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Expanding the Discussion Regarding Parentification and Its Varied Outcomes: Implications for Mental Health Research and Practice

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Studies have demonstrated that parentification, a potential form of child maltreatment, is a ubiquitous phenomenon that most community counselors as well as other mental health care providers (e.g., school and family counselors, social workers) face. Although these studies have pointed to a relationship between parentification and later psychopathology, the potential for divergent outcomes is rarely discussed. This article advances an often-absent balanced discussion of the extent to which varied outcomes are evidenced in adulthood after one has been parentified in childhood. For example, varied outcomes such as psychopathology and posttraumatic growth may be feasible in adulthood after parentification in childhood. Suggestions related to research and practice efforts are put forth for mental health counselors.

CHILD MALTREATMENT AND NEGLECT

Child maltreatment has long been viewed as significantly contributing to poor outcomes in adult functioning (Afifi, Brownridge, Cox, & Sareen, 2006). The deleterious effects of maltreatment on the child—and, later, on the adult—have been well documented in clinical and research literature (see Belsky, 1990; Briere, 1992; Cicchetti & Toth, 1995; Erickson & Egeland, 1996; Finkelhor, 2002; Garbarino, 1977; Kempe, Silverman, Steele, Droegmueller, & Silver, 1962; Polansky, Chalmers, Buttenweiser, & Williams, 1981; Rutter, 1990; Werner, 1990).

In the 1960s, Kempe et al. (1962) estimated that fewer than 1,000 children in the United States were victims of child maltreatment each year. Now, according to the National Child Abuse and Neglect Data System (NCANDS; U.S. Department of Health and Human Services [DHHS], 2006), in 2004 an estimated 3.5 million reports of child maltreatment were made in the United States.

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Of those 3.5 million cases, 62% involved neglect, 18% involved physical abuse, 10% entailed sexual abuse, and 9% comprised other neglect cases. NCANDS contended that child neglect is the most common form of maltreatment reported to public child protective services and that more than half of the reports of child maltreatment made in the United States each year are for neglect (DHHS, 2006).

Polansky et al.'s (1981) definition of neglect may serve as a guide to researchers, mental health counselors, and policy makers:

> a condition in which a caretaker responsible for the child, either deliberately or by extraordinary inattentiveness, permits the child to experience avoidable present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual, and emotional capacities. (p. 6)

Emotional neglect occurs when the parent or caregiver fails to provide the necessary attention to the child's need for affection and emotional support, fails to provide needed psychological care, and lacks the competence to foster an appropriate attachment relationship and environment for the child to develop (Herman, 1992; Marotta, 2003). Further, some of the same relationships and long-term effects that have been established between emotional neglect and poor functioning, psychopathology, and substance abuse (Cicchetti, 2004) have been observed among adults who have been parentified—a potential form of neglect (Chase, 1999). However, not all emotionally neglected children grow up to experience the same outcomes: some go on to experience high levels of functioning, and others go on to experience poor levels of functioning, and some may experience a combination of high and low functioning in different life domains (Cicchetti).

THE SIMILARITIES: PARENTIFICATION AND EMOTIONAL NEGLECT

When one juxtaposes the above definition of *emotional neglect* with that of *parentification*—the specific phenomenon discussed in this review—one is likely to conclude that emotional neglect and parentification are, in fact, similar. Based on prior literature (Bellow, Boris, Larrieu, Lewis, & Elliot, 2005; Boszormenyi-Nagy & Spark, 1973; Jurkovic, 1997; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), *parentification* is defined for this discussion as a disturbance in generational boundaries, such that evidence indicates a functional and/or emotional role reversal in which the child sacrifices his or her own needs for attention, comfort, and guidance in order to accommodate and care for the logistical and emotional needs of a parent and/or sibling. Historically, in the clinical and research literature, many researchers (Alexander, 1992; Bellow et al.; Boszormenyi-Nagy & Spark; Byng-Hall,

2002; Chase, 1999; Jones & Wells, 1996; Jurkovic, 1997, 1998; Jurkovic, Morrell, & Thirkield, 1999; Karpel, 1976; Liotti, 1992; Minuchin et al.) have identified serious destructive outcomes—up to and including trauma such as PTSD and dissociative symptoms (Ciccheti, 2004; Liotti; Kubiak, 2005; Widom, 1999)—that may arise in adulthood after varying degrees of parentification in childhood. Additionally, some researchers have distinguished between types of parentification—instrumental and emotional parentification—when examining the impact of parentification. For example, Minuchin et al. asserted that children can experience parentification in duties such as preparing meals, doing household chores, and handling financial matters (i.e., *instrumental parentification*) or in duties such as responding to emotional needs of the parent or siblings (including issues such as low self-esteem) or acting as the peacemaker for the family (i.e., *emotional parentification*).

According to Jurkovic's (1997) model of parentification, *destructive parentification* describes a family environment featuring an imbalance among family members' roles and behaviors, a lack of boundaries between family subsystems, and an excessive level of caretaking (emotional and/or instrumental) by a child to maintain the family system. Consequently, long-term developmental effects and inappropriate boundary distortion and dissolution are evident between the parent and child. These effects often lead to the child's being emotionally, physically, and psychologically deprived of parental caregiving, guidance, and a secure attachment in the parent-child dyad. Jurkovic stated,

> Pathological parentification is a discriminable category of maltreatment in its own right. In addition to being part of the spectrum of problems subsumed under the label 'child maltreatment,' severe forms of parentification may have specific etiologies, sequelae, intergenerational transmission patterns, and treatment responses. (p. xx)

During the process of parentification, either explicitly or implicitly, parents create an environment that fosters caretaking behaviors in their children that help maintain homeostasis for the family in general and for one or both parents in particular (Boszormenyi-Nagy & Spark, 1973; Minuchin et al., 1967). Above and beyond maintaining homeostasis for the family, the responsibilities carried out by the parentified child are traditionally behaviors that provide the parent with the specific emotional support that the parent likely did not receive while he or she was growing up (Boszormenyi-Nagy & Spark; Minuchin et al.). Thus, the child must be emotionally available for the parent, even though the parent is often emotionally unavailable for the child, a situation that may engender a chronic state of anxiety and distress in some emotionally parentified children (Bowen, 1978). The clinical literature has also suggested that this breakdown in generational hierarchy may rob the child of activities that are developmen-

tally appropriate; the child instead participates in either instrumental or emotional caregiving behaviors (or both) directed toward parents, siblings, or both that go unrewarded and unrecognized (Boszormenyi-Nagy & Spark; Jurkovic, 1997; Minuchin et al.).

Case example: Alex. This case illustrates age-inappropriate roles and responsibilities related to the parentification of Alex. It also describes the environment wherein the parentification process takes place. These roles and responsibilities and the context in which they take place could potentially lead to negative, positive, or both outcomes in adulthood, although negative outcomes and functioning in adulthood may be more likely.

Susan is a 31-year-old black mother who has recently separated from her boyfriend of two years. She has four children who are all under the age of 10. Alex, her oldest child, just turned nine years old and has been thrust into the role of nine-year-old mother as her mother takes on two new part-time jobs, in addition to her full-time job, in order to keep the family afloat. Before her mother's recent separation from her boyfriend, Alex had a pretty average life: she went to school, played sports (basketball and baseball) after school, and rode the bus home after her extracurricular activities. At home, family members were supportive of each other and got along well. Few fights occurred in this family, and everyone had private space to relax and a place to do homework. Now family fights occur all the time, and their new two-bedroom apartment (one bedroom for the mother and the other bedroom for four siblings) is clearly not big enough for the family. Her mother reports that this is their new life and it will not change any time soon. She also tells Alex that family survival is far more important than her academic or extracurricular activities. Because the mother has had to take on two more jobs, Alex has had to drop out of all of her extracurricular activities; prepare breakfast, lunch, and dinner for her three siblings; check her siblings' homework; and ensure that they are in bed at night and up in the morning. In addition, she babysits the neighbor's children after school to help financially support the family. Everything has suddenly and dramatically changed for this family, but in particular for Alex. She feels overwhelmed, unprepared, lost, and scared, but no one seems to notice: not her mother, teachers, friends, or siblings.

Whether or not Alex will go on to experience negative outcomes associated with being parentified will depend on many factors. However, not all children who are parentified are fated to difficulties in adulthood. Theorists have found that some children who experience parentification might not experience the negative outcomes often cited in the literature (Jurkovic & Casey, 2000). In their 1967 study of families of the slums, Minuchin et al. posited that the parentified child's functions may serve a significant purpose in the family and often appear necessary in order for the family to maintain equilibrium. For example, Minuchin and his colleagues observed families who had constructive

patterns and themes among the parentified children: such as when a sibling serves as a support for the younger sibling and thereby maintains the homeostasis of the family system. Consequently, the children's role or duty fosters a mutual reliance among the siblings and serves as a buffer to the parents' unpredictable and unreliable behaviors. Boszormenyi-Nagy and Spark (1973) also believed that, to some small degree, every child is parentified: a process that can serve as a positive and constructive contribution to the child's development and sense of responsibility. Without the parentification process, the child may not learn to identify with positive roles later in adulthood. In other words, a small dose of parentification, one that is recognized and rewarded, can be positive, necessary, and beneficial to both the child and parent. This next case represents just that: a "small dose" of parentification that *is* recognized and rewarded by the adult figures in Sharon's life.

Case example: Sharon. This case illustrates age-inappropriate roles and responsibilities related to the parentification of Sharon. It also describes the environment wherein the parentification process takes place. These roles and responsibilities and the context in which they take place could potentially lead to negative, positive, or both outcomes in adulthood, although positive outcomes and functioning in adulthood may be more likely.

Brad and Belinda's family has experienced one hardship after another in the last six months. Brad lost his job of 20 years along with the family's only medical insurance plan. One month after Brad was laid off, Brad's wife, Belinda, was diagnosed with cancer. The medical bills have been coming in; and in response to his inability to care for his family, Brad has experienced a deep clinical depression. Brad and Belinda have three children: Sherry, age five; Harry, age six, and Sharon, age nine. Neither Brad nor Belinda, who has been spending much of her time at the hospital, have been able to care for their children. As a result, over the past two months, Sharon, the nine-year-old, has had to take over complete care of the children, is paying the bills for the family (her father sometimes helps her do this), and is caring for both of her parents, who sometimes spend most of the day in their bedroom. She cooks, cleans, and tries to offer emotional support to the entire family. Sharon reports that she knows this drastic change is temporary and appreciates when her grandmother comes on the weekend to help her and the family. Also, her grandmother comes over two nights a week so that Sharon can continue to be a part of the band and choir club. Sharon feels "stressed" and not prepared to take on this role in her family—but she also feels a sense of responsibility and supported by her parents and her grandmother and knows that her current role is temporary. And even though money is very tight, Sharon's parents pay her a small allowance every week to recognize that she has taken over additional family duties.

Meaning Making and Varied Outcomes

Why do some children who experience adverse events and environments in their families of origin go on to live healthy, high-functioning adult lives, while others go on to have extensive distress, relational problems, and/or pathology? Models of stress and trauma may help mental health providers and researchers better understand the potential for bimodal outcomes and the cognitive processing (meaning making) associated with the parentification process and the environment where it takes place.

MODELS OF STRESS, TRAUMA, AND POSTTRAUMATIC GROWTH

Defining Stress

Lazarus and Folkman's (1984) model of stress and coping offers a cogent way to explicate the difference between stressors, stress, and trauma. The Lazarus and Folkman model defines *stress* as an interaction between the person, the environment, and a stressor, such that the person perceives the interaction as "taxing or exceeding his or her resources and endangering his or her well-being" (p. 21). This model is helpful in that it allows for idiosyncratic interpretations of perceived stress and trauma.

Stressors are often described as events, environments, or processes that may "cause stress." Stressors can be further identified by such features as "time-limited," "chronic-intermittent," "sequenced," and "chronic-continuous" (Elliott & Eisdorfer, 1982). Lazarus and Folkman (1984) suggested that stressors are what may lead to stress or trauma; they involve something that is perceived or appraised as being either harmful, challenging, or benign. The *primary appraisal process* entails the person's assessment of the gravity of the situation. Thus, the person's appraisal of the stressor leads to how he or she may or may not resolve the situation. To this end, this *secondary appraisal process* helps the person to identify how he or she might cope with the stressor. Documented stressors related to child maltreatment are numerous: poverty, parent's mental health, social supports, substance abuse, and a history of trauma and loss, to name a few (Cicchetti & Toth, 1995; Garbarino, 1977; Gold, 2001).

In Lazarus and Folkman's model (1984), each person determines whether an event or environment is traumatic. According to this model, two people could experience parentification at the same age in similar demographic situations and still experience diverse outcomes. Thus, how each person perceives and makes meaning of the event or environment affects how he or she might cope, what resources are available to him or her, and the associated aftereffects.

Single events may cause distress and have an effect on one's psychological health and functioning (McCann & Pearlman, 1990; Tedeschi & Calhoun, 1995). Alternately, events or environments in which the act happens gradually

and repeatedly can lead to similar outcomes and may be just as debilitating and devastating (e.g., child maltreatment or parentification). Both trauma processes have elements of uncontrollability: the former processes do not allow for preparedness, and the latter may or may not. Moreover, Tedeschi, Park, and Calhoun (1998) contended that even chronic trauma such as child maltreatment can at one time—that is, the first time—be sudden and unexpected, and thus the persons involved may experience both a chronic and an acute trauma. Nevertheless, a single event occurring in a brief period of time as well as a chronic, ongoing trauma (e.g., child maltreatment, parentification) can both equally threaten the health and well-being of the individual (Brewin, Dagleish, & Joseph, 1996).

Defining Trauma

What differentiates a traumatic event and environment from other events and situations? *Trauma*, like stress, lies in the individual's subjective perceived experience. And thus, as with stress, with trauma the individual lacks the ability to integrate his or her emotional, physiological, and psychological reaction with the stressor and environment. As a result, the person is often left feeling overwhelmed, challenged, alarmed, and unable to adequately cope. Trauma, in short, is one's response to *extreme* stress. Trauma has been traditionally described as something that comes as a shock to the system, is unexpected, and happens suddenly, thereby limiting one's ability to prepare for it. Brewin et al. (1996) argued that trauma does *not* necessarily have to involve an event outside of the ordinary range of human experience; the Diagnositic and Statistic Manual, Edition IV (American Psychiatric Association, 2000) supports this perspective.

Posttraumatic Growth

The construct of and the literature related to posttraumatic growth allows for an exploration of growth after childhood parentification. In the current discussion, and borrowing from Carver's model of growth and thriving, *posttraumatic growth* (PTG) is defined as the "assumption that the person who experiences the traumatic or stressful event [environment] benefits or gains in some way from the experience and can apply that benefit to new experiences, leading to more effective subsequent functioning" (Carver, 1998, p. 251).

Tedeschi and Calhoun's (1995) model, which is an extension of existential and cognitive theory, serves as a definitional link to the feasibility of growth as an outcome related to parentification. Posttraumatic growth is based on the premise that some people who experience trauma and adversity are able to use the traumatic experience as means to increase personal growth and development. Further, the term can be defined as an identifiable change, as a result of a traumatic experience, beyond the previous level of cognitive and emotional

functioning (Tedeschi & Calhoun). Saakvitne and Tennen (1998) contended that many survivors of potential traumatic life events (or severe life stressors [such as parentification] or environments [such as the family environment where parentification takes place]) experience posttraumatic growth. Consequently, posttraumatic growth can be understood as a measurable outcome following trauma, such as parentification.

As the originators of the posttraumatic growth construct, Tedeschi et al. (1998) contended that several assumptions underlie PTG: (1) traumatic events or environments are usually sudden and unexpected, so that an individual confronted with such an event lacks a sense of psychological preparedness; (2) a traumatic event or environment is one that leaves the person feeling like he or she has no control over the event; (3) trauma is often an unfamiliar event or environment that leaves one unaware of how best to cope or adapt to the unknown event; and (4) a traumatic event is one that creates long-lasting problems.

The process of parentification, as previously discussed, traditionally involves three of these four characteristics of trauma put forward by Tedeschi and Calhoun (1995) and Tedeschi et al. (1998). First, parentification often leaves the child feeling like he or she has no control over the traumatic situation. Second, when the child first experiences parentification—depending upon age, maturity level, and developmental stage—he or she often feels ill-equipped to carry out a parental role in the family. Third, the empirical literature has supported the finding that parentification can and often does lead to long-lasting problems in adult functioning (Anderson, 1999; Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Burt, 1992; Chase, 1999; Jones & Wells, 1996; Jurkovic, 1997, 1998; Karpel, 1976; Minuchin et al., 1967).

In focusing on positive outcomes evidenced in adulthood after childhood trauma, this discussion adds to the literature on parentification by broadening and deepening the conceptualization of varied outcomes. The posttraumatic growth concept is offered as a model that may help clinicians understand constructive outcomes related to parentification. A PTG framework can extend the deficit or medical model that is adopted by many mental health professionals. Assessing for and identifying the coping strategies that are employed by children and later adults who are parentified can be most helpful for clinicians and the clients with whom they work. Also, this framework assumes there will be variability in how people respond to stressful and traumatic events and environments but at the same time may be better for it irrespective of the level of adversity. Because traumatic events involve the potential for *both* negative and positive change, it is important for mental health counselors to assess the various outcomes that a person might experience. One possible assessment tool in this regard may be the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). This instrument can help mental health counselors avoid

focusing only on the negative outcomes of parentification. Several clinicians and researchers have concluded (cf. Updegraff & Taylor, 2000) that growth among trauma survivors is more the rule than the exception.

Thus for clients such as Alex and Sharon—who appeared in the case examples—mental health counselors will want to consider ways that clients' beliefs, meaning making, and positive narratives associated with the parentification process and environment emerge and evolve over time. Further, counselors can assist clients in incorporating these new narratives into their daily life and using the narratives to promote current positive functioning and posttraumatic growth.

IMPLICATIONS AND DIRECTIONS FOR THE FUTURE

Thus far I have attempted to clearly define parentification and describe how various outcomes can be seen among adults who have experienced childhood parentification. This section explores the implications for future research and discusses how mental health counselors might consider the concept of posttraumatic growth in their clinical practice efforts in general and in their work with clients who have been parentified in particular.

Directions for Future Research Efforts

Counselors and researchers have long demonstrated a clear awareness of the deleterious effects of parentification in general (Chase, 1999; Mayseless, Bartholomew, Henderson, & Trinke, 2004). However, they have also demonstrated a leaning towards investigations that explore the negative outcomes among parentified children. To this end, they have drawn sometimes oblique conclusions about adult functioning related to childhood parentification (Barnett & Parker, 1998; Boszormenyi-Nagy & Spark, 1973; Chase, 1999; Earley & Cushway, 2002; Hetherington, 1989; Minuchin et al., 1967; West & Keller, 1991). In spite of this potential inclination, a few researchers and counselors have concurrently argued for a need to broaden the scope of research and practice with regard to the varied aftereffects of parentified children and the adults they become (Barnett & Parker; Boszormenyi-Nagy & Spark; DiCaccavo, 2006; Earley & Cushway; Jurkovic, Morrell, & Casey, 2001; Karpel, 1976; Minuchin et al.).

While the deficit perspective has led to the identification of relevant and consistent meaningful outcomes related to research and clinical practice (Chase, 1999; Jurkovic, 1998), the major undertaking of the present discussion is to incorporate a new perspective that includes a positive lifetime developmental trajectory after relational and environmental adversity/trauma in childhood, such as parentification. Thus, I encourage future examination of the feasibility of a growth model as a first step in filling a gap in the literature.

Posttraumatic growth is plausible as an outcome of parentification. Many adverse events have been documented and empirically studied among trauma researchers (Liotti, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Tedeschi & Calhoun, 1995, 1996; Tedeschi et al., 1998; van der Kolk, 1996) and researchers and clinicians (Anderson, 1999; Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Burt, 1992; Jones & Wells, 1996; Jurkovic, 1997, 1998; Karpel, 1976; Minuchin et al., 1967), as well as researchers from other fields of study (e.g., anthropology, sociology, and education). What happens after the trauma, and who may benefit from these adverse events, have also been considered. For example, Saakvitne and Tennen (1998) suggested that trauma includes both devastation and resilience as outcomes; and recently, researchers have considered the benefits that individuals may experience as a result of these diverse traumatic events or environments (Saakvitne & Tennen; Tedeschi & Calhoun; Tedeschi et al.; Wolin & Wolin, 1993).

It may be beneficial for mental health counselors to examine to what extent differences in posttraumatic growth and psychopathology may be observed across different levels of emotional and instrumental parentification in different samples (e.g., differential effects across age, race, clinical populations). For example, among racially and ethnically diverse families, what may be maladaptive family functioning in one culture may be adaptive family functioning in another culture. Consequently, this culturally informed family system during childhood parentification may moderate outcomes in adulthood.

Implications for Assessment and Mental Health Counseling Efforts

I respectfully encourage counselors and other mental health providers to consider the following points. The utility of discovering how to counsel those at risk for severe levels of parentification in childhood, and for subsequent high levels of distress in adulthood, cannot be overstated (DiCaccavo, 2006; Mayseless et al., 2004). Mental health counselors should consider assessing historical and current family functioning, as well as individual roles and functioning in the context of the family system, as well as all of their potential contributions to current functioning and presenting problems—for example, the role that the parentification process may play for individual family members and for the family system.

Assessment methods directed toward the phenomenon of parentification might include specific questions embedded in the intake and clinical interview or may include a survey designed to assess the level of parentification (e.g., the Parentification Questionnaire of Jurkovic & Thirkield, 1998). Jurkovic et al. (1999) suggested that counselors should take into consideration the specific context and role adopted during the parentification process in order to inform intervention and counseling strategies for clients with a history of

parentification. The following questions may be helpful during the intake interview and throughout the counseling process.

First, consider the age of the client when the parentification process took place. *(How old was the client when the parentification process took place?)* Clients who experienced parentification when they were very young may report significantly different clinical outcomes than if they experienced parentification as a teenager. Second, consider the event that precipitated the parentification process. *(What—if anything—caused this parentification process to begin?)* For example, if the parentification process had an acute onset when a parent experienced a serious medical condition, as compared to a long chronic history of parentification across many generations, the outcomes may be different between such clients (DiCaccavo, 2006; Jurkovic, 1997; Mayseless et al., 2004). Other important questions that counselors ought to explore are as follows: *How often did the parentification process take place* (i.e., frequency)*? How long did the parentification process go on* (e.g., temporary, brief, across many years)*? Who was a part of the parentification process* (e.g., siblings, parents, both)*?* This last question—about who was involved—may also be related to different clinical outcomes (Chase, 1999; Jurkovic). A person who experiences a parentification process related to his or her siblings while having consistent support and recognition from a parent may experience little trauma related to this role, whereas a person who experiences the parentification process involving the entire family, with no support or recognition for an extensive length of time, will likely experience the process as overwhelming, unfair, age-inappropriate, and potentially traumatic (Jurkovic et al., 1999).

These questions may enable mental health counselors to better understand how a client has perceived the parentification process and the extent to which the process is influencing current levels of functioning. Additionally, these focused questions will help counselors to better understand the extent to which the parentification process had functional value (Anderson, 1999) and to understand how destructive or constructive this process was, given the context in which it happened (Jurkovic, 1997; Jurkovic et al., 1999). Responses to these questions can help the counselor focus counseling efforts and treatment planning when working with clients who have been parentified.

Indeed, ethical, competent mental health counselors' efforts are likely to include traditional counseling behaviors that also comprise the posttraumatic growth framework that Calhoun and Tedeschi (1999) propose: helping clients cope with traumatic and stressful circumstances. However, Calhoun and Tedeschi contend the major focus of clinical and research efforts directed toward the aftereffects of trauma traditionally focus on how clients are negatively affected. Thus, many opportunities for counselors to help the client perceive and achieve growth are missed, although mental health counselors cannot create growth in their clients, they can encourage growth.

Calhoun and Tedeschi (1999) include the following five recommendations—among many others—that may be added to a variety of counseling helping orientations to engender posttraumatic growth. First, *focus on listening, without necessarily trying to solve* the client's presenting symptoms associated with trauma (e.g., Calhoun and Tedeschi state, "the clinician should be quietly sympathetic, without disturbing the telling, and without usurping the affect the client has in response to his or her experiences" pg. 61). Also, they suggest counselors should avoid providing the client with solutions, suggestions, and advice. This stance will lead to the counselor having a better understanding of the client's worldview, beliefs, and view of self and others. Second, *notice growth as the client approaches it.* As previously mentioned, many counselors miss therapeutic moments when clients describe potential growth. Thus, an important step in fostering posttraumatic growth is to attend to and underline when clients hint at growth as they tell their story. Critical to this skill is the counselor being open to growth even as they encounter a range of trauma-filled stories. Third, *label it [growth] when it is there.* Clients can significantly benefit from the counselor's positive interpretations of the client's growth resulting from stress and trauma. However, a part of the counselor's skill in sensitively and ethically labeling growth is related to when and how it is done. Assessing the client's readiness to hear and understand growth as a consequence of trauma and the meaning making process is critical. Moving too quickly could have deleterious effects on the client and the therapeutic relationship and environment. Fourth, with *events that are too horrible,* the counselor may elect to put off labeling posttraumatic growth. Because growth after trauma varies from client to client, Tedeschi and Calhoun (1995) recommend therapists let our clients decide the feasibility of growth after the most severe trauma. Counselors can tentatively check out the potentiality of growth using carefully chosen respectful language. Fifth, *choosing the right words* is critical to our clients being receptive to posttraumatic growth. Calhoun and Tedeschi point out that some counselors mistakenly and exclusively connect growth with the traumatic environment (stressful life event) rather than the struggle and meaning making subsequent to the trauma. This misstep by counselors could, for example, engender anger and revulsion in the client, and thus thwart the posttraumtic growth process. Thus the counselor's purposeful, intentional word choice and language is critical in the context of applying the posttraumatic growth framework.

Because posttraumatic growth generally happens over time, counselors should be open to posttraumatic growth from the beginning to the end of the counseling relationship. The posttraumatic growth process will likely look different across clients and it is to be expected that some clients will find it hard to recognize the growth they have experienced. Calhoun and Tedeschi (1999) suggest later in the counseling process, posttraumatic growth may be evinced

when the client can describe his or her newly identified strengths to self and others.

In sum, and as previously noted, many mental health researchers and practitioners have described the negative outcomes associated with parentification seen in research and clinical practice (Chase, 1999; Jurkovic, 1997; Mayseless, Bartholomew, Henderson, & Trinke, 2004). These associations can possibly lead to mental health counselors over emphasizing and focusing on the deleterious aftereffects of parentification and thus miss client-described positive meaning making of the childhood parentification process. The delineated specific questions in conjunction with the posttraumatic growth framework may help mental health counselors assess and *recognize* both the potential negative *and* positive aftereffects of parentification.

SUMMARY

Parentification can be experienced by many individuals as stressful and by others as uncomplicated or easy (Barnett & Parker, 1998). Thus, not all parentified persons experience the event as stressful and subsequently as traumatic (Aldridge, 2006; DiCaccavo, 2006; Jurkovic, 1997). Some may experience parentification as uneventful and, when asked about their experience, they may attach little meaning or value to the process. Cicchetti and Toth (1995) suggested that researchers and counselors must recognize and consider that similar events and environments, occurring at different times for the individual and the family and at different family life cycle stages, may result in different outcomes. Understanding those who experience high levels of emotional and/or instrumental parentification in childhood and who are "better for it" in adulthood can inform prevention, intervention, and treatment of parentification across the lifespan. Similarly, those clients who experience the parentification process and role as traumatic and stressful, the posttraumatic growth framework in conjunction with a variety of theoretical helping orientations can help mental health counselors perceive, examine, and understand clients who report growth following trauma. Thus, counselors can play a pivotal role in appropriately and ethically encouraging posttraumatic growth among clients "who have experienced a wide range of highly stressful situations" (Calhoun & Tedeschi, 1999, pg. 54).

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