How the Interpersonal and Attachment Styles of Therapists Impact Upon the Therapeutic Alliance and Therapeutic Outcomes

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Objective: *Explore how therapist's interpersonal and attachment styles have an impact upon both the therapeutic alliance formed and therapy outcomes.*

Material and Method: *One hundred twenty one outpatients attending for routine psychiatric services were monitored for symptom outcomes, comprising depression, anxiety, and interpersonal problems. Patients were also asked about the level of therapeutic alliance that had been formed, covering goals, tasks, and the bond developed, using the Working Alliance Inventory (WAI). At the same time, the participating therapists reported upon their interpersonal styles by categorizing them into domineering or submissive styles using the IIP-32 questionnaire and their attachment styles by categorizing them into secure or preoccupied styles using the ECR-R. To explore therapist factors such as interpersonal and attachment styles, as well as to establish the presence of gender matching, the working alliance was used as a dependent variable.*

Results: *Multivariate analysis revealed that neither the gender of the therapist nor the gender of the patient, or the therapists' styles, had an effect on the Working alliance or working outcomes. The multivariate test for WAI-goal (Wilks' Lambda F (3, 134) = 4.24, p = 0.007), interpersonal style (Wilks' Lambda F (3, 134) = 2.77, p = 0.044), attachment style (Wilks' Lambda F (3, 134) = 2.76, p = 0.045) and IIP-Style*Attachment Style (Wilks' Lambda F (3, 134) = 3.13, p = 0.028) produced statistically significant results, while working alliance-goal was the only predictor of the level of anxiety and depression in patients (p = 0.014 and p = 0.002, respectively). Submissive style was positively correlated to anxiety (p = 0.011) and interpersonal difficulties (p = 0.006), whilst surprisingly, a secure attachment style was found to have a positive correlation with anxiety and depression. However, when both styles were combined, the resulting style negatively predicted anxiety (p = 0.002).*

Conclusion: *Therapist factors were found to have no effect on working alliance, as reported by the patients; however, it was reported that when the therapists employed a secure or submissive attachment style, this played a role in helping to reduce symptoms. The working alliance-goal element was found to be a predictor of a reduction in levels of both anxiety and depression among patients.*

Keywords: *Interpersonal style, Attachment style, Therapeutic alliance, Psychotherapy outcome*

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The formation of a good working alliance depends not only on a patient's attachment style, but also on the therapist's ability to provide a feeling of security and to reduce a patient's levels of anxiety[1]. Research into the effects of therapists' styles on the therapeutic relationship and on therapeutic outcomes has been conducted over a number of decades[2-10], and over the last two decades, the technical and relational aspects of the alliance, such as patient characteristics and therapist activities, have been the focus of a great deal of empirical research aimed at studying the relationship between the alliance and therapy outcomes[8,11-13]. Puschner[14] analyzed the alliances and symptom outcomes found in outpatient psychotherapy across different disciplines, as practiced in routine care, finding no correlation between the alliance and symptom outcomes and only initial symptom outcomes predicted the final outcome. In addition, interpersonal relationships-using a cold to warm rating, have also been examined and found to have a moderate impact on the level of therapeutic alliance formed-as rated by both patients and therapists[15].

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Wampold[16] reported that significant factors in the development of therapy effectiveness include the personality of the therapist and the alliance formed between him or her and the patient. A number of research studies have been conducted with regard to therapist factors, such as the techniques used plus the match between the therapist's and the patient's styles. Ackerman[17] reviewed those therapist attributes and techniques related to the therapeutic alliance and found that those therapist styles that contribute positively to the alliance include the degree of flexibility shown, the therapist's level of experience, honesty, respectfulness and trustworthiness, as well as the therapist's level of confidence, interest, alertness, friendliness, warmth and openness. Other studies have also researched therapist techniques based upon a range of psychotherapy orientations and those which have been found to positively influence the development and maintenance of the therapeutic alliance include affirming[18], helping[19], warmth/friendliness[20,21] and understanding[11,18,21-24].

Ostrowski[25] found that therapists who report a greater level of comfort in terms of closeness within personal relationships prefer to use a more directive rather than reflective helping style. Tyrrell[26] and Mallinckrodt[27] concluded that, although secure therapists are prone to forming strong alliances with all clients due to their interpersonal flexibility and care-giving sensitivity. Bruck E[28] used INTREX to identify therapists' personalities and the Relationship Scale Questionnaire (RSQ), while outcomes were identified using both Symptom Checklist-90R and the inventory of interpersonal problems. He found that therapists' secure attachment styles were significantly correlated to session depth and flow; those who were preoccupied produced negative outcomes in terms of session flow. He also found no correlation between a therapist's autonomous introjection and the presence of a fearful or dismissing style.

As mentioned by Maunder, "not all interpersonal behaviors could [be] predict[ed] by attachment style"[29]. What would then be a predictor of interpersonal style based on the interpersonal circumplex of a secure therapist? Does it have to be related to friendly-dominant or friendly-submissive behavior? A study by Bruck[28] found a correlation between therapists' total set of interpersonal problems and whether they possess a secure or insecure attachment style. Likewise, in the present study the authors found a correlation between anxiety attachment and 'cold' behavior, despite the fact that both cold and self-sacrificing behaviors are on opposite sides of the interpersonal style circle; therefore, both the attachment style and interpersonal behavior of the therapist were treated separately and both were used as interactional factors. To our knowledge, it has so far not been reported upon as to what impact the interaction between these two variables has on the therapeutic alliance and on therapeutic outcomes.

With regard to interpersonal style, Aldens et al[30] described interpersonal behavior as the interaction of affiliation (friendly) and domineering styles across eight dimensions. In a practical sense, it is difficult to use all eight dimensions when attempting to incorporate them with attachment style; therefore, the authors used an adapted four-quadrant interpersonal circumplex model, in which both attachment and interpersonal style were treated as categorical rather than dimensional, which is the norm and this created the interpersonal style categories domineering-cold, cold-submissive, submissive-friendly and friendly-domineering. Even though using such a categorical approach on the basis of continuous scores may affect the precision of a measure and lower its statistical power[31], it provided us with a practical and simple model to interpret.

The aim of this research was to identify which attachment and interpersonal relationship patterns in therapists would be able to predict the level of working alliance and the treatment outcomes reported by patients. The reason the authors used working alliance-as rated by the patients, was because previous research had shown that patients' own observations on the level of working alliance formed are a better predictor of outcomes than those of therapists[12,20]. To examine treatment outcomes, the working alliance-which represents the type of therapeutic relationship formed between the therapist and the patient, was also incorporated into the model as a covariate. In addition, the gender of the therapist and patient plays a role in helping determine the type of working alliance formed, thus gender was included in the analysis[32,33].

Material and Method

Subjects

The participating patients were recruited from Psychiatry Outpatient Service, Maharaj Nakorn Chiang Mai Hospital between January and March 2011. Potential patients, all of whom were clinically stable, were invited to participate in the study and provided with a pack containing a PIS, questionnaires and an informed consent form by a research assistant. The

patient inclusion criteria were 1) the patient's age must be at least eighteen years old and 2) the patient must be able to complete the questionnaires. The patient exclusion criteria were: 1) the patient reveals symptoms of psychosis, 2) the patient experiences bipolar syndrome, manic episodes or severe depression, 3) the patient has an organic mental disorder, 4) the patient has an active condition that requires medical attention regardless of the cause; for example, active suicidal behavior, delirium, or an intoxicated or withdrawn state, and 5) the patient has any condition that has required hospitalization. According to DSM-IV-TR, 39% of the patients were suffering from depressive disorder, 10% had problems with substance abuse/ dependence, and the rest were suffering from anxiety, somatoform, and psychosomatic disorders (Table 1).

Therapists

All 13 therapists used in the present study were psychiatrists and psychiatric residents who provide psychotropic medication combined with psycho-dynamically orientated supportive psychotherapy. The time spent for each session varied from five minutes to more than one hour depending on the severity of the patient's problems. Except for the psychiatric residents, the therapists used had between five and twenty years' experience, with their ages ranging from 26 to 54 years of age (SD 8.7); seven (54%) of them were male. All the participating therapists were asked to complete the IIP and the short version of the Experience of Close Relationships Questionnaire (ECR-R-18).

Instruments

The revised experience of close relationships questionnaire (ECR-R)

The Thai version of the ECR-R questionnaire was translated from its original English version. The short version of the ECR-R - the ECR-R18, consists of eighteen items and is a self-reporting instrument designed to assess adult romantic attachment. The ECR-R has two dimensions: anxiety and avoidance, with nine items assessing the anxiety sub-scale and nine items assessing the avoidance sub-scale. In the present study, respondents were measured using a seven-point scale that ranged from 1 ('strongly disagree') to 7 ('strongly agree'), such that a higher score was associated with higher levels of anxiety or avoidance. The results were examined for their reliability and validity and found to be acceptable[34].

Table 1. Characteristics of patients and therapists

Characteristics	n (%)
Patients	121 (100)
Gender	
Male	66 (54.5)
Female	55 (45.5)
Age, mean ± SD (min-max)	38.14 ± 9.37 (23-55)
Marital status	
Single	47 (38.8)
Married	54 (44.5)
Separate or divorced	13 (10.8)
Widowed	7 (5.8)
Educational level (n = 120)	
Below elementary (Pratom 6)	30 (25.0)
Elementary (Pratom 6)	12 (10.0)
Junior high school	16 (13.3)
High school and some bachelor	20 (16.7)
Bachelor and higher	42 (35.0)
Occupation	
Employed	118 (97.5)
Unemployed	3 (2.5)
Diagnosis (n, %)	
Mood disorder	71 (50.7)
Anxiety disorders and somatoform disorders	44 (31.4)
Alcohol related disorders	14 (10.0)
Schizophrenia and other psychotic disorders	7 (5.0)
Mixed diagnosis	4 (2.9)
Therapists	13 (100)
Gender	
Male	7 (53.8)
Female	6 (46.2)
Age, mean ± SD (min-max)	36.00 ± 8.70 (26-54)
Attachment style (n, %)	
Secure	9 (69.2)
Preoccupied	4 (30.8)
Interpersonal style (n, %)	
Submissive	6 (46.2)
Domineering	7 (53.8)

Inventory of interpersonal problems (IIP)

The IIP is a self-reporting instrument designed to assess interpersonal interaction problems, those reflected through difficulties in executing particular behaviors[35]. The instrument is based upon the common

theories of interpersonal behavior, which have a long tradition in personality and social psychology[36]. The Thai version of the IIP-32 was found to be a valid and reliable measure for the purposes of the present study[37] and its eight sub-scales reflect the following interpersonal behavioral problems: domineering, vindictive, cold, socially inhibited, non-assertive, self-sacrificing, overly-accommodating, and intrusive-needy. Since all the therapists' IIP scores in the present study fell within a normal range (not exceeding a T score of 60), the outcomes were treated as part of their interpersonal style rather than interpersonal problems. In addition, all eight sub-scales were grouped into four quadrants corresponding to the relevant interpersonal circumplex, that is: 1) domineering-cold, 2) cold-submissive, 3) submissive-friendly and 4) friendly-domineering. For example, domineering-cold was calculated based upon a summation of domineering, cold, and the sub-scale in the middle (vindictive). The highest score found among the four quadrants represents a given therapist's interpersonal style.

Working alliance inventory (WAI)

The twelve-item WAI was developed by Tracey and Kokotovic, while C-WAI[38] was developed to measure patient and therapist perceptions of goals, tasks and the quality of personal bond formed. There are both patient and therapist versions but only the patient version was used in this study, with one sample response item being: "My therapist and I have a common perception of my goals". The items are set out on a seven-point scale ranging from 1 = rarely, to 7 = always. WAI has a reported internal consistency estimate, with alphas, of 0.98. In the present study sample, the internal consistency reliability for the therapist scale was found to be 0.82 (Task 0.71, Bond 0.81, Goal 0.56) and confirmatory factor analysis revealed the following fit indices: CFI = 0.93, TLI 0.90, RMSEA = 0.08 and SRMR = 0.05.

Psychological distress questionnaire (PDQ)

The PDQ was developed by Wongpakaran and Wongpakaran[39], and is used to measure the outcomes of psychotherapy and other kinds of treatment. There are three sub-scales to the instrument: anxiety, depression, and interpersonal difficulties (mainly avoidance problems), and it consists of an eighteen-item questionnaire: seven questions for anxiety, six for depression, and five for interpersonal difficulties, asking how often the respondents experience problems. For answers, a four-point Likert scale is used, ranging from 'not at all' to 'always', and higher scores are associated with higher levels of psychopathology. Example responses for the anxiety, depression and interpersonal sub-scales include, respectively: 'I feel tense', 'I feel depressed', and 'I can't get along with others'. This questionnaire has been validated and found to demonstrate a fair to good reliability ($\alpha = 0.92$ for internal consistency, 0.88 for the anxiety sub-scale, 0.89 for the depression sub-scale and 0.72 for the interpersonal sub-scale). It has also demonstrated an acceptable concurrent validity with other measurement instruments, that is, with the Thai Depression Inventory, the State-Trait Anxiety Inventory, the Multi-dimensional Scale of Perceived Social Support (MSPSS), and the Inventory of Interpersonal Problems (all $p < 0.01$). Confirmatory factor analysis has revealed its acceptable construct validity, producing the following excellent fit indices: CFI = 0.96, TLI 0.95, RMSEA = 0.04 and SRMR = 0.03.

Procedure

After being given a written consent form, the patients were asked to complete a pack of questionnaires that included questions about demographics, plus the PDQ and WAI questionnaire; however, the therapists were asked to complete the ECR-R and IIP one time only, before meeting with their patients.

Data analysis

In the cross-sectional design study, which involved 121 patients attending for therapy and 13 therapists, two sets of variables were used; first, the working alliance was treated as a dependent variable and second, symptom outcomes, that is, anxiety, depression and interpersonal difficulties, were treated as dependent variables (during this stage, working alliance was also used as a covariate). The independent variables included the therapists' attachment styles, that is, secure or preoccupied, for which dismissing and fearful attachment styles were not reported among the therapists. For the therapists' interpersonal styles-domineering or submissive, then since there was a relatively small number found in the submissive-cold group (n = 11), this group and the submissive-friendly group were combined for statistical reasons; therefore, the IIP instrument was used on only two groups-the submissive and domineering groups. Finally, the patients' gender, age, marital status and educational level, as well as the therapists' gender, were all included

in the analysis, with the resulting data showing a multivariate normal distribution. Since there was a significant correlation between the outcome variables, a multivariate ANOVA was used, and in order to test the differences in working alliances formed, a two (attachment style-secure and preoccupied) by two (interpersonal style) MANOVA (therapists' gender x 2; patients' gender x 2) was conducted whilst testing the difference in outcomes, that is, anxiety, depression, and interpersonal difficulties. The MANOVA was used where the working alliance variables were covariate; furthermore, the Within-subject Effect Sizes (WES) value was calculated in order to quantify the importance of changes in all the measures.

Results

Table 1 show the patient and therapist characteristics. Most of the therapists revealed secure attachment (69.2%) and interpersonal relationship scores in the friendly domain (92.5%). Descriptive data for the type of working alliance formed, as rated by the patients, is shown in Table 2.

There was no difference found between patient demographics and the DSM-IV diagnosis with respect to the therapists' attachment and interpersonal styles, and no difference found between patients in terms of their WAI scores and symptom outcomes, according to demographics and their DSM-diagnoses.

There was also no significant difference found between WAI and attachment styles, or between WAI and interpersonal styles; however, a significant relationship was found between the level of interpersonal difficulties experienced and the therapists' attachment styles ($p = 0.026$) - but not the therapists' interpersonal styles.

Prediction of the working alliance using therapist styles and therapy outcomes

Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers; homogeneity of the variance-covariance matrices, and for multicollinearity - with no serious violation noted. After excluding age and educational level as non-significant, a follow-up MANOVA examined the associations between the DVs and IVs described above.

In an attempt to explore how therapist factors impacted on the working alliance, a one-way, between-groups multivariate analysis of the variances was performed, in order to investigate therapists' interpersonal and attachment styles, and from this, no statistically significant difference was found between the therapists'

Table 2. Descriptive data for the PDQ^{+} questionnaires

Source	n	POQ		
		Anxiety mean (SD)	Depression mean (SD)	Interpersonal difficulties mean (SD)
Sex of patient				
Male	36	17.28 (5.51)	12.31 (5.23)	12.94 (4.15)
Female	85	18.59 (6.09)	13.72 (6.51)	13.99 (4.54)
Sex of therapist				
Male	69	17.55 (6.01)	12.93 (6.11)	13.52 (4.30)
Female	50	19.08 (5.88)	14.02 (6.30)	13.84 (4.73)
IIP-Style				
Submissive	53	18.94 (6.05)	13.89 (6.35)	14.26 (4.38)
Domineering	68	17.62 (5.81)	12.85 (6.06)	13.24 (4.46)
Attachment				
Secure	82	18.61 (5.77)	13.70 (6.41)	14.12 (4.20)
Preoccupied	39	17.33 (6.24)	12.49 (5.63)	12.74 (4.82)
IIP x attachment				
Submissive x secure	32	19.31 (5.86)	14.63 (6.71)	14.38 (4.48)
Submissive x preoccupied	50	18.38 (6.43)	12.76 (5.74)	14.05 (4.34)
Domineering x secure	50	18.16 (5.73)	13.10 (6.21)	13.96 (4.06)
Domineering x preoccupied	26	16.11 (5.94)	12.17 (5.64)	11.22 (5.02)

$^{+}$ Not yet adjusted by covariates

styles or gender, in terms of the type of working alliance formed. Multivariate analysis revealed that the gender of the therapist, the gender of neither the patient nor the therapists' styles had an impact upon the type of working alliance formed, or the outcomes. A multivariate test for WAI-goal (Wilks' Lambda F (3, 134) = 4.24, p = 0.007), interpersonal style (Wilks' Lambda F (3, 134) = 2.77, p = 0.044, attachment style (Wilks' Lambda F (3, 134) = 2.76, p = 0.045 and IIP-Style*Attachment Style (Wilks' Lambda F (3, 134) = 3.13, p = 0.028) produced statistically significant results, and when the results for the dependent variables were considered separately using a Bonferroni adjusted alpha level of 0.017 in follow-up univariate ANOVAs (Table 3), working alliance-goal was the only predictor of the level of anxiety or depression experienced by the patients (p = 0.014 and p = 0.002, respectively). A submissive style was found to be positively correlated with anxiety (p = 0.011) and interpersonal difficulties (p = 0.006), whilst, surprisingly, a secure attachment style was found to have a positive correlation with anxiety and depression. However, when both styles were combined, the resulting style negatively predicted anxiety (p = 0.002).

Discussion

Some investigators have found therapists' self-reported attachment patterns to be significantly associated with their own views on the level of therapeutic alliance formed with the clients, both directly[40] and indirectly[17,41,42], and some have demonstrated mixed results[43]. Britton revealed that therapists' attachment levels are not related to the working alliance, perhaps because more experienced therapists are better at forming alliances, irrespective of their own attachment style; however, Britton's study has been critiqued for its relatively small sample size and the possibility that the therapists may not have given honest answers in their interviews[44]. Ligiero and Gelso[45] found no relationship between therapists' attachment styles and their or their supervisors' perceptions of the type of working alliances formed, suggesting that there are other factors waiting to be identified. In addition, this uncorrelated relationship may be attributed to the fact that there was no shared variance between measurements, which were rated independently.

Sauer found that therapists with insecure attachment styles receive higher alliance ratings early in the session, while therapists with secure attachment styles appear to be able to establish a better working

Table 3. Univariate analysis of variances for treatment outcomes (PDQ)[+]

Source	Dependent variables											
	Anxiety				Depression				Interpersonal difficulties			
	B	95% CI		p-value	B	95% CI		p-value	B	95% CI		p-value
		Lower	Upper			Lower	Upper			Lower	Upper	
Intercept	20.03	13.44	26.61	<0.001	15.81	9.19	22.42	<0.001	13.28	8.50	18.06	<0.001
WAI-goal	-1.18	-2.12	-0.24	0.014	-1.47	-2.41	-0.53	0.002	-0.10	-0.78	0.58	0.779
WAI-bond	0.42	-0.85	1.69	0.512	0.75	-0.52	2.02	0.244	-0.38	-1.30	0.53	0.409
WAI-task	-0.10	-1.52	1.32	0.893	0.05	-1.38	1.48	0.945	0.53	-0.50	1.56	0.313
Male	-8.61	-16.31	-0.91	0.029	-8.25	-15.98	-0.51	0.037	-3.72	-9.31	1.86	0.190
IIP-Style (submissive-cold/friendly)	5.70	1.33	10.06	0.011	2.88	-1.50	7.27	0.196	4.43	1.26	7.60	0.006
Attachment (secure)	8.95	3.76	14.15	0.001	8.25	3.03	13.46	0.002	2.02	-1.75	5.78	0.291
Male x IIP-Style (submissive)	7.07	0.96	13.19	0.024	7.40	1.25	13.54	0.019	1.63	-2.80	6.07	0.468
Male x attachment	1.83	-4.25	7.91	0.553	0.62	-5.49	6.73	0.841	3.49	-0.92	7.90	0.120
IIP-Style (submissive) x attachment (secure)	-10.50	-17.23	-3.77	0.002	-8.04	-14.80	-1.28	0.020	-4.47	-9.36	0.41	0.072

[+] Not yet adjusted by covariates

relationship as time passes[46]. For the present study, when only the working alliance was taken into consideration, the authors found no correlation between the alliance scores and the therapists' attachment styles and/or interpersonal styles. This means that other factors may play a more vital role, such as the interaction between the attachment and/or interpersonal styles of both the therapists and the patients, a relationship not included in the present study. In addition, other factors that may be involved include the number of therapy visits, which might be expected to directly affect the relationship, was not included in the present study.

The working alliance and symptoms

It is interesting to note that the goal element of the working alliance had an effect on anxiety symptoms, whilst bond and task did not, giving rise to the assumption that goal seems to be the first element of the therapeutic alliance to be formed, as compared to task and bond, since it is the only variable that predicts a sensitivity to changing symptoms, such as anxiety. This notion is also supported by Schonberger[47] - that goal is sensitive and changes over time in a reliable fashion when compared to the other two elements of the working alliance and as a result, goal is normally considered an early objective of both therapists and patients after teaming up-as it helps to resolve any problems experienced by the patients. Anxiety is the first symptom to decrease over a short period of time, as when a promise to help (goal) is made, the patient's level of anxiety falls. Interpersonal difficulties, on the other hand, require a longer period of time to change[48,49] and may need a stronger bond between the patient and therapist to develop first, though the sequence of this development is, in fact, still unclear[50]. Taber[51] studied personality similarities in 32 client-therapist dyads, for their relationship with the bond, task, and goal elements of the working alliance, plus the therapeutic outcomes. Taber's results indicate that (a) client-therapist personality congruence is associated with the level of bond formed, (b) bond is associated with task and goal, and (c) task and goals are associated with therapeutic outcomes. Our results support the relationship between goal and anxiety outcomes.

Therapists' interactional styles and the impact on symptoms

Our results are in contrast to those from the afore-mentioned studies-that a secure therapist is related to more anxiety and depression. However, when this was combined with a submissive style, it appeared that this combined style was significantly related to a reduction in anxiety symptoms. What are the characteristics of a 'secure and submissive' style and how does it impact upon the patient? This type of style might be illustrated as being warm and friendly (from the secure attachment part), but at the same time passive, and more receptive than proactive (from the submissive part) - and this may help anxious patients to calm down, or at least to perceive the attitude of the therapist as non-threatening.

Limitations

Limitations of the study should be addressed here. First, to examine the whole picture in terms of those styles that affect the working alliance, patient attachment and interpersonal styles should be included in further studies. Second, instead of using therapist self-reporting mechanisms alone, a patient's perception of the therapist's personality and interpersonal behavior should be captured and would be of interest, since this would closely relate to the working alliance and treatment outcomes as reported by patients and help to minimize measurement variance. Third, a longitudinal one should be explored in order to display the changing pattern of variables over time, especially the stability of therapist (or patient) characteristics, changes in the working alliance, and those symptoms reported by the patients.

Conclusion

Our findings have helped us to elaborate upon the importance of the therapist's style; for example, the interactions between a therapist's attachment and submissive styles, plus its impacts upon symptom outcomes. This suggest that the therapeutic alliance does not appear to be related to the therapist's style. It is a co-construction between both parties that has an impact upon anxiety and depression.

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Potential conflicts of interest

None.

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รูปแบบของความรู้สึกผูกพันและสัมพันธภาพระหว่างบุคคลของผู้รักษามีผลอย่างไรต่อสัมพันธภาพในการรักษาและผลของการรักษา

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วัตถุประสงค์: *เพื่อศึกษาปัจจัยที่เกี่ยวข้องกับผู้รักษาว่ามีผลอย่างไรต่อสัมพันธภาพในการรักษา (therapeutic alliance) และผลของการรักษา (therapeutic outcome)*

วัสดุและวิธีการ: *มีการศึกษาผู้ป่วยจำนวน 121 ราย ที่มารับการบริการแผนกผู้ป่วยนอกเป็นจิตเวชแบบภาคตัดขวาง (cross-sectional design) โดยใช้แบบสอบถามเพื่อวัดอาการวิตกกังวล (anxiety) ซึมเศร้า (depression) และปัญหาสัมพันธภาพระหว่างบุคคล (interpersonal difficulties) ผู้ป่วยยังได้ให้คะแนนระดับของสัมพันธภาพที่มีต่อผู้รักษาโดยมีสเกลย่อยคือ เป้าหมาย (goal) ภารกิจ (task) พันธะผูกพัน (bond) ในขณะที่ผู้รักษาได้ทำแบบสอบถาม เพื่อวัดลักษณะรูปแบบสัมพันธภาพระหว่างบุคคล (interpersonal style) และรูปแบบความรู้สึกผูกพัน (attachment style) ปัจจัยด้านเพศที่ตรงกันหรือต่างกันระหว่างผู้ป่วยและผู้รักษาได้ถูกนำมาวิเคราะห์ด้วย*

ผลการศึกษา: *ปัจจัยด้านเพศของทั้งผู้ป่วยและผู้รักษารวมทั้งรูปแบบสัมพันธภาพระหว่างบุคคล และความรู้สึกผูกพันไม่มีผลต่อสัมพันธภาพระหว่างผู้ป่วยและผู้รักษา อย่างไรก็ตามในการวิเคราะห์พหุตัวแปรของอาการพบว่า สัมพันธภาพชนิดเป้าหมาย (goal) บุคลิกของแพทย์แบบสมยอม (submissive) ความรู้สึกผูกพันแบบมั่นคง (secure) และปฏิสัมพันธ์ระหว่างลักษณะทั้งสองชนิดมีผลต่ออาการโดยมีค่า Wilks' Lambda F ตามลำดับดังนี้ $F (3, 134) = 4.24$, $p = 0.007$, $F (3, 134) = 2.77$, $p = 0.044$, $F (3, 134) = 2.76$, $p = 0.045$, $F (3, 134) = 3.13$, $p = 0.028$) สัมพันธภาพแบบเป้าหมาย (goal) เป็นตัวทำนายการลดลงของความรู้สึกวิตกกังวล ในขณะที่บุคลิกภาพแบบสมยอมสัมพันธ์กับความวิตกกังวลและปัญหาสัมพันธภาพของผู้ป่วย ($p = 0.014$ และ $p = 0.002$) ลักษณะของผู้รักษาแบบมั่นคงสัมพันธ์กับความวิตกกังวลและอาการซึมเศร้าเช่นเดียวกัน ($p = 0.014$ และ $p = 0.002$) อย่างไรก็ตามปฏิสัมพันธ์ระหว่างบุคลิกของแพทย์แบบสมยอม (submissive) ความรู้สึกผูกพันแบบมั่นคง (secure) มีผลในการลดความวิตกกังวลอย่างมีนัยสำคัญทางสถิติ ($p = 0.002$)*

สรุป: *ปัจจัยของผู้รักษาไม่มีผลต่อการเกิดสัมพันธภาพในการรักษาที่รายงานโดยผู้ป่วย อย่างไรก็ตามผู้รักษาที่มีรูปแบบบุคลิกภาพแบบมีความมั่นคงในความรู้สึกผูกพัน (secure attachment) ร่วมกับมีรูปแบบสัมพันธภาพระหว่างบุคคลแบบสมยอม (submissive interpersonal style) มีอิทธิพลต่อการลดลงของอาการของผู้ป่วยมากกว่ากลุ่มอื่น นอกจากนี้ยังพบว่าสัมพันธภาพระหว่างผู้ป่วยกับผู้รักษาชนิดเป้าหมาย (goal) มีอิทธิพลต่อการลดลงของอาการวิตกกังวลและซึมเศร้าของผู้ป่วย*