College Student Cohesive-Flexible Family Functioning and Mental Health: Examining Gender Differences and the Mediation Effects of Positive Family Communication and Self-Compassion

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Abstract
The current study examined the relationship between college students’ perception of cohesive-flexible family functioning and anxiety and depression and whether positive family communication and self-compassion mediated this relationship. Gender differences among these relationships were also explored. Five hundred college students from a southeastern public university completed an online survey (78% females, 46% Caucasian, 55% 18–19 years old). Multiple-sample latent structural equation modeling analyses revealed that cohesive-flexible family functioning was related to higher levels of positive communication, positive communication was related to higher levels of self-compassion, and that higher levels of self-compassion were related to lower levels of depression and anxiety. Positive communication and self-compassion mediated the relationship between cohesive-flexible family functioning and anxiety and depression. Moderation analyses revealed no significant differences between males and females. Implications for practitioners who work with college students are discussed.

Keywords
family functioning, college student, self-compassion, anxiety, depression

Anxiety and depression are the two most common mental health disorders affecting college students. In a report consisting of approximately 60,000 college students who sought mental health services at college counseling centers, 62% listed anxiety and 50% listed depression as a concern for seeking treatment (Center for Collegiate Mental Health, 2018). Furthermore, the Center for Collegiate Mental Health (CCHM; 2018) reports that, although the percentage of primary concerns for seeking counseling remained stable over the last 4 years, the number of students who report anxiety and depression as their top concern for seeking counseling have increased during that time period. If left untreated, individuals may be at risk of academic failure, course dropout, decreased socio-emotional functioning and well-being, and increased suicidal ideation and suicide attempts (e.g., American College Health Association, 2017; De Luca, Franklin, Yueqi, Johnson, & Brownson, 2016; Drum, Brownson, Denmark, & Smith, 2009; Eisenberg, Golberstein, & Hunt, 2009; Furr, Westefeld, McConnell, & Jenkins, 2001; Kitzrow, 2003; Schonfeld et al., 1997).

Understanding the factors associated with college student anxiety and depression may inform interventions to help the growing number of students who are afflicted with symptoms. Although most college students move away from home to attend college, relationships with family members, especially parents, still affect college students’ well-being. Not only are family relationships associated with anxiety and depression (e.g., Beiter et al., 2015), family concerns are the fourth most reported concern for college students seeking college counseling services (CCMH, 2018). The aim of the current study is to examine the interrelationship between family functioning, family communication, self-compassion, and anxiety and depression. Utilizing Olson’s (2000, 2011) circumplex model of family systems, we will explore the link between cohesive-flexible family functioning and anxiety and depression and whether family communication and self-compassion mediate this relationship.

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The Circumplex Model

In the present study, data analyses will revolve around the concept of the circumplex model, which conceptualizes family functioning with the two components of family cohesion and family flexibility (Olson, 2000, 2011). Cohesion and flexibility are rated on a continuum from balanced to unbalanced. Family members from balanced cohesive families are both independent and connected to their families, while unbalanced cohesion is labeled as enmeshment or disengagement. Enmeshed family members exhibit extreme emotional dependency and overinvolvement, while disengaged families have little to no involvement between family members.

Family flexibility measures “quality and expression of leadership and organization, role relationships, and relationships rules and negotiations” (Olson & Gorall, 2006, p. 6). Families with balanced flexibility are able to adjust their rules and operations in order to adapt to stress and normal developmental changes. Decision-making is democratic, with parents allowing influence from their children. Unbalanced families are either chaotic or rigid. Chaotic families have limited leadership and often alternate roles between family members. In contrast, rigid families are highly controlling and do not allow change.

The transition to college is marked by increased autonomy from one’s family of origin (Arnett, 2001). However, the way a family functions during this normal developmental period still influences college student well-being and mental health (e.g., Sokolowski & Israel, 2008). Parental emotional warmth is related to lower anxiety levels, while parental rejection and overparenting are linked with higher anxiety levels (van Oort, Greaves-Lord, Ormel, Verhulst, & Huizink, 2011). Moreover, college students’ negative perceptions of family cohesion significantly decreased their ability to adjust to college life and increased their amount of negative thoughts and mental stress throughout this transition (Johnson, Gans, Kerr, & LaValle, 2010). College-aged children from families who support their autonomy are less likely to exhibit anxiety or depressive disorders (Fosco, Caruthers, & Dishion, 2012). Parents who are emotionally overinvolved (i.e., unbalanced) with their college-aged child do not allow autonomy support during the transition to college, which in turn can increase the levels of depression, anxiety, and stress (e.g., LeMoyne & Buchanan, 2011; Padilla-Walker & Nelson, 2012; Schiffrin et al., 2014; Segrin, Woszdlo, Givertz, Bauer, & Taylor Murphy, 2012).

Self-Compassion

Self-compassion has been defined by researchers as “being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical” (Neff, Kirkpatrick, & Rude, 2007, p. 140). Self-compassion encompasses three components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification (Neff, 2003). During difficult experiences, self-compassionate individuals extend a warm and understanding tone toward themselves as opposed to berating oneself with harsh self-criticism. Rather than assuming the belief that “I am the only one suffering,” which translates into isolating behavior, common humanity refers to adopting the perspective that all people experience suffering and make mistakes. Mindfulness refers to accepting thoughts and emotions in a nonjudgmental way (Brown & Ryan, 2003). Overidentifying with difficult thoughts and feelings can sustain rumination or brooding; becoming more aware of present-moment experiences affords individuals to cope with difficult thoughts and feelings in a more balanced, regulated manner.

Research shows that self-compassion is related to reduced levels of depression and anxiety (e.g., Bergen-Cico & Cheon, 2014; Germer & Neff, 2013; Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013; MacBeth & Gumley, 2012; Raes, 2010; Samaie & Farahani, 2011). Self-compassion enables emotional resilience by providing a template for how people relate to themselves during difficult emotional experiences, suffering, and perceived inadequacies. Instead of trying to replace negative thoughts and emotions with positive ones, self-compassion fosters emotion regulation by (1) embracing negative emotions
through maintaining awareness of and understanding emotions and (2) extending a warm, patient, and supportive tone toward oneself (Neff, 2003, 2011). Self-compassion effectively copes with emotional distress, rumination, and brooding through increasing positive affect and reducing negative affect (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010; Neff et al., 2007; Neff & Vonk, 2009; Raes, 2010).

Previous literature suggests that family functioning and communication may influence self-compassion levels. Higher levels of family warmth and lower levels of family conflict are associated with higher levels of self-compassion (Kelly & Dupasquier, 2016; Neff & McGehee, 2010; Pepping, Davis, O’Donovan, & Pal, 2015; Potter, Yar, Francis, & Schuster, 2014) and mediate the relationship between family functioning and mental health outcomes (e.g., Jeon, Lee, & Kwon, 2016; Westphal, Leahy, Pala, & Wupperman, 2016). Social support, including family support, positively affects self-compassion levels, which then in turn positively affects well-being (Jeon et al., 2016). Westphal and colleagues’ (2016) findings also reveal that self-compassion acted as a partial mediator between negative parenting and increased mental health difficulties.

**Moderation**

The current study will test whether the relationships of interest are different for males and females. Studies have shown that females report higher mean levels of depression and anxiety and lower self-compassion levels (Ahmadi, Mustafia, Haghdoot, & Alavi, 2014; Dixon & Kurppius, 2008; Lockard, Hayes, Neff, & Locke, 2014; McLean, Asnaani, Litz, & Hoffman, 2011; Raudino, Ferguson, & Horwood, 2013; Soysa & Wilcomb, 2015; Sun, Chan, & Chan, 2016). Although family relationships have been shown to be more important for females (e.g., Fuligni & Masten, 2010; Tsai, Telzer, & Fuligni, 2013), research is mixed on whether gender moderates the relationship between family functioning and psychological outcomes. Even after controlling for negative peer interactions, negative family interactions are linked to depressive symptoms in females only (Telzer & Fuligni, 2013). Positive parent–child relationships are related to lower levels of depression in females (Moreira & Telzer, 2014; Telzer & Fuligni, 2013). Conversely, several studies show no gender differences in the levels of parent–child conflict during college (e.g., Lefkowitz, 2005; Nelson, Bahrassa, Syed, & Lee, 2015) and in the association between college student family functioning and psychological outcomes (e.g., Johnson et al., 2010; Raudino et al., 2013).

**The Present Study**

The current study examines the interrelationship between cohesive-flexible family functioning, positive family communication, self-compassion, and anxiety and depression. Specifically, we are exploring whether family communication and self-compassion mediate the relationship between college students’ perception of cohesive-flexible family functioning and anxiety and depression levels and whether these relationships differ between males and females. Based on the circumplex model of family functioning and extant research, we propose the following hypotheses: (1) Higher levels of cohesive-flexible family functioning will be directly associated with lower levels of anxiety and depression. (2) Higher levels of cohesive-flexible family functioning will be associated with higher levels of positive family communication and self-compassion. (3) Higher levels of positive family communication will be associated with higher levels of self-compassion and lower levels of anxiety and depression. (4) Higher levels of self-compassion will be associated with lower levels of anxiety and depression. (5) Positive family communication and self-compassion will mediate the relationship between cohesive-flexible family functioning and anxiety, and between cohesive-flexible family functioning and depression, (6) and The relationships of interest will be significantly stronger for females.

**Method**

**Participants**

The first author and graduate research assistants recruited college students from undergraduate courses at a large public southeastern university. After explaining the study, students were asked to complete an online survey. Five hundred college students finished the survey (n = 392 females, n = 108 males). Approximately 55% of the students reported being Caucasian (24% African American, 17% Hispanic, 1% Asian, 1% Native Hawaiian/Pacific Islander, 2% other), and the majority of students were 18–19 years old (mean age = 19.68 years old). See Table 1 for sample descriptive statistics.

**Measures**

**Cohesive-flexible family functioning.** The Family Adaptability and Cohesion Scale (FACES-IV; Olson, 2011; Olson & Gorall, 2006) is a 42-item questionnaire that measures family cohesion and flexibility with six subscales. Subscales (7 items each; 1 = strongly disagree to 5 = strongly agree) measure balanced (i.e., balanced cohesion and balanced flexibility) and unbalanced levels (i.e., enmeshment, disengagement, rigidity, and chaos) of family functioning. Cohesive-flexible family functioning was modeled as a latent variable with the individual items from the balanced cohesion and balanced flexibility subscales (7 items composed each subscale). The latent variable contained a total of 14 items. Standardized factors loading above .3 were included in the latent variable (Osborne & Costello, 2009). While all items met this criteria, all items theoretically aligned with components of cohesive-flexible family functioning per the circumplex model. Below are the 14 items used to create the latent variable, followed by their standardized factor loadings for males and females: (a) Family members are involved in each other’s lives (λ = .50, λ = .50), (b) Family members feel safe and close to each other (λ = .67, λ = .70), (c) Family members are supportive of each other during difficult times (λ = .74, λ = .77), (d) Family members consult
other family members on important decisions (λ = .64, λ = .62), (e) Family members like to spend some of their free time with each other (λ = .60, λ = .63), (f) Although family members have individual interests, they still participate in family activities (λ = .68, λ = .72), (g) Our family has a good balance of separateness and closeness (λ = .63, λ = .71), (h) Our family tries new ways to deal with old problems (λ = .51, λ = .53), (i) Parents equally share leadership within the family (λ = .54, λ = .57), (j) Discipline is fair in our family (λ = .64, λ = .64), (k) My family is able to adjust to change when necessary (λ = .54, λ = .62), (l) We shift household responsibilities from person to person (λ = .35, λ = .36), (m) We have clear rules and roles in our family (λ = .54, λ = .49), and (n) When problems arise, we compromise (λ = .69, λ = .74).

Positive family communication. Positive family communication was measured as a manifest variable using the FACES-IV positive family communication subscale (Olson & Gorall, 2006; 10 items; 1 = strongly disagree to 5 = strongly agree). Example items include the following: (1) Family members are satisfied with how they communicate with each other, (2) Family members are good listeners, (3) Family members express affection to each other, (4) Family members try to understand each other’s feeling, and (5) When angry, family members seldom say negative things about each other. Items were coded and summed, so that higher scores represented higher levels of positive family communication. Internal reliability was adequate for males and females (α = .88, α = .90, respectively).

Self-compassion. Self-compassion was assessed using the 26-item Self-Compassion Scale (SCS; Neff, 2003). The SCS utilizes six subscales to measure the three components of self-compassion: self-kindness, self-judgment, common humanity, isolation, mindfulness, and overidentification. Example items include (1 = almost never to 5 = almost always): “I try to be loving towards myself when I’m feeling emotional pain,” “When times are really difficult, I tend to be tough on myself,” “When I see aspects of myself that I don’t like, I get down on myself,” and “I’m kind to myself when I’m experiencing suffering.” Items were coded and summed, so that higher scores represented higher self-compassion levels. Internal reliability was adequate for both males and females (α = .89, α = .92, respectively).

Anxiety. The State-Trait Anxiety Inventory was used to measure anxiety (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). The current study employed the 20-item trait questionnaire, which participants reported on how they generally feel (1 = almost never to 4 = almost always). Example questions include the following: “I feel nervous and restless,” “I feel like I
a failure,” and “I am content.” Items were coded and summed, so that higher scores represented higher levels of anxiety. Inter-item reliability for both males and females were adequate ($\alpha = .88, \alpha = .90$, respectively).

**Depression.** The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) is a 20-item scale that rated how often individuals experience depressive symptoms in the last week ($0 = \text{rarely or none of the time to 3 = most or all of the time}$). The CES-D measures symptoms related to mood, feelings of helplessness and hopelessness, feelings of guilt and worthlessness, psychomotor retardation, sleep disturbance, and loss of appetite. Items were coded and summed, so that higher scores represented higher levels of depression. Inter-item reliability was adequate for males and females ($\alpha = .97, \alpha = .95$).

**Ethnic background.** Participants were asked to describe their ethnic background ($1 = \text{Caucasian}, 2 = \text{African American}, 3 = \text{Hispanic}, 4 = \text{Asian}, 5 = \text{Native Hawaiian/Pacific}, 6 = \text{other}$). This variable was coded as a control variable ($1 = \text{White}, 0 = \text{all else}$).

**Data Analytic Strategy**

We utilized multiple sample latent structural equation modeling (SEM) procedures to test the direct and indirect relationships between cohesive-flexible family functioning, positive family communication, self-compassion, and anxiety and depression (Kline, 2011). First, violations of skewness and kurtosis were consulted, with skewness values exceeding 3.0 and kurtosis values exceeding 10.0 violating normality assumptions (Kline, 2011). Because both values were within the normal range for all variables, full-information maximum likelihood was used to handle missing data. This method of handling missing values is considered less biased than other methods (i.e., mean imputation, listwise deletion, pairwise deletion; Acock, 2005).

The measurement model was tested in order to determine whether the hypothesized model, with the cohesive-flexible family functioning latent variable, was a good fit to the data. Next, we tested measurement invariance in order to determine whether the cohesive-flexible family functioning latent variable was similar among males and females (Kline, 2011). First, a configural baseline model was initially run, with factor loadings, item intercepts, item residual variances, and factor variances freely estimated for each group (i.e., unit loading identification). Following the configural model, the factor variances were fixed to 1 (i.e., unit variance identification), and all factor loadings were constrained to be equal for each group (i.e., metric or factor loading invariance). A $\chi^2$ difference test was run between the constrained and configural models, with a significant test revealing that constraints should be relaxed until the $\chi^2$ difference test was no longer significant. Beginning with this step, constraints were included in all subsequent steps of invariance testing. Next, item invariance was tested by constraining item intercepts to be equal between the groups. $\chi^2$ difference tests were run in order to determine which constraints should be relaxed until the model did not significantly worsen. The same invariance procedures continued for item residual invariance, factor variance invariance, and factor mean invariance. All constraints identified from invariance testing were included in the path analysis.

Following invariance testing, we tested whether the hypothesized pathways were different for males and females. Each pathway was constrained, one at a time, and a $\chi^2$ test determined whether the constrained model fit was significantly worse than the unconstrained model, with a significant test representing a significant difference between groups (i.e., gender moderated the pathway). All pathways that were not significantly different were constrained to be equal between groups during the path analysis. A final structural model with bootstrapping (2,000) then tested the direct and indirect effects between the variables of interest. Significant indirect effects occurred at the .05 level if the 95% confidence interval involving indirect variables did not include zero (Shrout & Bolger, 2002). All analyses were conducted using Mplus 7.3 (Muthén & Muthén, 1998–2011).

**Results**

According to traditional criteria (Kline, 2011), the hypothesized measurement model showed good fit to the data: $\chi^2(284) = 518.695, p < .001$; Comparative Fit Index (CFI) = .94; Root Mean Square Error of Approximation (RMSEA) = .058 (95% confidence interval [CI] = [.050 to .065]); Standardized Root Mean Square Residual (SRMR) = .06. Invariance testing revealed nonsignificant $\chi^2$ tests for factor loading invariance, item variance invariance, item residual invariance, and factor variance invariance. Factor mean invariance testing showed worse model fit: $\chi^2_{\text{df}(1)} = 6.336, p < .05$. Thus, this constraint was relaxed during the SEM path analysis.

$\chi^2$ tests showed that gender did not moderate the hypothesized relationships. Thus, these pathways were constrained for the testing of the final model. The final structural model was a good fit with the data: $\chi^2(334) = 581.150, p < .001$; RMSEA = .054 (95% CI [.049 to .062]); CFI = .94; SRMR = .07 (see Figure 1 for standardized path coefficients). The standardized path coefficients from cohesive-flexible family functioning to positive family communication was significant for males ($\beta = .83, p < .001$) and females ($\beta = .87, p < .001$). Significant standardized path coefficients also included the path from positive family communication to self-compassion ($\beta = .26, p < .05; \beta = .23, p < .05$), the path from self-compassion to anxiety ($\beta = -.67, p < .001; \beta = -.68, p < .001$), and the path from self-compassion to depression ($\beta = -.36, p < .001; \beta = -.45, p < .001$) for males and females. Ethnic background was negatively related to self-compassion for females only ($\beta = -.16, p < .05$). Bootstrapping results revealed that positive family communication and self-compassion mediated the relationship between cohesive-flexible family functioning and anxiety for males and females ($\beta = -.15, p < .05, 95\% \text{ CI} [-.27, -.022]; \beta = -.14, p < .05, 95\% \text{ CI} [-.25, -.019]$) and mediated the relationship between cohesive-flexible family functioning and
Positive communication and self-compassion mediated the relationship between cohesive-flexible family functioning and anxiety for both males and females ($\beta = -.08$, $p < .05$, 95% CI $[-.15, -.008]$; $\beta = -.09$, $p < .05$, 95% CI $[-.17, -.01]$). In other words, a 1 standard deviation unit increase in cohesive-flexible family functioning predicts a $-.13$ standard deviation decrease in anxiety for males ($-.12$ standard deviation for females), via its prior effect on positive family communication and self-compassion. A 1 standard deviation unit increase in cohesive-flexible family functioning predicts a $-.07$ standard deviation increase in depression for males ($-.08$ standard deviation for females), via its prior effect on positive family communication and self-compassion.

Discussion

The present study was a preliminary exploration of the inter-relationship between cohesive-flexible family functioning, positive family communication, self-compassion, and anxiety and depression among the college student population. Results indicated that cohesive-flexible family functioning was positively associated with positive family communication. This was expected, given that positive communication is considered a facilitating dimension for families to modify their cohesion and flexibility based on situational or developmental needs. During the normal developmental stress that infiltrates a family system when a child attends college, families who successfully adapt to this transition are likely to demonstrate positive communication. According to the circumplex model, balanced cohesive-flexible families sustain positive interactional patterns through attentive listening skills, empathy, showing respect, disclosing feelings, and being open to other family members’ perspective (Olson & Gorall, 2003).

Findings showed a positive relationship between family communication and self-compassion. Results are consistent with research that links family communication to self-compassion (e.g., Kelly & Dupasquier, 2016; Neff & McGhee, 2010). Self-compassion is a regulation strategy to effectively cope with difficult thoughts and emotions. From a family systems’ perspective, there may be a cascade effect by which positive communication between family members can influence individual intrapsychic processes (Cox & Paley, 1997; Masten et al., 2005). As positive communication increases, college-aged children may perceive that their parents are providing the appropriate balance of autonomy support and emotional connection. This may facilitate application of emotional regulation skills needed to navigate the normal psychological stresses of attending college. Indeed, research has shown that dysfunctional interaction patterns, from parents who exhibit emotional overinvolvement and intrusive behaviors, limit the opportunities for college-age children to learn the skills necessary to becoming a self-reliant adult (e.g., Padilla-Walker & Nelson, 2012; Schiffrin et al., 2014; van Ingen et al., 2015). Confiming previous research, self-compassion was negatively related to anxiety and depression levels (e.g., Germer & Neff, 2013; Raes, 2010). During difficult experiences, the self-compassionate constructs of self-kindness, common humanity, and mindfulness allow individuals to accept their thoughts and emotions and adopt a warm and supportive tone toward themselves (Neff & Dahm, 2015). Raes (2010) found that self-compassion can be a cognitive strategy for mitigating the worry or rumination that underlies both anxiety and depressive symptoms. Embracing negative thoughts and emotions, and extending a kind and nurturing tone toward oneself can increase emotional resilience, thereby lowering levels of depression and anxiety (e.g., Heffernan et al., 2010; Neff et al., 2007; Neff & Vonk, 2009).

Positive communication and self-compassion mediated the relationship between cohesive-flexible family functioning and anxiety, and cohesive-flexible family functioning and depression. Higher levels of perceived cohesive-flexible family functioning facilitated positive communication, which then in turn increased self-compassion levels, resulting in lower levels of anxiety and depression. Parents from cohesive-flexible families may be more likely to sustain communication patterns that mutually support their child’s autonomy and provide the
appropriate emotional connection. A cascade effect may occur, by which family functioning and positive communication between family members can influence individual intrapsychic processes that may mitigate mental health symptomology.

Findings were consistent across ethnic backgrounds. However, it is interesting to note that ethnic background was significantly related to lower levels of self-compassion for females only. While research is mixed regarding ethnic differences in self-compassion (e.g., Breines & Chen, 2012; Birkett, 2014; Neff, Hsieh, & Dejitterat, 2005; Neff, Rude, & Kirkpatrick, 2007), more research is needed to better understand the relationship between ethnic background and self-compassion (Neff, 2003; Neff & Vonk, 2009). Additionally, gender did not moderate any relationships of interest. Although these findings support previous research (Johnson et al., 2010; Raudino et al., 2013), it should be noted that the sample for the current study included a disproportionate number of females compared to male participants. Future research should examine these relationships using a more comparable sample.

A cohesive-flexible family environment that displays positive interactional patterns can potentially facilitate successful coping methods for handling situations that trigger emotional distress. Transition theory acknowledges that normal developmental transitions result in changed family relationships, roles, and routines (Schlossberg, 1981). A student’s transition to college often forces parents and children to adapt to the various stressors that come with this normal developmental change (Arnett, 2001). Schlossberg (1981) posits that social support, from family and friends, is connected to one’s coping strategies during this change. Theoretically, cohesive-flexible family functioning increases a college student’s perceived social support, which may foster positive coping strategies (i.e., self-compassion) when dealing with emotional distress. While future research is needed to tease out these processes, students may have learned how to treat themselves from their parents modeling how to effectively cope with difficult experiences (Neff & McGhee, 2010). Another explanation could be the development of a securely attached relationship with parents. Secure attachment is related to higher levels of self-compassion, suggesting that individuals from a secure, safe, and supportive family environment aid in the development of self-compassion (Neff & McGhee, 2010).

Implications

Approximately one third of college students who receive services at college counseling centers report family concerns as one reason for seeking counseling (Center for Collegiate Mental Health [CCMH], 2018); thus, the findings of the current study may have implications for practitioners who work with this population. First, it is important to assess college students’ perception of family functioning. The transition to college is a normal time of stress for families, and for families who exhibit a balanced level of cohesion and flexibility, they are more likely to navigate this transition successfully by displaying an appropriate balance of supporting the child’s need for autonomy while maintaining an emotional connection (Arnett, 2001). Second, in order to help families adjust to their child attending college, practitioners can provide psychoeducation on the family system changes during this transition and subsequent strategies for adapting and maintaining cohesion. For example, overinvolved parenting is associated with a critical family environment defined by parents lacking trust for their child to make decisions that are characteristic of this developmental age (Segrin, Woszidlo, Givertz, Bauer, & Taylor Murphy, 2012). Parents excessively monitor their college-aged child, trying to manage the child’s emotions, problem-solving, and making decisions for the child. These family patterns may stunt the development and implementation of strategies to cope with anxiety and depressive symptoms. Third, because positive communication is a specific method for behaviorally expressing a family’s adaption to developmental transitions, practitioners can focus on improving communication skills (Olson & Gorall, 2003). A hypothesis of the circumplex model is that “positive communication skills will enable balanced types of families to change their levels of cohesion and flexibility” (Olson & Gorall, 2003, p. 522). Helping families develop these skills may facilitate a healthier transition for the college-aged child, which may in turn allow the student to implement the coping skills to handle difficult experiences.

If working with the entire family is not an option, practitioners can help college students develop self-compassion skills to cope with family distress. Individuals with lower levels of self-compassion are more likely to act critically toward themselves following negative events, such as family conflicts (Leary, Tate, Adams, Allen, & Hancock, 2007). Interpersonally, individuals can begin to view parents as imperfect humans, and that family conflict is a part of the shared human experiences (Neff & McGhee, 2010). Results showed that individuals who scored high in self-compassion were more likely to show empathy and use compromise to solve conflicts (Yarnell & Neff, 2013). Through the components of self-kindness, mindfulness, and common humanity, individuals can cope with the emotional distress caused by family problems by relating to the self in a more supportive, kind, and balanced manner.

Limitations

There are a number of limitations in this study that should be acknowledged. First, the sample for the current study was a nonclinical sample that predominantly consisted of White, female participants. Results should therefore not be assumed to hold in a more clinically distressed and diverse sample. Second, the cross-sectional design does not provide conclusive evidence of the temporal ordering regarding the relationships of interest. Third, because the associations were examined at one time point, a true mediational cannot be established, as changing the ordering of variables would have created an equivalent model. Fourth, the interrelationships examined in this study may be bidirectional. Utilizing a longitudinal design, future research should focus on exploring the tested relationships in this study in a more clinical and diverse sample. Fifth,
the results of the structural equation models are correlational in nature. Finally, additional variables may also influence the relationship between constructs; thus, studies should explore covariates that may help describe the variance in college student anxiety and depression levels. Directions for future research should include the continued exploration of the interrelationship between the unbalanced dimensions of the circumplex model, family communication, self-compassion, and college student mental health.

Given that the transition to college is a time of normative stress for families, longitudinal dyadic analyses can elucidate the interplay between parent and child communication patterns, and the emotional processes that influence anxiety and depression. Research should also focus on the link between parent–child attachment and the associations tested in this study. Pepping and colleagues’ (2015) cross-sectional study found that college students’ recollection of parental rejection and overprotection, and low warmth was associated with lower levels of self-compassion, and that this relationship was mediated by attachment anxiety. Future studies should explore parent–child attachment as it relates to the maintenance of family communication patterns and the development of self-compassion, and how each is linked to anxiety and depression across the transition to college.

Prospective research can also examine whether interventions designed to enhance cohesive-flexible family functioning and positive family communication can increase self-compassion levels. While self-compassion is associated with increased interpersonal couple relationship functioning (e.g., Crocker & Canevello, 2008; Neff & Beretvas, 2013; Yarnell & Neff, 2013), it is unknown whether altering family communication patterns can enhance individual self-compassion, thereby lowering anxiety and depression levels. Theoretically, building positive communication skills may help family members exhibit empathy and use compromise to resolve conflicts, which then may influence one’s ability to exhibit self-compassion. Because self-compassion approaches difficult situations and emotions from a different perspective, future research can explore whether interventions that change family communication patterns alter perceptions of the self and family members. Finally, qualitative interviews of caregiver and child experiences of their transition, having them describe their communication interactions and their responses to this stress, will help provide insight into the quantity and type of cohesive-flexible communication that enhances one’s self-compassion.

In conclusion, the current study extends previous research by studying the mediating roles of positive family communication and self-compassion in the relation between cohesive-flexible family functioning and anxiety and depression. During the transition to college, the interrelationship between family functioning and their expression of cohesion and flexibility may facilitate self-compassion, which then may protect against the development or maintenance of anxiety and depressive symptomology. Results have practical implications for practitioners who work with the increasing number of young adults who suffer from anxiety and depression.

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