Towards understanding the child's experience in the process of parentification: Young adults' reflections on growing up with a depressed parent

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Abstract

This paper reports on a qualitative study with 21 young adults who grew up with a depressed parent. We examined how young adults make sense of their childhood experiences of parental depression and how their retrospective reflections help us to understand the experiences of children and the processes of parentification. Participants recounted that their childhood consisted mainly of actions in the service of family well-being and that they reflected on their own experiences only rarely. In adolescence, there was an evolution towards a greater consideration for oneself and a repositioning within the family. In the discussion we explore the therapeutic implications of this study – and in particular – the meaningfulness of silence in the family process of parentification.

The Stevens family was referred for family therapy when Mother was hospitalized for depression. During the intake session, Mother tearfully recounts how she and the children have been manipulated and unfairly treated by her ex-husband, and how she 'fell into a depression'. The attitude of the three daughters – as well as their positioning in the room - is remarkable. The youngest daughter, Janne sits next to her mother. She seems to be the spokesperson for the children and for her mother, as mother sometimes cannot find words to express what she wants to say. The middle one, Sien flanks her mother on the other side. She holds her hand and cries when mother cries. Conversely, Eva, the oldest daughter, sits straight and motionless, a bit aloof of the other family members. She keeps silent. Occasionally, when the therapist addresses her, she subtly smiles and answers very briefly to the therapist's questions.

In family therapy practice, the therapist has to deal with the different ways in which children express their concern for a parent with mental illness. In the Stevens family session, the youngest daughters, Sien and Janne, seem to be emotionally close to their mother and comfort her in an overt way. By contrast, the oldest daughter remains strong and hides her worry for her mother. What the three girls have in common, however, is that they keep silent most of the time and when they do talk the focus is on the mother. Often, it is difficult for family therapists to reach children of parents that are stressed or that suffer from mental illness. While the therapist may sense the vulnerabilities and pain of the children themselves, one of the main difficulties is dealing with the child's silence about their own experiences and feelings. Therapists often find themselves wondering: 'what is on the child's mind?', 'how does this child experience the situation at home?', and most of all: 'how can we be of help to these children and to their families?'

One of core themes in family therapy is the dynamic of parentification. The term 'parentification' was introduced by Ivan Boszormenyi-Nagy to refer to family processes in

which children take on roles or responsibilities in their families that are age inappropriate (Boszormenyi-Nagy & Spark, 1973). According to family systems theory (Minuchin, Montalvo, & Guerney, 1967; Minuchin 1974), boundaries between parental subsystem and child subsystem are flexible and can be rearranged in order to meet the family needs. Moreover, parentification is not restricted to overt role assignments but also involves "internalized expectations and commitment characteristics" (Boszormenyi-Nagy & Spark, 1973, p. 154). In other words, parentification refers to (a) an interactional process within the family and (b) an intrapsychic dynamic that is situated on an imaginary/symbolic level and often remains unspoken. In accordance to Boszormenyi-Nagy and Spark (1973), Jurkovic (1997) and Byng-Hall (2008) we consider parentification as a continuum starting from adaptive forms of caretaking in the family to more excessive and burdening patterns of caretaking. In general, we conceptualize parentification as a family process in which children sense the vulnerabilities of their parent and the needs in their family and try to act in response to these needs in an active way. Parentification is a bidirectional family process involving experiential and behavioral aspects in both children and their parents. Furthermore it is a ubiquitous family process to be considered within a given societal context (Author 1, 2012).

Parentification in Families with a Parent with Depression

Parentification is a common feature of families with a parent suffering from depression as children in these families are often confronted with their parent's vulnerabilities and the needs in the family (Champion et al., 2009; Chase, 1999; Focht-Birkerts & Beardslee, 2000). For a child, active involvement in the family's functioning or in the parent's emotional life is one particular way of dealing with a parent with mental illness (Göpfert, Webster, & Seeman, 2004). In recent years, a growing number of studies have focused on the influence of parental mental illness on general family functioning (e.g. Dickstein et al., 1998; Foster et al. 2008) and on children's well-being in particular (e.g. Cummings, Keller, & Davies, 2005;

Goodman, Connell, & Hall, 2010). According to Champion et al. (2009), emotional caretaking can be a predictor of anxiety and depression symptoms in adolescent children of mothers with a history of depression. In a broader sample consisting of children with a parent with (mental) illness or disability, caregivers show higher levels of psychosomatic symptoms, less problem-solving coping, and a decreased life satisfaction (Pakenham, Bursnall, Chiu, Cannon, & Okochi, 2006). However, no difference could be perceived on social support, subjective health and positive affect variables (Pakenham et al., 2006). Studies examining the relation between childhood parentification in the general population and adult psychopathology show that parentification is a significant risk factor for mental illness (e.g. Jacobvitz & Bush, 1996; Katz, Petracca, & Rabinowitz, 2009; Shifren & Kachorek, 2003). However, other research also suggests a link between parentification and posttraumatic growth (Hooper, Marotta, & Lanthier, 2008).

Apart from this quantitative work on the outcomes of parentification in families with a parent who suffers from depression, a number of qualitative studies have also accelerated our understanding of the dynamics of parentification (Earley & Cushway, 2002; Goodman, Tully, Connell, Hartman, & Huh, 2011; Mordoch & Hall, 2008). A first theme that is critical in studies on children's and adolescents' experiences of parental depression is *the child's meaning making*. Children try to make sense of what is going on in the family. As the parental depression itself is often one of the subjects that are not discussed in the family, children and adolescents sometimes lack information about their parent's illness (Meadus & Johnson, 2000; Stallard & Norman, Huline-Dickens, Salter, & Cribb, 2004). Apart from enabling an understanding of the parent's behavior, making sense of the parental depression and their own experiences is also related to coping with this parental condition (Aldrigde & Becker, 2003; Meadus & Johnson, 2000).

A second theme that emerges in these studies is *the child's sensitivity and caregiving*. It was found that children of parents with depression are sensitive for behavioral signs of their parent and cues in the conversation with their parent that inform them about their parent's well-being or distress (e.g. Pölkki, Ervast & Huupponen, 2004). Along with this sensitivity, children worry about their parent's emotional well-being and they experience increased responsibility for their families (Aldridge, 2006; Knutsson-Medin, Edlund & Ramklint, 2007) especially as a reaction to family stress and/or the parent's tempers (Riebschleger, 2004). Being a caregiver in the family can become part of the child's identity (Byng-Hall, 2008). Moreover, there may often be some degree of secrecy in the family with regard to this caring role (Aldridge & Becker, 2003; Rose & Cohen, 2010). Pölkki et al. (2004) suggested that younger children in particular do not talk about their caretaking actions. In general, Focht-Birkerts and Beardslee (2000) stated that for parents and children alike the most difficult discussion point is the distress that children experience about having a parent with a mental illness. In these studies parentification is not identified as such, however these findings are revealing for a better understanding of the process of parentification.

Retrospective Understanding of Growing up with a Parent with Depression

Several authors have called for more qualitative research addressing the experience of parentification and the individual perceptions of one's own childhood role in the family (e.g. Byng-Hall, 2008; Davies, 2002; Earley & Cushway, 2002; East, 2010). Little research has focused on the children's perceptions of their roles as agents in relationships with family members (Cummings & Schermerhorn, 2003; De Mol & Buysse, 2008). Since it is difficult for family therapists to reach children in a process of parentification, we have set up a qualitative research project to explore parentification in families with a parent who suffers from depression. After conducting a first study including a current perspective on these

experiences (Author 1 & Author 5, 2013), we believed that children's retrospective accounts could form an additional source of information on the phenomenon under investigation.

Research on how young adults reflect on growing up with a parent with depression is limited. Two studies focused on childhood experiences from a retrospective point of view (Knutsson-Medin et al., 2007; Pölkki et al. 2004) and one study addressed young adults' current perspectives on parental depression (Kaimal & Beardslee, 2009). These studies suggest that through a prolonged and ongoing process of self-reflection, learning and understanding, these young adults start to make sense of their childhood experiences and of the way they grew up in their family (Kaimal & Beardslee, 2009). In line with Kaimal and Beardslee (2009), the current study aims to "track the nature of self-reflection through autobiographical narratives" in order to obtain a better understanding of young adults' experiences of parental depression and their role within the family (Kaimal & Beardslee, 2009, p. 1214). We interviewed young adults (18-29 years old) who identified themselves as having been raised by a parent with depression. They were asked to report their childhood experiences and how they perceived their transition towards adulthood. The research question for this study was twofold. First, we set out to determine how young adults make sense of their childhood experiences of parental depression. Second, we explored how their retrospective reflections could enable us to understand the experiences of children in processes of parentification.

Methods

Participants

The study included 18- to 29-year olds who grew up in a family in which one of the parents suffered from depression starting before the participant turned 18. Recruitment was conducted via several channels in the Flemish part of Belgium (university newsletters, advertisement in woman's magazine, emails to students and personal networks, etc.). Thirty

young adults responded to our request and filled out a demographic questionnaire. All respondents who reported having a parent being hospitalized for depression or engaging in long-term ambulant treatment for depression were contacted to participate in a focus group. Twenty-one participants (18 women and 3 men) agreed and participated in one of six focus groups (each focus group constituting of 3 or 4 participants). Table 1 presents the characteristics of the sample and the constitution of the focus groups. All participants identified as White. Fifteen participants referred to their mother when they talked about their 'parent with depression' and six referred to their father. Although in their narratives the parents' depression was central, respondents occasionally reported that it was co-morbid with anxiety, alcohol abuse and schizoaffective disorder. None of the participants had children of their own. In order to distinguish this study with young adults from another study in our project including older adults this criterion was added. The names of the participants have been changed to protect participant identity.

[Insert Table 1 about here]

Procedure

We employed focus groups as this data collection method facilitated access to in-depth personal accounts of young adults' experiences. This group context has been argued to enable personal disclosures about high-involvement topics such as parent-child relationships (Överlien, Aronsson, & Hydén, 2005; Wilkinson, 2003). All focus groups were both videotaped and registered on audio-recorder, in order to be able to make verbatim transcriptions afterwards. The focus groups had a duration of 60-90 minutes and were semi-structured. The fifth author was the moderator of the focus group conversation, whereas the first author took the role of observer (except for the two last focus groups, where the first author was the moderator of the focus group and no observer was present). Both are clinical psychologist and are trained family therapists.

In accordance with the regulation of the University of Leuven's ethical commission, all participants filled out an informed consent form that stated the purpose of the research and guaranteed the anonymous analysis of all data. The focus groups started with a request from the moderator to each of the participants to recount a concrete childhood memory concerning their parent with depression. The focus group conversation then developed around the topics participants generated from memory. More specifically, the topics 'worry and care', 'feelings of responsibility', 'support figures' and 'family communication' were explored in detail. Furthermore, participants were asked about the meaning of the parent's depression in their later life. Participants all showed respect to each other's story, presumably because of the delicate nature of the subject. Furthermore, the moderator and the observer of the focus groups tried to facilitate the active presence of each participant's voice. In order to guarantee confidentiality, participants were asked to respect each other's anonymity.

Qualitative Data Analysis

The first author transcribed the focus group conversations verbatim. Compatible with the focus on experiences and meaning making processes, a grounded theory approach was adopted (Daly, 2007; Charmaz, 2006; Glaser & Strauss, 1967). After careful and repeated readings of the transcripts, open coding served a first analytical view and capturing of the data. Constant comparison across data and across codes was used to build the categories. After this was completed for the first four focus groups, a focus on the category 'towards a reflective stance' was developed. This category seemed to point to a core issue in the participants' experience but was underdeveloped. Theoretical sampling was implemented in that two additional focus groups were organized to refine this category and to strengthen our emerging analytical concepts. This means that the preliminary research results were presented to these new participants who were asked to reflect on them from their point of view. After all transcripts were coded using focused coding, the analytic relations between codes and

categories were mapped through a process of axial coding (Payne, 2007) and theoretical integration was found in the construction of three domains (Payne, 2007). This resulted in the conceptual framework that will be presented below. Memo writing sustained the analytical process both on the level of the data and on the level of coding and forming categories of codes (Payne, 2007). The analysis was facilitated by the use of the software program MAXqda10.

During our study we implemented integral and self-correcting verification strategies to ensure reliability and validity (Morse, Barrett, Mayan, Olson & Spiers, 2002; Morrow, 2005). At several points in the analysis a team of external auditors was called upon in order to enhance the reliability of the coding. They were invited to challenge the way in which categories were constructed and based on their feedback a conceptual framework was developed by the first author (Hill, Thompson & Nutt-Williams, 1997). This team consisted of the second, third and fourth author. They are all skilled qualitative researchers with a background in family therapy. In dialogue with this team of independent auditors, considerable discrepancies as well as gaps in the analysis were identified and adjustments were made. In addition, an audit document trail was kept in order to keep track of all analytical decisions that had been made during the data collection and data analysis process (Lincoln & Guba, 1985; Rodgers & Cowles, 1993; Morrow, 2005).

Results

Our findings reflect both retrospective meaning making of childhood experiences, and ongoing meaning making processes in emerging adulthood, including the way the young adults sculpt their current family relationships. On the most abstract level of the conceptual framework, three general domains seemed to capture the data. The first domain ‘perceiving little room for own experiences’ reflects a retrospective view on the childhood experiences in relation to the parent with depression and the family. The second (‘towards a reflective

stance') and third domains ('ongoing processes of repositioning in the family') were interrelated and evolved from ongoing meaning making processes. Participants describe a sequential relationship between domain 1 and domain 2 and between domain 1 and domain 3. Each domain includes several categories. The interrelations between the three domains and categories are represented in Figure 1.

[Insert Figure 1 about here]

Domain 1: Perceiving Little Room for Own Experiences

The first domain reflects the participants' recollections of their childhood experiences. It is important to keep in mind that they emerge out of the *retrospective* stories of the participants. It is only in retrospect that these experiences could be recounted because when they were younger these experiences had not been storied, as they generally did not dwell or did not allow themselves to dwell on these experiences at that time. There are four categories within this domain: (1) not in touch with own feelings, (2) reluctance towards talking in the family, (3) feeling responsibility for the family well-being, and (4) finding no response outside the family.

Not in touch with own feelings. Reflecting on their childhood, the participants recalled the painful experiences, and the impact of their parent's depression on their own development. At times they felt hardly able to handle the overwhelming and confusing parental crises. However, although they retrospectively recalled the impact of parental depression, most participants stated that they were not aware of their own feelings at that time. Occasionally, being out of touch with their own feelings seemed to be related to the sense that they were not allowed to experience difficulty due to the troublesome situation at home. For instance Lea as a child wondered whether she had the right to feel burdened by the situation. She did not allow herself to complain about it:

"In the beginning I did not talk about it because I thought, I thought I could not be the one who was burdened by the situation. I'd rather say: 'It is no big deal'."

Similarly, Kobe felt torn between his own feelings of anger and disappointment ("these things that I feel, is this true, am I allowed to feel it?") and his understanding for his depressed father ("he cannot help it").

After her mother committed suicide when she was 14, Lea (now 18 years old) felt an increased responsibility to take care of the household and to look after her three younger sisters. In the past four years she experienced no 'room' for her own grief process:

"My sisters all dealt with it at the appropriate moment. The first weeks and months after she died, they all thought about it a lot, and they tried to handle it. But I didn't, I was occupied with completely different things, and with them".

Only when she moved out of the house, grieving her mother's death and reflecting on her own experience in her childhood became possible (cfr. domain 2: towards a reflective stance).

Reluctance to talk in the family. Participants in the focus group recalled their families' reluctance to talk about parental depression. There was no explicit prohibitions about discussing depression; it just was 'not done'. It was taboo. As a consequence, several participants did not know what exactly was happening at home during their childhood. They had not been given any explanation of the alarming things they saw and heard, neither did they feel allowed to ask questions about it.

Some participants indicated that as a child they did not feel that there was room to talk about their experiences at home. They had the impression that their family would not be able to manage their worries in addition to what was already burdening the family. Anna for instance recounted a conversation with her depressed mother:

"I always reassured her 'no I'm alright, I'm alright',…whereas I probably was not alright at all at that moment."

Reassuring their parents and silencing their own worries can be seen as a way to protect the family from additional harm or to not complicate the situation at home even more. However, children sometimes struggled with their wish to talk about their parent's depression and the ways they tried to protect themselves and others by not talking about it. Thea, for instance, recounted a conversation she had with her mother shortly after Thea's uncle had committed suicide:

> *"…my mother proposed 'if you would like to talk about what happened to me, about the [her own] suicide attempt then tell me'. But then I uh … I think I just went upstairs…"*

One question is why Thea did not accept mother's invitation to talk about her suicide attempt. Our data seem to indicate that either Thea was afraid of the painful emotions a conversation like this could provoke in her mother, or she was concerned about her own emotions to her mother's disclosure.

Talking and not talking in these families seemed to be a balancing act in which children consider their parent's well-being, as well as their own ability to cope with difficult emotions. In that respect, the participants recounted that when they sensed that their parent was open and receptive to their story they weighed up what they would disclose about themselves in order to not trigger another depressive reaction in their parent. They tried to find out how far they could go in terms of openness and as a result they adjusted the communication about their own worries and distress to this appraisal. Participants also indicated that in addition to hiding their own distress or worries feelings of anger could not be expressed as these feelings would be too hard for their parent with depression to bear: *"During periods when she really felt down, I just could not get mad with her, because at those times she needed too much care" (Rose).*

Feeling responsible for the family well-being. Related to the impact of the parental illness on the family, participants conveyed that they felt very involved as a child. For instance, they tried to contribute to the family by reassuring their parent that they were doing fine and by proving that they could handle the situation at home. Also, some participants explained how they tried to support their parent emotionally. Karen for instance recounted feeling emotionally close to her depressed father and at the same time feeling responsible for him:

> *"…and I told my father that I wanted to help him and that I loved him very much. […] He always said to me 'you're the only one I've got', which made me feel even more responsible."*

Participants told us that apart from a sense of agency in trying to improve the parent's well-being, feelings of responsibility for their parent with depression sometimes resulted in a feeling of being 'locked up'. Rose for instance stated: "*once I stepped into [a caring role], there was no way back"*.

It is interesting to look more closely at the way the participants frame the emotional responsibility they felt for their parent with depression. Some participants felt like responsibility was delegated to them by a grandparent, a doctor or by the parent him/herself.

> *"I fled to my grandmother and she just told me to go back home immediately: 'you're gonna take care of my daughter', that's what she said. Really, I felt so bad after that. […] And then I just stood there and thought 'ok then' and I returned home."(Rose)*

Others told us that they took responsibility themselves without outside pressure. For several participants such emotional caretaking was linked to a sense of *moral obligation* or to feelings of guilt. For others caretaking was not experienced in the first place as a burden - some described it as *a habit*. Some even talked about it as if it was a *heroic act*. Thus, the children's contribution to helping their parent with depression was framed in very diverse ways.

Finding little response outside the family. Earlier, we explored how participants were reluctant to discuss the topic of depression and what this meant for the child in the family. Also outside the family, it was not easy to find a response for one's problems or recognition for one's experiences. For some participants the general feeling they recalled from this early period was loneliness:

> *"Sometimes it was kind of hard to feel that I did not have anybody, but I suppose it [mother's depression] just happened in a bad period in my life." (Anna)*

Anna talks about the lack of support she experienced as a child. The quote also illustrates how she avoids blaming her mother for her loneliness by reframing it as a matter of bad luck: her mother's depression co-occurred with a period when she did not have a good friend to rely on.

Furthermore, the participants also described their struggle between the wish to talk about their worries with people they could trust and the wish to keep these worries silent. The participants usually chose to prioritize the protection of their parent by not sharing their worries with people in their social network. In that way they carried the burden of their worries themselves, in order to protect their parent from being blamed and feeling ashamed. When they did share some of their worries with members of the extended family this sometimes resulted in feelings of relief but also made them feel guilty and disloyal:

> *"Sometimes I talked about it with my friend or cousins, because they also realized that my mom wasn't the easiest person. (...) And they usually tell you 'yes, that's really annoying, that's not normal…'. So on the one hand you get some recognition, but on the other hand, you don't really feel better because it's yet again a confirmation that your mom is not normal. And then they also get a negative impression of your mom." (Marianne)*

From their retrospective point of view participants sometimes criticized the mental health care system and school for not succeeding in detecting the difficult family situation

they were experiencing and doing something about it:

> *"The only time that I mentioned problems at home – I hadn't been able to prepare for a test at school – the teacher didn't believe me and said I was making up excuses. (…) Then you think, 'well, that's the last time I say anything about it'" (Kobe)*

In their view, the mental health services were difficult to reach or were perceived as not attuned to the child's needs. Several participants noted that they needed a therapist to help them to find words to tell their story and that such a therapist was not always available at the time.

Domain 2: Towards a Reflective Stance

In domain 2, the transition towards more (self) reflection in adolescence is described. Three categories are were related to this domain: (1) growing awareness of parental depression and own emotions, (2) relating parental depression to own identity, and (3) finding supportive connections.

Growing awareness of parental depression and own emotions. The participants recounted that through an inner process of reflection on parental depression and through an 'outer' process of dialogue with significant others, they gradually developed new perspectives on parental depression and family life. Over time, they discovered more information about mental illness and also found a way to make more sense of some of their diffuse childhood memories. Moreover, some participants had been actively searching for information about what was going on in more clandestine ways. Marianne for instance had secretly read her mother's personal notes:

> *"I knew about a drawer we were not allowed to look in, where my mother kept all her notes. […] I was really curious to know what this problem was about, and I nosed around in her notes. I have to admit that it didn't do me any good…"*

Incited by worry for her mother and being curious to know more, Marianne secretly started to look for more information. However, by doing so she was confronted with things she did not want to know. Marianne's story illustrates what most of our participants told us: what they used to see as their normal daily reality during adolescence gradually took on another meaning as they realized what was actually going on with their parent. As a result, they started to look for ways to assimilate this new perspective on their family. Some reported an internal conflict between understanding and resenting the parent. In an attempt to get a grip on their mixed feelings towards the parent some participants differentiated between their parent as a person and the depression they experienced: *there's my parent and there's the depression*.

When they started to obtain a new perspective on their family they were confronted more with feelings and experiences they had 'not dwelled on' in the previous years. For instance, Chris describes the moment she came to realize the seriousness of her mother's depression:

> *"At the end of the 6th grade, when my mother did a suicide attempt, for me that was a turning point, which really decreased my belief that 'it would be alright'. My confidence disappeared, and the more it disappeared, the older I became, and then at a certain point I was kind of confronted with myself."*

When Chris could no longer hold on to the belief that things would get better, a reflective process was started eventually opening up for her own feelings of distress. Still other participants told us that in the growing awareness of their own experiences and emotions anger and resentment emerged for being kept in the dark about what was really going on in the family. Lea (18 years old), for instance, said:

> *"Over time I found out many details about my mother's illness, and at that point I also started to resent my father. Many things had happened and all this time I had been*

ignorant about them".

Relating parental depression to personal development. With the elaboration of the story about their parent's condition participants also started to reflect on the way parental depression was related to their own personal development. Some participants had an explicit wish to differentiate from their parent. They not only feared genetic transference of mental illness but also intimated that they were afraid of 'losing the ability to enjoy life' because of what they had experienced in their childhood. Participants were actively trying to reassure themselves by formulating differences between themselves and their parents. Marianne for instance said:

> "*People often tell me how I resemble my mother (physically). And at times when I don't feel very well myself, then I immediately start to think 'I'm going to become like my mother'. In fact I want to fight this tendency to compare everything to my mother's situation."*

Apart from her fear to resemble her mother, Marianne also articulated how she wanted to avoid her mother's situation as being the point of reference for her own personal development. This suggests that she was weighing belonging and differentiation and trying to find a balance between these two processes: I am a child of my mother but I do not want to be as vulnerable as she is.

While participants realized that their childhood impacted their development and that their parent's experiences makes them vulnerable to developing mental illness themselves, others stated that they felt that they became stronger as a person through their adverse childhood experiences. This strength emerged, for instance, in their ability to put things into perspective. They were aware of their rapid personal development in the last few years and they had a sense that they were 'ahead' in comparison to their peers:

"I feel like I have a different kind of wisdom, like I'm more mature than my peers. I feel they can't possibly understand because after my father's depression, I really started to think a lot about the meaning of life. (…) I also listen to lyrics that are very profound and then I think about them (…) and write up some things myself." (Karen)

Finding supportive connections. This category refers to both the presence of people who supported them during critical moments (e.g., the grandparent who occasionally took over the caring role at home) and to the forging of social connections with people that helped them to reflect on their own experiences and their family of origin (e.g., friends, teachers and mental health workers). In some cases the efforts of mental health services were appreciated, especially when children were invited to a family conversation with the parent and his/her psychiatrist. Some participants acknowledged the beneficial role of individual therapy as a means to encourage and support self-reflective processes. The help from friends could take different forms ranging from just being there and having a nice time together, to finding comfort in friends when they needed it as well as being invited by friends to talk about their experiences. Apart from these supportive connections with people outside the family several participants also reflected on the support they found in their siblings and the close connection they sometimes felt with their parents.

Finally, a number of participants considered the focus group conversation with peers as an exceptional occasion to elaborate on their experiences together:

"When I read the e-mail about this study I thought 'this is just perfect'. I'm not saying that it is not helping when you talk to people [outside the context of this focus group], but I would love to listen to you more, just to hear your experience." (Kato)

Focus group dynamics are beyond the scope of this article but we will discuss some initial thoughts on this topic in the discussion below.

Domain 3: Ongoing Processes of Repositioning in the Family

Parallel with the developing reflective stance, processes of repositioning in the family emerged. This repositioning includes (1) taking more distance from the family of origin and (2) expressing oneself more openly towards the parents.

Finding oneself through distance taking. Along with a growing awareness of the parental depression and one's own emotions as adolescents or young adults participants started to reflect on a self-conscious repositioning within the family of origin. Even though several participants expressed that they still felt responsible for their parent and some missed having a close bond with their parents, others showed a strong tendency to take distance from their parents and their families. One way of taking distance was making choices about one's own life and development which was often guilt laden (e.g., focusing on studies).

Although physical and psychological distancing are clearly interconnected a distinction can be made between these two forms of taking distance from the family of origin. By moving out of the house several participants took on an outsider perspective and found space to reflect on feelings that they did not dwell on in their childhood. Lea, whose mother committed suicide when she was fourteen said:

> *"Now I left home and I have some time for myself. I don't have to think about my sisters now because they're not there. And I feel I am able to reflect on myself, I can do what I want, all of a sudden it's a very 'open' world."*

Kobe referred to psychological distancing that was partly informed by previous experiences abroad:

> *"I can distance myself from that [his father's depression]. I've been abroad for some time, that changes a lot. […] So what you need is an 'outsider perspective', as long as you have that critical perspective of an outsider… You have to find a way to deal with it in your daily life, so that it does not interfere too much with your own life, and your will, and your routine, and your social life."*

Taking an outsider perspective while still living with his parents enabled Kobe to cope with daily family life. Psychological ways of distancing oneself further included going through a personal crisis which urged them to self-reflect and resulted in there being 'no room' left for the caring role they previously adopted. Letting go of the caring role could then be seen as a consequence of more reflection on oneself and new dwelling on one's own experiences and feelings.

Interestingly, two participants differentiated the position of being a caregiver for a parent with depression from that of being a daughter of the parent. For several participants, trying to understand the parent and being helpful as a caregiver seemed to be incongruent with the feelings of hurt and disappointment they felt as a daughter. Some participants recounted that they tried to combine these two roles but eventually it wore them out. Taking a caregiver position created distance from the painful emotions they would feel in a daughter position. So caring protected them from feeling pain. Yet for other participants psychological distancing was related to taking into account one's own feelings with regard to contact with the parent. For instance, some of them maintained contact with their parent at a more superficial level. Gina for instance - after a long period of trying to keep up with her mother including various attempts to talk to her mother about her own feelings - decided to change her way of looking at their relationship. She distanced herself by avoiding to have expectations from her mother:

"At a certain moment I told myself not to expect anything anymore from my mother. … That works. … It's the only thing that is possible."

This seems to suggest that Gina tried to protect herself by giving up looking at her mother 'as a mother' and letting go of her expectation that her mother would be there for her. It seems that for Gina this clarity was the only possible route in order to be able to move on.

Expressing oneself towards parents. While in their childhood participants did not allow themselves to express their feelings towards the parent with depression (see domain 1), repositioning during adolescence and young adulthood seemed to involve more room for expressing one's feelings. In particular, feelings of anger that used to be suppressed were more and more expressed towards the parent. Sometimes this expression of anger resulted in relief for the child, like for Anna whose anger was addressed at both her parents:

> *"At that moment I poured out so many things that I had been bottling up before. I cannot remember that I had ever been so mad at my parents, and I expressed my anger towards them. […] I think I used to keep it for myself. […] I felt very relieved…"*

Expressing anger can be related to the growing awareness not only of one's feelings but also of one's growing agency as a child. The child allows her/himself to take a position of her/his own.

Discussion

First we summarize the general framework that emerges out of our data as an answer to our first research question: *how do young adults make sense of their childhood experiences of parental depression?* Then we focus more closely on our second research question: *how can these retrospective reflections help us to understand the experience of the child in the process of parentification?*

The three interrelated domains that emerged from our grounded theory analysis constitute a framework to understand young adults' perspective on their experiences of growing up with a parent with depression. In their childhood they perceived little room for their own experiences as all attention was focused on the family's well-being (domain 1). In retrospect they say that there was a taboo in the family to talk about the depression of the parent. In some way this prohibition to talk about the depression was related to their own

reluctance to talk about their feelings and their experiences. This seems to have had important consequences for their inner experiences: they recounted not being in touch with some of their own feelings at that time. Furthermore, they described a movement towards more reflection in adolescence. It is as if they started to experience what they felt previously not allowed to experience (domain 2). Linked with this inner evolution on a personal level, there was also a more overt evolution in their relationship with their family. A repositioning in their dealing with their parents started and was related to a search for psychological or physical distance in order to be able to 'find themselves' and to develop and reflect on their own identities (domain 3). Retrospectively our participants have highlighted that they sometimes felt 'not in touch with' their own feelings when they were younger, and that only afterwards, when they found enough distance towards their family, it became possible to describe what they had been experiencing when they were a child. In this respect, the retrospective nature of the study brought about some advantages, in that the young adults advanced their current perspective as a 'new' and 'richer' perspective on their childhood experiences. They are now able to describe some of the family processes and experiences that used to be difficult to articulate when they were younger.

The Child's Experience in the Process of Parentification

Even though it is clear that the parental depression made a deep impression and invited the child to actively try to help the parent with depression, it seems that the child's experiences both dialogically and emotionally did not take up a lot of space in childhood. Some children perceived their family (and broader, their environment) as only moderately receptive to their experiences, emotions and worries. According to Focht-Birkerts and Beardslee (2000) children need explicit permission from their parents to talk about their fears and feelings of anger and disappointment. Sensing that their parent is overwhelmed by depression, some children see their own feelings as potentially burdening their parent even

more. Consequently, they did not talk about their emotions in the family. However, retrospectively they also conveyed that at that time, they were not able to really experience what they experienced. It seems that for them this was a way to cope and a way to sidestep being overwhelmed themselves. This may be an expression of what Boszormenyi-Nagy and Spark (1973) described as the emotional and more 'invisible' dimension of the concept of parentification. Related to that a certain ambiguity in the child's need for information is described in the literature (e.g. Meadus & Johnson, 2000; Stallard et al., 2004). Our findings reveal a paradox wherein the child tries to make sense of what is happening in the family by acquiring additional information and yet there are also strong indications that they often attempt to avoid that same information. For instance, the young adults in our focus groups acknowledged that too much information could have been harmful for them as a child. So while not talking was sometimes frustrating it also felt safer for them as in this way one's own painful experiences could be kept at a distance. Somehow this not-experiencing can be seen as a coping mechanism of the child.

Parallel with the growing awareness of their parent's depression and their own emotions, young adults described how they continuously try to reposition themselves within or just outside of the family. The focus on distancing from the family can be situated within a more general developmental goal of young adults in Western countries (Arnett, 2006). However, in this group of young adults who grew up with a parent with depression, some specific processes may be involved. For instance, it was remarkable that some participants saw their 'caring' or 'helping' role as a way to create a certain distance from their own feelings of distress with regard to the parent and the depression. This is compatible to the findings of Mordoch and Hall (2008) who described several ways in which adolescents try to preserve themselves and screen themselves from possible negative impacts from the parent's condition. Furthermore, our findings also connect with those of Gore, Aseltine, & Colten

(1993), who suggest that it is easier to distance from a parent with mental illness when the bond is less intimate. These new meanings attached to parentification processes also call for adjusted therapeutic approaches.

Therapeutic Implications

Family therapy is considered to be a cost-effective treatment for people suffering from depression (Crane et al., 2013). While couple interventions have been reviewed recently (Beach & Whisman, 2012), family interventions taking the child's well-being into account got less attention. Based on an intervention to prevent negative outcomes and to improve coping skills in children of parents with mood disorder (Beardslee et al., 1992, 1993, 2003), recently a family focused intervention 'Keeping Families Strong' was developed (Riley et al., 2008; Valdez, Mills, Barrueco, Leis, & Riley, 2011). Both parents and their children were invited to group meetings as well as to individual family therapy sessions. The project using a combination of cognitive restructuring and solution-focused and narrative approaches shows good outcomes (Riley et al., 2008; Valdez et al., 2011). Cooklin (2006) described a similar prevention project, the 'Kidstime project', with outcomes such as children feeling less alone and parents feeling more respected as a parent. However, it remains important to find ways to handle the child's reluctance to talk, without pushing the child to meet the prevention program's prerequisites of talking.

If we consider not dwelling on their experiences as a coping mechanism for these children, what then can a family therapist treating a family with a parent who suffers from depression best do? In addition, how best to approach the children's silence described in the introductory vignette and evidenced in the current study? The therapist's invitation to the child to express his/her emotions is likely to only lead to more silence. Should the therapist accept this silence as it seems that it helps the child to survive this difficult family situation? Indeed, making the child express his/her feelings might result in stripping away the child's

protective shield that helps the child survive an adverse family situation. In this respect we advise therapists to be careful not to push the young child towards expression of his/her emotions as it may push the child closer to experiencing things that are difficult to process in the (temporarily) burdened family context. Perhaps the best strategy a therapist can adopt is to knowingly respect the child's silence and be present with the child in his/her ambivalence around silence, as it is at the same time an expression of the child's loneliness but it is also the best way the child found to deal with the pressing difficulties in the family. In addition, the 'loss' for the child, losing his/her exclusive caretaking position when the therapist takes over, or losing the feeling of being indispensable to the parent when the parent gets better, has to be considered. Byng-Hall (2002) formulated this as "children may need help to give up their position of power" (p. 382).

When we situate the child's tendency to silence emotions and worries within a cultural perspective this can be seen as a more general coping mechanism in our Belgian culture with its catholic legacy. In general, Belgian people are thought to be more restrained than, for instance, our Dutch neighbors. Our findings lend support to a social movement that challenges this culturally sanctioned coping mechanism by addressing and supporting (grown up) children of parents with a mental illness in Flanders and Belgium (e.g. KOPP Flanders) as well as in other European countries (e.g. young caregivers organizations in the United Kingdom).

Our findings also suggest that for adolescents and young adults there may be more therapeutic possibilities as in the second domain of our general framework ('towards a reflective stance') the transition to obtaining new perspectives on the parental depression in adolescence is described. Not only did young adults reflect on their parent's depression and the family situation, they also became aware of their own experiencing and of the emotions they had felt when they were younger. In that way they started to reflect on their own identity

and on the influence their parent's depression might have had on their personality. Participants were able to put their vulnerabilities and strengths side-by-side and reflect on them by acknowledging the emotional impact of negative experiences in the past while actively analyzing this impact and the meaning of these negative experiences (Pals, 2006). Family therapists may play a helpful role in this process of reflecting and repositioning. Also individual therapy and involvement in the parent's therapy can be helpful in this growing awareness and development of an own identity apart from, but connected with, the parent(s).

In contrast with the results of Kaimal and Beardslee (2009), our analysis emphasized the transitional paths from family-oriented to self-oriented perspectives. Participants own experiences seemed to gradually take up more space even if they conflicted with the family's interests. For instance, our participants reported that as they grew older, there was a cautious evolution in the direction of more open expression of anger and disappointment towards the parent. Expressing anger entails both connecting with the parent while differentiating allowing the young adults to shape their own identity and to preserve their own boundaries. If this, as our findings suggest, is what adolescents are going through in parentification processes then a number of possible avenues for therapeutic help emerge:

- Helping the adolescent to find support outside of the family (domain 2),
- Helping the adolescent to reflect on his/her own identity (domain 2),
- Helping the adolescent to deal with his/her own emotions (domain 2),
- Helping the adolescent to take some distance (psychologically and physically) (domain 3)
- Helping the adolescent to find an appropriate way to express one's emotions (domain 3).

Limitations

While we implemented several strategies to ensure the reliability and validity of our findings, a number of limitations remain. The data of 21 participants who retrospectively report on their childhood experiences can only provide an initial glimpse of what it means for a child to grow up with a parent with depression. In particular, the fact that our study is based on retrospective accounts of childhood experiences needs to be taken considered. In what way may the current developmental phase of the participants have shaped their accounts? In what way did their meaning making in the context of a focus group color the picture they have painted of their childhood? Participants inspired each other and stimulated one another's thinking about the family processes in their family of origin. In a social constructionist view, participants in a focus group construct their narrative together (Daly, 2007). In two focus groups the participants explicitly referred to the beneficial experience of this retrospective meaning making together with others who grew up with a parent with depression. Other participants saw their participation as a test of their capacity to cope. Some authors have argued that the actual interaction in focus groups should be taken into account when analyzing the data (Halkier, 2010; Markova, Linell, Grossen, & Orvig, 2007; Onwuegbuzie, Dickinson, Leech, & Zoran, 2009; Wilkinson, 2003). Microanalysis of one or more of these focus groups can be considered as a suggestion for future research.

In light of these limitations we remain modest in the claims that we make. However, we believe that there is value in the processes we have described and in the clinically relevant questions that we have raised. We emphasize the need for further clinical reflection and process research to forward our understanding of these complex family situations, and of the child's vulnerability and resilience.

Conclusion

Through an explorative research design nuances in the dynamics and experiences of parentification have been documented. This qualitative study of young adults' retrospective accounts of their experiences of growing up with a parent with depression suggests that there is an important transition from childhood to adolescence for these children. In their retrospective view of their childhood experiences young adults who participated in our study recounted that their childhood consisted mainly of action in the service of family well-being and little reflection. They felt ambivalent about disclosing their own feelings and experiences in the family. They also recounted that not dwelling on their own experiences was an important coping mechanism to deal with the difficult family situation. In adolescence there seems to be a gradually increasing consideration paid to oneself and more room for the expression of negative feelings towards the parents. Adolescents seemed to evolve towards more reflection and new 'thoughtful' action.

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Focus group	Pseudonym	Gender	Age	Statute	Parent with Depression	Number of parent's hospitalisations (age child)	Number of siblings	Position in child row
1	Karen	Female	19	student	Father	1 (18)	2	second
	Thea	Female	23	student	Mother	1 (5)	1	youngest
	Janne	Female	18	student	Mother	2 (at age 12 and 16)	2	oldest
2	Ingmar	Male	28	working	Mother	1 (15)	1	oldest
	Rose	Female	29	working	Mother	1 (18)	2	youngest
	Janette	Female	22	student	Mother	Several times	3 (2 stepsiblings)	second
	Eva	Female	28	working	Mother	Several times	1	oldest
3	Lara	Female	21	student	Mother	3 (at age 4, 6, 10)	0	only child
	Lea	Female	18	student	Mother	3 (at age 9, 10, 11)	4 (1 halfsibling)	oldest
	Giselle	Female	18	student	Father	Several times	2	youngest
	Dorien	Female	23	student	Mother	1 (9)	1	oldest
4	Laura	Female	18	student	Father	2 (at age 1 and 16)	1	oldest
	Catherine	Female	19	student	Mother	/	5 halfsiblings	youngest
	Koen	Male	23	working	Father	/	2	oldest
5	Kato	Female	27	working	Father	/	6 (4 stepsiblings)	third
	Chris	Female	28	working	Mother	2 (at age 10 and 11-12)	2	oldest
	Kobe	Male	26	working	Father	1 (11)	2	oldest
	Gina	Female	29	working	Mother	1 (21)	1	youngest
6	Marianne	Female	22	student	Mother	/	5 (3 stepsiblings)	third
	Anna	Female	25	student	Mother	Several times	6 (4 stepsiblings)	fifth
	Eline	Female	19	student	Mother	2 (at age 10 and 11)	3	youngest