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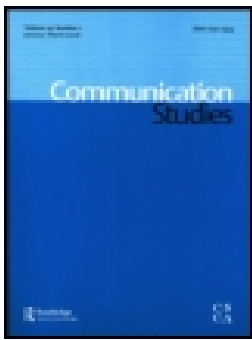
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Transgenerational Patterns of Communication Orientations and Depression Among Mothers and Adult Children

Timothy Curran, Jennifer A. Samp, & Anastacia Janovec

This study investigated intergenerational transmissions of conversation orientations, conformity orientations, and depressive symptoms among 235 (N = 470) mother–child dyads. The analysis revealed that mothers’ reports of conformity orientation in her family of origin positively predicted her child’s report of conformity orientation and conversation orientation. Moreover, maternal depressive symptoms predicted child reports of family communication climates, which in turn predicted child depressive symptoms. A mediation analysis showed a significant indirect effect from maternal depressive symptoms to child depressive symptoms through child reports of conformity orientation. Implications for transgenerational patterns of family communication climates and depressive symptoms are discussed.

Keywords: Conformity Orientation; Conversation Orientation; Depressive Symptoms

Through genetic influences and social learning, children exhibit similar behaviors and experience similar psychological states as their parents. Family experiences including health behaviors (Wickrama, Conger, Wallace, & Elder, 1999), social skills, loneliness (Burke, Wozidlo, & Segrin, 2013), psychological well-being (Arroyo, Segrin, & Curran, 2016) and proclivity to violence (Sutton, Simons, Wickrama, & Futris,

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2014) transmit across generations. However, communication-theory-based research examining intergenerational patterns of family characteristics is limited.

The purpose of this study is twofold: first, to examine transgenerational patterns of family communication climates; and second to examine the role of family communication orientations as mediators between mother-child depressive symptoms. Using social learning theory (Bandura, 1977) as a meta-theoretical lens, we argue that family communication orientations can be transmitted from generation to generation. Further, we examine maternal depressive symptoms as a predictor of child reports of family communication orientations and child depressive symptoms as an outcome of their perceptions of family communication orientations. This study highlights the intricate relationship between family communication climates, depressive symptoms, and transgenerational patterns in families. First, we elaborate on the theoretical principles that demonstrate how family communication orientations may be transmitted. Second, we review the link between maternal depressive symptoms, child depressive symptoms, and child perceptions of family communication climates.

How Communication Orientations Transmit Across Generations

Family communication patterns theory (FCP; Koerner & Fitzpatrick, 2002a, 2002b) claims that two cognitive orientations form family communication climates: *conversation orientation* (i.e., degree to which parents emphasize open and frequent communication) and *conformity orientation* (i.e., degree to which parents expect obedience and consistent family beliefs). The theory asserts that children develop a family schema based on the degree to which both conversation and conformity orientations are emphasized in their family-communication climate. Children from high-conversation-oriented families develop schemas that encourage them to communicate with family members freely and frequently, whereas children from low-conversation-oriented families learn that communication is not essential to family functioning (Koerner & Fitzpatrick, 2002a). Families high in conformity orientation form relational schemas that stress interdependence and uniformity among family members (Koerner & Fitzpatrick, 2002a). Children learn that parents are the primary decision makers in the family. The child's role in the family is to obey and follow beliefs and expectations set by parents. On the other hand, schemas developed in low-conformity-oriented families promote individuality and independence from family relationships.

Research employing this theoretical framework typically uses conformity and conversation orientations (either as separate variables or integrated to make four family types) as independent variables that predict various behavioral, informational processing, and psychological outcomes (see Schrodtt, Witt, & Messersmith, 2008). In a meta-analytical review, Schrodtt et al. (2008) found that conversation orientations generally promote the development of social and conflict-management skills, emotional regulation, and general well-being. On the other hand, conformity orientations are associated with lower social skills, increased emotional suppression, and

psychological health problems (Schrodt et al., 2008). Undoubtedly, this research yields important theoretical and practical implications; however, the purpose of this study is to shift from the dominant method of studying family communication patterns theory and to examine characteristics that *predict* perceptions of conversation and conformity orientations. Below, we argue that theoretical principles from social learning theory help explain how family communication orientations may be consistent throughout generations.

Social learning theory contends that people model behaviors displayed by their social network based on perceived rewards and punishments (Bandura, 1977). Although individuals model behaviors from numerous people, Smith (1982) argues that children are particularly influenced by their parents, as people develop most of their values and beliefs based on their parents' values and beliefs. Numerous empirical studies demonstrate that individuals develop expectations for family interactions through observing parental behavior. Parenting styles such as punitive discipline and harsh parenting beliefs transmit across generations, as children tend to model discipline behaviors after their parents (Erzinger & Steiger, 2014; Lukek, 2015). Moreover, specific positive parenting behaviors such as warmth, responsiveness, and encouragement have transgenerational tendencies (Schofield, Conger, & Neppl, 2014). In a longitudinal study, Madden et al. (2015) reported that parenting behaviors such as parental control, responsiveness, and decreased engagement transmitted across generations. Clearly, children learn how to communicate as a parent based, in part, on observing their parent's behaviors. The specific types of communicative messages reviewed above relate directly to conformity and conversation orientations. Conformity and conversation orientations are broad cognitive schemas that relate to expectations of power and control and expressiveness in families. These general expectations of family communication are established and reinforced through specific communicative messages from parents such as acts of discipline, warmth, and responsiveness. Thus, the research reviewed above indicates that individuals may observe the overall emphasis that their parents place on conversation and conformity orientations, and subsequently model those levels when they become parents. Therefore, this study posits that mothers may establish similar family-communication orientations in their family of orientation based on their perceptions of family-communication climate from their family of origin. As such, the following hypotheses state:

- H1: Mother reports of conversation orientation in her family of origin will positively predict her child's report of conversation orientation.
- H2: Mother reports of conformity orientation in her family of origin will positively predict her child's report of conformity orientation.

FCP Mediating Mother-Child Depressive Symptoms

In addition to predicting that conversation and conformity orientations are modeled across generations, we also postulate that maternal depressive symptoms will predict child depressive symptoms through perceptions of both family-communication orientations

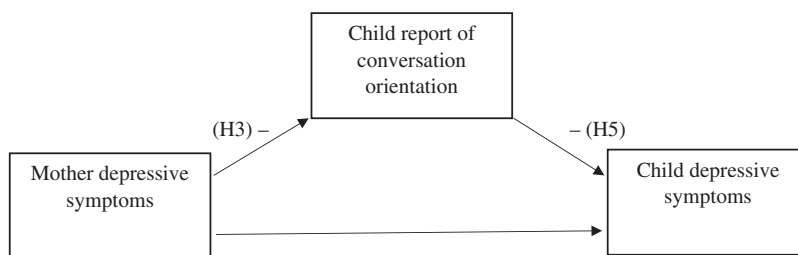


Figure 1 Conversation orientation mediating mother–child depressive symptoms.

Note: H7a predicts the indirect path from mother depressive symptoms to child depressive symptoms through conversation orientation.

(see Figures 1 and 2 for the hypothesized models). Family research consistently observes that maternal psychological distress is related to child psychological distress. In a meta-analytical review, Goodman et al. (2011) observed that maternal depression was consistently linked to psychological distress in offspring. Goodman and Gotlib (2001) claim that there are four mechanisms through which mother–child depression is linked: heritability of depression, innate dysfunctional neuroregulatory, exposure to stressful environments, and exposure to mother’s negative behaviors and affect. Heritability refers to gene expression whereas dysfunctional neuroregulatory mechanisms include factors such as sleeping patterns and birth weight (see Beardslee, Gladstone, & O’Connor, 2011). Rice, Harold, and Thapar (2002) assert that heritability accounts for roughly 30–80% of the variance in parent–child transmissions of depression while the remaining variance is explained by external factors such as environment and behaviors. The present study is focused on child perceptions of communication orientations as variables representing exposure to mothers’ negative behaviors and affect. As Beardslee et al. (2011) point out, maternal depressive symptoms can transmit to children when depressed mothers exhibit behaviors such as disengagement, hostility, and overinvolvement. Given that parental overinvolvement promotes conformity and disengagement promotes low conversation orientation, it is logical to reason that depressed mothers may communicate in ways that influence a child’s perception of conversation orientation and conformity orientation,

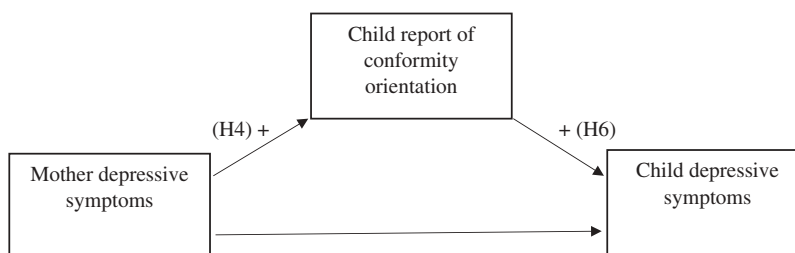


Figure 2 Conformity orientation mediating mother–child depressive symptoms.

Note: H7b predicts the indirect path from mother depressive symptoms to child depressive symptoms through conformity orientation.

ultimately influencing their level of depressive symptoms as well. The paragraphs below elaborate on the hypothesized paths in the model.

Maternal depressive symptoms predicting child perceptions of FCP

Extant research suggests that children with depressed mothers report higher levels of cold and unsupportive family climates. For example, depressed mothers communicate with less emotional responsiveness, increased levels of verbal aggression, and physical assault during parent–child interactions (Silberg & Rutter, 2002; Turney, 2011). Children who receive low amounts of maternal warmth often experience low levels of mental health, as they tend to ruminate after negative parent–child conversations (Gaté et al., 2013). This research indicates that specific communicative behaviors are mechanisms through which maternal depressive symptoms are linked to their child’s mental health.

We build upon this work by first focusing on the association between maternal depressive symptoms and child perceptions of conversation orientation within the family. Mothers with depressive symptoms tend to speak less with, to ignore, and to withdraw from their children (Lovejoy, Graczyk, O’Hare, & Neuman, 2000). Depressed mothers are also more likely to neglect their children compared to non-depressed mothers (Tyler, Allison, & Winsler, 2006). This indicates that mothers with depressive symptoms likely communicate with low levels of frequency and enthusiasm for their child’s thoughts and beliefs. Parental communication is the basis for which family-communication environments are established, as a child learns their family-conversation orientation based on parental feedback to their thoughts and ideas (Koerner & Fitzpatrick, 2002a). Parents who communicate with encouragement and enthusiasm foster an environment wherein children perceive reward for self-expression. On the other hand, parents who ignore and withdraw from their children create an environment that deemphasizes open and frequent communication among family members. It seems that maternal depression generates a family environment wherein mothers seldom communicate with their children, and children do not feel encouraged to communicate openly in family settings. As such, we expect that maternal depressive symptoms are negatively associated with their adult child’s report of conversation orientation in their family. Thus, we pose the following:

- H3: Maternal depressive symptoms will negatively predict child perceptions of conversation orientation.

We also anticipate that maternal depressive symptoms influence a child’s perception of conformity orientation. Depressive symptoms may be positively associated with conformity orientations because depressed individuals experience a reduced ability for complex and creative thoughts during interpersonal interactions (Brede-meier et al., 2012). When family members engage in conflict conversations, depressed mothers tend to use low-effort messages such as control rather than engage in collaboration (Downey & Coyne, 1990). In addition, distressed mothers tend to be irritable and rejecting towards their children (Burke, 2003) and are prone towards

coercive communication (Downey & Coyne, 1990). In a study examining conflict interactions in families, these types of behaviors were shown in parents who stressed high levels of conformity in their families (Sillars et al., 2014). Specifically, Sillars et al. observed that high-conformity parents are less likely to negotiate and more likely to pressure a child during conflict. This study also showed conformity was negatively associated with mothers' attempts to show supportiveness or willingness to resolve the conflict with her child. Given that these behaviors mirror symptoms of depression, we posit that maternal depressive symptoms predict family-communication climates that are controlling and stress obedience. Therefore, we hypothesize that the following:

- H4: Maternal depressive symptoms will positively predict child reports of conformity orientation.

FCP Orientations Predicting Child Depressive Symptoms

As noted above, families that stress high levels of conversation orientation value their child's thoughts and opinions and encourage openness in the family. Children who perceive their family environment is as open and accepting of their thoughts also tend to report high levels of psychological adjustment. Koesten, Schrodt, and Ford (2009) observed that family expressiveness was related to a child's cognitive flexibility, which in turn predicted their level of mental and physical well-being. Moreover, high conversation orientation is associated with high self-esteem and low levels of psychological distress (Kelly et al., 2002). Similarly, Schrodt, Ledbetter, and Ohrt (2007) argue that children from high-conversation-oriented families may be less likely to experience psychological distress because family expressiveness promotes higher levels of social skills. As such, children from high-conversation-oriented families have consistent positive social interactions and social relationships. Schrodt et al. (2007) also reported that conversation orientation was positively associated with mental health and well-being for adult children. In line with the research reviewed above, we pose the following hypothesis:

- H5: Child reports of conversation orientation negatively predict child reports of depressive symptoms.

In contrast to conversation orientation, we expect increased levels of conformity orientation to positively predict child depressive symptoms. Increased levels of conformity orientation have been linked to lower levels of emotional bonds with family members and children report experiencing the "chilling effect" wherein they refrain from expressing their concerns and opinions during family conversations (Afifi & Olson, 2005). Likewise, Rangarajan and Kelly (2006) observed that family conformity was negatively related to child reports of self-esteem. Given that suppression (Koerner & Fitzpatrick, 1997) and feelings of self-worthlessness (American Psychiatric Association, 2015) are linked to depression, a family environment that devalues a child's expression of individual thought and ideas may put them at risk for increased depressive symptoms. Thus, we postulate the following:

- H6: Child reports of conformity orientation positively predict child reports of depressive symptoms.
- H7: There will be an indirect effect from mother reports of depressive symptoms to child reports of depressive symptoms through (a) child reports of conversation orientation and (b) child reports of conformity orientation.

Method

Participants

Data from this study were part of a larger study on family communication and health outcomes. Participants were recruited in two ways. First, participants were recruited from undergraduate classes at a large Southeastern university in the United States in exchange for credit in an introductory-level communication studies course. Second, students enrolled in an advanced undergraduate communication course at the same university solicited participants via convenience sample in exchange for course credit. A total of 284 adult children completed questionnaires. From this sample, 235 mothers also completed surveys, for a parental response rate of 82.7%. The remaining 49 adult child questionnaires were removed from the analysis. Overall, 235 ($N = 470$) mother-child dyads were assessed. Adult children were mostly female (70.2%) and ranged in age from 18–53 years old ($M = 20.87$, $SD = 4.67$), whereas mothers' age ranged from 37–78 years old ($M = 50.15$, $SD = 5.64$). The sample was largely white: 80.4% White, 8.7% African American, 2.8% Latina, 5.5% Asian, and 2.6% other.

Procedure

Those who wished to participate were asked to send their e-mail and their mother's e-mail addresses to the researchers, so that they could gain access to their respective survey. Both adult children and mothers were asked to complete measures regarding their perceptions of family-communication climates in their family of origin, depressive symptoms, as well as report on other scales not used in the present study such as self-esteem, personalization of conflict, and general social skills. Students earned credit if both members of the mother-child dyad completed their online survey. In order to pair the data, participants were asked to provide their full name as well as their partners. Once dyads were paired and assigned matching identification numbers all identifying information was permanently deleted. The surveys took roughly 15 minutes for participants to complete. All procedures were approved by the Institutional Review Board.

Measures

Family communication patterns

The Revised Family Communication Patterns (Richie & Fitzpatrick, 1990) instrument was used to assess conversation and conformity orientations. Both mothers

and adult children were asked to respond to the items based on their family of origin. All items were rated on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). Fifteen items (e.g., “I can tell my parents almost anything.”) assessed conversation orientation. Higher scores indicated a higher conversation orientation ($\alpha = .92$; $M = 3.79$, $SD = 0.70$ for child reports; $\alpha = .95$; $M = 3.16$, $SD = 0.85$ for mother reports). Eleven items (e.g., “My parents feel that it is important to be the boss.”) assessed conformity orientation. Higher scores indicated a higher conformity orientation ($\alpha = .82$; $M = 3.12$, $SD = 0.62$ for child reports; $\alpha = .86$; $M = 3.38$, $SD = 0.64$ for mother reports). Koerner and Fitzpatrick (2002b) argue that the RFCP scale is a more reliable and valid measure of family-communication orientations compared to the original FCP scale, as it assesses behavioral features of the family-communication climate. Schrodtt et al.’s (2008) meta-analysis showed that the RFCP scale outperformed the FCP scale. Moreover, Koroshnia and Latifian (2008) found the RFCP scale had both criteria and construct validity.

Depressive symptoms

Depressive symptoms were measured with a subscale of the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). Seven items were rated on different 4-point Likert scales (e.g., “I feel cheerful”: 1 = *not at all*, 2 = *not often*, 3 = *sometimes*, 4 = *most of the time*). Higher scores indicated the presence of more depressive symptoms ($\alpha = .70$; $M = 1.47$, $SD = 0.37$ for child reports; $\alpha = .72$; $M = 1.47$, $SD = 0.37$ for mother reports). The alpha scores here are similar to past research (e.g., Arroyo, Segrin, & Curran., 2016); however, the scale tends to perform more reliably (Turk et al., 2015).

Results

To begin, *t* tests were computed to determine if there were any significant differences between adult children whose mother completed a survey ($n = 235$) compared to adult children whose mothers did not complete a survey ($n = 49$). There were no significant

Table 1 Zero-Order Correlations

Variable	1	2	3	4	5	6
1. Child Depressive Symptoms	–					
2. Child Conversation	–.25**	–				
3. Child Conformity	.28**	–.48**	–			
4. Mother Depressive Symptoms	.31**	–.30**	.18**	–		
5. Mother Conversation	–.10	.05	.02	–.23**	–	
6. Mother Conformity	.22**	–.11	.26**	.28**	–.49**	–

** $p < .01$ level, two-tailed test.

differences between groups on reports of depressive symptoms, conversation orientation, or conformity orientation. Adult children whose parents did not complete a survey were dropped from all other analyses. Prior to analyzing the studies hypotheses, correlations between the variables in the study were computed. Results are presented in Table 1. As seen, there was a significant negative correlation between conformity orientation and conversation orientation. Although these orientations are theoretically orthogonal, a recent meta-analysis shows that the negative correlation found here is consistent with past research using these scales (Keating, 2016). Because mother-child dyadic data are assumed to be interdependent (Kenny, Kashy, & Cook, 2006), H1 and H2 were tested using multilevel regression analyses using the MIXED command in SPSS. This command produces unstandardized regression coefficients.

Results from the multilevel regression did not support H1, as mother reports of conversation orientation did not significantly predict child reports, $F = (1, 233) = 0.65$, $B = 0.04$, $t = .80$, $p > .05$. Based on the results from H1, we ran a post hoc analysis to further examine the relationship between mother and child reports of conversation orientations in their family of origin. A paired samples t test revealed that adult children ($M = 3.16$) reported significantly higher levels of conversation orientation in their families compared to mothers ($M = 3.79$), $t(468) = 8.79$, $p < .001$. Moreover, H2 predicted that mother reports of conformity in her family of origin would positively predict her adult child's report of conformity orientation. Results revealed a significant positive association between mother reports of conformity and child reports of conformity, $F = (1, 233) = 17.30$, $B = 0.24$, $t = 4.16$, $p < .001$. Thus, although we did not observe support for H1, H2 was supported.

The remaining hypotheses (H3-H7) were tested using Hayes' (2013) PROCESS macro for SPSS. The model tests for indirect effects using 5000 bootstrapped resamples and calculates 95% bias corrected and adjusted confidence intervals. This analysis produces regression coefficients between four paths: the independent variable to the mediator variables (a paths); the mediator variables to the dependent variable (b paths); the independent variable to the dependent variable while controlling for the mediators (c' path); and the independent variable to the dependent variable through the mediators, also referred to as the indirect effect (ab paths). Conformity and conversation orientations were run simultaneously as mediators between mother-child depressive symptoms. This allows the communication orientations to control for one another. The direct effect from mother depressive symptoms to child depressive symptoms accounts for the dependency in the data. Significant indirect effects are indicated by confidence intervals that do not include zero. Figures 3 and 4 show the results from the analysis. Overall, maternal depressive symptoms significantly predicted child reports of conversation orientation (H3) and conformity orientation (H4). Child reports of conversation orientation did not significantly predict child reports of depressive symptoms (H5). However, child reports of conformity orientation significantly predicted child reports of depressive symptoms (H6).

Last, H7 was partially supported, as there was a significant indirect effect from mother-child depressive symptoms through conformity orientation but not conversation orientation. The partially standardized indirect effect for this model was $B = 0.01$,

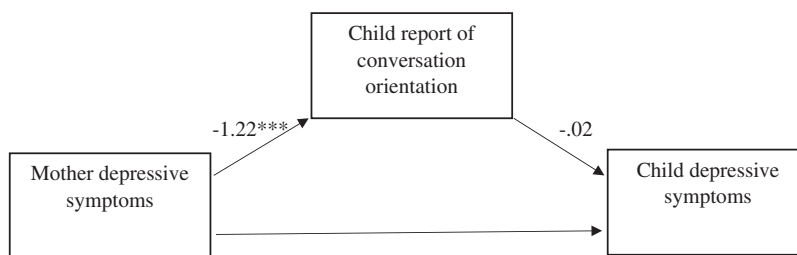


Figure 3 Results of conversation orientation mediating mother–child depressive symptoms.
Note: Direct effect: $B = 0.24$, $t = 3.98$, $p < .01$. Indirect effect: $B = 0.02$, $SE = .02$, $CI = [-.01–.08]$.

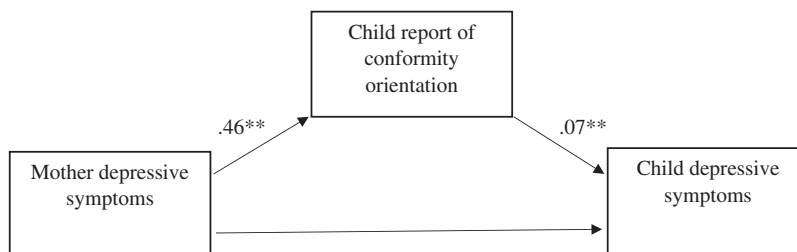


Figure 4 Results of conformity orientation mediating mother–child depressive symptoms.
Note: Direct effect: $B = 0.24$, $t = 3.98$, $p < .01$. Indirect effect: $B = 0.03$, $SE = 0.01$, $CI = [.01–.07]$.

$SE = 0.05$, $CI = [.004, -.02]$. A post hoc analysis was computed to test a moderated mediation effect between conversation and conformity orientation in the intergenerational transmission of depressive symptoms. The results showed an insignificant interaction effect between conversation and conformity orientation, $B = 0.0002$, $SE = 0.002$, $t(231) = 0.08$, $CI = [-.004–.004]$. The process macro also produced partial correlations for the effect sizes of each mediation path in the model and the total effect of the model. The partial correlation for the conversation-orientation path was not significant because the b path in the conversation-orientation mediation was not significant. However, the partial correlation for conformity orientation was, $B = 0.01$, $SE = 0.005$, $CI = [.004–.03]$. The total effect of the model was, $B = 0.31$, $SE = 0.06$, $CI = [.18–.43]$.

Discussion

The goal of this study was to investigate the intergenerational transmission of family-communication orientations among mothers and adult children, to test maternal depressive symptoms as a predictor of child reports of communication orientations, and to test child perceptions of family-communication orientations as mediating links between mother–child depressive symptoms. The analyses showed that mother reports of conformity orientation in her family of origin positively related to child perceptions of conformity in their family of origin; however, the relationship between

mother–child conversation orientation was not significant. Further, maternal depressive symptoms positively predicted child perceptions of conformity orientation and negatively predicted child perceptions of conversation orientation. Consistent with previous research, we observed that child reports of conformity orientation positively predicted child depressive symptoms, yet results showed child reports of conversation orientation did not predict child depressive symptoms. The results reported here suggest that conformity orientations cluster in families across generations. These findings also indicate that adult children’s perceptions of openness and expressiveness in their family increase when maternal depressive symptoms decrease. Alternatively, as maternal depressive symptoms increase, adult children perceive higher expectations to conform to family beliefs.

H1 and H2 predicted that mother reports of communication orientations in her family of origin would predict her child’s perception of communication orientations, yet we only found evidence of intergenerational transmissions of conformity orientations. The nonsignificant results from conversation orientations may reflect cultural shifts in family environments, as mothers reported significantly lower levels of conversation orientation compared to their adult children. This may reflect a cultural shift in parenting values over time. For example, Morman and Floyd (2002) observed a change in cultural values of fatherhood wherein fathers have become more affectionate and peer like with their children over time. In contrast, the results do suggest there is an intergenerational-transmission conformity orientation from a mother’s family of origin to their child’s family of origin. Conformity orientations establish who the dominant decision makers are in the family, the level of interdependence between family members, and overall uniformity in family beliefs and values (Koerner & Fitzpatrick, 2002a). Compared to conversation orientation, deciding on an appropriate level of conformity orientation to establish as a parent may be more obscure—particularly given that research shows mixed results when comparing the positive outcomes associated with consensual families and pluralistic families (both family types are high in conversation orientation). Adult children from consensual families have more frequent conversations with parents about safe-driving practices compared to teens from pluralistic families (Yang et al., 2013). However, research also shows that children from consensual families are more likely to experience negative outcomes such as communication apprehension compared to children from pluralistic families (Elwood & Schrader, 1998). Therefore, whereas mothers may perceive that increased levels of conversation orientation result in benefits for their offspring, we argue that ambiguities on ideal levels of conformity may lead mothers to reference their family of origin as a model.

We also predicted that maternal depressive symptoms would negatively predict child reports of conversation orientation. Our results are consistent with work on parental depression and child outcomes highlighting that maternal depression is related to less emotional responsiveness to their children as well as low communication frequency and overall withdrawal from interactions (e.g., Lovejoy et al., 2000; Silberg & Rutter, 2002). We reason that depressive symptoms may manifest in ways that can lead children to perceive the family environment as closed and unavailable

for open and frequent communication. Given that mothers with depressive symptoms tend to communicate with increased rejection (Kopala-Sibley, Zuroff, & Koestner, 2012) and that depressive symptoms are related to poor social skills and low-quality personal relationships (Segrin, 2000; Segrin & Flora, 2000), children may observe maladaptive behaviors from their mothers and learn that talk is not accepted or encouraged within the family.

Higher reports of maternal depressive symptoms predicted higher reports of conformity orientation from adult children. We reason that the symptoms related to depression may influence a mother's communication with family members in a way that naturally promotes high conformity. In close relationships, individuals with depression engage in less eye contact, speak with less enthusiasm and talk with more hostility and irritability (Downey & Coyne, 1990; Segrin, 2000). Moreover, depressive symptoms include egocentricity, reduced capacities for complex thought, and reduced energy overall (Bredemeier et al., 2012; Downey & Coyne, 1990). Therefore, it stands to reason that mothers suffering from depressive symptoms may be less able to acknowledge differing perspectives on various conversational topics within the family.

A high-conformity-oriented family climate allows mothers with depression to resolve family conflict and to communicate generally with low-effort, self-centered messages. Subsequently, and as expected, increased child perceptions of conformity orientation predicted increased child depressive symptoms. These results are in line with past research showing that conformity within families fosters an environment wherein children suppress their ideas, emotions, and thoughts and suffer from ill psychological health (Affifi & Olson, 2005; Schrodt et al., 2007). As Schrodt et al. found, children from high-conformity families receive less confirming messages. Parents who stress high conformity perceive themselves as the decision makers in the family and tend to devalue their children's thoughts, especially if they deviate from their own. Therefore, children who develop this schema appear more likely to devalue their own thoughts and opinions and thus to suffer from depressive symptoms. We speculate that this schema development may have resultant consequences for behaviors in adult relationships. For example, children who are taught to devalue their beliefs may experience difficulties expressing themselves assertively in various relational domains including friendships, romantic partners, and workplace interactions. Certainly, more research is needed to address this possibility and to fully understand the potential long-term effects of schema development in families.

The indirect effects observed provide evidence that child perceptions of family-conformity orientation mediate the link between mother depressive symptoms and child depressive symptoms. Various fields have examined theoretical moderators and mediators that influence the intergenerational transmission of depression. Goodman et al. (2011) reported that child age and sex both moderate the strength of the relationship between mother-child mental health such that it is strongest in young children and females. Biological explanations have been provided for the relationship between parent-child transmission of depression as LeMoult, Chen, Foland-Ross, Burley, and Gotlib (2015) found similarities in cortisol production in parents and

their children. Also, family of origin characteristics such as negative life events, parental education, and socioeconomic status predict depressive symptoms and social status attainment in young adults (Wickrama, Conger, Lorenz, & Jung, 2008). Wickrama et al. argue that factors such as low-socioeconomic status during childhood and adolescence likely influence the development of psychological problems, which in turn negatively influences one's social attainment in adulthood. Thus, a cycle of psychological problems and adverse social characteristics occur across generations in families (Wickrama, Conger, & Abraham, 2005; Wickrama et al., 2008). We contend that communication patterns between family members is another way in which these transmissions may occur. Just as Wickrama et al. (2008) claim that there is a cycle of ill mental health and social attainment, we postulate that a cycle of negative family communication climates and ill mental health may also occur in families. Wickrama et al. (2008) argues that the social adversity caused by low-socioeconomic status is the mechanism through which socioeconomic status and depression are related. Similarly, the social-skills-deficit hypotheses (Lewinsohn, 1974; Segrin, 2000) claim that individuals with low social skills are vulnerable to depression because low social skills correlate with social rejection and negative social encounters. Therefore, just as there are biological and sociological explanations for the intergenerational transmission of depression in families, it appears that interpersonal communication tendencies also facilitate depressive symptoms across generations.

One of the major contributions of this research is that it extends the development of family-communication-patterns theory. An abundance of research has demonstrated the various behavioral, psychological, and emotional outcomes associated with a child's perception of conformity and conversation orientations in their family of origin; however, research has yet to demonstrate theoretical explanations for the developments of these climates. Our results provide a few possible answers to this theoretical query. First, the findings suggest that mothers may learn how to establish a family environment based in part on the environment in which they were raised. This interpretation is consistent with the principles of social cognitive theory indicating that mothers may behave similarly to their parents once they find themselves in a new role in their family of orientation. Additionally, we argue that maternal depressive symptoms may—consciously or subconsciously—manifest in ways that stress high conformity and low conversation. In other words, the symptoms of depression that are inherently social (e.g., irritability, hostility) appear to influence the child's schema development regarding the communication expectations in the family.

Moving forward, researchers should continue to investigate the mechanisms that may influence the development of family-communication patterns. For example, maternal loneliness, self-esteem, and emotional dysregulation may also predict child perceptions of family-communication orientations. Understanding the various factors psychological, emotional, and behavioral that influence a family's preference for conformity and conversation have practical implications for the general well-being and overall adjustment of individuals embedded in certain family types. To prevent a cycle of dysfunctional family environments and psychological problems, family

therapists and psychologists may attempt to help depressed parents create family environments that facilitate and encourage all family members to openly express thoughts and ideas to one another.

Limitations and Future Research

The results of the current study should be interpreted with several limitations in mind. First, the data analyzed here are cross-sectional, inhibiting our ability to make causal inferences. It is possible, for example, that levels of depressive symptoms in adult children cause depressive symptoms for mothers, particularly considering the principle of interdependence in systems wherein members mutually influence one another. Longitudinal data could also allow researchers to collect mother reports of family-communication orientations while she is still immersed in her family of origin. Second, we only examine mother reports of depressive symptoms as a predictor of conversation and conformity orientations, and it is likely that the mental-health states of both parents form these communication patterns. Although maternal depressive symptoms have been shown to be more powerful predictors of child depressive symptoms compared to paternal depressive symptoms (see Klein, Lewinsohn, Rohde, Seeley, & Durbin, 2002), fathers undoubtedly influence their children's mental states. Third, there was a floor effect with depressive symptoms given that both mothers and adult children reports were low and had little variance. Future studies should examine the relationship between family-communication climates and depressive symptoms in a clinical sample. A sample with diverse reports of depressive symptoms would offer more robust conclusions. For example, conversation orientation may indeed predict a child's depressive symptoms—yet the floor effect observed reduces our ability to observe such effects. Fourth, the data were collected via convenience sample and largely heterogeneous, thus limited the generalizability of the results. Specifically, the sample was mostly white, mother–daughter dyads. Given that daughters have been shown to be particularly affected by maternal psychological health (Goodman et al., 2011) a more representative sample of sexes may have yielded different results.

Future research should address these limitations as well as examine additional variables that may explain the communicative mechanisms through which mother–child psychological health is related. For example, a child's general social skills may also mediate mother–child depressive symptoms, as depressed mothers seem to foster an environment where children would lack the proper training in communication competence. Research on family-communication patterns should seek to better understand the various outcomes associated with the conversation and conformity orientations established in one's family of origin versus their family of orientation. Here, we asked mothers to report on communication orientations in their family of origin. However, it is likely that parents have two working schemas of family communication—one based on their family of origin and the second based on their family of orientation. Thus,

future research should explore how these two perspectives have differing effects on behavioral, emotional, and psychological outcomes.

In summary, this study highlighted several contributions to research on family-communication climates and depressive symptoms. First, it illustrates that family-conformity climates transmit from generation to generation. Importantly, this shows that a family's emphasis on conformity predicts levels of depressive symptoms in adult children. Additionally, this study showed that maternal depressive symptoms link to child perceptions of family-communication orientations. In their review of FCP, Koerner and Schrodtt (2014) note that there is limited research demonstrating how perceptions of family-communication climates become established. The results here partially address their point by showing that a mother's depressive symptoms may influence how children perceive conversation and conformity orientation in their family. Last, we observed that communication orientations are one way in which mother's psychological-health problems are transmitted to their adult children. Overall, this research demonstrates that the mental schema formed by family-communication patterns may be consistent across generations and facilitate mental well-being or distress for family members.

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