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Parentification, Substance Use, and Sex among Adolescent Daughters from Ethnic Minority Families: The Moderating Role of Monitoring

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Abstract

Guided by structural family systems theory, this study explored the relationship between parentification and adolescent daughters' sexual risk engagement and substance use. We also explored how adolescent reports of parental monitoring moderated the relationship between parentification and adolescent risk. Data were from a cross-sectional, cross-generational study of 176 mother-daughter dyads from low-income, inner-city, ethnic minority families. In this sample, which included a subset of mothers with HIV, parental physical symptoms were associated with slightly higher levels of parentification. Parentification was associated with adolescent daughters' intention to have sex (but not substance use) in a direction opposite to prediction. Higher parentification was associated with lower intention to have sex. Parental monitoring did not moderate relationships between parentification and adolescent risk. These findings highlight that despite the negative influence hypothesized in structural family systems theory, parentification was not associated with risk engagement of high-risk adolescent daughters in ethnic minority families with low income.

Keywords

monitoring; parentification; sex risk; substance use

Family stress is a risk factor for psychosocial problems in children and adolescents. Stressors such as economic hardship, intimate partner violence, parental illness, substance dependence, marital conflict, and divorce can affect the character of roles and relationships between parents and children. In particular, family stressors may result in parents leaning on children to take on greater emotional and or instrumental support roles for the parent within the family system (Champion et al., 2009; Fitzgerald et al., 2008; Godsall, Jurkovic,

Emshoff, Anderson, & Stanwyck, 2004; McMahon & Luthar, 2007; Peris, Goeke-Morey, Cummings, & Emery, 2008). Within a family unit, having a child take on a “parental role” for either the parent or other family members has been referred to as *parentification*. Although many child outcomes have been examined in family systems that have been disrupted by stress, empirical research investigating the relationship of parentification with adolescents’ engagement in risky behaviors (i.e., substance use and sex) is scarce. Structural family systems theory (Minuchin, 1974) provides a framework for considering the relationship between parentification and risk engagement. It proposes that parentification is best understood as a distortion in generational boundaries between parents and children. As such, the current study applies structural family systems theory to understand the association between parentification and engagement in substance use and sex among adolescent daughters from ethnic minority families and how the role of parental monitoring may modify this association.

Adolescent Risk Behavior

Youth in the United States are at significant risk for engagement in substance use and sex (Centers for Disease Control and Prevention, 2012). For example, 66.1% of African American high school female students (grades 9–12) report ever having consumed alcohol; this is higher for Hispanic (74.1%) and White (71%) females. More than one-third of high school females report lifetime marijuana use; 37.7% among African American, 39.1% among Hispanic, and 35.4% among White females, respectively. While less likely to use alcohol and similar to peers in marijuana use, African American female students (53.6%) are significantly more likely than Hispanic (43.9%) and White females (44.5%) to report ever having had sexual intercourse. Given these high rates of risk engagement, there is a pressing need to identify and understand factors related to adolescent females’ risk engagement.

Parentification

Boszormenyi-Nagy and Spark (1973) described the process of parentification as the expectation that a child will fulfill a parental role within the family system. Other terms that have been used in the literature include *adultification*, *peerification*, *spousification* (Burton, 2007), *burdened child* (Chase, 1999), *inverted child-parent relationships* (Bowlby, 1973), and *generational boundaries* (Frances & Frances, 1976). Some have chosen to use more value-neutral terms such as *filial responsibility* (Kuperminc, Jurkovic, & Casey, 2009), *family obligation and assistance* (Telzer & Fuligni, 2009), and *family caretaking* (East, 2010). Although these terms are not synonymous, professionals have often used them interchangeably. Mika, Bergner, and Baum (1987) described four parentification domains: (a) *spousal role vis-à-vis parents*—the child taking on spousal roles to the parent, (b) *parental role vis-à-vis parents*—the child acting as a parent to the parent, (c) *parental role vis-à-vis siblings*—the child taking on a parental role to the siblings, and (d) *non-specific adult role-taking*—includes doing household chores for other family members. In this context, parentification is defined as a pattern of parent-child interactions characterized by a child assuming adult-like instrumental caregiving and emotionally supportive roles in the family system. We use Mika et al.’s (1987) first three domains to explore parentification and adolescent risk behavior. The last subscale, non-specific adult role-taking, was not utilized

in this study because of its general nature; this subscale has been critiqued for its insufficient accounting of cultural norms (Anderson, 1999).

Structural family systems theory (Minuchin, 1974) posits that an important aspect of healthy family functioning involves maintaining clear, appropriate boundaries between each family subsystem. When one finds the parent depending upon the child for care, generational boundaries may be crossed that potentially put the child in a parentified position with respect to one or more roles. Dissolution or distortion of boundaries between the child and the parental subsystems may be viewed as problematic because the child is not functioning within the generational boundaries. Blos (1979) emphasizes that one of the most important developmental tasks for adolescents is the process of separation-individuation, where a child disengages from dependent ties with parents and gains autonomy. If the separation-individuation process is interrupted by heavy responsibilities to care for a parent (or other family members), it may contribute to adolescents' engagement in risky behaviors. Parentification is considered problematic particularly when children are responsible for tasks that go beyond their developmental abilities and for which they do not receive acknowledgement or adequate support from their parents or other caregivers (Chase, 1999; Patterson, 2002). Jurkovic (1997) referred to this pathological parent-child relationship as destructive parentification.

Destructive parentification in children has more often been linked with detrimental outcomes, particularly among families experiencing stressful family environments such as parental physical or mental illness or economic hardship. Taking on parental roles at a time of family stress has been associated with increased problems at school (Burton, 2007; Fuligni, Tseng, & Lam, 1999), emotional problems (Champion et al., 2009; Godsall et al., 2004), and externalized problem behaviors (Stein, Riedel, & Rotheram-Borus, 1999).

Some studies suggest that there may be potential adaptive mechanisms related to parentification. For example, adopting parental roles may be linked to an increased sense of competence (Kuperminc et al., 2009), enhanced coping (Fuligni, Alvarez, Bachman, & Ruble, 2005), and a greater sense of happiness and role fulfillment (Telzer & Fuligni, 2009). Adaptive parentification may be associated with no or less detrimental outcomes for a child, particularly if the child is from an ethnic minority family that values family obligation and receives credit or appreciation for the efforts (Jurkovic, 1997). This underscores the fact that children taking on adult responsibilities within their families may not always lead to adult-like stressful roles, but rather may be associated with feelings of happiness and self-worth.

Parentification in a Culture and Gender Context

Culture plays an important role in how families function; this includes normative responsibilities. As such, similar responsibilities in one household may have a different impact than in another. In many families, especially those who identify as racial or ethnic minorities, family obligations are considered an important duty for children and are necessary to keep the family in harmony (Kuperminc et al., 2009; Orellana, 2001). Also, in many working-class and poor families, each family member is expected to contribute to the family system by caring for and assisting family members (Winton, 2003). Thus, taking on

instrumental adult responsibilities is a natural part of childhood in many cultures (Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997). However, there are concerns about children assuming responsibilities that require them to care for the emotional well-being of the parent (Chase, 1999; Jurkovic, 1997) as emotional caregiving has been found to be related to more negative outcomes than other parentified roles (Earley & Cushway, 2002; Jurkovic, Jessee, & Goglia, 1991). Daughters may be at particular risk for this kind of parentification (Hetherington, 1999; McMahon & Luthar, 2007) and may feel more burdened by these caretaking roles (Cree, 2003). So, although parentification has often been considered as negative, within a culture and gender context it may be considered otherwise.

Adolescent Risk Behavior and Parentification

The risk-taking behaviors of adolescents in families experiencing stress may in part be attributable to parentification, particularly when family dynamics place adolescents in adult roles before they are ready to handle the responsibilities. In such circumstances, if parents fail to help their children understand the meanings of the role(s), children may be more likely to imitate adult-like behaviors, such as risky sexual behaviors (Burton, 2007). For example, Hetherington (1999) found that when mothers treated their daughters as confidants and disclosed their own sexual relationships, the daughters were more likely to become sexually active at younger ages. Further, parents under stress may have more difficulty functioning effectively in their roles as parents, creating stressful familial conditions (Hooper, Marotta, & Lanthier, 2008). For example, parents may feel overwhelmed about shouldering emotional and financial burdens alone. Hearing about these adult problems, witnessing the difficult realities the family faces, providing emotional support to parents, and supervising younger siblings can all be overwhelming and stressful experiences for children. Parentified children may turn to their peers to escape from their stressful responsibilities at home and then choose to engage in risky behavior as a coping mechanism (Jurkovic, 1997; Koerner, Wallace, Lehman, Lee, & Escalante, 2004) including sex and use of substances (Cree, 2003; Stein et al., 1999).

In addition, many parentified children are thought to struggle with feelings of abandonment, deprivation from parental protection and care, frustration with their responsibilities, and anger towards (and a longing for) the absent parent who is either physically or emotionally unavailable (Jurkovic, 1997). Despite these feelings, children may be unable to express them for fear of further burdening their parents. This could negatively affect parent-child relationships and reduce the ability of parents to influence decisions about risky behaviors.

Parental Monitoring

Within a family system, one of the factors most frequently associated with adolescent risk behavior is parental monitoring (parental knowledge of the child's whereabouts, activities, and company; Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2006; Li, Feigelman, & Stanton, 2000). Previous research indicates that more frequent parental monitoring is associated with decreased adolescent risk behavior, including sex and substance use (Byrnes, Miller, Chen, & Grube, 2011; DiClemente et al., 2001; Sieverding, Adler, Witt, & Ellen, 2005), particularly among females (Donenberg, Wilson, Emerson, & Bryant, 2002).

This study proposes that parental monitoring may act as a buffer that serves to reduce the relationship between parentification and risk intention and behavior among adolescent daughters. Parentified children may be particularly vulnerable if parents exhibit low levels of monitoring. Parentified adolescents may be at increased susceptibility to engaging in risky behaviors because they are either unsupervised or make their own rules (Wallerstein, 1985). These children often take responsibility for their own care, and this responsibility increases their susceptibility to risk behavior. On the other hand, if parentification is combined with high levels of protection, such as parental monitoring, it may be associated with lower levels of risk engagement. Despite assuming their children are capable of taking on age-inappropriate responsibilities, parents may still be able and willing to monitor their child's whereabouts, activities, and well-being. When monitoring is high, these children may be protected; they may feel obligated to act in pro-social ways, which may be related to lower engagement in risky behaviors.

Study Aims and Hypotheses

To summarize, studies examining parentification have produced mixed findings. Given the literature that highlights the increased detrimental consequences of parentification in children from families experiencing life stress (like those who participated in this work), this study examines parentification in relation to its potential adverse effects on adolescent daughters from ethnic minority families with predominantly low income. We begin by examining several child and parent characteristics that may be associated with parentification among adolescent daughters. We then explore the relationship between parentification and adolescent substance use and sex. It is hypothesized that parentification among adolescent daughters will be associated with increased levels of risky behavior. However, it is also hypothesized that the relationship between parentification and risky behavior may be much lower in families where parents maintain strong awareness of adolescents' friendships and activities, an appropriate parental role and responsibility.

Methods

This is a secondary data analysis of a cross-sectional, cross-generational study conducted with 176 African American and Hispanic mother-daughter dyads from low-income inner-city families engaged with social service organizations in eastern U.S. cities. Data were collected between May 2008 and July 2009 through paper and pencil surveys in participants' homes or at a community based service organization. The survey was devised, in part, from the synthesis of data from qualitative work (Cederbaum, 2011). The protocol was approved by the Institutional Review Board of the University of Pennsylvania, and secondary de-identified data use approval was received from the University of Southern California.

Sample and Sampling Strategy

Non-probability sampling was utilized for this study. Participants were recruited from service organizations in Philadelphia, PA, Newark, NJ, and New York City (see Cederbaum, 2011; Cederbaum, Hutchinson, Duan, & Jemmott, 2012, for further details). The agencies where recruitment occurred provided services to HIV-infected women, victims of intimate partner violence, and those in substance use recovery. Recruitment was accomplished

through flyers and provider referrals. Inclusion criteria for adults were: (a) female, (b) living with an HIV-negative daughter between the ages of 14 and 18, (c) self-identifying as African American, black, or Hispanic, and (d) English speaking. When the adult had more than one daughter between the ages of 14 and 18, the child that was closest in age to 16 (measured in months) was selected to participate. Mothers consented to their own and their daughters' participation and the daughters provided assent. Mothers and daughters completed the surveys individually (though simultaneously); the survey was read to those who needed assistance.

Means, standard deviations, and frequencies for the characteristics of the study participants are presented in Table 1. Mothers' mean age was 40.89 years; 86.3% self-identified as African American. Mothers had diverse educational backgrounds; however, 35.9% had not completed 12th grade. The majority of the mothers were currently unmarried (75%); almost half of the mothers were employed. Thirty-seven percent reported that they were HIV-positive. The mean age of adolescent daughters was 15.8 years; 87.5% self-identified as African American. With regard to risk engagement, 39% reported having ever had alcohol, 22% reported having ever used marijuana, 43% reported having ever had sex, and 22% reported having the intention to have sex in the next three months.

Measures

Demographics—Demographic variables included: child's age; mothers' HIV-status; mother's employment status; and mother's level of education. With respect to the involvement of a father, mothers were asked "Is your daughter's other parent involved in her life?" (yes/no).

Physical Symptoms—Mothers' physical symptoms were obtained using an adapted version of the Physical Symptoms Inventory (Wahler, 1968); this modified version (Armistead, Tannenbaum, Forehand, Morse, & Morse, 2001) consists of 23 items. Responses were based on a 5-point Likert scale with higher scores indicating more symptoms. Physical symptom items were added together to form a scale, with a maximum possible value of 108. For the purpose of presentation simplicity, the continuous variable was then divided into quartiles to create an ordered categorical variable (analyses using the variable as continuous did not yield different results). Reliability in the original study was .91 (Armistead, Tannenbaum, Forehand, Morse, & Morse, 2001) and .94 in the current study.

Depression—The 10-item short version of the Center for Epidemiologic Studies Depression Scale (CES-D 10; Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001) was used as a measure of maternal depression. Items were rated on a 4-point scale from 0 to 3 about how the individual had felt or behaved in the past week: (0) *rarely or none of the time* (less than 1 day); (1) *some or a little of the time* (1–2 days); (2) *occasionally or a moderate amount of time* (3–4 days); and (3) *all of the time* (5–7 days). Scores ranged from 0 to 27. The original internal consistency was .84 (Lorig et al., 2001); in the current study, the alpha coefficient was .82.

Parentification—Adolescent daughters completed the following three subscales: (a) spousal role vis-à-vis parents (8-items); (b) parental role vis-à-vis parents (6-items); and (c) parental role vis-à-vis siblings (12-items) of the Parentification Scale (Mika et al., 1987). Daughters responded on a scale of 1 (“*never or does not apply*”) to 5 (“*very often*”). Examples are “My mother shares her intimate secrets (like about relationships or sex) with me”, “I have helped make the peace when my parents fight”, and “I am in charge of bathing my brothers or sisters.” Reliability of the original scale was .98 (Mika et al., 1987). Internal consistency estimates in this sample were excellent for all three subscales ranging from .84 to .92.

Substance Use—To determine lifetime use of alcohol and marijuana, daughters were asked “Have you ever used alcohol?” and “Have you ever used marijuana?” Both questions had a yes or no response format. Given the potential for infrequent use of alcohol and marijuana by many adolescents (they often lack availability and opportunity), the “ever used” variable was chosen to assess daughters’ substance use in this study.

Sex—Daughters’ sexual behavior was measured with two items indicating both lifetime sexual activity and sexual intention: “Have you ever had sexual intercourse (a boy’s penis in your vagina)?” and “I plan to have sex in the next three months.” In addition to the “ever had sex” variable (yes/no), intention was used as the outcome of interest because adolescent engagement in sex can be variable (i.e., the adolescent could have been in a relationship and had sex but is not in one now). Using an intention variable may capture the dynamic nature of adolescents’ sexual activity, predicting whether an adolescent will engage in sex within a future time period (e.g., in the next three months). The response choices for the intention variable ranged from 1 (“*disagree strongly*”) to 5 (“*agree strongly*”).

Parental Monitoring—Monitoring was assessed using the 6-item Parental Monitoring Scale (Li et al., 2000). Completed by daughters, items were rated on a 5-point Likert scale with higher scores corresponding to higher levels of monitoring. The scores ranged from 6 to 30. Examples are “My mother knows where I am after school,” and “I talk to my mother about the plans I have with my friends.” In the current study, the scale showed internal consistency reliability of .93.

Analyses

Analyses emphasized understanding the relationship between parentification and adolescent risk, both as a main effect and as potentially moderated by parental monitoring. In preparation for multivariate analyses of risk behaviors, correlations were calculated between parentification and other independent variables. Predictors of parentification were also examined using linear regression. Primary analyses utilized logistic regression to assess the relationship between parentification and each risk behavior (alcohol, marijuana, and sex). In an initial step, each risk behavior was modeled as a function of overall parentification and other independent variables. Follow-up analyses entered parentification subscales separately. To study the possible moderating relationship between parentification and parental monitoring, logistic models were extended by including interactions between parentification and parental monitoring. Stratified analyses were also conducted separately

to cross-check results of interaction analyses between parental monitoring and parentification predicting risk behavior among adolescents.

Results

Predictors of Parentification

Table 2 provides a correlation matrix summarizing associations between five predictor variables (four measuring aspects of family stress) and parentification. None of the four indicators of family stress (father involvement, maternal HIV status, maternal physical symptoms, maternal depression), or child's age, were associated with the overall parentification index or with the two subscales measuring emotional dimensions of parentification. Having heavier responsibilities for sibling care (parental role vis-à-vis siblings subscale) was correlated with maternal physical symptoms, but not with other predictors. Multivariate linear regression analyses were conducted to determine whether family stress variables combined to predict parentification, after accounting for child's age. When independent variables were entered one at a time, the pattern of results was identical to the bivariate Pearson correlations. However, when the five independent variables were entered together, no variables made significant contributions to prediction of parentification, either overall or to specific dimensions (not shown).

Parentification as a Predictor of Risky Behavior

Logistic regression analyses tested whether parentification was associated with substance use and sex. Prior to these analyses, correlations among the independent variables were examined to identify possible areas of collinearity that could affect interpretation. No potential problems were present, with the independent variables having moderate to low correlations with one another.

Four separate logistic regression models were run (Table 3), one each for the risk behavior or intention. With regard to sex, intention to have sex had a significant negative relationship with overall parentification. Daughters with higher reported levels of parentification were less likely to report an intention to have sex than those with lower levels of parentification (OR = .98, 95% CI = .956, .998). Since parentification was measured as a continuous variable, for illustrative purposes we also computed the estimated odds ratio of reporting intention to have sex for a daughter with a parentification score one standard deviation above average as compared to a daughter with an average parentification score; the odds ratio was .62. Neither the "ever had sex" variable nor the other two risk behaviors (alcohol and marijuana) had significant relationships with overall parentification. In separate versions of the models (not shown), dimensions of parentification were tested in the models individually. Results showed no significant associations between each parentification subscale and the risk behaviors. Maternal HIV-status, however, was related to sex (both lifetime and intention). Daughters with HIV-positive mothers were more likely to report ever having sex (OR = 2.22, $p < .5$) and an intention to have sex in the next three months (OR = 2.77, $p < .05$) than daughters with HIV-negative mothers. Exploratory analyses of the primary hypotheses were also run separately by race/ethnicity. No meaningful differences were present in the pattern of results, but statistical power was limited to conduct a strong

test of the similarities and differences in patterns of findings by race/ethnicity. Therefore, in this paper results are only presented for the study sample as a whole.

Parental Monitoring as a Moderator of the Relationship between Parentification and Risky Behavior

As discussed in the introduction, parentification was hypothesized to be most problematic when it occurs in the context of a family system in which parent(s) are less involved in important aspects of adolescents' lives, situations in which parental monitoring is low. To test this prediction, logistic regression models were elaborated by adding interaction terms between indicators of parentification and parental monitoring. Results from these analyses are described below but not shown in tabular form because they closely mirror results in Table 3. Stratified analyses examining the relationship between parental monitoring and risk behavior among adolescents reporting low and high levels of parental monitoring were also conducted and yielded the same results: Thus, they are not discussed further.

Alcohol Use—None of the interactions between parental monitoring and parentification were significant in analyses predicting reported use of alcohol.

Marijuana—None of the interactions between parental monitoring and parentification were significant in analyses predicting reported use of marijuana. Maternal physical symptoms, however, had a significant positive relationship with adolescent use of marijuana. Daughters of mothers with more physical symptoms were more likely to report lifetime marijuana use than daughters of mothers with fewer physical symptoms (OR = 4.49). No other variables were related to marijuana use.

Sex—None of the interactions between parental monitoring and parentification were significant in analyses predicting sex. Mother's HIV-status, however, continued to predict the likelihood of adolescent daughters' sex in lifetime (OR = 2.22; 95% CI = 1.085, 4.532) and intention to have sex (OR = 2.77; 95% CI = 1.154, 6.644). The odds ratios indicate that daughters with HIV-positive mothers had more than twice the odds of sexual engagement as daughters whose mothers were HIV-negative.

Discussion

The purpose of this study was to examine the relationship between parentification and adolescent daughters' risk engagement. Guided by structural family systems theory (Minuchin, 1974), it was hypothesized that parentification would be associated with daughters' substance use and sex. This study is one of the first to examine the relationship between parentification and adolescent risk behavior, and how parental monitoring may modify this association in a low-income sample of adolescent daughters and their mothers. The results revealed that parentification, specifically parental role vis-à-vis siblings, is slightly higher among daughters whose mothers reported having higher rates of physical symptoms. This is consistent with existing literature (Stein et al., 1999; Tompkins, 2007). When parents are less able to take on parental responsibilities, the parental role may be assumed by or delegated to a child. Parents who are physically ill may be more likely to turn to a child for help, or children may feel more responsible for performing parental tasks.

Other variables of interest (child's age, biological father's involvement in the child's life, maternal HIV-status, and maternal depression) were not found to relate strongly to parentification in either bivariate or multivariate models. Although previous studies (McMahon & Luthar, 2007; Tompkins, 2007) demonstrated that the age of the child was an important determinant of parentification, age had no significant relationship with parentification in this study. This may have occurred because the sample had a limited range of age (14 to 18 years old). The absence of relationship with child age may also reflect cultural expectations that children who have reached adolescence carry the responsibilities of assisting their parents and caring for their younger siblings. Family stressors such as father's absence, maternal depression, and maternal physical symptoms were also unrelated to the level of reported parentification. Such findings are in line with those of McMahon and Luthar (2007), who reported that maternal psychopathology only plays a limited role in parentification and suggested that "parentification is a complex, multidimensional, and multidetermined phenomenon" (p. 278).

Contrary to expectations, few main effects were detected between parentification and adolescent risk engagement. We found that parentification was associated with adolescent daughters' intention to have sex, but not substance use. Interestingly, the direction of the relationship between parentification and daughters' intention to have sex was opposite to our expectation. Rather than serving as a risk factor for adolescent daughters, overall parentification was related to a lower likelihood of having an intention to have sex. Such findings contrast with Stein, Riedel, and Rotheram-borus (1999), who reported that parentification predicted alcohol and marijuana use and sexual behavior among adolescents with AIDS-infected parents. This may be due to the different characteristics of the samples. Although both Stein et al. and the current study used a sample of ethnic minority families, the participants in the Stein et al. study were all parents with AIDS, and the levels of family stress and hardship was likely much higher due to lack of effective antiretroviral treatments at that time. As noted in their 2007 follow-up study, three years post-intervention, 40 percent of youth in the study had a deceased parent (Stein, Rotheram-Borus, & Lester, 2007). Participants in the present study, on the other hand, were from a non-clinical sample. This may suggest that parentification in families with substantial stress, such as parental illness, may be more problematic than among families where parentification is part of culturally normative family responsibilities.

The unexpected finding of the negative relationship between parentification and adolescent sexual intention may have occurred for several reasons. One explanation is that having responsibilities to assist families may provide fewer opportunities for these daughters to socialize with potential sexual partners. Another possible explanation may relate to how daughters perceive the roles they are taking within the family. If daughters feel that they are taking positions of leadership within the family, they may feel that they matter in their families, have a strong belief in the role of assisting the family, and thus have a tendency to engage in more responsible behaviors than their non-parentified peers (Burton, 2007). One additional possibility is that this result is driven by characteristics of this sample, which consisted only of adolescent daughters. Females may have a higher tendency to cope with challenges by turning to friends, family, or other important people rather than acting out by engaging in substance use and sex. There is evidence that female adolescents are more likely

to seek social support to cope with distress (Hampel & Petermann, 2005). As this study did not collect information on family and community support, we are unable to examine whether social support played a role as a protective factor for the daughters in this sample.

While structural family systems theory provides a framework in which parentification is predicted to relate to risk engagement, the results of this study reveal that other variables are stronger predictors of adolescent risk engagement. Daughters whose mothers had more physical symptoms were more likely to have ever used marijuana; and daughters with HIV-positive mothers were more likely to report engagement in sex than those with HIV-negative mothers. This is consistent with previous studies showing that maternal HIV-status was related with daughters' sexual activity (Chabon, Futterman, & Hoffman, 2001; Lee, Lester, & Rotheram-Borus, 2002). Offspring of HIV-positive women are at high risk for acquiring HIV through their own sexual behavior because they are often exposed to the same factors that placed their mothers at risk (e.g., living in low-income, high seroprevalence inner-city areas; Brackis-Cott, Mellins, Dolezal, & Spiegel, 2007). What the findings do suggest is that characteristics of mothers, such as physical symptoms and HIV-status, are more powerful predictors of the negative outcomes related to substance use and sex than whether children take on adult roles within their families.

Important to note is the role that race and culture may have on parenting processes and normative family roles. There is known variation in parenting behaviors by ethnicity. Although prior research has found that minority parents are less likely to discuss sensitive issues (e.g. substance use) with their adolescents (Baumeister, Flores, & Marin, 1995), more current work notes that African American youth are more parent-oriented, perceive greater support from parents than do Whites, and prefer parents to peers as sources of sensitive information (Fasula & Miller, 2006; Henrich, Brookmeyer, & Schrier, 2006; Maguen & Armistead, 2006; Tinsley, Lees, & Sumartojo, 2004). Although peer influence is prominent for adolescents, in African American families parents are perceived as a stronger source of support (Peterson, Buser, & Westburg, 2010). Prior research with Hispanic families notes the use of indirect communication strategies (e.g. discussing risky behaviors when their children are in earshot; Marin & Gomez 1997; Raffaelli & Green, 2003); however, concepts like familism may be protective for adolescents. For example, greater reports of familism are highly associated with successful parenting and have an indirect effect on problem behaviors in early adolescents (Santisteban, Coatsworth, Briones, Kurtines, & Szapocznik, 2012). Shared decision-making about parenting tasks further supports family functioning for Hispanics (Sotomayor-Peterson, Figueredo, Christensen, & Taylor, 2012). Level of acculturation or cultural adaptation, however, is important to account for (Parra Cardona et al., 2012). Therefore, the cultural process of risk communication and the barriers that parents might face in initiating these discussions is an issue that needs further exploration.

Clinical Implications

While findings were limited, the results of this study have a number of clinical implications. First, understanding the roles individuals within family systems play is important. Practitioners cannot assume that traditional roles exist within families but must also be careful not to assume that because there are stressors on the family system that roles have

been permanently shifted. In times of crisis, it is natural for individuals within the family system to shift priorities and potentially take on new responsibilities. What practitioners can explore with families is what these roles look like, how these new roles have impacted the individual members, whether these roles are temporary, and how the shifts within the family system can be recognized so that all individuals feel acknowledged and appreciated.

Particularly when there are stressors within a family (i.e., substance use, mental health, illness, incarceration), children can feel responsible to their parent(s) and siblings, wanting to diminish the impact the event has on the family system. These new roles may not have overt immediate effects but can increase an adolescents' emotional or physical burden over time. As such, it is important that the adolescent have a "safe" outlet for sharing their feelings, with the goal of effectively managing feelings of anxiety, depression, or feeling overwhelmed. Lastly, when encountering adolescents enacting parental roles, particularly in minority families, clinicians should be careful not to assume such roles as negative experiences. Perhaps, this is an opportunity for clinicians to introduce the relationship orientations typology, particularly emphasizing the relationship directed typology (Tuttle, Knudson-Martin, & Kim, 2012); this concept seems particularly relevant to parentification as it emphasizes shared responsibility and the need to tune into others. As shown in the aforementioned literature, family roles vary among cultures and parentification may look different across ethnic groups. Therefore, understanding normative family systems within cultures is important. Further, some researchers note that family role shift may contribute to resilience among adolescents; this should not be overlooked.

Limitations

Limitations of this study must be noted. These results may not be generalized to all populations of adolescents because of several factors. The sample was primarily African American and the data pertained only to families of mothers and daughters, who received services from clinics and service organizations in eastern U.S. cities. A second limitation is that the participants represented a convenience sample. Participants were limited to those who self-selected to participate and so families with greater numbers of stressors may not be represented. For example, it may be that mothers who did not have positive relationships with their daughters self-selected out because the daughter was not likely to participate or mothers were embarrassed by these relationships. Furthermore, because data were cross-sectional, causal associations cannot be evaluated. In addition, self-report was used to measure the family-level process of parentification. This can be problematic for adolescents, who may over- or underestimate their level of family labor or care (Dodson & Dickert, 2004). Future work may benefit from operational measures that include direct observation of the parentification process, not just self-reports. Lastly, single-item indicators were used to measure adolescent risk behavior. Although multi-item measures can provide a more nuanced look at issues of sexual behavior, single item measures have been used successfully to understand sexual behavior patterns (e.g., Cederbaum, Hutchinson, Duan, & Jemmott, 2012; Flewelling & Bauman, 1990; Hawkins et al., 2009; Kavanaugh & Schwarz, 2009). Nevertheless, future studies should include more thorough measures of risk behavior.

Conclusion

In this study, parentification and parental monitoring did not have interaction effects with daughters' risk engagement. This shows that parentification was not related to the likelihood of engaging in risk behaviors in adolescent daughters, regardless of their levels of parental monitoring. This study highlights that parentification among low-income families is not necessarily a risk factor for substance use and sex among adolescent daughters. This study adds to the literature a greater understanding of the concept of parentification and the role that it plays in adolescent daughters' lives. This will help clinicians not to misinterpret the potential impacts of parentification, to understand some of its potentially positive correlates, and to place parentification accurately in the context of other factors that do negatively impact adolescent risk engagement.

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Table 1

Sample Demographics (N = 176 mother-daughter dyads)

Variable [range]	Mean (SD) or Frequency (percent)
Age (years)	
Moms [27–70]	M=40.89 (SD=7.13)
Daughters [14–18]	M=15.8 (SD=1.55)
Race or ethnicity	
Moms	
African American	145 (86.3%)
Hispanic	28 (17.2%)
Daughters	
African American	147 (87.5%)
Hispanic	19 (11.3%)
Mother's highest level of education	
Less than 12 th grade	60 (35.9%)
High school degree	71 (42.5%)
Vocational school or college	36 (21.6%)
Mother's marital status—ever married	51 (30.5%)
Mother is employed—yes	83 (46.9%)
Mother is HIV-positive—yes	65 (37.1%)
Biological father is involved in child's life—yes	110 (65.9%)
Daughter has ever used alcohol—yes	69 (39.2%)
Daughter has ever used marijuana—yes	39 (22.2%)
Daughter has ever had sex—yes	75 (42.6%)
Daughter's intention to have sex in the next three months	
No intention	91 (52.9%)
Neutral	44 (25.6%)
Have the intention	37 (21.5%)
Parentification	
Overall (26 items)	M = 62.11 (SD = 20.99)
Spousal role vis-à-vis parents (8 items)	M = 19.97 (SD = 7.9)
Parental role vis-à-vis parents (6 items)	M = 15.07 (SD = 5.78)
Parental role vis-à-vis siblings (12 items)	M = 27.15 (SD = 11.20)
Parental monitoring [6–30]	M = 24.38 (SD = 5.70)

Table 2
Pearson Correlations Among Child or Parent Characteristic Variables and Parentification Subscales

	1	2	3	4	5	6	7	8	9
1. Father	1.00	-.18*	-.06	.17*	-.10	.04	.13	.11	-.07
2. HIV		1.00	.41**	.14	.03	.05	-.11	-.06	.00
3. PHSY			1.00	.25**	.17*	.09	-.00	.04	.15*
4. Depression				1.00	.03	.00	.10	.12	-.07
5. Child's age					1.00	.02	.06	-.03	.00
6. Overall P						1.00	.82**	.46**	.85**
7. SP							1.00	.53**	.44**
8. PP								1.00	.19**
9. PS									1.00

Note. Significant results are in boldface.

* $P < .05$,

** $P < .01$.

PHSY = Physical Symptoms; Overall P = Overall Parentification; SP = Spousal Role vis-à-vis Parents; PP = Parental Role vis-à-vis Siblings

Table 3
Logistic Regression Analyses of Risk Engagement, Controlling for Demographic Variables

	Risk Behavior Odds Ratio (95% CI)			
	Alcohol	Marijuana	Sexual Activity	Sexual Intention
Control Variables				
HIV-status	1.09 (.533, 2.218)	2.24 (.981, 5.129)	2.22 (1.085, 4.532)	2.77 (1.154, 6.644)
PS				
PS (1)	1.04 (.433, 2.510)	1.42 (.419, 4.824)	.88 (.360, 2.171)	.82 (.252, 2.651)
PS (2)	1.40 (.569, 3.436)	1.79 (.535, 6.008)	1.066 (.427, 2.661)	1.10 (.346, 3.510)
PS (3)	1.12 (.416, 3.007)	2.84 (.829, 9.742)	1.645 (.612, 4.420)	1.34 (.395, 4.513)
Overall Pparentification	1.00 (.982, 1.012)	1.00 (.978, 1.015)	1.01 (.992, 1.023)	.98 (.956, .998)
Model χ^2	.96	12.25	11.60	15.17

Note. Significant results are in boldface.

CI = Confidence Interval.

For the physical symptoms variable, the lowest response level served as a reference category.