Original Article

Comparison of family communication patterns and attachment styles among depressed OCD patients

Saman Abdollahzadeh Davani[1], Changiz Rahimi[1]*, Mehdi Imani[1]

[1]Department of Clinical Psychology, Shiraz University, Shiraz, Iran.

Correspondence: Changiz Rahimi, Department of Clinical Psychology, Shiraz University, Shiraz, Iran. crahimi@hotmail.com

ABSTRACT

Family is one of the main foundations for maintaining people's health over a lifetime. Attachments and family communication patterns are mental structures that are formed in the family environment in conjunction with parents and primary caregivers. The purpose of this study was the comparison of family communication patterns and attachment styles among three groups of depressed and obsessive-compulsive disorder patients and normal subjects. The research method was casual-comparative. For this study, 60 subjects (20 patients with depression, 20 patients with OCD, and 20 normal subjects) were chosen through the purposive sampling method. After the diagnosis of their psychiatric disorder, the participants completed self-assessment questionnaires of Fitzpatrick and Ritchie family communication patterns and Collins and Read attachment styles. Findings have shown that family members of patients use conformity orientation and family members of healthy people often use communication orientation. Depressed patients have an insecure-avoidant attachment style, OCD patients have an insecure-ambivalent attachment style, and healthy people have a secure attachment style. It seems that family communication patterns and attachment styles can affect mental health and the types of disorders people suffer from.

Keywords: Family communication patterns, Attachment, Depression, Obsession

Introduction

Family is one of the social institutions that play an important role in determining the overall level of community health. The rapid rate of globalization has created challenges for families and these challenges have become a growing crisis for families and required more roles of families with their children. As an important element to handle problems, communication can help to create a coherent family [1].

In families, communication between two generations reflects obedience to parents and other adults [2]. According to Bigner, communication between parents and children can be described as complex interactions which occur in families and are factors that affect their decision-making process. In addition, the theory of the family system explains how family members react to changes (inside and outside the system) [1]. Family communication patterns can be described as the quality of relationships between parents and children in the family, as well as the ways of expressing thoughts and emotions among family members [3]. Due to the relationships among family members, Ritchie has named dimensions of family communication patterns as conversation and conformity orientations [3]. Conversation orientation refers to the extent to which a family provides comfortable and free conditions for engaging and interacting with all members [3]. In families with high conversation orientation, a favorable family environment will lead to the formation of desirable self-esteem in children to express their opinions [4]. Conformity orientation is a kind of communication in families that forces members to equate attitudes, values, and beliefs. It means families with high conformity orientation emphasize the similarity of beliefs and attitudes, and in these families, communications between two generations are based on obedience to parents and other adults (Koerner & Fitzpatrick, 2002, quoted by Jowkar & Rahimi, 2008) [4, 5].

Access this article online	
Website: www.japer.in	**E-ISSN:** 2249-3379

How to cite this article: Davani SA, Rahimi Ch, Imani M. Comparison of family communication patterns and attachment styles among depressed OCD patients. J Adv Pharm Educ Res. 2022;12(4):107-13. https://doi.org/10.51847/voPW1uOqbJ

Research has shown that there is a significant relationship between family communication patterns and the level of mental health, so conversation orientation is a good predictor of mental health, while conformity orientation does not predict mental health [6]. Studies by Nason and Mazzelli, (2019) have indicated that conformity orientation does not conform to depression disorder in family communication patterns, while Tajalli (2007) has shown a negative relationship between conformity orientation and depression [7]. Other studies on family communication patterns and mental health indicators have shown a negative relationship between conformity orientation and depression (Beck, Steer & Brown, 1997, quoted by Tajalli, 2007) [7, 8]. However, other studies have shown a positive significant relationship between conformity orientation and depression (Kertner, Smith & Bent, quoted by Koroshnia, 2006) [9]. Also, in other studies conversation orientation has a positive relationship with self-esteem and social support, and a negative relationship with depression and anxiety (Koerner & Maki, 2004; Gudykunst & Nishida, 2001; Landman-Peters, 2005, quoted by Jowkar & Rahimi, 2008) [5]. Additionally, another study on family communication patterns has shown that conversation orientation of family has been a positive predictor and conformation orientation has been a negative predictor in all four dimensions of quality of life such as physical health, mental health, social communications, and perception of living environment and it can be said that promotion of conversation orientation in the family increases individuals' quality of life, while an emphasis on conformity orientation decreases the quality of life [10].

Like family communication patterns, attachment is also formed in interaction with family members. Attachment is a deep emotional connection with special individuals in our lives that we enjoy engaging with them and feel relaxed with them in stressful situations [8]. Siegel (2020) have claimed that attachment is a process created between the mother or primary caregiver and child in the early months after birth through mutual emotional connection [11]. This primary attachment forms the basis of the child's future relationships with others and leads to the creation of an effective behavioral pattern and a set of expectations that determine the child's next relationships with others [12]. Bowlby and Ainsworth, according to their research, have categorized attachment into three styles secure, insecure-avoidant, and insecure-ambivalent [13]. People with a secure attachment style have higher levels of confidence and satisfaction and lower level of conflicts; while people with an insecure ambivalent attachment style have instability of feelings and a higher level of conflicts; also, people with an insecure-avoidant attachment style have lower satisfaction and intimacy and higher conflicts (Collins, Kooper, Albino & Alard, 2002, quoted by Naebi-Nyia, Salari & Gharavi, 2011) [14].

Research results of Besharat, Mohamadi Hasel, NikFarjam, ZabihZadeh, and Fallah (2013) have shown that the dominant attachment styles in depressed patients, anxious patients, and normal subjects are avoidant, ambivalent, and secure, respectively [15]. Also, Ghorbani Sefideh Khan and Hossein Sabet (2016) have found that fundamental psychological needs can affect the pathology of depression and attachment styles better than the direct relationship between attachment and depression [16]. More research has shown that adolescents with the insecure-avoidant attachment style have higher levels of depression symptoms. But there is no connection between secure and insecure-ambivalent attachment style and depression symptoms [17]. Additional research results have shown that an insecure ambivalent attachment style leads to a kind of depression that is focused on problems of dependency, loss, and abandonment, while an insecure-avoidant attachment style leads to depression that is focused on self-worth and self-criticism [18]. Since family is the most important foundation that affects individuals, and family communication patterns and attachment styles are formed there, by knowing that these variables affect the individuals' mental health and also by considering that depression is the most common psychiatric disorder and has high comorbidity with obsessive-compulsive disorder (which has recently been categorized as anxious disorders), this study compares different dimensions of family communication patterns and attachment styles among three groups of depressed patients, OCD patients, and normal subjects, and seeks to answer the following questions: 1) Is there any difference in family communication patterns of these three groups of depressed patients, OCD patients and normal subjects? and 2) Is there any difference in attachment styles of these three groups of depressed patients, OCD patients, and normal subjects?

Materials and Methods

The casual-comparative method was used in this study and its statistical population included adults who were referred to psychiatric clinics in Shiraz. A sample of 40 subjects (20 patients with OCD and 20 patients with depression disorder) was selected through the purposive sampling method. Also, 20 staff of the same clinics that were matched for their age and education with the patients were selected. The criteria for entering this study were over 18 years old, having at least 8 classes of literacy, and resident of Shiraz. Subjects with certain physical diseases (like MS or asthma), and mental illnesses other than depression or obsession based on the Diagnostic and Statistical Manual of Psychiatric Disorders (fifth edition) and illiteracy were eliminated from this study. The instrument used in this study was the revised family communication patterns and attachment questionnaire.

Research instruments

1. *The revised family communication patterns scale:* This instrument is a self-assessment questionnaire designed by Whittington (2022) that questions the respondent's agreement or disagreement with 26 items about his/her family communication status in a 5-degree range [19]. Score 4 shows the respondent's complete

agreement and score 0 shows complete disagreement. The first 15 items are about conversation orientation dimensions and the next 11 items are about conformity orientation dimensions. Each respondent gets two scores from this instrument. The higher score on each scale refers to the respondent's perception of conversation or conformity orientation in his/her family. Fitzpatrick and Ritchie (1990) have reported that the reliability coefficient of the test-retest method about conversation and conformity orientation of three different age groups after a three-week period was close to 1, and between 0.73-0.93, respectively. Koroshnia (2006) has reported the desirability of the validity questionnaire and 0.87 and 0.81 Cronbach's Alpha for conversation and conformity orientations, respectively, for its Persian version. The validity questionnaire of this study is estimated at 0.89 and 0.87 Cronbach's Alpha for conversation and conformity orientations, respectively.

2. *Attachment questionnaire:* In 1990, Collins and Reid prepared their attachment questionnaire based on Hazan and Shaver's theory. This questionnaire has 18 items and its three subscales include Anxiety style (which is consistent with ambivalent attachment style), Closeness style (which is consistent with secure attachment style), and Dependency style (which is almost the opposite of avoidant attachment style).

Walker and Double (2022) found Cronbach's Alpha of the questionnaire more than 0.80 in their research [20]. In another study conducted in Iran, Cronbach's Alpha is reported 0.45 for the attachment subscale, 0.52 for the closeness scale, and 0.75 for the anxiety subscale. Pakdaman (2001) assessed the validity of this questionnaire by a divergent validity method [21]. The results have shown that the correlation coefficient among subscales like ambivalent attachment style and secure, and avoidant attachment style and secure in level 0.001are -0.31 and -0.33, respectively; and in the significant level of 0.01 the correlation coefficient among subscales is 0.25. The scoring of the Collins and Reid attachment style questionnaire is based on the Likert scale from complete disagreement (0) to complete agreement (4). The reliability coefficient of this study is estimated as 0.57, 0.71, and 0.81 for secure, avoidant, and ambivalent attachment styles, respectively.

Procedure

For this purpose, the referrals to consulting centers were clinically interviewed and they were chosen for this study after diagnosis of depression and OCD disorders by a psychiatrist, and the questionnaires were completed individually and randomly by them. Also, normal subjects completed the questionnaires after approving their mental and physical health and reviewing their medical records. A written commitment was made by the participants concerning their voluntary participation in the test and they were allowed to leave the test whenever they want.

Statistical analysis

Multivariate analysis of variance (MANOVA) has been used for statistical analysis of data.

Results and Discussion

Table 1 shows the mean and the standard deviation of family communication orientations in three groups of depressed patients, OCD patients, and normal subjects.

Table 1. Mean & Standard Deviation of family communication orientations of participants

Variables	Groups	Mean	Standard Deviation
Conversation Orientation	Depressed	18.10	12.32
	Obsessed	31.15	9.07
	Normal	42.7	6.97
Conformity Orientation	Depressed	32.20	5.27
	Obsessed	26.75	7.03
	Normal	14.25	6.63

To compare these three groups in terms of family communication patterns, MANOVA was performed. The results are shown in **Table 2**. The results of the analysis of variance (ANOVA) show that the differences among these three groups are significant.

Table 2. Comparison of Depressed Patients, Obsessed Patients, and Normal Subjects in Relation to Family Communication Patterns through Multivariate Analysis of Variance

Source	Amount	F Statistics	Test Degree of Freedom	Error Degree of Freedom	P Amount	
Wilks' Lambda Statistics	0.328	20.879	4	112	0.001	0.427

Considering the requirement of Wilks' Lambda statistics ($F>4$, $P<0.05$), the results of the ANOVA test show a significant difference among the three groups.

A comparison of the scores of these three groups shows that normal subjects get more scores in conversation orientation, and depressed and OCD patients get more scores in conformity orientation, respectively.

The Games- Howell post-hoc test and LSD was used to compare the groups to each other. **Table 3** shows the results of the post-hoc test.

Table 3. The Post-Hoc Test for Dimensions of Family Communication Patterns

Test Type	Independent Group	Group i	Group j	Mean Difference	Standard Deviation Error	P-Amount

Games-Howell	Conversation	Depressed	Obsessed	-13.05*	3.421	0.002
			Normal	-24.6*	3.165	0.001
		Obsessed	Normal	-11.55*	2.557	0.001
LSD	Conformity	Depressed	Obsessed	5.45*	2.051	0.01
			Normal	17.95*	2.051	0.001
		Obsessed	Normal	12.5*	2.051	0.001

Based on these results, families of normal subjects mostly use conversation orientation, while families of depressed patients use conformity orientation more than families of OCD patients.

Table 4 shows the mean and the standard deviation of attachment styles in three groups of patients with depression and OCD, and normal subjects.

Table 4. Mean & Standard Deviation of Attachment Styles of Subjects

Variables	Groups	Mean	Standard Deviation
Ambivalent	Depressed	12.95	2.23
	Obsessed	18.95	4.02
	Normal	7.8	2.87
Secure	Depressed	9.2	2.37
	Obsessed	10.75	2.05
	Normal	17.8	2.87
Avoidant	Depressed	13.6	3.60
	Obsessed	10.35	2.34
	Normal	8.30	2.94

To analyze the research data and compare the attachment styles of these three groups, the results of MANOVA were examined for the significance of differences among the groups. The results are shown in **Table 5**.

Table 5. Multivariate Analysis of Variance of Attachment Styles

Source	Amount	F-Statistics	Test Degree of Freedom	Error Degree of Freedom	P-Amount
Wilks' Lambda Statistics	0.111	36.736	6	110	0.001

Considering the requirement of Wilks' Lambda statistics ($F>4$, $P<0.05$), the results of the ANOVA test show a significant difference among the three groups.

The mean scores of these three groups show that OCD patients, depressed patients, and normal subjects get more scores in insecure-ambivalent attachment style, insecure-avoidant attachment style, and secure attachment style, respectively.

The Games- Howell post-hoc test and LSD was used to compare the groups to each other. **Table 6** shows the results of the post-hoc test.

Table 6. Post-Hoc Tests of Attachment Styles

Test Type	Independent Group	Group i	Group j	Mean Differences (i-j)	Standard Deviation Error	P-Amount
Games-Howell	Ambivalent	Depressed	Obsessed	-6.00*	1.028	0.001
			Normal	5.15*	0.815	0.001
		Obsessed	Normal	11.15*	1.105	0.001
LSD	Secure	Depressed	Obsessed	-1.55*	0.777	0.045
			Normal	-8.6*	0.777	0.001
		Obsessed	Normal	-7.05*	0.77	0.001
LSD	Avoidant	Depressed	Obsessed	3.25*	0.951	0.001
			Normal	5.3*	0.951	0.001
		Obsessed	Normal	2.05*	0.951	0.035

Based on these results, normal subjects, and patients with depression and OCD have secure and insecure attachment styles, respectively. Also depressed and OCD patients have insecure-avoidant and insecure ambivalent attachment styles, respectively. The findings of this study have shown that families of patients use conformity orientation and families of normal subjects often use conversation orientation. Depressed patients, OCD patients, and normal subjects have insecure avoidant, insecure ambivalent, and secure attachment styles, respectively.

The present results have shown that the family communication patterns of these groups are significantly different, while normal subjects use conversation orientation more than other groups, and also depressed patients use conformity orientation. These findings are consistent with the results of Koroshnia and Latifian (2008) in the sense that the conversation orientation for depression disorder is a negative predictor; at the same time, they are inconsistent with the conclusion that conformity orientation is not a significant predictor for depression [22]. Also, Sepehri and Mazaheri (2010) have found that families, that emphasize more on conformity, not only do not prevent problems but also will cause fundamental problems in the future [23]. In addition, other studies have shown a significant positive relationship between depression and conformity orientation (Kertner, Smith & Bennett, 1995, quoted by Koroshnia, 2006) [9]. In other research, conversation orientation has a positive relationship with self-esteem and social support, and a negative relationship with depression and anxiety (Koerner & Maki, 2004; Gudykunst & Nishida, 2001; Landman-Peters, 2005; quoted by Jokar & Rahimi, 2008) [5]. Similarly, Schrodt, Witt, and Messersmith (2008, quoted by Koroshnia & Latifian, 2012) have shown that conversation and conformity orientations of family communication patterns have significant relationships with different types of psychological and cognitive consequences [24]. Zarnaghash (2013) has concluded that there is a significant relationship between family communication patterns and mental health level, so that conversation orientation is a good predictor

for mental health while conformity orientation does not predict mental health.

In families with high conversation orientation with open and spontaneous communications, there are always wide debates on various topics, while in families with conformity orientation, there is more emphasis on obedience of children to parents, there are no debates on different topics and no opportunity is given to children to express their opinions and thoughts, so they review their thoughts on their minds and the level of mind rumination rises which results in lower mental health level of children and cause disorders such as depression and OCD in children. However, it should be considered that in the culture of Iranian families' obedience to parents is important and it prohibits discussion, so this can help conformity orientation in families and leads to depression.

The results of the second question have indicated that the attachment styles of these three groups have a significant difference. It means that patients with depression and OCD and normal subjects have avoidant, ambivalent, and secure attachment styles, respectively.

These results are consistent with the findings of Naebi-Nyia *et al*. (2011) in relation to the negative relationship of secure attachment style with depression, anxiety, and tension [14]. Also, in justifying this relationship, Roberts *et al*. (1996, quoted by Naebi-Nyia *et al*. 2011) have believed that the psychological consequences of insecure attachment styles are stressful, anxious, and depressed situations, and in such situations, the consequences of secure attachment style are mental relaxation [14]. In addition, the findings of Besharat *et al*. (2013) have shown that the dominant attachment styles in patients with depression and anxiety and normal subjects are avoidant, ambivalent, and secure, respectively, which are consistent with our results. Another study has shown that anxiety attachment style (ambivalent) can predict anxiety [25]. The findings of Khanjani *et al*. (2011) have shown that adolescents with insecure-avoidant attachment styles have higher levels of depression symptoms. Bifulco *et al*. (2002, quoted by Ahmadi Tahoor Soltani, Daneshpour & Karimi, 2011) have shown that an insecure attachment style is associated with depression [26]. Also, the relationship between attachment style and clinical depression increases with varying degrees of insecurity of styles and hostile and non-hostile avoidance.

Conclusion

According to the research findings, it is clear that a secure attachment style indicates mental health and being normal, while insecure attachment styles are related to mental disorders, so OCD patients have ambivalent attachment styles and depressed patients have avoidant attachment styles. Based on the principles of the formation of attachment styles, secure children have more confidence in the availability of their mother and use her as a secure base more than insecure children (avoidant and ambivalent). When the mother returns after a short separation, secure children can easily contact and interact with her; avoidant children react with breakdown and avoidance; and ambivalent children wander through increasing uncertainty and ambivalence between attachment and rage. As can be seen, the main features of the avoidance attachment style are breaking the links and adding spaces, and the dominant features of the ambivalent attachment style are uncertainty, worry, and anxiety. On the other hand, the continuity of attachment styles has been confirmed after childhood and in adulthood (Ainsworth, 1978; Bowlby, 1998; Besharat 2013 & Waters, 2000, quoted by Besharat *et al*. 2013) [15]. Based on these assumptions and empirical findings, it can be explained the bond between the main features of avoidance attachment style and the symptoms of dominant depression on one hand, and the correlation between the main features of ambivalent attachment style and the symptoms of anxiety disorder on the other hand [15]. Until recently OCD disorder was a subset of anxiety disorder, it can be concluded from the similarity of its characteristics with anxiety features that the attachment styles of obsessed and anxious patients are similar and most of them have insecure-ambivalent attachment styles.

Therefore, it can be generally concluded that depressed patients have conformity orientation and insecure-avoidant attachment style, while OCD patients have conformity orientation but insecure ambivalent attachment style. Normal subjects have a conversation orientation and secure attachment style.

Practical and theoretical application

The results of this research can be applied in both theoretical and practical fields. Given that in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, OCD disorder has separated from the spectrum of anxiety disorders and the fact that previous research have been examined depression and anxiety, in the theoretical field the present study should have tried to examine obsessive disorder specifically and compared it with depression disorder (which is the most common psychiatric disorder), also by using these findings, there would be a small progress to improve the available knowledge about family issues, attachment and excitement and provide groundwork for future research [27]. Since family communication patterns and attachments are formed at home and in conjunction with parents and primary caregivers, in the practical field these results can provide important information for families, schools, and consulting centers. By using the findings of this research, parents, and families can be informed. Since our culture and religion of our country care about respect for parents and their obedience, parenting techniques can be educated to parents to learn how to communicate with children by preserving cultural and religious values, thus developing positive and constructive interactions while creating a secure attachment style for them. They also use conversation orientation in their communications and allow their children to express themselves so the young generation learns how to express their thoughts, opinions, emotions, and feelings and how to express them correctly. These results can also be used in consulting centers. By using this information and teaching techniques of appropriate communication and interaction and

parenting styles, psychologists and counselors can prevent insecure attachment styles and teach the appropriate orientations of family communication patterns to parents. The present study can provide a way for healthy and correct education of the new generation.

Limitations and suggestions

Some limitations of this study are the method of collecting data (questionnaire) and self-reporting, the low number of case studies, and the limit in generalization of results to other communities other than the Shirazi. Moreover, based on these findings, it can be suggested that future studies should be undertaken on patients with other psychiatric disorders, conducted in other cities, and researchers examine more case studies.

Acknowledgments: We are grateful to the participants who generously gave their time and shared their experiences with us. We also acknowledge the support provided by Shiraz University, and the supervisor Dr. Changiz Rahimi, who helped us in accessing the necessary resources for this research.

Conflict of interest: None

Financial support: None

Ethics statement: None

References

1. Eatesamipour R, Bagheri F, Zareh Bahramabadi M. Emotion management and self-esteem in the relationship between parent-child relationship pattern and communication skills: structural equation modeling. J Islam Educ. 2020;15(33):111-35.
2. Fitzpatrick MA. Family communication patterns theory: Observations on its development and application. J Fam Commun. 2004;4(3-4):167-79.
3. Nason R, Mazzelli A, Carney M. The ties that unbind: Socialization and business-owning family reference point shift. Acad Manag Rev. 2019;44(4):846-70.
4. Koerner AF, Cvancara KE. The influence of conformity orientation on communication patterns in family conversations. J Fam Commun. 2002;2(3):133-52.
5. Jowkar B, Rahimi M. Study of the effect of family communication patterns on happiness in a group of high school students in Shiraz. Iran J Psychiatr Clin Psychol. 2008;13(4):376-84. [In Persian]
6. Zarnaghash M, Zarnaghash M, Zarnaghash N. The relationship between family communication patterns and mental health. Procedia-Soc Behav Sci. 2013;84:405-10. [In Persian]
7. Tajalli F. *The Effect of dimensions of family communication patterns on mental health, based on Emotional Intelligence of the Adolescents* (Doctoral dissertation, MA thesis). Shiraz: Shiraz University. [In Persian]
8. Berk L. Development through the lifespan (4th ed.). Sayed Mohammadi, Y. (translator). Tehran: Arasbaran (2011). 2007;19(1-2):345-50. [In Persian]
9. Koroshnia M. Analysis of communication patterns on the level of psychological adjustment of children. M.A. thesis, Shiraz University. 2006. [In Persian]
10. Rahimi M, Khayer M. Relationship between family communication pattern and quality of life in middle eastern students of shiraz. Educ Psychol Stud Ferdowsi Univ. 2009;10(1):5-25. [In Persian]
11. Siegel DJ. The developing mind: How relationships and the brain interact to shape who we are. Guilford Publications; 2020.
12. Ilali EA, Loleti HA, Charati JY, Khatir MA. The Relationship between Attachment Styles and Meaning in Life in Elders. Pharmacophore. 2019;10(5):37-44.
13. Pinto AM, Geenen R, Wager TD, Lumley MA, Häuser W, Kosek E, et al. Emotion regulation and the salience network: a hypothetical integrative model of fibromyalgia. Nat Rev Rheumatol. 2023;19(1):44-60.
14. Naebi-Nyia A, Salary P, Modarres Gharavi M. Studying the relationship between adult attachment style to parents with stress, anxiety and depression. J Fundam Ment Health. 2011;2(50):194-202. [In Persian]
15. Besharat MA, Mohammadi Hasel K, Nikfarjam MR, Zabihzadeh A, Fallah M. A comparison of attachment styles in individuals with depression, anxiety disorders and those without these disorders. Dev Psychol: Iran Psychol. 2013;9(35):227-26. [In Persian]
16. Ghorbani Sefidekhan M, Hossein Sabet F. The relation between indicators of basic psychological needs satisfaction and attachment style with depression (through path analysis). Pejouhandeh. 2016;21(1):13-20. [In Persian]
17. Khanjani Z, Hashemi T, Elhamfar F. A study of relationship between parental rearing methods and attachment styles with depression symptoms in adolescents. J Instr Eval. 2011;4(14):91-106. [In Persian]
18. Ryan RM, Deci EL, Grolnick WS, La Guardia JG. The significance of autonomy and autonomy support in psychological development and psychopathology. Dev Psychopathol. 2015:795-849.
19. Whittington DD, Turner LA. Relations of Family-of-Origin Communication Patterns to Attachment and Satisfaction in Emerging Adults' Romantic Relationships. Am J Fam Ther. 2022:1-6.
20. Walker SA, Double KS, Kunst H, Zhang M, MacCann C. Emotional intelligence and attachment in adulthood: A meta-analysis. Pers Individ Differ. 2022;184:111174.
21. Pakdaman S. Evaluate the relationship between attachment styles and adolescents seeking community. Tehran: University of Tehran. 2001. [In Persian]

22. Koroshnia M, Latifian MO. An investigation on validity and reliability of revised family communication patterns instrument. J Fam Res. 2008;3(12):855-75. [In Persian]
23. Sepehri S, Mazaheri MA. Patterns of family communication and personality variables among college students. Dev Psychol: Iran Psychol. 2010;6(22):141-50. [In Persian]
24. Koroshnia M, Ltifian M. The relationship between dimension of family/teacher's communication patterns and students' critical thinking disposition with the mediation of basic psychological needs satisfaction. 2012;7(4):493-519. [In Persian]
25. Sarvghad S, Rezaei A, Irani F. Relationship between attachment styles and personality traits with anxiety. Q J Woman Soc. 2012;3(2):117-36. [In Persian]
26. Ahmadi Tahoor Soltani M, Daneshpour Z, Karimi L. The relationship between attachment styles and depression in university students. J Sabzevar Univ Med Sci. 2011;18(3):217-23. [In Persian]
27. Mehri M, Iravani M, Bargard MS, Hosein M. Effectiveness of Cognitive Behavioral Therapy-based self-management on depression in Pregnant Women: A Randomized Controlled Trial. J Biochem Tech. 2019;10(3):92-7.