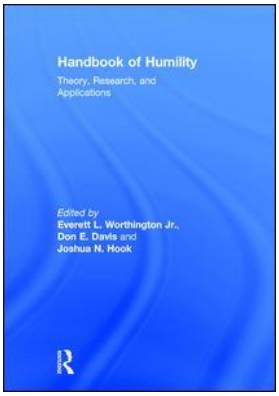

Handbook of Humility
Theory, Research, and Applications

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HUMILITY AND PSYCHOTHERAPIST EFFECTIVENESS

Humility, the Therapy Relationship, and Psychotherapy Outcomes

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Research has robustly shown psychotherapists vary in their effectiveness in promoting positive psychotherapy outcomes (Baldwin & Imel, 2013). In this chapter, we build on this research and argue that psychotherapist effects on outcomes occur primarily via how the psychotherapist's qualities and behaviors affect the therapy relationship, which in turn affects outcomes. We highlight the potential role of psychotherapist humility in this process.

Definitions

To begin, we define our terms. First, *psychotherapist effects* refer to "the effect[s] of a given therapist *on patient outcomes* as compared to another therapist" (Baldwin & Imel, 2013, pp. 259–260, emphasis in original). The *therapy relationship* refers to "the feelings and attitudes that [the] therapist and client have toward one another, and the manner in which these [feelings and attitudes] are expressed" (Norcross & Lambert, 2011b, p. 5).

Humility is defined as "a multidimensional construct comprised of (a) a willingness to perceive the self accurately, (b) other-orientedness and avoidance of self-enhancement, (c) openness, and (d) the ability to acknowledge one's limitations and mistakes" (Paine, Sandage, Rupert, Devor, & Bronstein, 2015, p. 5). We view humility as both a trait and a state (e.g., Davis et al., 2013; Kruse, Chancellor, Ruberton, & Lyubomirsky, 2014). *Trait humility* refers to the degree to which a person tends to exhibit humility across time, situations, and contexts, whereas *state humility* refers to the degree to which a person exhibits humility at a specific time or in a specific situation or context. Also, we view humility as having several distinct yet interrelated subtypes, which are expressions of humility within specific contexts or domains (Paine et al., 2015). Cultural and clinician humility are two of those subtypes. *Cultural humility* is "having an interpersonal

stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience" (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 353). *Clinician humility* is an "evolving inclination toward accurate self-assessment, recognition of limits, the regulation of self-centered emotions, and the cultivation of other-centered emotions in a clinical setting" (Paine et al., 2015, p. 10).

Literature Search and Chapter Limitations

For our literature search, we first identified relevant articles, chapters, and books by reviewing reference sections of seminal scholarly sources (e.g., Baldwin & Imel, 2013; Norcross, 2011; Paine et al., 2015). Next, we conducted searches in the PsycINFO, PsycBOOKS, and PsycARTICLES databases through November 24, 2015, using the limiters "English language" and "exclude dissertations." Here we used the following key terms: (a) [*humility* OR *humble*] AND [*therapist* OR *counselor*] (144 results, 16 of which were empirical), (b) *therapist effects* OR *therapist variables* (363 results), and (c) *therapy relationship* AND *outcome** (88 results).

As can be seen, there as yet is very little empirical research on psychotherapist humility, which is thus the main limitation of this chapter. Therefore, in what follows, we mainly extrapolate from the robust literature on psychotherapist effects and the therapy relationship. In particular, we theorize about how psychotherapists affect positive psychotherapy outcomes by exhibiting high trait, clinician, and cultural humility and thereby cultivating and maintaining strong therapy relationships. Ultimately, we aim to provide a theory-based, research-informed guide that researchers and clinicians can use to advance their research and improve their practice.

Psychotherapist Effects on Outcomes

Baldwin and Imel (2013) conducted the most rigorous meta-analysis of psychotherapist effects to date. Averaging across 46 random-effects studies (including 1,281 therapists [per-study median: 9] and 14,519 patients [per-study median: 7.6 patients per therapist]), the mean intraclass correlation was 0.05 (95 percent CI: .03–.07). That is, on average, roughly 5 percent of the variance in psychotherapy outcomes is attributable to the psychotherapist. When Baldwin and Imel (2013) only examined naturalistic/effectiveness studies (i.e., studies maximizing external validity [real-world generalizability]; $N = 17$), they found 7 percent of the variance in outcomes is attributable to the psychotherapist. In sum, the psychotherapist makes a notable impact on patient outcomes (e.g., symptoms, functioning, and well-being), especially in real-world settings.

This contribution may seem rather small. However, research suggests only 60 percent of the variance in psychotherapy outcomes is explained (i.e., attributable to known factors), with 30 percent of outcome variance attributable to patient factors (e.g., baseline severity), 12 percent to the therapy relationship, 8 percent to the treatment method, 7 percent to the psychotherapist, and 3 percent to other factors (Norcross & Lambert, 2011b). Although psychotherapists account for a relatively small percentage of explainable outcomes, their contribution is not negligible. Thus, it is worthwhile to examine psychotherapist factors (e.g., humility) that might contribute to positive outcomes.

Regardless, it is worth noting that psychotherapists' 5 percent to 7 percent contribution means 93 percent to 95 percent of the variability in psychotherapy outcomes is *within* a particular psychotherapist's caseload. Stated differently, a given psychotherapist's effectiveness will vary widely across his or her caseload, such that he or she has positive outcomes (e.g., recovery or improvement) with certain patients but less-than-optimal outcomes with others (e.g., no change or deterioration; Baldwin & Imel, 2013; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011). For example, Okiishi et al.'s (2006) seminal study of psychotherapist effects suggests that when the best- and worst-performing psychotherapists are compared, the best-performing psychotherapists will have roughly 22 percent of patients who recover (i.e., experience clinically significant positive change), 22 percent who improve (i.e., experience notable but not clinically significant change), 51 percent who experience no change, and 5 percent who deteriorate in outcomes (compared to 11%, 17%, 61%, and 11% for the worst-performing psychotherapists, respectively). Thus, even if one is seeing a high-performing psychotherapist, one still has a roughly 50 percent chance of experiencing no measurable change, and if one is seeing a poorly performing psychotherapist, that chance is around 60 percent (Baldwin & Imel, 2013; cf. Chow et al., 2015, p. 341). Of itself this finding suggests psychotherapists need to cultivate humility regarding how many patients they can expect to help experience recovery or improvement.

In another study, Kraus et al. (2011) found psychotherapists' differential effectiveness with patients on their caseload may be domain specific, reflecting differential competence in treating certain presenting concerns or functional impairments. This finding ought to promote psychotherapists' humility as well, in that it encourages psychotherapists to maintain openness to feedback that will help them identify growth areas (e.g., areas of less-than-optimal effectiveness or competence). It also encourages psychotherapists to acknowledge humbly there are limitations to their competencies. That is, there are certain disorders or impairments they can treat competently, whereas there are others they are not yet competent to treat. To illustrate, in Kraus et al.'s (2011) study

of 696 psychotherapists, the modal number of treatment areas in which psychotherapists (42 percent) were competent was 5 out of 12, with most psychotherapists (96 percent) being competent in at least 1 domain and *no one* being competent in all 12 assessed domains.

Unfortunately, psychotherapists normatively lack humility when it comes to appraising their psychotherapeutic effectiveness and skills. For instance, in a landmark study, Walfish, McAlister, O'Donnell, and Lambert (2012) found that, on average, psychotherapists reported roughly 75 percent of their patients improved by participating in psychotherapy with them, with two out of three psychotherapists indicating 80 percent or more of their patients improved. (Recall the aforementioned evidence that only 30 percent to 45 percent of patients will improve; Okiishi et al., 2006.) Walfish et al. (2012) also found 25 percent of respondents rated their overall psychotherapeutic skills at the ninetieth percentile or above. Only 8 percent of respondents rated their overall skills as below the seventy-fifth percentile, and *no one* rated their skills as below average (i.e., below the fiftieth percentile).

In fact, Tracey, Wampold, Lichtenberg, and Goodyear (2014) argued psychotherapists' inaccurate self-appraisals are a key reason psychotherapists do not tend to demonstrate increased psychotherapeutic effectiveness with increased professional experience. To remedy this effectiveness–experience disconnect, Tracey et al. (2014) have recommended psychotherapists improve their effectiveness by routinely obtaining outcome feedback. Adopting such an open, feedback-welcoming stance may require psychotherapists to cultivate greater humility, yet it could result in demonstrable growth in psychotherapists' effectiveness (Paine et al., 2015).

Miller, Hubble, and Duncan (2007, 2013) have identified three main elements for fostering improved psychotherapist effectiveness, and they call these elements the "cycle of excellence" (Miller, Hubble, Chow, & Seidel, 2013, p. 91): (a) determine one's baseline degree of effectiveness; (b) obtain formal, ongoing, systematic feedback; and (c) engage in deliberate practice designed to enhance effectiveness in growth areas. Humility may play a key role in each of these elements. First, psychotherapists need humility to welcome data about their baseline degree of *overall psychotherapeutic effectiveness* (e.g., does their average patient reliably improve, deteriorate, or neither improve nor deteriorate) and *domain-specific psychotherapeutic effectiveness* (e.g., does their average depressed patient reliably improve, deteriorate, or neither improve nor deteriorate). Relatedly, psychotherapists need humility to welcome data comparing their baseline effectiveness to that of other practitioners in their setting, as well as to national/international norms and standardized benchmarks (e.g., reliable improvement; Kraus et al., 2011; Miller et al., 2007, 2013).

Second, psychotherapists need humility to welcome formal, ongoing, systematic feedback about patient progress (or lack thereof), about the therapy relationship, and about their performance relative to that of other psychotherapists. It takes humility to be open to feedback that some patients are "not on track" toward improvement or are dissatisfied with some aspects of their treatment. Likewise, it requires humility to be other-focused and teachable enough to make needed adjustments, so as to prevent patient deterioration, unplanned termination, or alliance ruptures. It also takes humility to compare one's progress in overall and domain-specific effectiveness to that of other psychotherapists. Getting such feedback can be scary and humbling, but it can foster better awareness of one's psychotherapeutic strengths and growth areas, including areas of demonstrated competence and areas where further training, education, or experience may be needed (see Kraus et al., 2011; Okiishi et al., 2006; Tracey et al., 2014).

Nonetheless, obtaining feedback is a necessary but insufficient ingredient for promoting psychotherapist effectiveness. To become more effective, psychotherapists need to engage in deliberate practice designed to enhance effectiveness in their feedback-identified growth areas (Ericsson & Lehman, 1996; Miller et al., 2007, 2013; Tracey et al., 2014). Humility (e.g., being open to growth and fighting inklings one "has arrived") may be crucially involved in deliberate practice too. Such activities may include (a) thoughtfully reflecting on past sessions and planning for future sessions, (b) reviewing recordings of psychotherapy sessions, or (c) participating in training seminars or workshops. In fact, Chow et al. (2015) found the amount of time psychotherapists engage in deliberate practice predicts their psychotherapy effectiveness.

Psychotherapist Effects on Outcomes via the Therapy Relationship

Psychotherapists' differential effectiveness is presumably tied to certain psychotherapist qualities and behaviors. We suggest humility undergirds many of these qualities and behaviors and mainly contributes to psychotherapists' effectiveness by contributing to the development and maintenance of facilitative therapy relationships (cf. Norcross, 2011; Paine et al., 2015).

Psychotherapist qualities and behaviors traditionally have been classified along two intersecting dimensions: (a) objectively *observable* versus subjectively *inferred* and (b) extra-therapy/context-general *traits* versus therapy-specific *states*. Research has reliably shown that observable traits (e.g., sex, age, and race), observable states (e.g., type and amount of professional training and experience), and inferred traits (e.g., personality characteristics, emotional well-being) account for little, if any, psychotherapist variability in outcomes (Baldwin & Imel, 2013; Beutler et al., 2004). Conversely, inferred states—particularly

the therapy relationship—have received the most empirical support (Baldwin & Imel, 2013; Baldwin, Wampold, & Imel, 2007; Owen et al., 2014). In other words, high-performing psychotherapists are generally able to establish and maintain stronger therapy relationships with their patients, and those stronger therapy relationships are the main contributor to why these psychotherapists outperform their less psychotherapeutically effective colleagues (cf. Norcross, 2011). Indeed, Baldwin et al. (2007) found that 97 percent of the variation in outcomes between psychotherapists is attributable to variation in psychotherapists' ability to establish and maintain strong therapy relationships. This finding is consistent with Anderson, Ogles, Patterson, Lambert, and Vermeersch's (2009) landmark study indicating psychotherapists' differential effectiveness is largely due to their *facilitative interpersonal skills* (i.e., ability to perceive, comprehend, and communicate wide ranging interpersonal messages and to persuade patients to adopt positive behaviors and abandon negative behaviors).

Notably, because humility is such a critical ingredient for cultivating, maintaining, and repairing relationship bonds in general (Davis et al., 2013), within the psychotherapy context, humility is likely a core ingredient of facilitative interpersonal skills as well (Hook et al., 2013). In particular, humility is likely centrally involved in a psychotherapist's ability to form, maintain, strengthen, and repair therapy relationships with their patients, given the emotional complexity and intensity that characterizes psychotherapeutic encounters. For example, humility helps psychotherapists maintain other-orientedness (e.g., focusing empathically on their patients' emotions, experiences, and needs), even in the face of therapy-relationship strain and even when working with difficult patients. Moreover, humility helps psychotherapists remain teachable (e.g., open to feedback and to making adjustments), even in the face of criticism or resistance.

More broadly, it is important to consider (a) what specific psychotherapist qualities and behaviors influence the therapy relationship and (b) what specific therapy relationship components influence psychotherapy outcomes. The most comprehensive reviews of the former were the critical qualitative reviews conducted by Ackerman and Hilsenroth (2001, 2003) and Norcross (2010), and the most comprehensive reviews of the latter were the quantitative meta-analyses presented in Norcross (2011) and Norcross and Lambert (2011a). Building on these critical and meta-analytic reviews, we present a model (see Figure 20.1) explaining psychotherapist effects on outcomes via the effect of psychotherapist qualities and behaviors (e.g., trait, clinician, and cultural humility) on evidence-based therapy relationship components (e.g., working alliance, empathy, and adapting the treatment to the patient), which in turn affect psychotherapy outcomes. Next we unpack this model, highlighting the role of psychotherapist humility.

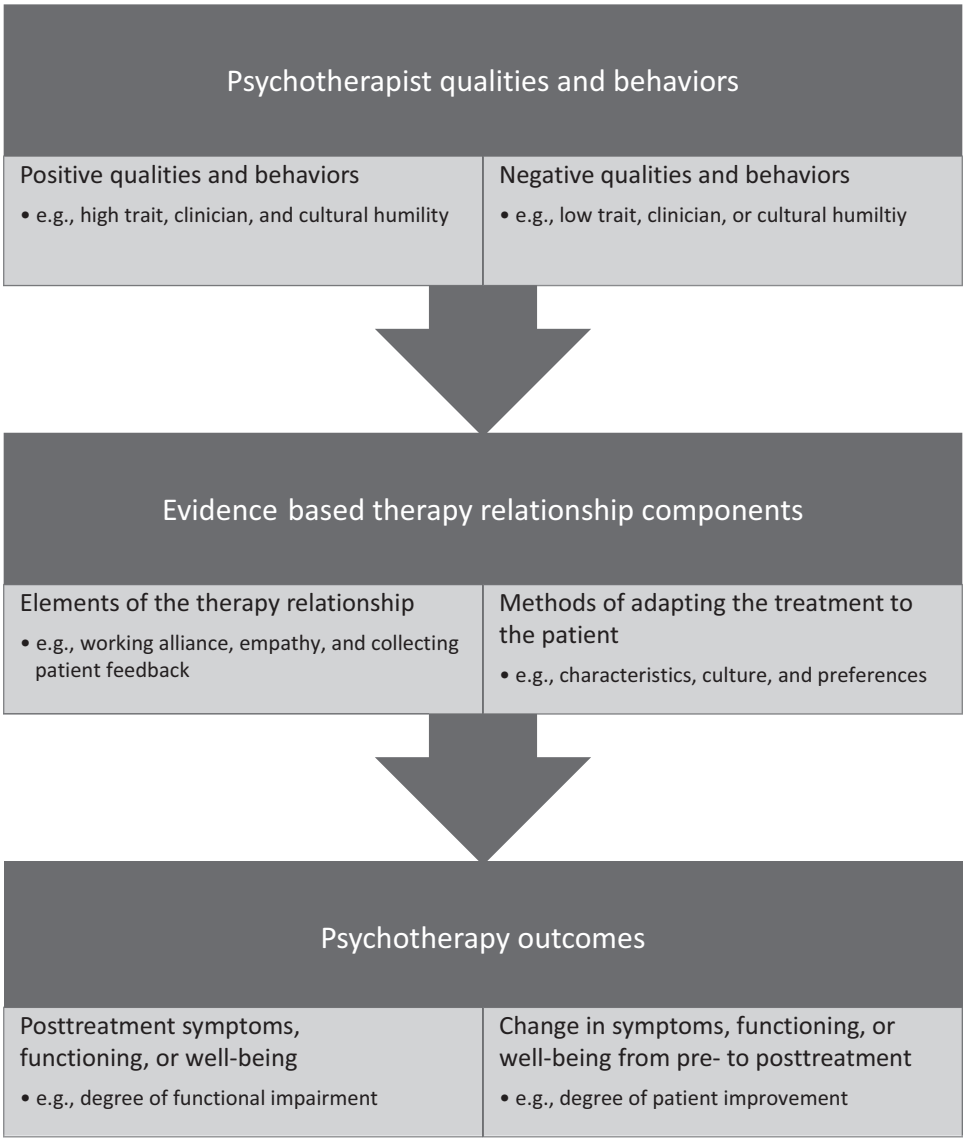

Figure 20.1 **Model explaining psychotherapist effects on outcomes via the effect of psychotherapist qualities and behaviors on evidence-based therapy relationship components, which in turn affect psychotherapy outcomes.**

Psychotherapist Qualities and Behaviors Affecting the Therapy Relationship

Positive Qualities and Behaviors

Certain psychotherapist qualities positively affect the therapy relationship, including psychotherapists' flexibility, openness, warmth, friendliness, honesty,

respectfulness, trustworthiness, confidence, enthusiasm, and alertness. Likewise, certain psychotherapist behaviors have a positive impact on the therapy relationship, including when the psychotherapist (a) adopts a psychotherapeutic stance that is supportive, affirming, understanding, empathic, active, collaborative, and empowering; (b) facilitates patients' exploration, reflection, and emotional expression; and (c) focuses on patients' experiences, successes, and strengths (Ackerman & Hilsenroth, 2003; Norcross, 2010, 2011).

Negative Qualities and Behaviors

In contrast, certain psychotherapist qualities negatively affect the therapy relationship, including psychotherapists' rigidity, emotional distance, aloofness, distractedness, uncertainty, manipulativeness, and criticalness. Similarly, several negative psychotherapist behaviors have a deleterious impact on the therapy relationship, including when the psychotherapist (a) adopts a psychotherapeutic stance that is therapist-centric, controlling, unyielding, or confrontational; (b) conducts therapy in an overstructured, understructured, superficial, or one-size-fits-all way; (c) uses silence or self-disclosure in a psychotherapeutically inappropriate manner; (d) makes comments that are belittling, hostile, condescending, critical, blaming, or rejecting; or (e) fails to address therapy-relationship strain or rupture (Ackerman & Hilsenroth, 2001; Norcross, 2010, 2011).

Impact of Psychotherapist Humility on the Therapy Relationship

Taken together, many of these psychotherapist qualities and behaviors can be distilled into the presence or absence of psychotherapist humility. For instance, relative to their less humble counterparts, psychotherapists who exhibit high-trait humility will presumably also exhibit *more* positive qualities (e.g., flexibility, confidence, friendliness, and openness) and behaviors (e.g., behaving in a supportive, affirming, empathic, collaborative, and other-focused way), while concurrently exhibiting *fewer* negative qualities (e.g., rigidity, manipulativeness, and aloofness) and behaviors (e.g., behaving in a controlling, critical, confrontational, or excessively self-focused way). Thus, psychotherapists high in trait humility will likely demonstrate better ability to build and maintain strong relationships in general, including therapy relationships. Indeed, research suggests trait humility is related to the quality of one's social (Peters, Rowatt, & Johnson, 2011) and workplace relationships (Owens, Johnson, & Mitchell, 2013), and longitudinal research suggests trait humility helps people develop, repair, and strengthen social bonds (Davis et al., 2013).

Likewise, within the psychotherapy context, relative to their less humble counterparts, psychotherapists who exhibit high clinician or cultural humility will presumably exhibit more positive qualities and behaviors (and fewer

negative qualities and behaviors), which likely enables them to build and maintain better therapy relationships. Preliminary evidence supports this possibility. For example, Hook et al. (2013, Study 2) demonstrated that patient perceptions of their psychotherapist's cultural humility predicts the quality of the therapy relationship, even when controlling for patient ratings of their psychotherapist's overall multicultural competencies.

Although quantitative research on clinician humility has not yet been conducted (partly because there as yet are no reliable and valid measures of clinician humility), there is convincing qualitative evidence that effective psychotherapists exhibit high clinician humility and harness that humility to develop and maintain strong therapy relationships. For instance, in a series of qualitative studies of the distinguishing characteristics of peer-nominated expert psychotherapists in the United States and Singapore, Jennings and colleagues (e.g., Jennings & Skovholt, 1999; Jennings et al., 2005, 2008) found that both American and Singaporean expert psychotherapists are characterized by high humility, facilitative interpersonal skills, self-awareness, and commitment to ongoing professional growth. In sum, cross-cultural evidence suggests highly effective psychotherapists exhibit teachability, other-orientedness, and accurate and balanced self-views.

Evidence-Based Therapy Relationship Components Affecting Psychotherapy Outcomes

Effective Elements of the Therapy Relationship

But what components of the therapy relationship actually account for the impact of the therapy relationship on psychotherapy outcomes? The meta-analyses presented in Norcross (2011) and Norcross and Lambert (2011a) reveal the following elements of the therapy relationship are demonstrably or probably effective in promoting positive psychotherapy outcomes: alliance (in individual, youth, family, and couples therapy), cohesion (in group therapy), empathy, collecting patient feedback, goal consensus, collaboration, and positive regard (see Norcross, 2011, for a review). Across these elements, one can recognize the core features of humility—other-orientedness, openness, and the willingness both to receive accurate feedback and to acknowledge mistakes and limitations.

Effective Methods of Adapting the Treatment to the Patient

Likewise, those meta-analyses reveal that psychotherapy outcomes are enhanced by adapting (i.e., tailoring) the therapy relationship to particular patient characteristics. Specifically, it is demonstrably or probably effective to adapt the therapy relationship to the patient's reactance/resistance level (e.g., state or trait opposition to external demands and influence), preferences (e.g., role, therapist-characteristic, and treatment preferences), culture (e.g., cultural metaphors, symbols, goals, and values), religion/spirituality, stage of change,

and coping style (e.g., internalizing vs. externalizing; see Norcross, 2011, for a review). Humility (e.g., other-orientedness, openness, teachability, and flexibility) may be centrally involved in adapting the treatment to the patient's characteristics, culture, and preferences, perhaps even placing it at the nexus of evidence-based practice (Paine et al., 2015; cf. APA Presidential Task Force on Evidence-Based Practice, 2006).

Impact of Psychotherapist Humility on Outcomes via the Therapy Relationship

The empirical research on psychotherapist humility and psychotherapy outcomes is in its nascence. However, the existing evidence suggests psychotherapist humility has an influence on outcomes and primarily does so via its influence on the therapy relationship. For instance, Hook et al. (2013, Study 3) demonstrated that patient perceptions of their psychotherapist's cultural humility predict patients' self-rated improvement in psychotherapy, and this relationship is mediated (i.e., explained) by patients' perceptions of the therapy relationship (working alliance). In fact, 37 percent of the variance in patient improvement was explained by the indirect (mediated) influence of cultural humility on outcomes via the therapy relationship, indicating a large-size indirect effect.

In another study, Owen, Jordan et al. (2014) found that patients' perceptions of their psychotherapist's cultural humility predict positive psychotherapy outcomes (e.g., patients' self-rated improvement in psychotherapy). Yet here the relationship between cultural humility and psychotherapy outcomes was only evidenced among patients who were highly religiously committed. This finding suggests the degree to which a psychotherapist humbly responds to the culturally salient aspects of a patient's identity has a direct effect on the quality of the therapy relationship and thereby affects psychotherapy outcomes. Such a possibility is consistent with the aforementioned evidence that adapting the therapy relationship to the patient's culture is demonstrably effective in promoting positive outcomes (Smith, Rodriguez, & Bernal, 2011).

Taken together, preliminary evidence suggests patients of psychotherapists who exhibit higher humility experience better psychotherapy outcomes than patients of psychotherapists who exhibit lower humility, and these better outcomes are mainly the result of having a higher-quality and culturally responsive relationship with their therapist (Hook et al., 2013; Owen, Jordan, Turner, Davis, Hook, & Leach, 2014). Next, we discuss research and practice implications of the literature we have reviewed.

Discussion

IMPLICATIONS AND RECOMMENDATIONS FOR RESEARCHERS

Develop and Validate a Patient-Report Measure of Clinician Humility Future research on psychotherapist humility might begin by developing and validating

a psychometrically robust patient-report measure of clinician humility (Paine et al., 2015), so psychotherapy research on that construct can ensue. Validated measures of trait humility (Davis et al., 2011; Owens et al., 2013) and cultural humility (Hook et al., 2013) already exist and can be used with confidence.

Explore the Unique and Interactive Effects of Trait, Clinician, and Cultural Humility Researchers can explore the unique and interactive effects of psychotherapists' trait, clinician, and cultural humility in predicting psychotherapy outcome variables (e.g., patient improvement) and process variables (e.g., working alliance). For example, research could explore the hypothesis that these three types of psychotherapist humility uniquely and jointly affect outcomes and primarily do so via the therapy relationship, as preliminary evidence suggests (Hook et al., 2013; Owen, Jordan et al., 2014). Research could also explore hypotheses about which type of psychotherapist humility affects outcome and process variables under which set of clinical circumstances. For instance, cultural humility may be especially important in predicting outcome and process variables when the psychotherapist and patient differ in culturally salient ways or when providing a culturally adapted treatment. Clinician humility may be quite vital in predicting outcome and process variables when the patient has strong preferences or expectations for treatment and thus wants or expects the psychotherapist to adjust treatment accordingly (cf. Norcross, 2011). Trait humility may be particularly crucial when working with certain types of patients whom the psychotherapist finds challenging (e.g., patients toward whom the psychotherapist has strong countertransference; patients with significant personality pathology).

Examine How Humility Affects Psychotherapy Process and Outcome Research on how humility affects the psychotherapy process (e.g., therapy relationship) and outcomes is needed too. Various facets of humility may primarily explain (mediate) the effect of the aforementioned positive and negative psychotherapist qualities and behaviors on the therapy relationship, thereby affecting outcomes. For instance, the other-orientedness facet may be a mechanism by which a psychotherapist's empathy and warmth (vs. emotional distance) contributes to a strong psychotherapist–patient emotional bond, leading to better outcomes. The openness facet may be a mechanism by which a psychotherapist's flexibility and collaborative stance (vs. rigidity or a therapist-centric or one-size-fits-all approach) lead to strong consensus on psychotherapeutic goals and tasks, which in turn yields better outcomes (cf. Bordin, 1979; Norcross, 2011).

In the same way, the effect of certain evidence-based therapy relationship components on psychotherapy outcomes may be mediated by particular

humility facets. For instance, the effect of collecting patient feedback on outcomes may be mediated primarily by the accurate self-views and openness/teachability facets. The accurate self-views facet helps psychotherapists seek and welcome feedback (vs. passively ignoring or actively rejecting it), and the openness/teachability facet enables them to be open to adjusting treatment based on feedback (vs. being wedded to the inherent correctness of their typical methods and pre-existing ideas; cf. Norcross, 2011).

Study Whether Humility Differentiates the Most and Least Effective Psychotherapists Researchers also need to study whether psychotherapist humility (trait, clinician, and cultural) differentiates the most effective psychotherapists from the least effective psychotherapists. As mentioned previously, qualitative evidence suggests this possibility is true (e.g., Jennings et al., 2005, 2008), but quantitative and mixed methods research is needed to explore more fully if and when humility is a distinguishing characteristic of highly effective psychotherapists. For instance, is psychotherapist humility especially differentiating of high- and low-performing early-career psychotherapists because it motivates novice psychotherapists to work hard at becoming more effective and learning from their mistakes? Alternatively, is humility especially differentiating of high- and low-performing late-career psychotherapists because it helps experienced psychotherapists keep improving and fight inklings they "have arrived"?

Investigate How Psychotherapists Can Grow in Humility There is a need for research on how psychotherapists can grow in humility. For example, research could explore whether obtaining feedback (e.g., about patient progress and/or relative psychotherapist performance) helps psychotherapists grow in humility over time. Such feedback may be an effective method for helping psychotherapists develop and maintain more accurate, humble self-appraisals of their psychotherapeutic effectiveness and competencies (cf. Tracey et al., 2014; Walfish et al., 2012). There also is a need to investigate whether targeted humility interventions (see Chapter 19) can help less effective psychotherapists improve their psychotherapeutic effectiveness and skills.

Implications and Recommendations for Practitioners

Cultivate Humility and Facilitative Interpersonal Skills

As is clear from this chapter, psychotherapists' humility and facilitative interpersonal skills seem to be key ingredients of psychotherapist effectiveness (Anderson et al., 2009; Hook et al., 2013; Jennings & Skovholt, 1999; Jennings et al., 2005, 2008; Paine et al., 2015). Thus, we encourage psychotherapists to

cultivate their trait, clinician, and cultural humility and facilitative interpersonal skills, because doing so will likely improve their psychotherapeutic effectiveness. For instance, growth in humility may enhance psychotherapists' ability to learn from their mistakes, avoid ethical dilemmas, act more modestly with their patients (and avoid relationship strain), and behave in a more other-focused way (and thus promote better empathy toward patients, openness to patient feedback, and emotional bonds with patients). More broadly, given the robust link between humility and various indicators of well-being (e.g., psychological, physical, and spiritual well-being; see Toussaint & Webb, this volume), cultivating psychotherapist humility will likely improve psychotherapists' overall well-being, thereby enabling them to be even more effective agents of healing (Paine et al., 2015).

Engage Humbly in the "Cycle of Excellence"

As mentioned earlier, Miller et al. (2007, 2013) identified the three key ways for psychotherapists to become more effective: determine baseline effectiveness, obtain ongoing feedback, and engage in deliberate practice. We argued humility plays a crucial role in each element. Therefore, we suggest psychotherapists make it a routine practice to engage humbly in this "cycle of excellence." In so doing, they can cultivate humility by becoming more aware of their limitations and by pursuing continued growth.

Develop and Maintain Humble Self-Appraisals

Relatedly, psychotherapists tend to lack humility when it comes to appraising their psychotherapeutic effectiveness and skills (Walfish et al., 2012). In fact, they "routinely overestimate their effectiveness—on average, by about 65%" (Chow et al., 2015, p. 343). Thus, we recommend psychotherapists develop and maintain more accurate, humble self-appraisals of their psychotherapeutic effectiveness and skills. Doing so can help them grow in their overall effectiveness and expertise (Tracey et al., 2014), as well as in their domain-specific competencies (Kraus et al., 2011) and self-awareness (Paine et al., 2015).

Conclusions

This chapter focused on the role of psychotherapist humility in promoting positive outcomes via the therapy relationship. We have built on the robust literature demonstrating that psychotherapists vary in their effectiveness and that certain characteristics and behaviors play a key role in that variation, especially as it relates to establishing and maintaining strong therapy relationships. We have argued that humble characteristics and behaviors play a key role in psychotherapist effectiveness, and we eagerly await future research examining this possibility.

Note

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