The Effects of Parentification, Attachment, Family-of-Origin Dysfunction and Health on Depression: A Comparative Study between Gender and the Ethnic Groups of South Koreans and Caucasian Americans

Sunnie Giles

Brigham Young University - Provo

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The Effects of Parentification, Attachment, Family-of-Origin Dysfunction and Health on Depression: A Comparative Study between Gender and the Ethnic Groups of South Koreans and Caucasian Americans

Sunnie Giles

A thesis submitted to the faculty of Brigham Young University in partial fulfillment of the requirements for the degree of Master of Science

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School of Family Life
Brigham Young University
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ABSTRACT

The Effects of Parentification, Attachment, Family-of-Origin Dysfunction and Health on Depression: A Comparative Study between Gender and the Ethnic Groups of South Koreans and Caucasian Americans

Sunnie Giles
School of Family Life, BYU
Master of Science

Parentification is a process where children or adolescents assume adult roles before they are emotionally or developmentally ready which, in turn, disrupts the development of healthy, secure attachment in childhood. Using 1,001 men and women from South Korea and the United States with equal division between males and females and multiple group comparison technique in structural equation modeling, this paper examined the relationship between parentification during childhood and depression during adulthood. It explores the cross-sectional long-term effects of parentification into adulthood, using a retrospective survey technique. This study also confirmed previous research findings that attachment, physical health and family-of-origin dysfunction, parental addiction in particular, significantly predict depression. This study is one of the few studies that allow a direct comparison between different sample groups in two different countries and by gender.

Keywords: parentification, depression, Korea, Korean, gender, attachment, health, illness, dysfunction, addiction, ethnic groups, adolescence, adolescent, Asian, male, female, parentify, Caucasian, children, childhood, family, contextual therapy, SEM, multiple group analysis
ACKNOWLEDGEMENTS

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Introduction

While family therapists assert that parentification has long lasting effects in adulthood (Boszormenyi-Nagy & Sparks, 1973; Ducommun-Nagy, 2003), relatively limited empirical research has focused on the long-term effects of parentification in different cultures and across gender groups. Much research has established the association between depression and attachment quality in current relationships, health, and family-of-origin dysfunction respectively, but the examination of how parentification may be associated with depression in adulthood remains an under researched topic. Examining the role of parentification in predicting depression after accounting for known predictors of depression (i.e. the impact of attachment in a current romantic relationship, family-of-origin dysfunction and health) would help in understanding the relative predictive value of parentification to explain depression.

Parentification is a process where children or adolescents assume adult roles before they are emotionally or developmentally ready to manage those roles successfully. This, in turn, disrupts the development of healthy, secure attachment in childhood (Stein, 1999). Jurkovic (1997) describes parentification as the process of children performing caregiving functions in the family and fulfilling parental needs and fantasies, often at the expense of their own development and self-realization.

Depression has enormous costs to U.S. society, with costs related to lost productivity and increased medical expenses estimated at $83 billion per year (Greenberg, et al., 2003). According to Smith and Smith (2010), the lifetime loss of income for a family with a depressed member is around $300,000. Children and adolescents who suffered depression have, as adults, 30% - 37% lower incomes and 31% lower levels of educational attainment. (Smith & Smith, 2010). If parentification is associated with depression, understanding its etiology would offer an additional strategy for intervention with depression, namely resolving family-of-origin
dysfunction and interrupting patterns that have resulted from parentification.

From an ethnicity-based point of view, it is logical that parentification would be more prevalent in the Eastern culture where filial piety is a revered value and collectivism is more dominant than in Western culture where individuation from family-of-origin is valued. It also seems logical that the societal role-expectations placed on women to care-take their families would render women more likely to be parentified than men. However, no study, to date, has examined how gender and ethnicity influence the level of parentification in relation to depression. With the large societal costs of depression, this study examined how parentification in childhood is related to adult depression, after accounting for the effects of the known sources of depression, namely the quality of attachment in the current relationship, family-of-origin dysfunction, and the health problems one is experiencing. While some studies have shown an association between parentification in childhood and depression (Jacobvitz & Bush, 1996; Willert, 2003; Williams & Francis, 2010), they have not examined the relative weight of parentification on depression in relation to other predictor variables. Neither have gender or ethnicity differences been investigated. This study was the first in its kind to establish the relative weight of parentification on depression in the context of other previously known predictors of depression. In addition, gender and cultural differences between Korea and the U.S. were examined.

**Review of Literature**

**Parentification**

Parentification can be examined from its structural and functional components. From the viewpoint of structural family therapy, a hallmark element of parentification is a role reversal between parent and child, which is a violation of subsystem boundaries (Minuchin, 1981). It can be manifested in children’s triangulation, as cementing agents, when drawn into the marital dyad
to hold their parents’ marriage together or the oldest sibling assuming the parental role. From the contextual family therapy perspective, parentification is defined as “reversal of positions where the child is so overburdened with demands for responsibility that he is never given the chance to be a child” where the parent experiences “the subjective distortion of a relationship as if one’s partner or even children were his parent” (Boszormenyi-Nagy & Spark, 1973, pp. 151-153). During the parentification process, parents create an environment that fosters developmentally-inappropriate caretaking behaviors in their children. When children assume a parental role, they exhibit physical caretaking of young children and even take care of parents physically or emotionally because of the overtly regressive behavior of the parents, which depletes the child both emotionally and physically (Jurkovic, 1997).

The functional component of parentification includes both the instrumental function of taking care of the household and emotional function of supporting the parent(s). The instrumental function is the process of children performing physical caregiving role in the family, often at the expense of their own development and self-realization (Jurkovic, 1998). Emotional function refers to the process where the child sacrifices his or her own needs for attention, comfort, and guidance in order to accommodate and care for emotional needs of the parent (Chase, 1999). This ostensibly altruistic self-sacrifice by the parentified child is an attempt to create some semblance of order in a chaotic family situation and maintain pseudo-mutuality among family members. This self-abnegating attempt by the child allows for toxic symbiosis with the parent who does not possess the capability or willingness to separate the child’s needs from his/her own and does not demonstrate an attitude of positive self-care to meet his/her needs through other means than from the child (Morris, 1982).

While the researchers above have provided negative consequences of parentification,
others have identified some positive effects resulting from parentification. Hooper (2008) found that parentification was linked to beneficial effects, such as resiliency and posttraumatic growth in parentified children. However, Jurkovic (1997, p.51) concluded that parentification is one of the most egregious family conditions that results in a “variety of emotional, cognitive, and sociofamilial difficulties: loss of childhood, parents, and trust; anger and resentment, stress, guilt and shame; physical and sexual abuse; peer problems; school difficulties; disruption in identity development; conflicts about leaving home; occupational concerns; and personality dysfunction”.

Supporting this argument, parentification has been found to be linked to other negative outcomes including low academic achievement. In a study of 360 young adults, researchers established that low academic status participants reported having experienced greater levels of parentification (Chase, Wells, & Deming, 1998). Others have found parentification to be linked with poor child social adjustment in school (Woolgar & Murray, 2010). Finally, parentification has also been linked to such deleterious conditions as low self-esteem. In a study of 416 children (ages 10 -18), researchers found that parentification was linked to poorer self concept and lack of self-esteem (Godsall, Jurkovic, Emshoff, Anderson, & Stanwyck, 2004).

This arrested development for full selfhood, shackled by the contravening loyalty for family, seems to create what some researchers call the “imposter phenomenon” among the parentified children. The imposter phenomenon refers to the internal experience of parentified children where they feel fraudulent and unworthy despite objective evidence of success in the form of academic or professional achievements (Clance, 1985). Castro, Jones and Mirsalimi (2004) studied 213 graduate students and found that those parentified as children performed tasks that were developmentally too advanced and adapted their true selves to meet the needs of
their parents, developing a schema of self as inauthentic and frequently viewing themselves as “imposters” whose true identity will soon be revealed. From the contextual family therapy perspective, the double-bind construct provides an insight into the mechanism of the loss of self in parentified children. Parentified children’s constant struggle between yearning for true individuation and the shame and guilt-laden symbiotic togetherness with the family-of-origin is at the heart of the parentification construct:

“From the viewpoint of the parentified person, parentification is an overtly exploitative maneuver. The exploitation of a child is of a double-binding type: He is expected to be obedient, yet behave in accordance with the ostensibly superior or senior position he is cast into…. He pays for his assigned rank by his captive role. The great cost of such captivity is arrest of individual development and autonomy” (Boszormenyi-Nagy & Spark, 1973, p. 164).

This symbiosis is consistent with what Satir referred to as an insoluble struggle between fusion and alienation (Satir, 1967).

In summary, parentification is a loss of a child’s self in an effort to secure the love and approval from fragmented parents by performing functions beyond their age or inappropriate for the parent-child boundaries. Consequently, parentification can be associated with many deleterious effects for one’s self and relationships.

**Depression**

Depression is defined by a contextual therapy theorist as aggression turned against the self (Boszormenyi-Nagy & Spark, 1973, p. 265). Perhaps depression occurs as a reaction to the loss of an emotionally significant object or of a personal ability or attribute – being so attuned to meet the needs of others and with disturbed boundaries, the individuals react as if it were a loss from their own self-image as opposed to a loss of the object (Boszormenyi-Nagy & Spark, 1973). Miller (2008) asserted that people are free from depression when self-esteem is based on
the authenticity of their own feelings about their inherent self and not on the possession of certain qualities or successful performances. Possessing of certain qualities or successful performances of tasks can be ephemeral, which one cannot control fully since it can depend on the vicissitudes of life or other external factors beyond one’s control. Self-esteem based on these elements could therefore turn out to be quite fragile, in which case, it could lead to anger towards self and a sense of unworthiness, a hallmark symptom of depression.

A solid sense of self can buffer the stress from the exigencies of life, rendering one more resilient and less susceptible to depression. A loss of self can result from the unbalanced attunement for the needs of others vis-à-vis efforts for self-care, which is demonstrated by the lack of alternative social support, contact with others, leisure activities and outlets for creativity. Supporting this point of view, Wolkin (1984) found in a study of 368 college students that an impaired sense of individuation, self and autonomy is manifested in depression.

The feeling of unworthiness is another symptom of depression. Klein theorizes that depression arises from failed attempts to preserve attachment, at which point the failure can be internalized as being unworthy (Klein M., 1975). Supporting Klein’s view, researchers found in a study of 527 caregivers for patients with Alzheimer’s disease that a sense of loss of self was significantly related to lower self-esteem and depression (Skaff & Pearlin, 1992).

Since loss of self and the feeling of unworthiness are manifested in depression and depression is link to parentification (Carroll & Robinson, 2000), it is logical to conclude that the loss of self and the feeling of unworthiness are present among parentified children. This connection has already been established in the Parentification section above.

**Attachment**

The quality of attachment in a current romantic relationship was used as a context
variable in this study since it has been shown to predict depression. Insecure attachment is a previously-known predictor of depression, which is corroborated by several studies (Carnelley & Pietromonaco, 1994; Marchand, 2004; Roberts, Gotlib, & Kassel, 1996; Wei, Shaffer, Young, & Zakalik, 2005; Whiffen, V. E.; Kallos-Lilly, A.V; MacDonald, B. J, 2001)

Attachment can be defined as “the emotional tie or affectionate bond that exists between an individual and an attachment figure” and events that interfere with attachment have “short-term and possible long-term negative impacts on the child's emotional and cognitive life” (Mercer, 2006, pp. 2; 103-127). According to attachment theory, human beings are guided by the evolutionary instinct of bonding with important others in their environment and seeking out “attachment figures” when they become distressed to ensure self-preservation (Bowlby, 1969; 1973; 1980). Depression is an integral part of separation distress that arises after children’s protest and attachment seeking behaviors have not elicited responsiveness from an attachment figure (Johnson, 2008).

Many studies have established the relationship between depression and quality of attachment. Using data from a national survey of preretirement- and retirement-aged couples, researchers discovered the association between depression and marital quality in mature marriages (Sandberg & Harper, 1999). Researchers also found in three studies of 486 college students that insecure attachment styles are associated with increases in depressive symptoms over time, which were mediated by depleted self-worth contingencies and self-esteem (Roberts, Gotlib, & Kassel, 1996).

The deleterious effect of insecure attachment on depression seems to apply universally to other ethnic groups as well. In a study of 1,698 Southeast Asian refugees in Canada, researchers
discovered that unmarried or otherwise unattached Laotians and Vietnamese refugees experienced high levels of depression 10 – 22 months after arrival, which they continued to display two years after the initial investigation (Beiser, 1988). Therefore, it seemed important to control for the effects of current relationship attachment on depression when examining the association of parentification and depression. Likewise, other known predictors of depression such as physical health were also used as context variables.

**Physical Health**

Several pathways could explain how physical illness may be related to emotional or psychological dysfunctions: by causing cerebral pathophysiology, by disturbing the subjective meaning of illness, by impairing the capacity to cope with needs and goals, by aggravating unresolved intrapsychic conflicts, by impairing the ability to meet the sexual, social and economic role demands and to maintain identity, by altering sensory inputs and feedback, by changing the body image and by disturbing the normal sleep pattern (Aneshensel, Frerichs, & Huba, 1984). Many studies have established the relationship between depression and physical health (Alpass & Neville, 2003; Aneshensel, Frerichs, & Huba, 1984; Berkman, et al., 1986; Spitzer, et al., 1995). To address the question of the direction of causality between depression and illness, researchers found that physical illness and depression have a reciprocal relationship where illness has a large, contemporaneous effect of increasing depressive symptoms, and depression has been found to have a smaller effect on physical illness (Aneshensel, Frerichs, & Huba, 1984). In a study of 2,806 elderly adults, researchers found a significant link between depressive symptoms and functional disability and chronic health conditions (Berkman, et al., 1986). In a different study of 217 men, researchers found that self-reported health was associated with depression, with poorer health predicting greater depression (Alpass & Neville, 2003). In a
study of 1,000 adults, researchers found that mental disorders such as depression were associated with impairments in health-related quality of life (Spitzer, et al., 1995).

**Cultural Differences: Comparison of Koreans and Americans**

Since parentification and depression are the primary variables to be examined in this study, this section will review these two variables only.

**Parentification.** The research on parentification in the context of ethnicity has been primarily with Asian immigrant families in the United States. Due to language difficulties, first-generation immigrants often depend on their children to function as culture brokers and to communicate with the larger society, thus parentifying their children (Chun & Sue, 1998; Hafford, 2010). From the literature reviewed so far, very limited amount of research about parentification is available on racial/ethnic differences. Some researchers have concluded that the sample size for Asian population has not sufficient to make statistical conclusions or no significant differences was observed (Castro, Jones, & Mírsalimi, 2004). No research could be found examining parentification of Korean children in South Korea or even Asian children in the broader sense. One of the purposes of this study was to examine whether there are differences in how parentification in childhood is related to adult depression in Koreans living in South Korea and Americans living in the United States.

In Korea, social acceptance for parentification stems from the Confucian heritage which encourages filial piety, loyalty to the family and collectivism whereas the more dominant force shaping the U.S. psyche is individualism (Hofstede G., 1984). Hofstede (2001) characterizes individualism as being “I” conscious, autonomy, emotional dependence, individual initiative, right to privacy, pleasure seeking, financial security, need for specific friendship and
universalism. On the other hand, collectivism is associated with a “we” consciousness, collective identity, emotional dependence, group solidarity, sharing, duties and obligations, need for stable and pre-determined friendship, group decisions and particularism. Being true to Confucian principles, Korean children are expected to respect and obey parents, take care of their parents’ every need, honor their parents even after the parents have died, make sure that parents are comfortably housed, fed and dressed, and keep parents from worrying about children (Kim & Choi, 1994). A popular children’s folktale, which every Korean child knows, illustrates (and almost glorifies) an example of this parentification of children:

Shim Chung’s mother passes away while Shim Chung is still very young, leaving her with the task of taking care of her blind father. Even at a very young age, she takes care of her father with utmost care and becomes an example of filial piety spoken about by many in the community. One day, a Buddhist monk tells them that Shim’s father can have his sight restored if they offered 300 sacks of rice to Buddha. To save her father from the lifetime misery of blindness, Shim, without letting her father know, sells herself to a marine merchant for 300 sacks of rice, who throws Shim in a lake as a sacrifice to appease Dragon King. There she is led to the Dragon Palace where she is reunited with her mother who wraps Shim in a lotus flower which floats her back up to the surface. She is then discovered by farmers who take her to the king of the land who marries her. Wanting to find her father, Shim asks the king to host a party for the blind where she finds her father. The shock of hearing the voice of his daughter whom he thought was dead opens his eyes, and they live together happily ever after (Park, 2000).

As illustrated in this story, parentification of children under the banner of filial piety is commonly accepted and even glorified in Korea. In stereotypical Korean families, the good of the group trumps the good of individuals. In Confucianism, the duty of the child to the parent remains even after they are married. On the other hand, maturity in the U.S. is defined by a movement away from ascribed relationships to philosophy which encourages independence, autonomy and self-reliance (Kim & Choi, 1994). The self-sacrifice expected of children and wives, the porous intergenerational boundaries and collectivistic culture likely render Koreans
more susceptible to parentification than Anglo-Americans. Indeed, in a study of 40 countries, Hofstede (1984) found that the United States scored the highest in individualism, and Eastern cultures such as China, Hong Kong and Taiwan scored high on collectivism.

**Depression.** The prevalence rate of depression in Korea ranks it first for depression among the 34 most developed countries in the world. Prevalence of suicides related to depression in Korea is 31.0 suicides per 100,000 people (World Health Organization, 2008). In comparison, the U.S. is ranked 20th with 11.1 suicides per 100,000 people. While there are several reasons for depression in Korea such as rapid structural change in Korean society over the last couple of decades, nuclearization of family, disintegration of family values, and focus on materialism, no studies have examined how parentification in a society which is adopting more Western expectations, even for social relationships, may be linked to depression.

**Gender Comparisons**

Only a limited amount of research is available on gender differences in parentification, but the research available to date seems to indicate no gender differences in the US (Castro, Jones, & Mirsalimi, 2004); (Jurkovic, Thrikield, & Morrell, 2001). However, due to different expectations of care-taking levels between females and males, it is logical to hypothesize that gender differences are more likely to exist in Korea than in the United States.

**Methods**

The measurement and conceptual model for this study is illustrated in Figure 1. Figure 1 shows the predicted path between variables from which the following hypotheses were generated:
- Parentification during childhood is a significant positive predictor of depression in adulthood for both Koreans in South Korea and Caucasian Americans in the U.S., even when controlling for family-of-origin dysfunction, current relationship attachment, and health.
- The impact of parentification on depression will be significantly stronger for Koreans than it is for Americans, even when controlling for family-of-origin dysfunction, current relationship attachment, and health.
- The impact of parentification on depression will be significantly stronger for women than it is for men, even when controlling for family-of-origin dysfunction, current relationship attachment, and health.

Figure 1. The Conceptual Measurement and Structural Model

Participants
The participants for this study were randomly selected from marketing databases of Bellweather Interactive, a market research company in the United States and by TNS Korea, a
global market research company in South Korea. Potential participants were contacted through an e-mail blast by these two organizations, and 500 Koreans (250 females and 250 males) and 501 Americans (251 females and 250 males) completed questionnaires online. To ensure an adequate sample size to perform SEM multiple group comparisons, the US samples were restricted to Caucasians.

Inclusion criteria required that participants were between 18 – 54 years old residing in their native country (either South Korea or the United States), and had at least 2 previous committed relationships (seriously dating or marriage), including the current one. Table 1 shows the demographic characteristics of these two samples. Overall, both men and women reported they had good health with 4.6% of males and 4.0% of females reporting serious health problems. These percentages are within the range of what would be expected in a community sample of men and women whose average age is between 36 and 38 years old (Asakawa, Fenny, Senthilselvan, Johnson, & Rolfson, 2009; Ullman & Seigel, 1996).

Bellweather Interactive contacted adults in their market research panel throughout the United States to solicit participation in the study. TNS Korea, the Korean division of an international market research company operating in 80 countries and headquartered in Great Britain, contacted adult Koreans from its market research panel database to participate in the study. The members on each panel amounted to tens of thousands and are randomly drawn from a variety of segments in respective society to approximate the broader population in each country. When individuals in these panels indicated willingness to participate in the study, links to the Informed Consent and the respective English or Korean questionnaires were sent to them. Since the survey was conducted online both in US and Korea, programming restrictions prevented unanswered questions to prevent missing data in this study.
Table 1: Means, Standard Deviations, two-sample two-tailed t Test Results and Percentages for Full Sample and Race and Gender

<table>
<thead>
<tr>
<th></th>
<th>Full Sample (N=1,001)</th>
<th>US (N=501)</th>
<th>South Korea (N=500)</th>
<th>Male (N=500)</th>
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<tbody>
<tr>
<td></td>
<td>US (N=501)</td>
<td>South Korea (N=500)</td>
<td>Male (N=500)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male (N=250)</td>
<td>Female (N=251)</td>
<td>Male (N=250)</td>
<td>Female (N=250)</td>
</tr>
<tr>
<td>Age</td>
<td>37.59 (8.47)</td>
<td>36.09 (7.54)***</td>
<td>37.4 (7.73)</td>
<td>36.2 (8.33) *</td>
</tr>
<tr>
<td># yr in current relationship (Unmarried) (N=399)</td>
<td>4.69 (5.14)</td>
<td>1.92 (1.97) ***</td>
<td>3.20 (4.25)</td>
<td>3.28 (3.84)</td>
</tr>
<tr>
<td># yr in current marriage (N=602)</td>
<td>11.92 (8.19)</td>
<td>9.94 (7.58) ***</td>
<td>10.76 (7.85)</td>
<td>11.15 (8.05)</td>
</tr>
<tr>
<td># of Children at Home</td>
<td>1.13 (1.32)</td>
<td>0.87 (0.96) ***</td>
<td>0.91 (1.13)</td>
<td>1.09 (1.19)</td>
</tr>
<tr>
<td># of Siblings</td>
<td>2.14 (1.75)</td>
<td>3.01 (1.33) ***</td>
<td>2.43 (1.59)</td>
<td>2.71 (1.63) *</td>
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Percentages:

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<th>Relationship Status</th>
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<td>Male (N=250)</td>
<td>Female (N=250)</td>
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<tr>
<td>Married</td>
<td>62.0%</td>
<td>58.1%</td>
<td>57.8%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Single, never married</td>
<td>21.4%</td>
<td>36.7%</td>
<td>31.4%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Divorced/ Separated</td>
<td>10.2%</td>
<td>2.2%</td>
<td>6.0%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>0.6%</td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>5.8%</td>
<td>2.6%</td>
<td>4.8%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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Religion:

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<th>South Korea (N=500)</th>
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<td>Female (N=250)</td>
</tr>
<tr>
<td>Catholic</td>
<td>23.7%</td>
<td>14.4%</td>
<td>25.5%</td>
<td>22.0%</td>
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<tr>
<td>Protestant/Other Christian</td>
<td>38.4%</td>
<td>22.0%</td>
<td>38.9%</td>
<td>38.0%</td>
</tr>
<tr>
<td>Jewish</td>
<td>6.2%</td>
<td>0.0%</td>
<td>6.5%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Islam</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0.4%</td>
<td>20.4%</td>
<td>0.4%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Greek Orthodox</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Mormon/ LDS</td>
<td>1.2%</td>
<td>0.2%</td>
<td>1.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>1.8%</td>
<td>0.4%</td>
<td>1.2%</td>
<td>2.4%</td>
</tr>
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<tr>
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Education:

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<td>Total</td>
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<td>100.0%</td>
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</table>

*** statistically significant at the .001 level; ** at the .01 level; * at the .05 level
Translation of Measures into Korean

To maximize the accuracy of translation, an adjusted approach from the 6-step Modified Serial Approach proposed by Carroll and his colleagues was implemented (Carroll, Holman, Segura-Bartholomew, Bird, & Busby, 2001). First, the English survey was translated into Korean by two native Koreans, one with extensive residency and acculturation to the U.S. and the other with more recent residency. A third native Korean bilingual in English with 25 years of residence in the US and 20 years of residence in Korea compiled the two versions of the translation. Second, to assess clarity and equivalence, the instrument was then taken to three Koreans to verify comprehension. Third, the measures were then back-translated from Korean into English by a Korean native with 10 years of U.S. residency and a college education. The original English version and the back translated version were then compared, and appropriate changes were made. Bi-cultural individuals familiar with both cultures and languages then reviewed the instrument for content validity and appropriate changes were made to ensure correct translation of even minute nuances in the survey instrument.

Measures

As shown in Figure 1, the latent variable of parentification was used to predict depressive symptoms while controlling for quality of current relationship attachment, and family-of-origin dysfunction. Quality of current relationship attachment was created using the insecure and secure attachment subscales of the Relationship Scales Questionnaire (RSQ) as indicators of the latent variable. The latent variable, Family-of-origin dysfunction, was created using three indicators, father’s problems, mother’s problems, and “not talking openly about feelings” question. Severity of health problems was measured by the participants’ answers of how serious
their health problems were. The latent variable, parentification, was created using three subscale indicators from the Filial Response Scale – Adult (FRS-A) (Jurkovic & Thirkield, 1998). Confirmatory factor analysis was used to determine how well the 20 items for the Center for Epidemiological Studies Depression Scale was done to determine which items best loaded on a latent variable called depressive symptoms, and the resulting items were used as indicators of this latent variable. Details of these factor loadings are described below.

**Parentification.** The Filial Responsibility Scale - Adult (FRS-A) (Jurkovic & Thirkield, 1998) is one of the most widely used measures for parentification and assesses various levels of parentification during childhood. The FRS-A contains 30 questions which ask adults to retrospectively consider their childhood and 30 questions which ask adults their current experiences with their family of origin. Respondents answered using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

The FRS-A includes family background factors and other ethical factors examined by Boszormenyi-Nagy (Boszormenyi-Nagy & Spark, 1973) as well as perceived fairness and captures interaction among various systems such as family, parents, society, peers, siblings and community. In this study, the 30 questions in the retrospective section were used.

The FRS-A contains three subscales, each with 10 items: instrumental parentification, expressive caregiving and perceived fairness. The sum for each of these three subscales formed the three indicators for the latent variable called parentification. Instrumental parentification covers the same function as what Boszormenyi-Nagy & Spark refer to as the “manifest caretaking role” and includes questions such as “I did a lot of the shopping (e.g., for groceries or clothes) for my family.” Expressive caregiving is equivalent to what Boszormenyi-Nagy and Spark refer to as the “sacrificial role” and includes questions such as “At times, I felt like I was
the only one my mother or father could turn to.” and “In my family, I was often described as being mature for my age.” Perceived fairness measures the degree to which the individual feels that the parentification roles, responsibilities, and process were “fair.” It includes questions such as “In my family I often made sacrifices that went unnoticed” and “It often seemed that my feelings weren’t taken into account in my family.” The possible range of scores for each subscale is 10 to 50 with higher scores indicating more parentification.

Jurkovic, Thirkield and Morrell (2001) confirmed the validity and reliability of FRS-A. Cronbach’s alpha scores for instrumental, emotional, and fairness subscales were .74, .79 and .86 respectively. A comparison of FRS-A subscales with the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982) subscales reflected significant correlations in theoretically expected directions (Hooper & Wallace, 2010). The factor loadings were .86, .90, and .82 for instrumental, expressive care, and unfairness respectively. Reliability coefficients were .88, .67, and .80.

**Depression.** The Center for Epidemiologic Studies Depression Scale-revised short version (CES-D) developed by Radloff (1977) was used to measure depression. The scale is a composite of 11 items which were selected from the following sources: the Zung Self-Rating Depression Scale (Zung SDS), the Beck Depression Inventory (BDI), the Raskin Scale, and the Minnesota Multiphasic Personality Inventory Depression Scale (MMPI-D) (Radloff & Locke, 2000). Respondents answer four-point Likert scale indicating how much they experience the description (0-none of the time to 3-all of the time). Items were selected to represent the major components of depression on the basis of the clinical literature and factor analytic studies. Components include depressed mood, feelings of worthlessness, feelings of hopelessness, loss of appetite, poor concentration, and sleep disturbance. The scale does not include items for increased appetite or sleep, anhedonia, psychomotor agitation or retardation, guilt, or suicidal
thoughts. The original CES-D items were derived from previously validated depression scales and were selected to represent the major symptoms of depression that have been identified in clinical and factor analytic studies (Radloff, 1977). Possible scores range from 0 to 44.

Internal consistency reliability has been reported as .85, and split half reliability as .90. Test-retest reliability has been reported as .53. In terms of validity, correlations of the score from the CES-D with the Symptom Checklist 90 ranged from .44 to .75 indicating that the measure has good concurrent validity. This CES-D has been used in other studies with subjects from South Korea (Choi, Fogg & Lee, 2009; Radloff, 1977).

Confirmatory Factor Analysis was used to determine how well the 11 items loaded onto one factor called depressive symptoms. Only those items loading higher than .50 were kept. These included “I felt depressed” (.87), “Everything I did was an effort” (.62), “My sleep was restless” (.57), “I felt lonely” (.78), “I felt sad” (.88), “I felt that people disliked me” (.62), and “I could not get going” (.63). These seven items were kept as indicators of the depressive symptoms latent variable. The reliability coefficient for the 7 items was .89.

**Attachment.** The Relationship Scales Questionnaire (RSQ) (Griffin & Bartholomew, 1994) is one of the most widely-used self-report concerning adult attachment. It contains 30 short statements drawn from Hazan and Shaver's (1987) attachment measure, Bartholomew and Horowitz's (1991) Relationship Questionnaire, and Collins and Read's (1990) Adult Attachment Scale. Scores for each attachment pattern are derived by taking the mean of the four or five items representing to arrive at four attachment types: secure, fearful, preoccupied, and dismissing, which can be divided into secure and insecure attachment. The questions are posed on a five-point Likert scale from “Not At All Like Me” to “Very Much Like Me”. The underlying construct of this scale is based on two dimensions, positive and negative view of the self and
others, yielding four quadrants. The construct validity of this model has been found to be adequate, with the structural coefficient between each attachment dimension and its hypothesized outcome ranging between .96 and .93. According to the authors of this instrument, the reliability is adequate for research. In this study, the summed score from the secure attachment subscale, and the summed score from the insecure attachment composite were used as the two indicators of the quality of attachment in current relationship latent variable. The factor loading for secure attachment was .75, and the factor loading for insecure attachment was -.67. The reliability coefficients for these two subscales were .92 for secure and .81 for insecure.

**Physical health (illness).** Survey respondents were asked (1) if they had “serious, extended illness(es)” and asked (2) how they rated the severity of the illness(es) on a five-point Likert scale, ranging from mild to severe. The number of reported illness ranged from 1 to 6. The mean score from the answers to these items was used as the measure of severity of physical health.

**Family-of-origin dysfunction.** This latent variable was created using self-reported data related to various addictions and abuses participants reported were experienced by the respondent’s father and mother. These 11 dysfunctional conditions included alcohol addiction, drug addiction, gambling addiction, computer game addiction, pornography addiction, sex addiction, compulsive spending, cosmetic surgery addiction, computer/internet addiction, eating disorders/bulimia/anorexia/compulsive eating and mental disease. These questions were posed on a five-point Likert scale ranging from mild to severe. The answers to these items were summed separately for mothers and for fathers. In addition, participants were asked to rate the degree to which their families-of-origin did not talk openly about feelings. The sum of addiction and abuse items for mother was one indicator; the sum of the same item for father was used as a
second indicator; and the answer to the item about “not discussing feelings” was used as the third indicator of the latent variable, family-of-origin dysfunction. The factor loadings for these three variables were .81, .82, and .69 respectively. The reliability coefficients were .59 for mother’s severity of problems and .68 for father’s severity of problems.

Results

Tables 2 and 3 present correlations of all variables and mean differences between US and Korea and males and females respectively for the full sample. Multiple Group Analyses were used in Structural Equation Modeling (AMOS) to compare a fully unconstrained model with a fully constrained model the model first between Koreans and Americans (see Figure 2), and second between males and females (see Figure 3). Figure 2 presents the results for group comparison in SEM comparing U.S. vs Korea with current relationship attachment quality, family-of-origin dysfunction, current physical illness and parentification as predictors of depressive symptoms. The results indicated that parentification significantly predicted depressive symptoms even when controlling for quality of current relationship quality, family-of-origin dysfunction, and severity of health problems (β=.18, p<.01 in US, and β=.26, p<.001 in Koreans). As expected, quality of current relationship attachment, family-of-origin dysfunction and severity of health problems, were all significant predictors of depressive symptoms (β=.55, p<.001 for relationship quality; β=.19, P<.01 for family-of-origin dysfunction; and β=.13, p<.05 for severity of health) for the US sample. In the Korean sample all three variables were significant predictors (β=.39, p<.001; β=.28, p<.001; and β=.12, p<.05 respectively). In the country comparison model, goodness of fit indices showed that the hypothesized model was a good fit to the data ($\chi^2=361.65, df=323, p=.07$, $CFI=.975, RMSEA=.041, RMSR=.043$). To be considered a good fit, the Chi Square value should not be statistically
significant and the CFI should be above .95, and the RMSEA and RSMR should be less than .05 (Kline, 2005). Hypothesis 1 that parentification would significantly predict depressive symptoms for both Americans and Koreans, even when controlling for other known predictors of depression, was supported.

Figure 2. Results of Group Comparison in SEM comparing U.S. vs Korea with Current Relationship Attachment Quality, Family-of-origin Dysfunction, Current Physical Illness and Parentification as Predictors of Depressive Symptoms.

*A*<.05, **p<.01, ***P<.001   NOTE: All coefficients are standardized. Standardized Betas for Koreans are reported in parentheses. Control variables of age, income, and education were included in the analysis, but since none of them were statistically significant, they are not included in the figure.

A fully unconstrained model was compared against a fully constrained model in which all the paths were constrained to be equal between Americans and Koreans. A Chi Square difference test showed that the models were not equal (Chi Square difference=23.37, df difference=14, p<.05). Beginning with the fully constrained model, one path was allowed to unconstrained, and then model fit was analyzed. The next path was allowed to be unconstrained, and the fit was analyzed, and this was continued until the best model fit was reached.
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<td>11.68</td>
<td>11.56</td>
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<td>2.16</td>
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<td><strong>U.S. Standard Deviation</strong></td>
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<td><strong>Korean Mean</strong></td>
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*p<.05, **p<.01, ***p<.001  
NOTE: Correlations for Americans below the diagonal and for Koreans above the diagonal.
Table 3. Correlations, Means, Standard Deviations of All Measured Variables for Males and Females.

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<td>-0.41***</td>
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<td>-0.18**</td>
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<td>-0.25***</td>
<td>-0.09</td>
<td>-0.17*</td>
<td>-0.38***</td>
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<td>0.52***</td>
<td>0.25***</td>
<td>0.18**</td>
<td>0.41***</td>
<td>0.19**</td>
<td>0.31***</td>
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<td>3. Preoccupied Attachment</td>
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<td>0.32***</td>
<td>1.0</td>
<td>-0.06</td>
<td>0.13*</td>
<td>0.03</td>
<td>0.15*</td>
<td>0.05</td>
<td>0.20**</td>
<td>0.26***</td>
<td>0.01</td>
<td>0.36***</td>
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<td>4. Dismissing Attachment</td>
<td>0.01</td>
<td>0.48***</td>
<td>0.04</td>
<td>1.0</td>
<td>0.12*</td>
<td>0.15*</td>
<td>0.29***</td>
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<td>1.0</td>
<td>0.34***</td>
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<td>0.27***</td>
<td>0.31***</td>
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<td>6. Mother Severity of Problems</td>
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<td>0.12*</td>
<td>0.10*</td>
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<td>0.50***</td>
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<td>0.28***</td>
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<td>-0.20**</td>
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<td>0.19**</td>
<td>0.22***</td>
<td>0.10*</td>
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<td>0.10*</td>
<td>0.20**</td>
<td>0.53***</td>
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<td>8. Instrumental Parentification</td>
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<td>0.12*</td>
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<td>0.67***</td>
<td>0.54***</td>
<td>-0.01</td>
<td>0.14*</td>
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<td>9. Expressive Care Parentific.</td>
<td>-0.11*</td>
<td>0.27***</td>
<td>0.16*</td>
<td>0.13*</td>
<td>0.17*</td>
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<td>0.72***</td>
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<td>-0.33***</td>
<td>0.47***</td>
<td>0.27***</td>
<td>0.19**</td>
<td>0.23***</td>
<td>0.20**</td>
<td>0.42***</td>
<td>-0.52***</td>
<td>0.59***</td>
<td>1.0</td>
<td>0.06</td>
<td>0.43***</td>
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<td>11. Severity Physical Prob.</td>
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<td>0.03</td>
<td>0.01</td>
<td>0.07</td>
<td>0.10*</td>
<td>0.21***</td>
<td>0.01</td>
<td>-0.07</td>
<td>-0.02</td>
<td>0.09</td>
<td>1.0</td>
<td>0.14*</td>
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<td>12. Depressive Symptoms</td>
<td>-0.38***</td>
<td>0.44***</td>
<td>0.20**</td>
<td>0.22***</td>
<td>0.22***</td>
<td>0.23***</td>
<td>0.19**</td>
<td>0.11*</td>
<td>0.22**</td>
<td>0.39***</td>
<td>0.18**</td>
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<table>
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<tr>
<th></th>
<th>Mean for Males</th>
<th>Standard Deviation for Males</th>
<th>Mean for Females</th>
<th>Standard Deviation for Females</th>
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<td>11.42</td>
<td>11.61</td>
<td>5.04</td>
</tr>
<tr>
<td>2</td>
<td>15.78</td>
<td>2.28</td>
<td>11.82</td>
<td>3.55</td>
</tr>
<tr>
<td>3</td>
<td>15.57</td>
<td>2.67</td>
<td>3.62</td>
<td>3.85</td>
</tr>
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<td>4</td>
<td>2.28</td>
<td>1.61</td>
<td>3.95</td>
<td>3.03</td>
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<tr>
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<td>2.89</td>
<td>1.26</td>
<td>1.12</td>
<td>1.81</td>
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<td>1.26</td>
<td>3.95</td>
<td>3.03</td>
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<td>2.89</td>
<td>1.26</td>
<td>1.12</td>
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<td>1.26</td>
<td>3.95</td>
<td>3.03</td>
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</tbody>
</table>

*p<.05, **p<.01, ***p<.001

NOTE: Correlations for Males below the diagonal and for Females above the diagonal
The results showed that the strength of the path from quality of current relationship attachment to depressive symptoms was significantly stronger for Americans, but the paths from family-of-origin dysfunction and from parentification to depressive symptoms were significantly stronger for Koreans. Hypothesis 2 that the relationship between parentification and depressive symptoms would be significantly stronger for Koreans was supported.

Figure 3 shows the results for group comparison between males and females. Parentification was a significant predictor of depressive symptoms, even when controlling for the other variables, in both males and females ($\beta=.16, P<.05$ for males and $\beta=.26, p<.001$ for females). As expected, quality of attachment in the current relationship, family-of-origin dysfunction, and severity of health problems were also significant predictors of depressive symptoms for both males ($\beta=.34, p<.001$ for attachment; $\beta=.21, p<.01$ for family-of-origin dysfunction; and $\beta=.15, p<.05$ for severity of health) and females ($\beta=.52, P<.001$ for attachment; $\beta=.28, P<.001$ for family-of-origin dysfunction; and $\beta=.11$ for severity of health). Overall fit indices showed that the hypothesized model was a good fit with the data ($\chi^2=355.32, df=323, p=.09, CFI=.979, RMSEA=.032, RSMR=.039$).

A fully unconstrained model was also compared to a fully constrained model in which all the paths were constrained to be equal between males and females. The Chi-Square difference test showed that the models were significantly different (Chi Square difference=24.11, df difference=15, p<.05). Beginning with the unconstrained model, each path was successively constrained. Results showed that the best model was one that allowed the paths from quality of attachment in current relationship to depressive symptoms and from parentification to depressive symptoms to be unconstrained. Through this secondary-level analysis, quality of current attachment relationship was found to be a stronger predictor of depressive symptoms for females,
and parentification was a stronger predictor of depressive symptoms for females. These findings supported hypothesis three that the relationship from parentification to depressive symptoms would be stronger for females.

*Figure 3. Results of Group Comparison in SEM comparing Males vs. Females with Current Relationship Attachment Quality, Family-of-origin Dysfunction, Current Physical Illness and Parentification as Predictors of Depressive Symptoms.*

In addition to multiple group comparison, two-sample t-tests were performed to determine differences in parentification, the variable of interest in this study, between Americans and Koreans and between males and females. The results are presented in Table 4. The results indicate that the level of overall parentification among Koreans is significantly higher than that among Americans. However, the statistical significance failed for the unfairness subscale. The level of parentification among genders failed the statistical significance test both at the overall
level as well as all the subscale levels. These results lend further support for hypotheses one and two, but it does not appear that overall parentification is higher for females. This is not contrary to the SEM comparisons for gender since that analysis was examining the strength of the paths and confirmed that parentification was a stronger predictor of depressive symptoms for females.

Table 4: Results of Two-Sample t Test of Means for Parentification

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>H₀: mean(US) - mean (Korea)&lt;0</td>
<td>H₀: mean(male) - mean (female)&lt;0</td>
<td></td>
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<td>Parentification</td>
<td>US</td>
<td>Korea</td>
<td>P Value</td>
<td>Male</td>
<td>Female</td>
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<td>75.9441</td>
<td>81.3800</td>
<td>0.0000</td>
<td>78.9720</td>
<td>78.3473</td>
</tr>
<tr>
<td>Unfairness</td>
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<td>26.4720</td>
<td>0.6281</td>
<td>26.3800</td>
<td>26.7365</td>
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<tr>
<td>Caregiving</td>
<td>26.6088</td>
<td>28.3460</td>
<td>0.0001</td>
<td>27.6520</td>
<td>27.3014</td>
</tr>
<tr>
<td>Instrumental</td>
<td>22.6906</td>
<td>26.5620</td>
<td>0.0000</td>
<td>24.9400</td>
<td>24.3094</td>
</tr>
</tbody>
</table>

Discussion

The findings of this study confirmed that parentification is indeed a significant predictor of depressive symptoms, even when examined in the context of relationship attachment, family-of-origin dysfunctions and the severity of health problems. This finding is consistent with other previous research on parentification as a predictor of depression (Carroll & Robinson, 2000). The finding also suggests that the relative weight of the impact of parentification on depressive symptoms, in relation to the other three context variables (quality of attachment in the current relationship, parental dysfunctions primarily arising from addictions, and physical health) is indeed greater among Koreans than among Americans. This is likely due to the Confucian foundations in Korea which view the vertical loyalty of the child to a parent to one of the most significant relationships, even more important than the less-vertical bond between husbands and wives (Yammarino & Jung, 1998). This perspective is evident in the common practice in Korea where daughters retain their maiden last names upon marriage.
In addition, the level of parentification among Koreans is greater than that among Americans, and as hypothesized, the relationship between parentification and depressive symptoms was higher for Koreans. However, it is interesting to note that there seems to be no difference in the absolute level of the unfairness subscale of parentification between the two countries. This finding seems to suggest that what constitutes unfairness in the context of parentification is consistent across the two very divergent geographies and that its impact transcends cultural heterogeneity. A closer examination of the individual items in the unfairness subscale reveals that the unfairness-related items primarily refer to being able to depend on parents to meet children’s needs, recognition of children’s contributions and fair give-and-take of responsibilities. Because these parental duties relating to the unfairness subscale are so basic to a family, these items appear to transcend cultural boundaries. It may be that children in the US are more protected from duties related to the instrumental subscale functions such as shopping for the family and making money for the family because of the more structured social services safety net provided by governmental infrastructure. Even with the recent nuclearization of families, extended Korean families still provide a major source of support and welfare in Korea where formal social welfare structure is a nascent concept (Harvie, Yi, & Oh, 2004). The social welfare support provided by extended families can be more informal and hence enforced less stringently, leaving Korean children more vulnerable to instrumental parentification. In addition, the higher levels of parentification in Korea relating to expressive caregiving, such as “I often felt more like an adult than a child in my family,” and “I often felt that my family could not get along without me,” could be attributed to Korea’s Confucian cultural heritage and social expectations on children to take care of their parents.
The findings from the multiple group comparison in SEM reveal that the relationship between attachment quality and depressive symptoms was stronger for women than for men, indicating that attachment quality in current relationship render women more vulnerable to depression than other factors when compared to men, which is consistent with previous research (Kandel & Davies, 1986). The SEM findings also suggest that the relationship between parentification and depression was stronger for women than men, which probably reflects greater expectations for women to perform parental duties, resulting in higher levels of depressive symptomatology. In addition, the SEM results revealed that the quality of current relationship attachment was a stronger predictor of depression for Americans than Koreans. This finding seems to indicate, and consistent with previous research, that Easterners are emotionally more reserved than Westerners, which results in more subdued emotional expressions and lower socialized value for romantic relationships (Averill, Chon, & Hahn, 2001), perhaps from the cultural heritage of ascetic self-denial in Buddhism or that of Confucianism which emphasizes the importance of proper appearance commanding respect. This cultural expectation could have been internalized and adopted by Koreans, thus becoming less influenced by attachment quality.

The finding from this study that there seems to be no significant differences in the absolute level of parentification between genders seems to suggest that other, more significant factors to explain parentification could be explored (e.g. birth order). In addition, this study has found, as predicted, that one’s physical health, attachment level in current relationship and family-of-origin dysfunctions are significant predictors of depression.
Limitations

A major limitation of this study is that it included only Caucasians in the US sample. Future research could expand the scope to other ethnic groups in the US. In addition, there are variations among Koreans based on regional cultures within Korea. The composition of the Korean sample in terms of region was not known so these differences could not be examined. Another limitation is the cross-sectional nature of this study, whereas a longitudinal study could provide a deeper understanding of the causal nature of parentification and depression. In addition, sample bias might have excluded those who do not have Internet access, which risk is potentially greater in the US because the Internet penetration rate in Korea is much higher than that in US.

Clinical Implications

These findings could have implications for therapists treating parentified women who are clinically depressed and in Korean families where they need to assess the unspoken family rules and norms and provide appropriate role induction, as suggested by previous research (Kim, Bean, & Harper, 2004). In addition, Korean families could benefit from increased awareness of the deleterious effects of a socially benign, often revered, concept of parentification and therapists could take prophylactic measures by instituting stronger intergenerational structural boundaries with Korean families. To facilitate healing in clients who were parentified as children, restoring the lost self would be the primary goal for treating depression. The following clinical example with a Korean couple can illustrate this point.

The husband (Tom, name disguised) is 43 with an engineering PhD degree, working for an engineering firm. The wife (Amy, name disguised) is 42 and the couple have been married 13 years with 2 children, ages 8 and 5. Tom was parentified as the oldest child who frequently
witnessed his father’s severe physical and verbal abuse against his mother. His mother depended on Tom as an emotional confidant, thus triangulating him into the marital dyad. Amy was also a parentified child, only in a different context. She was the only child in her family, and Amy’s mother poured her energy into living her unfulfilled dreams vicariously through Amy’s academic excellence. Amy had no childhood memories to speak of, other than the ones relating to studying and excelling in school and producing paintings to please her mother. This couple presented themselves for therapy saying it was their last-ditch effort before they started divorce proceedings. They both exhibited symptoms of depression. During the initial evaluation, it became clear that Amy’s identity was formed only in the context of being Tom’s wife and the children’s mother. Amy was not an individual with a distinct voice and did not know who she was as a person. Analogously, Tom’s identity was defined only in the context of Amy to the point where he felt physical pain if they had different opinions. His primary source of joy was seeing Amy happy, in which he took manly pride. In early therapy sessions, he answered for Amy and constantly interrupted the conversation intended for Amy. Their interaction pattern was limited to him coming home around 7 or 8 pm and spending the rest of the evening locked up in a basement office. She prepared dinner for him, laid it out on the table and retired to her bedroom, and he would come out to eat and return to his office.

After the initial interventions to reduce conflict levels, treatment involved restoring their respective individual selves and strengthening their boundaries. Tom was instructed not to speak for Amy and to ask for her opinion, not weighing in until after she has expressed it. He was also instructed not to tell her how to dress or how to wear her makeup, which he frequently used to do. He was asked not to give her advice unless she asked for it first. Amy was asked to form and express an opinion, even in such trivial a matters as voicing where she would like to go out for
dinner. She was asked to tune into her needs and wants and provide for them herself, such as deciding how to dress to please herself, not to please Tom. They were instructed on how to discuss it if they felt their boundaries were violated. In addition, they were instructed to find outlets to express their creativity. Amy chose origami and painting. Tom chose writing. They both expressed immense pride in the product of their creativity. While they both focused on their own individual needs, instead of focusing on each other, they were able to assert stronger sense of self and boundaries. They also nurtured their own selves by expressing their creativity. After 6 sessions, they reported they felt like they were “dating all over again” and reported their marriage had improved dramatically. They started a ritual of going out for dinner Friday evenings while their children are in a Korean language class.

**Conclusion**

In conclusion, parentification appears to be related to depressive symptoms in both Americans and Koreans and in both men and women. Since quality of current relationship attachment, family-of-origin dysfunction, and severity of illness were all controlled for in this study, it appears that parentification is a significant predictor in addition to these other known factors in depression. The relationship between parentification and depressive symptoms was stronger for Koreans and for females.
Bibliography


Appendix

Filial Responsibility Scale—Adult (FRS-A)

Gregory J. Jurkovic, Ph.D., and Alison Thirkield, M.A

Past
The following 30 statements are descriptions of experiences you may have had as a child growing-up in your family. Because each person’s experiences are unique, there are no right or wrong answers. Just try to respond with the rating that fits best. Please respond to every statement. Mark your ratings on the answer sheet.

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

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

This test will only be scored correctly if you answer each one of the questions. The 11 items below refer to how you have felt and behaved during the last week. Please use the following scale:

1: Rarely or none of the time (less than 1 day); 2: Some or little of the time (1-2 days); 3: Occasionally or a moderate amount of time (3-4 days); 4: Most or all of the time (5-7 days).

1. I did not feel like eating; my appetite was poor. □ □ □ □
2. I felt depressed. □ □ □ □
3. I felt everything I did was an effort. □ □ □ □
4. My sleep was restless. □ □ □ □
5. I was happy. □ □ □ □
6. I felt lonely. □ □ □ □
7. People were unfriendly. □ □ □ □
8. I enjoyed life. □ □ □ □
9. I felt sad. □ □ □ □
10. I felt that people disliked me. □ □ □ □
11. I could not get “going”. □ □ □ □

**RSQ**

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships.

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<th>Somewhat like me</th>
<th>Very much like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1. I find it difficult to depend on other people.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. It is very important to me to feel independent.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. I find it easy to get emotionally close to others.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. I want to merge completely with another person.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. I worry that I will be hurt if I allow myself to become too close to others.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. I am comfortable without close emotional relationships.</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
7. I am not sure that I can always depend on others to be there when I need them.  
8. I want to be completely emotionally intimate with others.  
9. I worry about being alone.  
10. I am comfortable depending on other people.  
11. I often worry that romantic partners don't really love me.  
12. I find it difficult to trust others completely.  
13. I worry about others getting too close to me.  
15. I am comfortable having other people depend on me.  
16. I worry that others don't value me as much as I value them.  
17. People are never there when I need them.  
18. My desire to merge completely sometimes scares people away.  
19. It is very important to me to feel self-sufficient.  
20. I am nervous when anyone gets too close to me.  
21. I often worry that romantic partners won't want to stay with me.  
22. I prefer not to have other people depend on me.  
23. I worry about being abandoned.  
24. I am somewhat uncomfortable being close to others.  
25. I find that others are reluctant to get as close as I would like.  
26. I prefer not to depend on others.  
27. I know that others will be there when I need them.  
28. I worry about having others not accept me.
29. Romantic partners often want me to be closer than I feel comfortable being.

30. I find it relatively easy to get close to others.