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EMPIRICAL PAPER

Therapists' honesty, humor styles, playfulness, and creativity as outcome predictors: A retrospective study of the therapist effect

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Abstract

Objective: This study examined whether therapists' honesty, humor style, playfulness, and creativity would retrospectively predict the outcomes of therapies ended five years earlier. **Method:** In the Jerusalem-Haifa study, 29 therapists treated 70 clients in dynamic psychotherapy for 1 year. The Outcome Questionnaire 45 scores were collected at five time points. Five years later, the therapists were contacted via email and asked to fill out honesty, humor styles, playfulness, and creativity self-report questionnaires. Five were excluded since they had only one client in the study each. The remaining 24 therapists treated 65 clients out of whom 20 therapists with 54 clients completed the questionnaires. **Results:** Therapists' Aggressive Humor Style (AHS) was a significant negative predictor of clients' symptom change over time. The therapists' honesty scores were positively correlated with symptom change. That is, higher AHS therapists were more effective, while higher honesty therapists were less effective. **Conclusions:** Therapists' inferred traits of Honesty-Humility and AHS may influence the effectiveness of their treatments.

Keywords: outcome research; psychoanalytic/psychodynamic therapy; therapist effect; aggressive-humor style; honesty-humility

Clinical or methodological significance of this article: The current article suggests an explanation for part of the therapist effects. Understanding the contribution of therapist effects to therapy outcomes has major implications for selection and training of therapists. For instance, in addition to teaching specific skills and therapy models, training may include helping therapists become familiar with their negative parts, and recognize and use them productively in treatment.

A robust body of research supports the notion that therapists differ considerably in their effectiveness (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Okiishi, Lambert, Nielsen, & Ogles, 2003; Orlinsky & Howard, 1980; Ricks, 1974; Saxon & Barkham, 2012). Overall, therapist effects account for about 5% of the outcome variance (Baldwin & Imel, 2013). Five percent is a small effect size, but relatively it implies that the clinician accounts for a higher share of effectiveness than treatment modality (Wampold, 2001) or the use of evidence-based treatment (Wampold, 2005). In one study, being assigned to a therapist from the uppermost compared to the lowest 10% in average effectiveness increased the chances of improvement twofold (Okiishi et al.,

2006). An understanding of the therapist effect can have an important positive impact on public mental health via better training and selection of therapists. Very little is known regarding the specific variables behind the difference between therapists (Castonguay, 2013). However, age, gender, clinical experience, marital status, ethnicity, and professional degree were not found to reliably predict their effectiveness (Beutler et al., 2004; Wampold & Brown, 2005). The process-outcome literature shed some light on possible mechanisms. A recent meta-analysis found that 9% of the outcome variance could be explained by the therapist' use of empathy (Elliott, Bohart, Watson, & Greenberg, 2011). In another recent study, therapists' facilitative interpersonal

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skills predicted therapy outcomes; however, this was true only for therapies of up to eight sessions and not for longer-term therapies (Anderson, McClintock, Himawan, Song, & Patterson, 2016). As in many other occupations, the amount of time therapists spend on activities aimed at improving professional skills also predicted effectiveness, again, in very short therapies (Chow et al., 2015). Finally, therapist effects were found to be higher in naturalistic settings than in controlled studies (Baldwin & Imel, 2013; Wampold & Imel, 2015). Therapist effects seems to be even larger when longer-term therapies are examined (Crits-Christoph et al., 1991). Goldberg, Hoyt, Nissen-Lie, Nielsen, and Wampold (2016) found that the discrepancy in outcomes between high- and low-performing therapists increased somewhat with treatment duration.

While most of the existing empirical research on therapist effects deals with a-theoretical variables, including demographical variables such as age, professional variables such as level of experience, and personality and interpersonal variables (Beutler et al., 2004), the current study focuses on four core personality components that emerge from the psychoanalytic literature as characterizing good therapists and mental health more generally: honesty, humor styles, playfulness, and creativity. To the best of our knowledge, this is the first study that empirically examines these traits as predictors of therapist effectiveness.

Honesty, Humor Styles, Playfulness, and Creativity as Core Components of Mental Health

In the psychoanalytic tradition, honesty and the commitment for the truth take the roles of both a means and an end in itself. Freud wrote that “the great ethical element in [psychoanalytic] work is truth and again truth” (1914; quoted in Hale, 1971, p. 171), and that that the aim of treatment was to bring about “the highest ethical and intellectual development of the individual” (letter to Putnam, 1914; quoted in Hale, 1971, p. 176). McWilliams (2004) suggested that this moral stance included an element of caring for others.

These elements of truth loving and caring for other as definitions of mental health have been discussed from different perspectives by many (e.g., Blass, 2003; Racker, 1966; Rieff, 1959; Thompson, 2002). Note that honesty here is a moral stance, and the search for truth is not merely a technique or a skill but an ethical norm. On one end of the spectrum, we have an honest person who cares about others: it is important for him to be fair and not to pretend to be someone he is not. On the other,

we find a combination of Machiavellianism, narcissism, and psychopathy, a person who is defined by grandiosity and entitlement together with low empathy and manipulative social conduct (Paulhus & Williams, 2002). The sixth personality dimension—the H factor (Honesty–Humility) in the HEXACO model (Honesty–Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness, Openness to Experience; Lee & Ashton, 2004)—matches this definition. It is negatively correlated with the “black triad”: Psychopathy, Machiavellianism, and narcissism (Lee & Ashton, 2005) and predictive of workplace delinquency (Lee, Ashton, & de Vries, 2005).

In classic psychoanalysis, humor is considered a healthy defense mechanism (Freud, 1905/1973, 1927). Greenson (1967) suggested that sense of humor is a trait that should characterize successful analysts. Dziegielewski, Jacinto, Laudadio, and Legg-Rodriguez (2003) argue that humor can be utilized to break a client’s resistance, reduce tension, generate catharsis, and increase trust in the client/therapist relationship. In recent years, an extensive literature has developed around the uses of humor in therapy. Some write from the clinical perspective (Fabian, 2002; Lemma, 2000; MacHovec, 1991; Ortiz, 2000), whereas others address the issue from an empirical one. Process studies have found, however, that therapists who use humor are perceived more negatively and are considered less empathic than those who do not (Rosenheim & Golan, 1986; Rosenheim, Tecucianu, & Dimitrovsky, 1989). Laughter and humoristic interventions have been found by some researchers to lead to less understanding and insight (Killinger, 1987). Saper (1987) hypothesized that humor would predict therapist effects beyond theoretical orientation. Franzini (2001) called for empirical research of humor as a component of the therapist effects in order to determine whether it should be part of the training and selection considerations.

Finally, Martin, Puhlik-Doris, Larsen, Gray, and Weir (2003) pointed out that humor in interpersonal context was not a one-dimensional construct. They presented a model that included four humor styles: Self-enhancing: the use of humor to enhance the self; self-defeating: the use of humor to enhance relationships at the expense of the self; affiliative: the use of humor to enhance one’s relationships with others; and aggressive: the use of humor to enhance relationships at the expense of others. This is the model selected for the present study.

Much like humor, and perhaps even more so, the psychodynamic discourse commonly refers to therapy as a unique form of play. Being playful or

able to play is about being authentic and connected to one's true self. Winnicott wrote that

The general principle seems to me to be valid that psychotherapy is done in the overlap of two play areas, that of the client and that of the therapist. *If the therapist cannot play then he is not suitable for the work.* If the clients can't play, then something needs to be done to enable the client to become able to play. (1971, p.38; authors' italics)

In 1997, Schaefer and Greenberg (1997) presented the playfulness scale for adults, referring to the predisposition to play as a neglected therapist variable. The construct is composed of five factors: (i) fun-loving; (ii) sense of humor; (iii) enjoys silliness; (iv) informal; and (v) whimsical. Playfulness was found to be positively correlated with indicators of mental health (FitzMedrud, 2008). To the best of our knowledge, however, it was never researched empirically as a predictor of therapists' effectiveness.

Sense of humor is one of the factors that make up the construct of playfulness, leading to potential overlap between two independent constructs of the current research. From the theoretical perspective, some overlap and positive correlations between the positive components of mental health is acceptable. However, this is not an issue in the current study, as the humor model chosen for this research does not relate to being funny or having sense of humor, but to the ways people use humor in social contexts. This is not the humor factor included in the playfulness scale.

Another frequently used metaphor is therapy as a form of art and the therapist as an intuitive or creative artist (Loewenstein, 1957). The therapeutic process has been equated to writing a poem, composing music and painting a picture (Loewald, 1975). There is an ongoing debate on whether creativity is domain specific or a general trait (Baer, 1991, 1994, 1998; Kaufman & Baer, 2004; Lubart & Guignard, 2004; Lubart & Guignard, 2004; Plucker, 1998; Root-Bernstein & Root-Bernstein, 2004). There are many definitions of creativity and hence many ways to measure it (Plucker & Beghetto, 2004). In the current study, we have chosen to assess creativity in terms of divergent thinking, since it is a basic cognitive ability widely considered responsible for the general phenomena of creativity and independent of acquired knowledge (Guilford, 1967; Plucker & Renzulli, 1999; Torrance, 1968). Divergent thinking has also been extensively studied in psychological research (Beaty & Silvia, 2012; Gilhooly, Fioratou, Anthony, & Wynn, 2007).

Taken together, these personality traits constitute the core variables of a healthy personality according to the psychoanalytic tradition and are meaningful

factors in the therapeutic process according to variety of theoretical and clinical approaches.

We found little or no research relating these four therapist variables to therapy outcomes. Some studies examined the Rogerian concept of congruence (genuineness and openness; Kolden, Klein, Wang, & Austin, 2011). However, it differs from the Honesty–Humility concept used in the current study. Congruence refers to the therapist being true to him- or herself in the therapeutic relationship, whereas Honesty–Humility is a broader personality factor that does not relate specifically to the therapeutic relationship. Therefore, based on both clinical writing and psychoanalytic theory, we hypothesized that in a retrospective, naturalistic study of a year-long dynamic therapy, honesty, creativity, playfulness, and the positive humor styles (affiliative and self-enhancing) would predict better therapy outcomes, while negative humor styles (aggressive and self-defeating) would predict worse outcomes.

Method

Participants

Therapists. The Jerusalem-Haifa study had originally included 29 therapists at a university counseling center (Wiseman & Tishby, 2011, 2014). Five were excluded from the current study since each had only one client in the study, in order to prevent confounding (Anderson et al., 2016; Crits-Christoph & Mintz, 1991). Out of the 24 therapists contacted, 20 completed the research questionnaires. The remaining therapists were 17 women and 3 men, with a mean age of 35.53 ($SD = 8.03$; range: 23–57). The therapists were mostly Israeli-born (89.5%) from intact families (84.2%). The majority held MA degrees (73.7%) in clinical psychology (68.4%) or social work (21.1%), which is the required degree for licensing. In terms of experience level, 73.3% were interns (with 2–3 years of experience) and 20% were licensed therapists (with 5–15 years of experience). All interns received weekly individual and group supervision at the time of study. Licensed therapists could receive consultation as needed. The number of clients per therapist ranged from 2 to 6 ($M = 2.7$; $SD = 1.13$).

Clients. The outset sample of the Jerusalem-Haifa study consisted of 70 clients at a university counseling center (Wiseman & Tishby, 2011, 2014). After excluding the patients treated by the 5 therapists who treated 1 client each and those treated by the 4 therapists who had not completed the questionnaires, 54 clients remained. Two-thirds were female (36 females and 18 males). They had mean age of 24.84 ($SD = 2.62$; range: 20–32) and the majority

were undergraduate students (79.6%). They were mostly single (96.1%), the majority were Israeli-born (81.1%), and 80% came from intact families. Most of the clients were diagnosed with mild depression and/or anxiety, presenting with difficulties in relationships, in their academic studies, or issues pertaining to identity formation.

Client Measure

Outcome Questionnaire 45. The Outcome Questionnaire 45 (OQ-45; Lambert et al., 1996) is a 45-item self-report instrument designed to assess symptom change along the course of therapy. Clients are asked to rate their functioning in the past week on a 5-point Likert scale from 0 (*never*) to 4 (*almost always*). OQ-45 is composed of three subscales—Symptom Distress, Interpersonal Problems, and Social Role—that are summed to provide a total score. High scores indicate higher overall levels of symptom severity. OQ-45 has adequate test-retest reliability (0.84) and high internal consistency (0.93) (Lambert et al., 1996). We used its Hebrew validated version (Gross et al., 2014). In the Jerusalem-Haifa study, its Cronbach's alpha was 0.91.

Therapist Measures

Translation of measures. A reliability study was conducted on a community sample of 126 participants (84 women, 42 men). The average age was 36 ($SD = 15.76$; range: 18–80). The measures were translated from English to Hebrew and back by a team of experts. The internal consistency scores of the translated measures were highly similar to those of the original instruments, as reported below.

Honesty–Humility. HEXACO-H (Ashton, Lee, & Goldberg, 2007) is a 40-item self-report inventory for personality assessment taken from the international personality item pool (Goldberg et al., 2006). It is based on the HEXACO six-dimensional model of personality (Honesty–Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness, Openness to Experience) (Lee & Ashton, 2004). Therapist were asked to rate the extent to which these items describe them as they generally are in the present on a 5-point Likert scale ranging from *very inaccurate* (1) to *very accurate* (5). It is composed of four subscales: Sincerity (Don't pretend to be more than I am); Fairness (Return extra change when a cashier makes a mistake); Greed avoidance (Would not enjoy being a famous celebrity); and Modesty (Am just an ordinary person). They all have Cronbach's alphas that range between 0.69 and 0.8. The Honesty–Humility domain with the four above-mentioned subscales has a Cronbach's

alpha of 0.88. In the translation reliability study, the reliability of the subscales' Hebrew version ranged between 0.74 and 0.86. The reliability of the Honesty–Humility factor was 0.9. In the current study, Cronbach's alpha of the subscales ranged between 0.8 and 0.88 and the Honesty–Humility reliability score was 0.92.

Humor styles. The Humor Style Questionnaire (Martin et al., 2003) is a 32-item self-report inventory designed to measure individual differences in the way people use humor in their life. Participants respond to the degree to which they agree with each statement on a scale from 1 (*totally disagree*) to 7 (*totally agree*). It is composed of the four above-mentioned styles (eight items each): Self-enhancing (If I am feeling depressed, I can usually cheer myself up with humor); affiliative (I don't have to work very hard at making other people laugh—I seem to be a naturally humorous person); aggressive (If I don't like someone, I often use humor or teasing to put them down); and self-defeating (I let people laugh at me or make fun at my expense more than I should). These subscales have Cronbach's alphas that range between 0.77 and 0.81. In the translation reliability study, the Hebrew version yielded similar reliability. The subscales' reliability scores ranged from 0.75 to 0.84. In the current study, they ranged between 0.66 and 0.78.

Playfulness. The Playfulness Scale for Adults, a self-report questionnaire designed to measure the predisposition to play (Schaefer & Greenberg, 1997). For the purposes of this study, we created a short version based on the translation reliability study by selecting the nine items with the highest loading on the scale's main factor. Examples of items include: "I enjoy acting silly or goofy at times"; "At times I'll sing in the shower or do a little dance at home." The short version had a correlation of 0.89 with the long-translated version. Participants indicated the degree to which they agreed with each statement on a scale of four options (1, 3, 5, 7), from 1 (*totally disagree*) to 7 (*totally agree*). Our short version had Cronbach's alphas of 0.79 in the translation reliability and 0.69 in the current study.

Creativity. Generating novel uses for a familiar object is a divergent thinking task widely used in experimental studies of creativity (Guilford, 1967; Plucker & Renzulli, 1999; Torrance, 1968). Participants are asked to write down as many novel uses for a familiar object within a time limit of 2 min. Only novel and coherent uses are counted. Studies

have used familiar objects for this task. In our research, we asked for novel uses of an ice-pop stick. Two raters separately identified responses as coherent and novel, and their agreement ratio was higher than 95%; the remaining cases were discussed between them until consensus was obtained.

Procedure

The complete description of the Jerusalem-Haifa study was published elsewhere (Wiseman & Tishby, 2014). In brief, therapy was provided in a large university counseling center. Clients were seen once a week for 50 min for 1 year. The model of psychotherapy in this naturalistic study can be described as based mainly on principles of contemporary psychodynamic psychotherapy (e.g., Summers & Barber, 2012) and on object-relations (Winnicott, 1971) and relational psychotherapy (Aron, 1996; Mitchell, 1993). Clients completed OQ-45 at five points in time: intake, and after sessions 5, 15, 28, and 32.

Five years after completing the Jerusalem-Haifa study and after attaining the institutional review board (IRB) approval, the therapists were contacted via email and asked to participate in a study on attitudes that was partly a continuation of the previous research. They were requested to fill out an online survey that included a consent form for this part of the study. Therapists who replied were compensated by a voucher worth about 10\$. The questionnaires were presented in random order to prevent order effects.

Data Analysis

The hierarchical nature of the data in which each patient was measured several times and each therapist had more than one patient has resulted in dependency between the observations of each therapist and each client. Hierarchical linear modeling was used to address this potential bias (HLM; Raudenbush & Bryk, 2002). Intra-class correlation (ICC) in hierarchical data refers to the amount of variance that a certain level accounts for. The ICC for the therapists' level at the beginning and end of therapy was assessed using a two-level HLM with clients nested within therapists. The ICC at intake can provide an estimation of that part of the difference between therapists that may result from uncontrolled assignment of clients to therapists. When assessing the ICC at the end of therapy, the measurement of OQ-45 at the intake was entered as a fixed predictor in order to control for initial differences (following Kim, Wampold, & Bolt, 2006). This measurement provided an estimation of the overall therapist effects size.

A three-level HLM with time points nested within patients and patients nested within therapists was chosen. One of the strengths of this research is that the therapies included the same measurement points, so there was no need to control for treatment length. To provide the best fit between the model and the unconditional growth curve, three-time coding options (linear, quadratic, and logarithmic) were compared.

A simultaneous examination of the covariates on Level 3 as fixed effects was performed. The time effect and the intercepts were allowed to fluctuate and calculated as random effects on both the therapist and the patient levels. A second three-level model was fitted, and this time only its predictors that were found to be significant at the $p < .1$ level at the simultaneous test were included.

The HLM analysis was conducted via the R software. The amount of variance explained by the therapists' level (ICC) was calculated using the nlme package, ICC significance was computed using the intervals function for the random effect (Pinheiro, Bates, DebRoy, & Sarkar, 2014). The significance analysis of the regression predictors was conducted using the lmerTest package, with Satterthwaite approximations to degrees of freedom and restricted maximum likelihood (REML) estimation method (Kuznetsova, Brockhoff, & Christensen, 2015). Finally, the amount of variance explained by the significant predictors was calculated using the MuMin package (Barton, 2013).

Results

Table I provides descriptive statistics and zero-order correlations of the predictor variables.

The amount of variance attributed to the therapist level (ICC) at the first OQ-45 measurement calculated on a two-level model was 0 ($0.0001/[0.0001 + 524.8] = 0$). The ICC of the therapist level on the last measurement of the OQ-45 calculated on a two-level model with the first measurement as a fixed effect was significant and equal to 13.3% ($56.1/[56.1 + 365.46] = 0.133, p < .05$).

For the three-level HLM, different shapes of unconditional (without predictors) growth curves were compared; a curve with linear time term for the possibility that the change (increase or decrease) had a constant rate over time; a curve with quadratic time term for the possibility that increase followed a decrease or vice versa; and a curve with logarithmic time term to assess the possibility that the change rate (increase or decrease) was higher at the beginning than at the end of the therapy. The time variable was coded with zero for the first measurement at

Table I. Descriptive predictor variables.

Measure	M	SD	Range	Honesty-Humility	AHS	Self-defeating Humor Style	Self-enhancing Humor Style	Affiliative Humor Style	Creativity Task	Playfulness
Honesty-Humility	3.85	0.39	2.98-4.35	1						
AHS	3.17	0.64	2-4.37	-0.08	1					
Self-defeating Humor Style	2.64	0.83	1.25-4	-0.26	0.3	1				
Self-enhancing Humor Style	3.9	0.87	2.25-6.12	-0.40	-0.002	0.37	1			
Affiliative Humor Style	4.86	0.79	3.5-5.87	-0.05	0.37	0.37	0.42	1		
Creativity Task	7.02	2.44	4-13	0.23	0.1	0.3	0.33	0.18	1	
Playfulness	4.27	1	2.77-6.33	0.11	0.08	0.3	0.18	0.6**	0.15	1

** $p < .01$.

Table II. Results of the three-level HLM simultaneous test of all variables on outcome.

Variable	Estimate	Significance	SE	T value
Intercept	78.81	$p < .0001$	2.7	27.12
logTime	-10.52	$p < .0001$	2.34	-4.5
AHS	-11.99	$p < .05$	5.28	-2.71
Honesty	16.2	$p < .1$	9.22	1.76
Self-defeating Humor Style	1.3	$p = ns$	3.88	0.34
Self-enhancing Humor Style	2.48	$p = ns$	4.11	0.6
Affiliative Humor Style	1.87	$p = ns$	5.27	0.36
Creativity Task	-0.6	$p = ns$	1.11	-0.54
Playfulness	0.8	$p = ns$	3.42	0.43
Random effect		Variance		
Therapists intercept	13.56			
Therapists slope	27.79			
Clients intercept	206.27			
Clients slope	59.07			
Residual	154.11			

intake, one for the next measurement, and so on. The logarithmic coding was applied to the time variable plus one, since a logarithm can only have positive values. The Akaike and Bayesian information criteria (AIC and BIC, respectively) both showed that the logarithmic time coding had the best fit among three model tested. Lower scores indicate better fit between the model and data ($AIC_{linear} = 2271.75$, $BIC_{linear} = 2296.86$; $AIC_{quadratic} = 2286.82$, $BIC_{quadratic} = 2312.03$; $AIC_{logarithmic} = 2265.73$, $BIC_{logarithmic} = 2290.84$). Therefore, logarithmic time coding was selected for the subsequent analysis. Next, the study variables were added to the model as fixed covariates on the third (therapist) level. The random effects structure remained as in the previous model. Overall, therapy was effective: Logarithmic time was significantly ($p < .0001$) negatively correlated with symptom severity. Therapists with higher aggressive humor level were significantly ($p < .05$) more effective. Therapists' aggressive humor scores were negatively correlated with symptom severity. Finally, Therapists with high honesty scores were marginally significantly ($p < .1$) less effective. Therapists' honesty scores were positively correlated with symptom severity (Table II).

After running the first simultaneous test on the three-level HLM model another model was fitted. The nonsignificant predictors were removed so that it included only the Honesty-Humility and the Aggressive Humor Style (AHS) scores. This model had no variance attributed to the therapist-level random intercept and failed to converge. Another

Table III. Results of the three-level HLM simultaneous test of Honesty–Humility and AHS only.

Variable	Estimate	Significance	SE	T value
Intercept	78.77	$p < .0001$	2.5	31.42
logTime	−10.6	$p < .0001$	2.39	−4.44
AHS	−10.46	$p < .05$	4.02	−2.6
Honesty	12.41	$p < .05$	6.14	2.02
<hr/>				
Random effect	Variance			
<hr/>				
Therapists slope	32.32			
Clients intercept	189.83			
Clients slope	58.73			
Residual	154.27			

model was fitted, this time without random intercept at the therapist level. In this model, both Honesty–Humility and AHS were found to be significant ($p < .05$). We used Nakagawa and Schielzeth’s (2013) R^2 estimate for the linear and generalized linear models. AHS explained 6% of the variance and Honesty–Humility accounted for 3% of the variance across the three levels (Table III).

Discussion

In this study, we measured the effects of therapists’ honesty, humor styles, playfulness, and creativity on patients’ outcome in a year-long dynamic therapy. The amounts of variance explained by the therapist level (ICC) were 0% at intake and 13.3% at the fifth measurement when controlling for differences possibly related to unbalanced assignment. In terms of the therapists’ specific attributes, we found that Honesty–Humility and AHS retrospectively predicted the outcomes of therapies that had ended five years earlier. Contrary to our hypothesis, the clients of therapists with higher honesty scores improved *less* than those of therapists with lower honesty scores. The clients of therapists with higher AHS improved *more* than those treated by therapists with lower AHS.

This study has several unique characteristics. The therapies investigated were of medium length (one year) and the setting was naturalistic, where the lion’s share of therapist effects exists. There were no differences in the type of psychotherapies or in treatment duration. In addition, since Honesty–Humility is a personality factor and humor styles were also found to be correlated with personality traits that are stable in time (Saroglou & Scariot, 2002), the fact that the therapists’ variables were measured five years after treatment indicates that the effect may not be due a transient state of the therapist during the therapy period. The therapists in the sample had a wide range of experience: The

findings are not limited to therapists in training. The therapist effect size found can be considered large compared to the 5% average effect found in Baldwin and Imel (2013).

Although the sample size in this study was relatively small and therefore the findings are tentative, our results indicate that part of the therapist effects can be explained using the personality traits studied. Self-enhancing, affiliative, and self-defeating humor styles together with playfulness and creativity were not found to be significant predictors of therapists’ effectiveness. The negative correlation between Honesty–Humility and the therapists’ effectiveness is in the opposite direction to our hypothesis. This finding is inconsistent with the common perception of the effective therapist as warm and emphatic or with the psychoanalytic literature that stresses the importance of honesty as the basic norm in the therapeutic process.

One possible interpretation of this finding is that being very sincere does not enable the therapist to “move out” of his real self and take roles for his or her clients. For example, in order to fully explore transference material and figures it is important that the therapist does not respond out of his immediate feelings. Not showing or responding out of ones’ authentic emotions may be perceived as dishonesty; however, it may be essential in order to explore the patients’ unconscious feelings. It is also possible that therapists at the extreme upper end of the honesty scale are seen as uncompromising and inflexible and that this overcomes the positive effect of honesty. A third alternative explanation relates to instances where Honesty–Humility reflected the therapists’ level of being in touch with and recognizing negative aspects of themselves such as aggression. In such cases, therapists describe themselves in positive or even ideal terms that might be reflected in a high Honesty–Humility score. This may deny therapists the ability to recognize “negative” elements in their clients’ personalities and ways of relating in the session, and address them in ways that may cause pain or discomfort even though they may foster progress. Klein (2002) and Winnicott (1949) wrote about the importance of the therapist’s acknowledgement of his own aggressive parts that may be targeted against his clients. Psychotherapeutic interventions of different kinds may involve mental pain and necessitate moderate levels of aggression.

The latter argument may also explain the surprising positive correlation between therapists’ effectiveness and AHS. Although the current study did not explicitly address the use of aggressive humor as a therapeutic technique, this finding is consistent with a long tradition of similar approaches, such as paradoxical intention (Frankl, 1975) and confrontation (Adler &

Myerson, 1991; Davanloo, 1980). Leiman and Stiles (2001) used Vygotsky's concept of zone of proximal development (ZPD) as an analogue to the dyadic aspect in therapy. They argued that in therapy, the client's ability to solve his problems is limited by the attempt to avoid psychological pain, in the same way a child's developmental path is limited by his current cognitive ability. The client's *therapeutic zone of proximal development* (TZPD) is the area where he can progress using the therapist's assistance. The therapist needs to respect this zone and help the client make progress only according to his capacity to bear the psychological pain. In other words, effective interventions are by definition painful, but not *too* painful. Interventions that are too painful may be useless or even harmful in that they cause the client to mobilize defense mechanisms. Ribeiro, Ribeiro, Gonçalves, Horvath, and Stiles (2013) developed a coding system to track the interaction between therapist and client on the base of the TZPD concept. In recent study, examples of clinical errors of exceeding the TZPD were presented with ways they can be repaired (Stiles, Caro Gabalda, & Ribeiro, 2016). Following the same line of thought, progress in dialectical behavior therapy involves fluctuation between two communication styles. On the one hand, warm acceptance and empathetic reflection, and on the other, blunt, irreverent, confrontational comments (Linehan, 1993; Lungu & Linehan, 2015).

The current findings—including both the positive correlation of therapists' effectiveness with AHS and the negative correlation with Honesty–Humility—are consistent with the notion that therapeutic progress may involve aggressive intervention and pain. These findings raise questions for future studies regarding the dominant prototype of the “kind” therapist and the therapeutic effect as exclusively derived from warmth and empathy. In future studies, it could be interesting to examine which types of interventions therapist high on AHS actually use. They may also examine the plausible assumption that the balance required between empathic and aggressive interventions may be different for different clients or client populations. It should be noted that as shown in the descriptive statistics, none of the therapists in the current sample was on the extreme pole of dishonesty or aggressive humor. Therefore, they might reflect the difference between someone who is more direct and daring and someone who is mainly supportive. The level of aggression referred to here should not be confused with hostility towards the client. This study has several limitations. The naturalistic design neither included random assignment to therapists nor experimental manipulation of therapist variables. Although there was no variability in symptom severity between the caseloads at the beginning of the treatment, there could have

been differences due to other characteristics that were not measured. The therapist variables were measured five years after the treatments had ended, and it is therefore possible that they changed during this time. Another limitation has to do with the client-to-therapist ratio that is relatively low, affecting the reliability of the findings (Schiefele et al., 2016). On the other hand, such low ratio can also reduce the inflation of Type I error if there are more than only one client per therapist (Anderson et al., 2016; Crits-Christoph & Mintz, 1991). In this study, therapists who had only one client were excluded to prevent confounding. Further research is required to replicate the findings in larger samples and with other sample characteristics such as type of therapy, therapy duration and client population and cultural contexts.

Understanding the contribution of therapist effects to therapy outcomes has major implications for selection and training of therapists. For instance, in addition to teaching specific skills and therapy models, training may include helping therapists become familiar with their negative parts, and recognize and use them productively in treatment.

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