.

Meanwhile, in a longitudinal study, Mayseless & Scharf (2009) investigated the effect of past parentification on psychological individuation and adjustment in a sample of 120 female participants, ages were 17-18 years old, "emerging adults", from Israel. Parentification was measured using the Inadequate Boundaries Questionnaire (IBQ), while individuation and separation was assessed using the Separation and Individuation Test of Adolescence (SITA) and Psychological Separation Inventory (PSI). A negative significant correlation was found between past parentification and all 3 scales of the PSI (i.e. Conflictual, Functional and Emotional Independence). Furthermore, parentification was found to have a positive and significant correlation with nurturance seeking, separation anxiety and dependency denial. Therefore, the more parentified an individual is, the less

independence they display, and the more separation anxiety they feel, and the more nurturance they seek. From these findings, one could extrapolate that parentification interferes with individuation and healthy/mature identity development.

Lastly, in a sample of high and low function children (n= 416; mean age: 14.09), Godsall, Jurkovic, Emshoff, Anderson & Stanwyck (2004) explored the effect of having an alcoholic parent on self-concept, and how family function (i.e., parentification) may explain the relationship between having an alcoholic parent and self-concept. The authors defined self-concept as a "multifaceted construct referring to one's perceptions of, attitudes toward, and beliefs about oneself in various domains (e.g., physical appearance, school, popularity)." Current parentification was measured using the Parentification Questionnaire- Youth (PQ-Y), a self-report measure. Self-concept was assessed using a self-report measure called the Piers-Harris Self-Concept Scale for Children. They found that Parentification was negatively correlated to self-concept. Furthermore in the high functioning group, parentification partially mediated the relationship between having an alcoholic parent and self-concept. Meanwhile in the low-function group, parentification was found to be a predictor of self-concept.

In consideration of the above-discussed literature, the author examined the following hypotheses:

Hypothesis 1: (1) Past Expressive Caregiving group and (2) Past Unfairness group are positively and significantly correlated to:

a) Identity distress

b) Mental health symptoms (i.e., GSI)

Hypothesis 2: (1) Past Expressive Caregiving group and (2) Past Unfairness group predict

a) Identity distress
b) Mental health symptoms (i.e., GSI)

Hypothesis 3: (1) On-going Caregiving group has significantly higher scores on

a) Identity distress than (i) Past Caregiving Only, (ii) Current Caregiving Only, (iii) No Caregiving groups.
b) Mental health symptoms (i.e., GSI) than (i) Past Caregiving Only, (ii) Current Caregiving Only, (iii) No Caregiving groups.

Hypothesis 4: (1) On-going Expressive Caregiving group and (2) On-going Unfairness are positively and significantly correlated to

a) Identity Distress
b) Mental Health Symptoms (i.e., GSI)

Hypothesis 5: (1) On-going Expressive Caregiving group and (2) On-going Unfairness group predicts

a) Identity distress
b) Mental health symptoms (i.e., GSI)

CHAPTER 3

Method

This purpose of this study is to investigate the impact of past and on-going emotional parentification, and past and on-going perceived unfairness on mental health and identity development on university students in Lebanon. The following chapter describes the study's design, which includes a description of the participants and, materials (i.e, questionnaires) and a detailed narrative of the procedure.

Participants

The sample consisted of 157 university students. Participants in this study were selected based on convenience sampling and willingness to complete the survey. The majority of participants were recruited from 2 different universities, Haigazian University (n=71) and Arab Open University (n=45), both located in Beirut, Lebanon. The remaining participants (n=41) were recruited online. Participant's ages ranged from 17-38 years old, with the majority of students being 17-24 years old (84.7%), and the mean age being 21.38 years old. There were 116 (73.90%) females and 41(26.10%) males, of which 147 (93.60%) were single. In terms of employment, seventy-nine (50.30%) participants were unemployed and 77 (49.10%) were employed (see Table 1).

Table 1

Frequencies and percentages of Demographics (n=157)

	Number	Percentage
Age		
17-20	74	47.10%
21-24	59	37.60%
25-28	18	11.40%
29-38	6	3.70%
Gender		
Males	41	26.10%
Females	116	73.90%
Employment		
No	79	50.30%
Yes	77	49.10%
Marital Status		
Single	147	93.60%
Married	9	5.70%
Parent's Marital Status		
Single	1	0.60%
Married	141	89.80%
Divorced	5	3.20%
Widow	8	5.10%
Parent with Chronic Medical Condition		
No	128	81.50%
Yes	27	17.20%
Parent with Mental Health Condition		
No	129	82.20%
Yes	28	17.80%
Number of Siblings		
Only Child	5	3.20%
1	46	29.30%
2	53	33.80%
3	33	21.00%
4	11	7.00%
5	3	1.90%
6 or more	6	3.80%
Birth Order		
First Born	51	32.50%
Middle Child	45	28.70%
Last Born	52	33.10%
Only child	5	3.20%
Twins	4	2.50%

Materials

At both universities, each participant was provided with a packet that included the following: an information form (See Appendix A), a consent form (See Appendix B), a demographic questionnaire (See Appendix C), the Familial Responsibility Scales- Adult (FRS-A) (See Appendix D), and Identity Distress Survey (IDS) (See Appendix E), and the Brief-Symptoms Inventory-18 (BSI-18) (See Appendix F). Online participants were asked to follow a Google Forms link that provided them with an electronic copy of the above forms and questionnaires. The following is a description of the materials used:

Demographics Questionnaire. A demographic questionnaire was created for the purpose of this study to collect information about the participant (i.e., age, gender, marital and employment status) and relevant information about the participant's family of origin (i.e. parent's marital status, parent with chronic medical or psychological illness, number of siblings and participant's birth order.) (See Appendix A)

Filial Responsibility Scale-Adult. The Filial Responsibility Scale-Adult (FRS-A; Jurkovic, Thirkield & Morrell, 2001) is a 60 item self-report questionnaire that was used to measure parentification in our sample. The FRS-A assesses the temporal presence of parentification (past and/or current), type of parentification experienced (i.e. instrumental and/or expressive) and if the experience of parentification was perceived as unfair. The FRS-A is comprised of 6 subscales: Past Instrumental Caregiving, Past Expressive Caregiving, Past Unfairness, Current Instrumental Caregiving, Current Expressive

Caregiving, and Current Unfairness. Each item is rated according to a 5-point Likert scale where number 1 indicates strong disagreement, and the number 5 indicates strong agreement. Subscale scores range from 10-50. Participants with higher scores are thought to have experienced a greater degree of parentification and perceived unfairness. The FRS-A is an updated version of the Parentification Questionnaire (PQ), which only assesses past parentification.

Jurkovic, Thirkield & Morrell (2001) reported the alpha coefficients for the current caregiving subscales are: current instrumental (.83), current expressive (.76) and current perceived unfairness (.87). Furthermore, Jurkovic et al., (2001) suggested that subscale scores that are at or above the median could be considered high or potentially destructive levels of caregiving. Hooper & Wallace (2009) reported acceptable level of internal reliability for the past caregiving subscale: past instrumental (.81), past expressive (.82) and past perceived unfairness (.88).

Identity Distress Scale. The Identity Distress Scale (IDS; Berman, Montgomery & Kurtines, 2004) is a 10 item questionnaire that is intended to measure distress stemming from unresolved identity related issues. The first 7 questions the participant is asked to rate the amount of worry and distress they may be experiencing in relation to a particular identity domain (e.g. long term goals, career, sexual orientation, etc.). Questions 8, 9 and 10 measure severity of distress, by assessing duration of distress and how the distress is affecting overall functioning and mood. For the first 9 questions, participants are asked to rate their level of distress on a 5 point scale, 1= not at all to 5= very severely. The last question asks about the duration of overall identity related distress, participants are asked

to indicate if they've experienced distress for the following durations: 1= never or less than one month, 2= 1-3 months, 3= 3-6 months, 4= 6-12 months, and 5= more than 12 months.

The IDS was modelled to measure "Identity Disorder" in the DSM-III (American Psychiatric Association, 1980), which was later downgraded in the DSM-IV to a v-code called "Identity Problem" (American Psychiatric Association, 1994). The IDS has an internal consistency that ranges from .75 (Berman, You, Schwartz, Teo & Mochizuki, 2011), .80 (Hernandez, Montgomery & Kurtines, 2006), 0.84 (Berman, Montgomery & Kurtines, 2004),

Brief Symptom Inventory-18. The Brief Symptoms Inventory- 18 (BSI-18; Derogatis, 2001), will be used to measure the amount of distress related to specific mental health symptoms in the last 7 days. The BSI-18 was derived from the 52 item Brief Symptom Inventory (Derogatis & Spencer, 1982). The BSI-18 is an 18-item self-report questionnaire, which includes 3 subscales (depression, anxiety and somatization) and a Global Severity Index (GSI). Each of the subscales comprises of 6 items and each item is rated according to how much distress experienced in relation to a particular symptom in the last 7 days. Distress is rated according to 5 –point Likert scale where 0 = not at all and 4 = extremely. Results are determined by calculating sum scores for individual subscales that can range from 0-24, and total scale score (GSI) that can range from 0-72. The most recent study, Franke et al., (2017) reported on the BSI-18 internal consistency for subscales: Depression (.87), Anxiety (.84), Somatization (.82) and GSI (.93).

Research Design

This was a quantitative study that is based on self-measure reports. Internal reliability was determined by checking the Cronbach's alpha coefficients for all the instruments used. FRS-A caregiving subscale scores were converted from continuous scores into six caregiving groups (past expressive, past instrumental, past unfairness, current expressive, current instrumental and current unfairness groups). Caregiving groups were defined by including all those who scored at or above the median score for each FRS-A subscale.

Furthermore, in order to explore those who scored high in past and current caregiving (i.e. continuous or ongoing caregiving) subscale scores were converted into four caregiving groups (no caregiving, past caregiving only, current caregiving only and ongoing caregiving) defined by the duration of caregiving experienced. Similarly, caregiving groups were determined based on the median score for the Past Caregiving subscale and Current Caregiving subscale. Those who scored below the median were considered to have experienced a low level of caregiving, and those who scored at or above the median were thought to have experienced a high level of caregiving. Participants who scored low in past and current caregiving were categorized as the "no caregiving" group. Those you scored high in only the past caregiving subscale, but low in the current caregiving subscale were categorized as the "current caregiving only" group. Participants who scored low in the past caregiving subscale but high in the current caregiving subscale, were categorized as being in the "past caregiving only" group. Those who scored high on both past and current caregiving subscales were categorized as being

in the "ongoing caregiving" group. The ongoing caregiving group was explored further by dividing it into 3 subgroups based on the type of caregiving experienced ("ongoing instrumental caregiving" and "ongoing expressive caregiving") and perceived unfairness ("ongoing unfairness") related to their experience.

This study included several types of analyses to explore the relationship between caregiving variables and the study's outcome variables, identity distress and mental health symptoms. A Pearson's correlation coefficient analysis was conducted to determine if there was a significant association between caregiving groups, identity distress and mental health symptoms (i.e., GSI). Multiple linear regression analyses were conducted in order to determine if specific caregiving groups predicted identity distress and mental health symptoms, specifically GSI. One-way ANOVA analyses were used to explore the differences in identity distress and mental health (i.e., GSI) scores across the caregiving groups.

Procedure

Permission was obtained to collect data at the universities. Specific professors at each of the universities gave permission to collect data during their classes. Data were collected from 5 classes at Haigazian University and 2 classes at Arab Open University. At the beginning of each class, the study was introduced to the students by briefly explaining the study's main objectives. Each student was provided with a packet that included a Participant Information Letter (See Appendix A), Participant Consent Form (See Appendix B), a Demographic Questionnaire (See Appendix C), the Familial Responsibility Scales- Adult (FRS-A) (See Appendix D), Identity Distress Survey (IDS)

(See Appendix E), and the Brief-Symptoms Inventory-18 (BSI-18) (See Appendix F). Students were given directions to read more about the study by reviewing the information form provided in each packet. Those interested in being participants were asked to sign the participant consent form provided in the packet. Participants were then asked to continue by filling out the questionnaires in the packet. Filling out the questionnaires took between 15 to 25 minutes. Participants handed back the packets once they completed the questionnaires.

Online recruitment was conducted by posting a brief description about the study on social media and providing a link which eligible individuals (i.e. university students), who are interested in participating, could follow in order to learn more about the study and fill out the study's questionnaires. The link provided online took interested individuals to Google Forms, where they were provided with more information about the study. Individual who consented to being participants were asked to continue by filling out the demographic form and the study's questionnaires, and then to click submit once they have completed answering the questions.

Data Analysis

After collecting the data, the researcher used the statistical tool IBM SPSS Statistics (Version 20) to produce the statistical results.

Chapter 4

Results

The purpose of this study was to explore the impact of parentification (i.e.: caregiving) and the different types of parentification on identity development and mental health. This chapter will present the results of the study's hypotheses and reliability testing of the instruments used.

Reliability Testing

Cronbach's alpha was calculated to determine the internal reliability of the scales used in this study. The reliability coefficients fell into the acceptable range for the Familial Responsibility Scale-Adult (α = 0.93), Identity Distress Survey (α = 0.83) and Brief Symptoms Inventory-18 (α = 0.94). The Familial Responsibility Scale-Adult subscales also had acceptable reliability coefficients and turned out to be as follows: Past Caregiving (α = 0.88), Past Instrumental Caregiving (α = 0.74), Past Expressive Caregiving (α = 0.76), Past Unfairness (α =0 .88), Current Caregiving (α = 0.86), Current Instrumental Caregiving (α = 0.77), Current Expressive Caregiving (α = 0.66) and Current Unfairness (α =0.89). Additionally, acceptable reliability coefficients were found for the Brief Symptoms Inventory Subscales: Anxiety (α = 0.89), Depression (α = 0.86) and Somatization (α = 0.86). Results of the internal reliability testing in this research are presented in Table 2.

Table 2
Cronbach's Alpha for the various Scales and Subscales

	Previous Cronbach's alpha	Current Cronbach's alpha
Current Instrumental Caregiving	0.83	0.77
Current Expressive Caregiving	0.76	0.66
Current Perceived Unfairness	0.87	0.89
Past Instrumental Caregiving	0.81	0.74
Past Expressive Caregiving	0.82	0.76
Past Perceived Unfairness	0.88	0 .88
Brief Symptoms Inventory–18 (GSI)	0.93	0.94
Anxiety	0.84	0.89
Depression	0.87	0.86
Somatization	0.82	0.86
Identity Distress Survey	0.75 - 0.84	0.83

Hypotheses Testing

Hypothesis 1: (1) Past Expressive Caregiving group and (2) Past Unfairness group have a positive significant correlation to

a) Identity distress

b) Mental health symptoms (i.e., GSI)

Table 3

Correlations between past and current caregiving groups, identity distress and mental health symptoms

		GSI	Identity Distress
Current Instrumental Caregiving	Pearson Correlation	.202*	.112
	Sig. (2-tailed)	.011	.161
	N	157	157
Current Expressive Caregiving	Pearson Correlation	.216**	.140
	Sig. (2-tailed)	.007	.080
	N	157	157
Current Unfairness	Pearson Correlation	.390**	.293**
	Sig. (2-tailed)	.000	.000
	N	157	157
Past Instrumental Caregiving	Pearson Correlation	.132	.145
	Sig. (2-tailed)	.100	.070
	N	157	157
Past Expressive Caregiving	Pearson Correlation	.219**	.176*
	Sig. (2-tailed)	.006	.027
	N	157	157
Past Unfairness	Pearson Correlation	.306**	.217**
	Sig. (2-tailed)	.000	.006
	N	157	157

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

A Pearson's correlation coefficient analysis was computed to examine the relationship between the caregiving groups, identity distress and GSI. Past Expressive Caregiving group was found to have a positive significant correlation to Identity distress (r

= .18, p < 0.05), and GSI (r = .22, P <0.01) (see Table 3). Therefore, parts (1a) and (1b) of hypothesis 1 are supported (see Table 3).

Past Unfairness group was found to have a positive significant correlation to Identity distress (r = .22, p < 0.01), and GSI (r = .31, P <0.01). Therefore, part (2a) and (2b) of hypothesis 1 are supported (see Table 3).

While not hypothesized upon, Current Instrumental Caregiving group was found to have a positive significant correlation to GSI (r= .20, p<0.05). Current Expressive Caregiving was found to have a positive significant correlation to GSI (r= .22, p<0.01). Furthermore, the Current Unfairness group was also found to have a positive significant correlation to GSI (r= .39, p<0.01) and identity distress (r = .29, p<0.01) (see Table 3).

Hypothesis 2: (1) Past Expressive Caregiving group and (2) Past Unfairness group predict

a) Identity distress
b) Mental health symptoms (i.e., GSI)

A multiple linear regression analysis was conducted to determine if caregiving variables predicted identity distress, while controlling for mental health (i.e., GSI). Past Expressive Caregiving group was not found to predict identity distress, b = -.408, β = -.022, t (136) = -.255, p = .799. In addition, Past Unfairness group was not found to predict identity distress, b = -1.099, β = -.058, t (136) = -.572, p= .568 (see Table 4). Therefore parts (1a) and (2a) of hypothesis 2 are unsupported.

Table 4

Regression Coefficients for identity distress, current and past caregiving groups, and demographic variables

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	28.454	5.945		4.787	.000
	Age	-.261	.192	-.115	-1.359	.176
	Gender	-1.982	1.362	-.108	-1.456	.148
	Employment Status	.342	1.130	.024	.303	.762
	Marital status	.008	2.636	.000	.003	.998
	Parent's marital status	.826	1.365	.048	.605	.546
	Parent with a chronic medical condition	-.145	.075	-.143	-1.934	.055
	Parents with a mental health condition	2.862	1.605	.135	1.783	.077
	Number of siblings	-.604	.478	-.095	-1.263	.209
	Birth order	-.041	.605	-.005	-.068	.946
	Current Instrumental Caregiving	-.893	1.488	-.050	-.600	.550
	Current Expressive Caregiving	.710	1.387	.040	.512	.610
	Current Perceived Unfairness	1.670	1.932	.092	.865	.389
	Past Instrumental Caregiving	2.323	1.651	.127	1.407	.162
	Past Expressive Caregiving	-.408	1.599	-.022	-.255	.799
	Past Perceived Unfairness	-1.099	1.923	-.058	-.572	.568
	GSI	.238	.040	.495	5.971	.000

a. Dependent Variable: Identity Distress

A separate multiple regression analysis was performed to explore caregiving variables as possible predictors of mental health symptoms, specifically GSI, while controlling for identity distress. Past Expressive Caregiving group was not found to predict GSI, $b = .766$, $\beta = .020$, $t(136) = .251$, $p = .803$. In addition, Past Unfairness group was not found to predict GSI, $b = .702$, $\beta = .018$, $t(136) = .191$, $p = .849$ (see Table 5). Therefore parts (1b) and (2b) of hypothesis 2 are unsupported.

While not hypothesized upon, it is important to note that Current Unfairness was found to predict GSI, $b = 10.453$, $\beta = .277$, $t(136) = 2.908$, $p = .004$ (see Table 5)

Table 5

Regression Coefficients for mental health symptoms, current and past caregiving groups, and demographic variables

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-17.776	12.195		-1.458	.147
	Age	.611	.366	.129	1.669	.098
	Gender	7.617	2.542	.200	2.996	.003
	Employment Status	.946	2.160	.032	.438	.662
	Marital status	-8.429	4.990	-.118	-1.689	.093
	Parent's marital status	-5.245	2.575	-.148	-2.037	.044
	Parent with a chronic medical condition	.108	.146	.051	.741	.460
	Parents with a mental health condition	1.612	3.102	.036	.520	.604
	Number of siblings	1.339	.913	.101	1.467	.145
	Birth order	.527	1.157	.031	.456	.649
	Current Instrumental Caregiving	3.288	2.836	.090	1.159	.248
	Current Expressive Caregiving	3.177	2.641	.086	1.203	.231
	Current Perceived Unfairness	10.453	3.594	.277	2.908	.004
	Past Instrumental Caregiving	-2.254	3.175	-.059	-.710	.479
	Past Expressive Caregiving	.766	3.058	.020	.251	.803
	Past Perceived Unfairness	.702	3.681	.018	.191	.849
	Identity Distress	.872	.146	.420	5.971	.000

a. Dependent Variable: GSI

Hypothesis 3: (1) On-going Caregiving group have significantly higher scores on

a) Identity distress than (i) Past Caregiving Only, (ii) Current Caregiving Only, (iii) No Caregiving groups.

b) Mental health symptoms (i.e., GSI) than (i) Past Caregiving Only, (ii) Current Caregiving Only, (iii) No Caregiving groups.

Separate one-way Anova analyses were conducted to explore differences in identity distress and mental health symptoms (i.e., GSI) based on the duration/degree of caregiving experienced (i.e.: No Caregiving, Past Caregiving Only, Current Caregiving Only and On-going Caregiving).

Identity distress differed significantly across the caregiving groups, F (3,153)= 6.072, p= .001. A Bonferroni post-hoc comparison of the four groups found the On-going Caregiving Group reported significantly greater identity distress than the No Caregiving Group ($p < .001$), but there was no significant difference when it was compared to the Past and Current Caregiving Groups. Therefore, parts 1 (a) (i) and (a) (ii) of hypothesis 3 were not supported, while part 1 (a) (iii) was supported. Table 6 shows the means for identity distress across the different caregiving groups, followed by Table 7 that shows the post-hoc comparisons.

Table 6

Means for identity distress scores across four caregiving groups

Dependent variable: Identity Distress	N	Mean	Std. Deviation
No Caregiving	62	23.8548	6.94910
Past Caregiving Only	15	25.7333	7.47822
Current Caregiving Only	16	25.8750	8.77021
Ongoing Caregiving	64	29.6719	8.24247
Total	157	26.6115	8.10717

Table 7

Post-hoc Bonferroni comparisons of mean identity distress scores across four caregiving groups

Dependent Variable: Identity Distress
Bonferroni

(I) Parentification Duration		Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Caregiving	Past Caregiving Only	-1.87849	2.22672	1.000	-7.8305	4.0735
	Current Caregiving Only	-2.02016	2.16996	1.000	-7.8205	3.7801
	Ongoing Caregiving	-5.81704*	1.37899	.000	-9.5031	-2.1310
Past Caregiving Only	No Caregiving	1.87849	2.22672	1.000	-4.0735	7.8305
	Current Caregiving Only	-.14167	2.78123	1.000	-7.5759	7.2925
	Ongoing Caregiving	-3.93854	2.21993	.468	-9.8724	1.9953
Current Caregiving Only	No Caregiving	2.02016	2.16996	1.000	-3.7801	7.8205
	Past Caregiving Only	.14167	2.78123	1.000	-7.2925	7.5759
	Ongoing Caregiving	-3.79688	2.16300	.487	-9.5786	1.9848
Ongoing Caregiving	No Caregiving	5.81704*	1.37899	.000	2.1310	9.5031
	Past Caregiving Only	3.93854	2.21993	.468	-1.9953	9.8724
	Current Caregiving Only	3.79688	2.16300	.487	-1.9848	9.5786

*. The mean difference is significant at the 0.05 level.

In a one-way Anova analysis, mental health symptoms (i.e., GSI) was observed to differ significantly across the caregiving groups, F (3, 153) = 9.501, p = .000. In a Bonferroni post-hoc comparison of the four groups, On-going Caregiving Group scored significantly higher on GSI compared to the No Caregiving group ($p < 0.001$) . Therefore, parts 2 (b) (i) and b (ii) of hypothesis 3 are not supported, while part 2 b (iii) is supported by the results. Table 8 shows the means for GSI across the different caregiving groups, followed by Table 9 that shows the post-hoc comparisons.

Table 8

Means for mental health scores across four caregiving groups

Dependant variable: GSI	N	Mean	Std. Deviation
No Caregiving	62	15.4516	12.66941
Past Caregiving Only	15	19.6667	13.98809
Current Caregiving Only	16	19.8125	13.51157
Ongoing Caregiving	64	30.0469	18.70611
Total	157	22.2484	16.84494

Table 9

Post-hoc Bonferroni comparisons of Mean mental health scores across four caregiving groups

Dependent Variable: GSI
Bonferroni

(I) Parentification Duration		Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Caregiving	Past Caregiving Only	-4.21505	4.49360	1.000	-16.2264	7.7963
	Current Caregiving Only	-4.36089	4.37907	1.000	-16.0661	7.3443
	Ongoing Caregiving	-14.59526*	2.78285	.000	-22.0338	-7.1567
Past Caregiving Only	No Caregiving	4.21505	4.49360	1.000	-7.7963	16.2264
	Current Caregiving Only	-.14583	5.61262	1.000	-15.1483	14.8567
	Ongoing Caregiving	-10.38021	4.47990	.131	-22.3550	1.5945
Current Caregiving Only	No Caregiving	4.36089	4.37907	1.000	-7.3443	16.0661
	Past Caregiving Only	.14583	5.61262	1.000	-14.8567	15.1483
	Ongoing Caregiving	-10.23438	4.36501	.122	-21.9020	1.4333
Ongoing Caregiving	No Caregiving	14.59526*	2.78285	.000	7.1567	22.0338
	Past Caregiving Only	10.38021	4.47990	.131	-1.5945	22.3550
	Current Caregiving Only	10.23438	4.36501	.122	-1.4333	21.9020

*. The mean difference is significant at the 0.05 level.

Hypothesis 4: (1) On-going Expressive Caregiving group and (2) On-going Unfairness group has a positive significant correlation to

a) Identity Distress

b) Mental Health Symptoms (i.e., GSI).

A Pearson's correlation coefficient analysis was computed to examine the relationship between the Ongoing Caregiving group, identity distress and mental health symptoms (i.e., GSI). Ongoing Expressive Caregiving Group is not significantly correlated to Identity Distress. Meanwhile, Ongoing Expressive Caregiving was found to have a positive significant correlation to GSI ($r = .33$, $p<0.01$) (see Table 10). Therefore, part (1a) of hypothesis 4 is unsupported, while part (1b) of the hypothesis is supported.

Ongoing Unfairness Group was found to have a positive and significant correlation to Identity Distress ($r = .24$, $p<0.01$) and GSI ($r = .33$, $p<0.01$) (see Table 10). Therefore, part (2a) and (2b) of hypothesis 4 are supported.

Table 10

Correlations between ongoing caregiving groups, identity distress, and mental health symptoms

		Identity Distress	GSI
Ongoing Instrumental Caregiving	Pearson Correlation	.145	.214**
	Sig. (2-tailed)	.070	.007
	N	157	157
Ongoing Expressive Caregiving	Pearson Correlation	.118	.223**
	Sig. (2-tailed)	.140	.005
	N	157	157
Ongoing Unfairness	Pearson Correlation	.236**	.332**
	Sig. (2-tailed)	.003	.000
	N	157	157

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Hypothesis 5: (1) Ongoing Expressive Caregiving group and (2) On-going Unfairness group predicts

a) Identity distress

b) Mental health symptoms (i.e., GSI).

A multiple linear regression analysis was conducted to determine if On-going Caregiving group predicted identity distress, while controlling for mental health symptoms (i.e., GSI). On-going Expressive Caregiving group and On-going Unfairness group were not found to predict identity distress, $b = -.755$, $\beta = -.032$, $t\ (139) = -.401$, $p = .689$, and $b = .380$, $\beta = .019$, $t\ (139) = .242$, $p = .809$, respectively (see Table 11). Therefore, part 1 (a) and 2 (a) of hypothesis 5 are not supported. It is interesting to note that before controlling for GSI, On-going Unfairness predicted identity distress but significance was lost after controlling for GSI.

Table 11

Regression Coefficients for identity distress, ongoing caregiving groups, and demographic variables

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	28.783	5.909		4.871	.000
	Age	-.279	.192	-.123	-1.452	.149
	Gender	-2.094	1.343	-.114	-1.559	.121
	Employment status	.192	1.119	.014	.172	.864
	Marital status	-.086	2.637	-.002	-.033	.974
	Parent's marital status	1.199	1.284	.070	.934	.352
	Parent with a chronic medical condition	-.139	.074	-.136	-1.876	.063
	Parent with a mental health condition	2.731	1.577	.128	1.732	.086
	Number of siblings	-.509	.469	-.080	-1.084	.280
	Birth order	-.102	.599	-.012	-.170	.865
	Ongoing Instrumental Caregiving	1.046	1.641	.050	.637	.525
	Ongoing Expressive Caregiving	-.755	1.880	-.032	-.401	.689
	Ongoing Unfairness	.380	1.574	.019	.242	.809
	GSI	.248	.039	.516	6.439	.000

a. Dependent Variable: Identity Distress

A separate multiple regression analysis was performed to explore On-going Caregiving as a possible predictors of mental health symptoms, specifically GSI, while controlling for identity distress. On-going Expressive Caregiving group was not found to predict GSI, $b = 3.911$, $\beta = .080$ $t(139) = 1.082$, $p = .281$ (see Table 12). Meanwhile, On-going Unfairness was found to predict GSI, $b = 9.846$, $\beta = .232$, $t(139) = 3.370$, $p = .001$. Therefore, part 1 (b) of hypothesis 5 is not supported, while part 2 (b) is supported.

Table 12

Regression Coefficients for mental health symptoms, ongoing caregiving groups, and demographic variables

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-25.365	12.151		-2.087	.039
	Age	.505	.372	.107	1.360	.176
	Gender	7.648	2.534	.201	3.019	.003
	Employment status	2.276	2.152	.078	1.057	.292
	Marital status	-6.784	5.057	-.095	-1.342	.182
	Parent's marital status	-3.180	2.472	-.090	-1.286	.201
	Parent with a chronic medical condition	.117	.144	.055	.811	.419
	Parent with a mental health condition	1.420	3.075	.032	.462	.645
	Number of siblings	1.753	.898	.132	1.953	.053
	Birth order	.846	1.153	.050	.734	.464
	Ongoing Instrumental Caregiving	3.561	3.158	.082	1.128	.261
	Ongoing Expressive Caregiving	3.911	3.616	.080	1.082	.281
	Ongoing Unfairness	9.846	2.921	.232	3.370	.001
	Identity Distress	.925	.144	.445	6.439	.000

a. Dependent Variable: GSI

Chapter 5

Discussion

Parentification should not be equated with pathology, as most people experience a degree of role reversal at some point during their childhood. To fully capture the parentification experience it has been conceptualized as a multidimensional continuum, whereby most people's experience with role-reversal rests somewhere on the parentification spectrum. At one end of the continuum, an individual is never or rarely engaged in role-reversal, and at the other end, an individual is frequently or continuously engaged in role-reversal. Furthermore, parentification is a multifaceted phenomenon, to accurately capture the experience, researchers must investigate its many co-occurring dimensions, which include: onset age of caregiving, type of caregiving tasks (i.e. emotional and/or instrumental) given to the child, the developmental appropriateness of the caregiving tasks given to the child, the duration of caregiving, and perceived fairness related to their caregiving experience (i.e. were they treated fairly or unfairly). Considering the complexity of the parentification process, outcomes related to parentification have been shown to vary. Nonetheless, there appears to be general consensus, theoretically, clinically and empirically, that specific parentification experience, i.e., frequent, emotional, and long-lasting caregiving that is perceived to be unfair, is more consistently associated to poorer outcomes. In a convenience sample of university students, the objective of this study was to explore the relationship between specific parentification dimensions, i.e. past and on-going emotional parentification and

perceived unfairness, on mental health and identity distress. This chapter discusses the findings of the investigated hypotheses.

The first hypothesis examined two specific caregiving dimensions, past expressive caregiving (part 1) and past perceived unfairness (part 2), and their relationship to mental health symptoms (a) and identity distress (b). In support of hypothesis 1, both, past expressive caregiving and past unfairness were positively and significantly correlated to mental health symptoms and identity distress. Our finding that past emotional caregiving and mental health symptoms are positively and significantly correlated is in line with findings from other studies (Hooper et al., 2007; Hooper and Wallace, 2009; Jankowski et al., 2013). Additionally, our finding that past perceived unfairness and mental health symptoms are positively and significantly correlated is consistent with other studies (Hooper and Wallace, 2009; Jankowski et al., 2011).

As previously mentioned, there are very few studies that empirically investigated the effect of parentification on identity constructs (Castro et al., 2004; Fullinwinder-Bush et al., 1993; Godsall et al., 2004; Mayseless et al., 2009; Perrin et al., 2013). Furthermore, to our knowledge there are no studies that explored the effect of parentification on identity distress. Nonetheless, we can extrapolate similar findings from the available studies. In a sample of adolescents, Godsall et al. (2004) found that parentification was negatively correlated with self-concept, meaning that higher parentification scores were associated with poorer self-concept. Furthermore, in a sample of adults, Castro et al., (2004) found that past parentification was positively and significantly correlated with imposter feelings (i.e., a discrepancy between how they viewed themselves and how others view them).

The second hypothesis of this study proposed that past emotional parentification (part1) and past perceived unfairness (part 2) would each predict mental health symptoms (a) and identity distress (b), but our findings did not support these claims. Our findings differed from other studies that found past emotional parentification (Hooper et al. 2007; Katz et al., 2009; Perrin et al., 2013; Schier et al., 2014) and past unfairness (Hooper and Wallace, 2009) to predict mental health symptoms. Furthermore, regarding parentification and identity distress, our findings are not consistent with Godsall et al (2004) who found that parentification predicted self-concept. However, our findings are similar to a study by Hopper and Wallace (2009), who reported that while past emotional parentification was significantly correlated with mental health symptoms, it was not found to predict mental health symptoms. Additionally, Jurkovic (2005), in a sample of adolescents, found that current parentification was significantly correlated to psychological distress, but parentification did not predict distress.

While some participants only reported experiencing high levels of past or current caregiving only, the majority of participants who reported high levels of past caregiving also reported high levels of current caregiving. Therefore, for the most part, parentification was observed to be chronic or stable over time (i.e. on-going). Our finding related to the stability of caregiving over time is in line with other research (Jurkovic et al., 2001; Khafi, et al., 2014). Perhaps those who experienced high levels of past caregiving only or current caregiving only, are those individuals who provided their parents with time limited support as a response to passing stressors or hardships. Similar to our findings, Jurkovic (2001), using the FRS-A, assessed two “temporal perspectives” of parentification (i.e.

past/retrospective and current) in sample of university students from divorced families, and found that high levels of parentification were observed to be relatively stable across retrospective and current parentification subscales. Furthermore, Jurkovic posed an important question: "is parentification part of a time-limited crisis…or is destructive parentification, particularly of the emotional genre…characterize the family relationship" (Jurkovic et al. 2001).

The duration of role-reversal or parentification is an important indicator of severity, with longer and consistent role-reversal being associated to poorer outcomes (Jurkovic, 1997; Shifren & Kachorek, 2003). Nonetheless, there is a scarcity of research that takes into account or assesses duration of caregiving, and its effect on mental health and identity distress. In the current study, an on-going caregiving group was created which includes those who reported high levels of past and current caregiving. The on-going parentification group is conceptualized as experiencing a more destructive degree of parentification as it implies a longer duration of caregiving compared to those who only reported high levels of past or current caregiving. To our knowledge, there are no published studies that explore an on-going parentification dimension, and its effect on mental health or identity distress.

Considering that most parentified individuals reported experiencing on-going caregiving, the third, fourth and fifth hypotheses focused on the effect of on-going caregiving on mental health and identity distress. The third hypothesis proposed that participants that experienced on-going caregiving would score significantly higher on measures of identity distress and mental health symptoms compared to participants who

reported little or no history of caregiving, and those who reported experiencing only past or only current caregiving. The third hypothesis was partially supported as we found that those who experienced on-going parentification scored significantly higher on measures of identity distress and mental health symptoms, but only when compared to participants who reported little or no parentification. Meanwhile, there were no significant difference between on-going caregiving and those who reported only past or current caregiving. Our findings are not comparable to other published studies because, to our knowledge, there are no published studies that explore an on-going parentification dimension and its effect on mental health or identity distress.

In our fourth hypothesis, we postulated that on-going emotional parentification and on-going unfairness would each have a positive and significant correlation to mental health symptoms and identity distress. The hypothesis was partially supported as we found that on-going emotional caregiving and on-going unfairness are both positively and significantly correlated to mental health symptoms. Meanwhile, only on-going unfairness was found to have a positive significant correlation to identity distress. Our findings concerning the correlation between on-going emotional caregiving and mental health symptoms are similar to studies that found current caregiving in adolescents (Khafi et al., 2014; Peris et al., 2008) or past caregiving in adults (Hooper & Wallace, 2009; Jankowski et al., 2011; Katz et al., 2009; Schier et al., 2014) to be positively and significant correlated to mental health problems.

Our fifth hypothesis predicted that on-going emotional parentification and on-going unfairness would each predict current mental health symptoms and identity distress.

However, only ongoing perceived unfairness was found to predict mental health symptoms. While this particular dimension of parentification, i.e. ongoing perceived unfairness has not been empirically investigated, there is evidence that past perceived unfairness in adult samples (Hooper and Wallace, 2009), and current perceived unfairness in adolescent samples (Jurkovic et al., 2005), are predictive of mental health symptoms or psychological distress.

Additional Analysis

A few interesting findings were observed that were not hypothesized on but are worth mentioning. Consistent with clinical observations and parentification research, past instrumental parentification was not significantly associated to mental health symptoms (Hooper et al. 2007; Hopper & Wallace, 2009; Khafi et al., 2014). Meanwhile, on-going instrumental caregiving was found to be positively and significantly correlated with mental health symptoms. This finding is in line with parentification theory suggests that chronic parentification, regardless of the type of role-reversal, may result in detrimental outcomes (Jurkovic, 1997). Furthermore, current instrumental caregiving was also significantly associated to mental health symptoms. Considering that the effect of current parentification in adult samples on mental health has not been investigated, this finding is not comparable to other findings in parentification research.

In addition, contrary to our expectations, we found that the current caregiving dimensions (i.e. current emotional and instrumental caregiving and currently perceived unfairness in relation to caregiving) were positively and significantly correlated to mental health symptoms, and current unfairness was correlated to identity distress. As mentioned

above, to our knowledge, there are no studies that directly explore the effects of current parentification on mental health or identity formation in an adult sample. There is a scarcity in studies that focus on current parentification in young adult or adult samples because caregiving is no longer considered developmentally inappropriate when expected from young adults (Borchet, Lewandowska-Walter & Rostowska, 2018). Role-reversal or caregiving during adulthood may even be considered common practice, or an expression of reciprocity in caregiving, for example when adult children provide care for aging parents.

According to Arnett (2000), individuals between 18-25 years belong to a developmental category called emerging adults. Emerging adults are conceptualized as being in a transitional stage of development (Arnett, 2000). Similar to adolescents, they may still be preoccupied with identity formation and becoming individuated from their families. Furthermore, emerging adults may not have achieved full financial dependence, and may still be living with their parents or receiving financial support from their parents. Perhaps our finding on the detrimental consequences of current caregiving can partially be explained if we consider that 84% of our sample falls into the emerging adult category, and they may not be developmentally prepared to provide extensive caregivers to their parents or families. Furthermore, it can be argued, that even if individuals are engaged in parentification for the first time during late adolescents or during emerging adulthood, there may still be detrimental consequences to psychosocial development. Frequent caregiving and a strong sense of loyalty towards the home and parents may detract from

pursuing developmentally appropriate milestones related to education, career and interpersonal relationships outside the home (Borchet et al., 2018)

In our study, we found that providing family members and parents with frequent emotional caregiving did not predict poor outcomes. Perhaps in the Lebanese culture, providing extensive emotional caregiving is considered normal. The only caregiving dimension that predicted poor mental health outcomes was perceived unfairness. Our findings are consistent with other findings that found perceived unfairness to be the dimension of parentification to be most significantly associated to poor outcomes (Hooper & Wallace, 2009; Jankowski et al., 2011; Jurkovic et al., 2005; Kuperminc et al., 2009; Kuperminc et al., 2013). This finding suggests that role-reversal or parentification is traumatic or akin to negligence or abuse when the child perceives the experience as unfair, i.e. there is a lack of reciprocity, support, recognition and appreciation. In the current study, on-going and current perceived unfairness predicted poor mental health outcomes, but past perceived unfairness did not. Perhaps those who experienced past perceived unfairness have since then processed these difficult feeling and experiences. Meanwhile, current and on-going perceived unfairness in relation to role-reversal is something that the participant is presently experiencing and has yet to psychologically process.

The current study predicted that specific aspects of parentification would be related and predictive of problems in identity development, as captured by identity distress. In correlational analyses, perceived unfairness dimensions (past, current and on-going), were the only caregiving dimensions, aside from past expressive caregiving, to have a positive and significant correlation to identity distress. Yet, in regression analyses, perceived

unfairness dimensions did not predict identity distress. It is interesting to note that in a regression analysis with identity distress as a dependent variable and on-going caregiving dimensions (on-going instrumental, on-going expressive and on-going unfairness) as independent variables, on-going unfairness was found to predict identity distress, but significance was lost once GSI (i.e., mental health symptoms) was controlled for. While none of the caregiving dimensions predicted identity distress, in a one-way ANOVA analysis, those who experienced on-going caregiving reported significantly higher levels of identity distress compared to those with little or no parentification experience.

Nonetheless, none of the parentification dimensions predicted identity distress. It has been suggested that without adequate exploration, identity formation is affected by forcing parentified individuals to become committed to parental ideals and goals (Fullinwinder-Bush & Jocobvitz, 1993), or to become committed or internalize their caregiving role (Jurkovic, 1997). Theoretically, committing to an identity without exploration is referred to as a foreclosed identity (Marcia, 1966). There is evidence that shows that possessing an identity status that is defined by commitment (e.g. foreclosed identity status) is negatively correlated with identity distress (Crocetti et al. 2012a, b). Perhaps this can partially explain why parentification variables, even perceived unfairness, did not predict identity distress.

Clinical Implications of the Study

The current study demonstrated that in a sample of Lebanese university students, a high level of past, current or on-going emotional and instrumental parentification were not predictive of mental health problems and identity distress. Instead, we found that how one

perceives their experience of caregiving, fair or unfair, as the only parentification variable that is predictive of poor mental health. The clinical implications of these findings are that when working with clients who report an extensive history of role-reversal, especially if caregiving is on-going and current, clinicians should explore how clients perceive their caregiving experience. In order to ascertain possible detrimental consequences pertaining to role-reversal, clinicians should explore if their clients felt that their basic needs were met, if they felt supported and if they felt that their efforts were acknowledged and appreciated by their parents/families. The parentified individual that comes to therapy and reports feelings of being treated unfairly may benefit from clinical work that focuses on: processing feelings associated to experiencing relational injustice, developing an awareness of how their experience may have affected other domains of life, and ultimately learning how to set and communicate personal boundaries.

Furthermore, the on-going caregiving group reported significantly more mental health symptoms and identity distress than those who had little or no history of caregiving. Therefore, when working with a client who reports a chronic history of parentification, it may be of use for clinicians to explore the possible presence of mental health symptoms and problems related to identity development.

Recommendations for Future Research

Although parentification did not predict identity distress, it was correlated with past expressive caregiving and perceived unfairness (on-going and current), and those who reported on-going caregiving also reported significantly higher identity distress compared to those who have little or no experience of parentification. In order to better understand

how parentification may affect identity development, future research could explore identity development using different constructs such as separation-individuation and/or identity status.

Additionally, considering variability in parentification outcomes, there is a growing effort to focus on possible positive outcomes that may be associated to parentification. In the current study, high levels of caregiving did not predict poor outcomes. In a society that upholds collectivist ideals, perhaps lower levels of caregiving and role-reversal may be associated to poorer outcomes. Therefore, future research on role-reversal and caregiving could explore possible positive outcomes associated to caregiving.

Limitations of the Study

The current study is the first quantitative study to investigate the effect of parentification on mental health and identity development. Nonetheless, some limitations should be considered.

The study used a convenience sample therefore we cannot use our finding to make inferences about the general Lebanese population. Furthermore, the FRS-A assesses past caregiving by asking participants to recall previous experiences that may have happened years ago, which may yield imprecise information due recall bias. Questions in the FRS-A that assess parent-focused parentification do not differentiate between mother and father interactions. Some participants expressed confusion because certain questions were applicable to one of their parents but not the other. Furthermore, parentified individuals

tend to have a strong sense of loyalty towards their families and if they perceive questions on the FRS-A as pathologising their family dynamic, this might affect how they respond.

Lastly, the current study assessed problems in identity development by measuring identity distress. Yet, identity distress may not detect or adequately capture aberrations in identity development, or tell us enough about how identity development is affects by parentification.

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Appendix A

Participant Information Form

Dear Ms./Mr.

I am Ranya Hajjar, an MA student in psychology at Haigazian. I am currently carrying out an MA thesis research study titled "The Impact of Parentification on Mental Health and Identity in a Sample of University Students in Lebanon", advised by Dr. Marwan Gharzeddine. You are being asked to take part in this study in order to collect data for an MA thesis in psychology. Kindly read the below information to decide whether you would like to participate in this research study.

Purpose of the Research Project

This research study aims to investigate the effect of past/current parentification on mental health outcomes (anxiety, depression and somatization) and identity development (as indicated by identity distress) in university students in Lebanon. This paper will also study the possible mediating role that identity distress has between parentification and mental health outcomes. Parentification is a well-researched topic, but variability in outcome studies, especially across cultures and ethnicities, indicate that there is still much to understand about the construct.

This study will contribute towards the partial fulfilment of my academic study requirements at Haigazian University.

What will I be asked to do?

- If you choose to participate in this research study, you will be asked to fill in a questionnaire. Your participation will involve completing a survey that entails statements that you will have to rate based on agreement and a demographic form, which will take approximately 15 minutes. Participation in this project is voluntary. You are free to withdraw anytime without having to give any reason for your withdrawal.

What are my rights?

- Participation in this study is completely voluntary, anonymous and confidential. Your name or any other identifying information will not be asked
- Data you provide along with data from all participants in the present research will be stored in aggregate in a password-protected folder on the principle investigator, Ranya Hajjar's, personal computer. The data will be analysed and reported in aggregate. Only the principle investigator of this study will have access to the compiled data that will be stored for a period of 10 years post data. During this time, you have the right to inspect the data.
- You have the right to withdraw your consent or discontinue participation at any time for any reason. Your decision to refuse participation or withdraw will not involve

any penalty or loss of benefits to which you are entitled. Discontinuing participation in no way affects your relationship with Haigazian University.
- If you have any further concerns about your rights as a research participant, please, do not hesitate to contact Dr. Marwan Gharzeddine (email: garzedin@gmail.com)

What are the risks and benefits of participation?

- Participation in this study does not involve any physical risk or emotional risk to you beyond the risks of daily life. Minimal risk may be associated to recalling potentially painful experiences while filling out the questionnaires.
- You will receive no direct benefits from participating in this research; however your participation does help researchers better understand the effects of parentification on identity and mental health outcomes in a Lebanese sample.

Contact information

If you have any questions or concerns about the research you may contact:

Ranya Hajjar

Haigazian student

Phone number: 03 478 458

Email: ranya.hajjar@gmail.com

Supervisor

Dr. Marwan Gharzeddine

Haigazian Professor

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Appendix B

Participant Consent Form

The Impact of Parentification on Mental Health and Identity in a Sample of University Students in Lebanon

Please read the following statements and place a check mark in the boxes adjacent to them.

☐ I have volunteered to participate in this research project conducted for purposes of study. My participation is voluntary and does not involve payment of any kind.

☐ I agree to participate in this research project conducted for purposes of study. My decision is voluntary and does not involve payment of any kind.

☐ I know that I can choose to withdraw from participation any time without any penalties or consequences whatsoever. I also hold the right to decline to respond to any question(s) that I may feel uncomfortable with.

☐ My participation involves answering a questionnaire that takes approximately 15 minutes.

☐ I have been assured that the researcher will maintain my identity confidential.

☐ I have been assured that the information from this survey will be used for the purpose of academic study only.

☐ I agree that the data gathered be kept in a secure location under the care of the study investigators for a period of 10 years.

☐ I have been assured that I can access my data (if identified) at any time.

☐ I have read, listened and fully understand the explanation given to me. All my questions have been satisfactorily answered.

☐ I, therefore, choose to voluntarily participate in this research study.

☐ I have received a copy of this consent form co-signed by the researcher.

Participant consent		**Investigator**	
Date:	_____	Date:	_____
Name:	_____	Name:	_____
Signature:	_____	Signature:	_____

Appendix C

Demographic Questionnaire

1. Age _____
2. Gender _____ Male _____ Female
3. Are you currently enrolled in a university? _____ Yes _____ No
4. Are you currently employed? _____ Yes _____ No _____ Freelancer
5. Please indicate your marital status

   _____ Single _____ Married _____ Divorced _____ Widow
6. Please indicate your parent's marital status

   _____ Single _____ Married _____ Divorced _____ Widow
7. Did one of your parents suffer from a chronic medical condition while you were growing up? _____ Yes _____ No
8. Did one of your parents suffer from a mental health condition while you were growing up? _____ Yes _____ No
9. Please indicate your number of siblings.

   _____ One _____Two _____ Three _____ Four _____ Five _____ Six or more
10. Please indicate your birth order

    _____ Only child _____ First born _____ Middle born _____Youngest/last born

Appendix D

Familial Responsibility Scales- Adult

Directions: The following statements are descriptions of **experiences you might have had growing up as a child in your family**. Because each person's experiences are unique, there are no right or wrong answers. Just try to respond with the rating that fits best. Please respond to every question.

1 = STRONGLY DISAGREE 2 = DISAGREE 3 = NEITHER AGREE NOR DISAGREE 4 = AGREE 5 = STRONGLY AGREE

1. I did a lot of the shopping (e.g., for groceries or clothes) for my family.
2. At times I felt I was the only one my mother or father could turn to.
3. I helped my brothers or sisters a lot with their homework.
4. Even though my parents meant well, I couldn't really depend on them to meet my needs.
5. In my family, I was often described as being mature for my age.
6. I was frequently responsible for the physical care of some member of my family (e.g., washing, feeding, or dressing him or her).
7. It often seemed that my feelings weren't taken into account in my family.
8. I worked to help make money for my family.
9. I often felt like a referee in my family.
10. I often felt let down by members of my family.
11. In my family I often made sacrifices that went unnoticed.
12. It seemed like family members were always bringing me their problems.
13. I often did the family's laundry.
14. If a member of my family were upset, I usually didn't get involved.
15. My parents were very helpful when I had a problem.
16. In my house I rarely did the cooking.
17. My parents often tried to get me to take their side in conflicts.
18. Even when my family did not need my help, I felt very responsible for them.
19. I was rarely asked to look after my siblings.
20. Sometimes it seemed that I was more responsible than my parents were.
21. Members of my family understood me pretty well.
22. My parents expected me to help discipline my siblings.
23. My parents often criticized my efforts to help out at home.
24. I often felt that my family could not get along without me.
25. For some reason it was hard for me to trust my parents.
26. I often felt caught in the middle of my parents' conflicts.
27. I helped manage my family's financial affairs (e.g., making decisions about purchases or paying bills).
28. In my family, I often gave more than I received.
29. It was hard sometimes to keep up in school because of my responsibilities at home.

30. I often felt more like an adult than a child in my family

The following statements are descriptions of experiences you may be currently having in your family of origin (the family in which you grew-up). Because each person's experiences are unique, there are no right or wrong answers. Just try to respond with the rating that fits best. Please respond to every statement.

1 = STRONGLY DISAGREE 2 = DISAGREE 3 = NEITHER AGREE NOR DISAGREE 4 = AGREE 5 = STRONGLY AGREE

31. At times I feel I am the only one my mother or father can turn to.
32. I rarely find it necessary to help members of my family of origin with their household chores.
33. Even though my parents mean well, I can't really depend on them to be there for me when I need them.
34. I often feel guilty when doing things that don't involve my family of origin.
35. My parents often seem so disappointed in me.
36. I often feel that my family of origin could not get along without me.
37. I sometimes give money to members of my family of origin to help them out.
38. There are certain members of my family of origin I can handle better than anyone else.
39. My parents expect me to help manage my siblings.
40. I often feel let down by members of my family of origin.
41. It is hard for me to enjoy myself knowing that members of my family of origin are unhappy.
42. I help my brothers or sisters a lot with their job responsibilities.
43. In my family of origin, I often make sacrifices that go unnoticed by other family members.
44. It is sometimes hard to keep up with my own duties at home or work because of my responsibilities to my family of origin.
45. I am very uncomfortable when things are not going well for members of my family of origin.
46. Members of my family of origin understand me pretty well.
47. It often seems that my feelings aren't taken into account in my family of origin.
48. In my mind, the welfare of my family of origin is my first priority.
49. I am very active in managing the financial affairs (e.g., making decisions about purchases, paying bills) of a member of my family of origin.
50. I often do the laundry for a member of my family of origin.
51. For some reason it is hard for me to trust my parents.
52. It seems that members of my family of origin are always bringing me their problems.
53. I do a lot of the shopping (e.g., for groceries or clothes) for one or more members of my family of origin.
54. My parents are very helpful when I have a problem.

55. I am frequently responsible for the physical care of some member of my family of origin (e.g., washing, feeding, or dressing him or her).

56. If a member of my family of origin is upset, I usually don't get involved.
57. I often feel like I am the adult, and my parents are the children.

58. Even when members of my family of origin do not need my help, I feel very responsible for them.

59. I hardly ever have to do the cooking for a member of my family of origin.

60. Sometimes it seems that I am more responsible than my parents.

Appendix E

Identity Distress Survey

To what degree have you recently been upset, distressed, or worried over any of the following issues in your life? (Please select the appropriate response, using the following scale).

None at all	Mildly	Moderately	Severely	Very Severely
1	**2**	**3**	**4**	**5**

___1. Long term goals? (e.g., finding a good job, being in a romantic relationship, etc.)

___2. Career choice? (e.g., deciding on a trade or profession, etc.)

___3. Friendships? (e.g., experiencing a loss of friends, change in friends, etc.)

___4. Sexual orientation and behavior? (e.g., feeling confused about sexual preferences, intensity of sexual needs, etc.)

___5. Religion? (e.g., stopped believing, changed your belief in God/religion, etc.)

___6. Values or beliefs? (e.g., feeling confused about what is right or wrong, etc.)

___7. Group loyalties? (e.g., belonging to a club, school group, gang, etc.)

___8. Please rate your overall level of *discomfort* (how bad they made you feel) about all the above issues as a whole.

___9. Please rate how much uncertainty over these issues as a whole has interfered with your life (for example, stopped you from doing things you wanted to do, or being happy)

___10. How long (if at all) have you felt upset, distressed, or worried over these issues as a whole? (Use rating scale below)

Never or less than a month	1 to 3 months	3 to 6 months	6 to 12 months	More than 12 months
1	2	3	4	5

Appendix F

Brief-Symptoms Inventory-18

DIRECTIONS: Below is a list of problems people sometimes have. Read each one carefully and circle the number that best describes HOW MUCH THATPROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Do not skip any items. If you change your mind, erase your first mark carefully and then fill in your new choice.

HOW MUCH WERE YOU DISTRESSED BY:	**NOT ATALL**	**A LITTLE BIT**	**MODERATELY**	**QUITE A BIT**	**EXTREMELY**
1. Faintness or dizziness	**0**	**1**	**2**	**3**	**4**
2. Feeling no interest in things	**0**	**1**	**2**	**3**	**4**
3. Nervousness or shakiness inside	**0**	**1**	**2**	**3**	**4**
4. Pains in heart or chest	**0**	**1**	**2**	**3**	**4**
5. Feeling lonely	**0**	**1**	**2**	**3**	**4**
6. Feeling tense or keyed up	**0**	**1**	**2**	**3**	**4**
7. Nausea or upset stomach	**0**	**1**	**2**	**3**	**4**
8. Feeling blue	**0**	**1**	**2**	**3**	**4**
9. Suddenly scared for no reason	**0**	**1**	**2**	**3**	**4**
10. Trouble getting your breath	**0**	**1**	**2**	**3**	**4**
11. Feelings of worthlessness	**0**	**1**	**2**	**3**	**4**
12. Spells of terror or panic	**0**	**1**	**2**	**3**	**4**
13. Numbness or tingling in parts of your body	**0**	**1**	**2**	**3**	**4**
14. Feeling hopelessness about the future	**0**	**1**	**2**	**3**	**4**
15. Feeling so restless you couldn't sit still	**0**	**1**	**2**	**3**	**4**
16. Feeling weak in parts of your body	**0**	**1**	**2**	**3**	**4**
17. Thoughts of ending your life	**0**	**1**	**2**	**3**	**4**
18. Feeling fearful	**0**	**1**	**2**	**3**	**4**