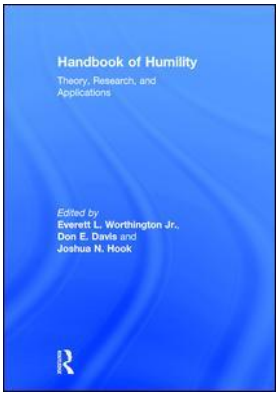


# Handbook of Humility
# Theory, Research, and Applications

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## Humility in Psychotherapy

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# HUMILITY IN PSYCHOTHERAPY

*Steven J. Sandage, David Rupert, David R. Paine, Miriam Bronstein, and Christopher G. O'Rourke*

Humility is a topic that has generated a long history of cultural and religious reflection. Many cultural and religious traditions have promoted humility as a virtue that can contribute to spiritual, social, and moral well-being (Paine, Sandage, Rupert, Devor & Bronstein, 2015; Wolfteich, Keefe-Perry, Sandage, & Paine, in press). Although the virtue-status of humility has been challenged by certain philosophers (e.g., Hume, Nietzsche, Rand), it is often described as a character strength by many theologians and spiritual leaders. Nevertheless, humility was a neglected topic in psychology until recent years, perhaps due to an emphasis on the individual in Western psychology, which could seem at odds with certain construals of humility. Interest in humility and other virtues has grown substantially in the social sciences over the past decade with the advent of the positive psychology movement, which called for a shift in focus from psychopathology to virtuous qualities that promote well-being (Peterson & Seligman, 2004).

Clinical applications of positive psychology research on virtue and well-being is a nascent but growing area (see Wood & Johnson, 2016). The popular clinical topic of mindfulness, which has been described as having "a quality of active humility" (Morgan, 2005, p. 142), is also part of a shift in psychotherapy seeking to balance emphases on human agency with practices grounded in acceptance. Humility is also an implicit part of mentalization-based therapy, which has gained empirical support for the treatment of borderline personality disorder (Allen, Fonagy, & Bateman, 2008). The basic thrust of mentalization is to relate to clients with an active curiosity about their subjective experiences without making assumptions about the validity of clients' self-understanding. The concepts of mindfulness and mentalizing share an emphasis on "open and receptive awareness" (Allen et al., 2008, p. 53). Mindfulness is broadly applied to any objects in awareness, whereas mentalizing is focused on the mental states of both self and other. Mindfulness- and mentalization-based approaches to

therapy offer valuable insights into the role of humility in psychotherapy, which we discuss later.

Theoretical and empirical research on humility has expanded greatly in the past few years, leading to advances in defining, measuring, and investigating factors related to humility. Yet almost all of this empirical research is outside therapeutic contexts. In the only humility intervention study we could locate, Lavelock et al. (2014) developed and tested the effects of a structured humility workbook with a nonclinical sample of undergraduate students and found participants in the workbook condition increased in humility, forgiveness, and patience, whereas participants in the control condition did not show change in these virtues. Humility has been discussed at length by a few clinical theorists (see Rowden, Harris, & Wickel, 2014; Worthington & Sandage, 2015), although the conceptual contributions to literature have been modest. Given these limitations, we will draw upon relational theories of psychotherapy and clinical experience to describe some applications of humility in the process of psychotherapy.

## Definitions of Humility in Psychology

Tangney (2000) authored a seminal article on humility, providing a conceptual understanding of the virtue that psychologists continue to utilize. Humility may be understood as a multidimensional construct with interpersonal and intrapersonal components, including (a) a willingness to perceive the self accurately, (b) other-orientedness and avoidance of excessive self-enhancement, (c) openness, and (d) the ability to acknowledge one's limitations and mistakes. Other dimensions included in some psychological accounts include appreciation of value in others (and the world) and avoidance of narcissistic or entitled behaviors and attitudes (Tangney, 2009; Worthington, 2008). Humility may be distinguished from low self-esteem or shame by the willingness to perceive the self accurately rather than making global negative self-evaluations. This has been an important concern for psychotherapists because shame tends to empirically correlate with psychological and relational dysfunction in Western contexts. Accurate self-understanding includes positive self-appraisals, acknowledgement of strengths, and facing limitations. Moore (2003, p. 72) offered a succinct summary of humility as (a) an awareness of one's personal limitations and (b) a willingness to get needed help. The latter dimension might be consistent with a clinically relevant client attitude of openness to receiving input and support from outside oneself.

The capacity for self-regulation of emotions, particularly pride and shame, has also emerged as an important dimension or correlate of humility (Jankowski, Sandage, & Hill, 2013; Paine et al., 2015). Excessive or dysregulated emotional

states could promote either grandiosity, elevating oneself above others, or dysphoric states of inferiority, defensiveness, and reactivity. Whereas many cultural and religious traditions have focused on pride (i.e., grandiose narcissism) as the antithesis of humility, psychological research now suggests negative self-appraisals, vulnerable narcissism, anxious-ambivalent attachment, or excessive needs to idealize others can also correlate negatively with humility (Jankowski & Sandage, 2014; Sandage, Jankowski, Bissonette, & Paine, in press; Sandage, Paine, & Hill, 2015). Our program of research on humility has shown that differentiation of self (DoS), or the ability to (a) relate flexibly with others across differences and (b) self-regulate emotions, mediates the relationship between humility and many other psychological processes. Therefore, we define humility as an expression of DoS related to (a) a balanced and accurate assessment of one's strengths and limitations and (b) a capacity to mentalize or practice relational mindfulness.

## Promoting Humility in Psychotherapy?

Humility has been linked with a number of positive psychological, relational, and spiritual indices, including prosocial behavior, social relationship quality, forgiveness, generosity, and spiritual maturity, among others (Exline & Hill, 2012; Jankowski & Sandage, 2014; Peters, Rowatt, & Johnson, 2011). Based on these findings in nonclinical samples, it might be tempting to assert that a worthy goal of psychotherapy is to increase client humility. However, clinical data are needed to support such an assertion, and several other contextual points must also be carefully examined.

First, clinicians who recognize the value of humility and its associated outcomes must be careful not to misrepresent what is meant by the term in discourse with clients, who may use the term quite differently. Lack of careful discernment on the part of therapists could lead to the promotion of shame, false modesty, and porousness to unhealthy inputs from others, thus undermining psychological and relational health. Second, all clinicians' understanding of humility (positive or negative) will be rooted in their own experiences and sociocultural perspectives, thus requiring intercultural competence (Paine, Jankowski, & Sandage, 2016) or cultural humility (Hook, Davis, Owen, Worthington, & Utsey, 2013) to remain attuned to differences between their worldview and that of clients. Predetermined ideas of how humility ought to manifest phenotypically may not hold across diverse contexts. For example, an unreflective clinician, influenced by ideas equating humility with meekness or modesty, may misunderstand a client with a more assertive cultural conflict style as lacking humility. Some clients will also understand the meaning and practices related to humility through their spiritual,

religious, and theological traditions, which might differ in certain ways from assumptions embedded in contemporary psychotherapy models (Wolfteich et al., in press). Learning about the diverse ways in which humility is embodied can help therapists consider this assertiveness as compatible with an accurate self-understanding and relational engagement. This mentalizing attitude is a kind of *double humility*, or humility about the diverse expressions and understandings of humility.

Third, clinicians must discern client needs on a case-by-case basis. Humility may not always be a primary goal in treatment planning. For example, building an awareness of personal limitations may not be the first goal for a severely depressed individual with chronically low self-esteem. That is not to say that humility is not compatible with recovery from depression. Accurate self-appraisal and emotion regulation are parts of many treatments for depression. However, clinical decisions require nuanced developmental and contextual awareness of individual differences. Even when cultivating humility would prove beneficial, one must also attend to other psychological and relational factors that act as barriers to cultivating this virtue. For example, grandiose narcissism, vulnerable narcissism, shame, insecure attachment, low differentiation of self, and spiritual and emotional dysregulation are all factors that may frustrate the development of humility (Jankowski et al., 2013; Sandage et al., 2015). Clients high in grandiose narcissism may seem the clearest candidates for humility intervention; however, they will often need considerable mirroring and pacing before they are prepared to trust a therapist with facing their own limitations. Thus, treatment strategies will need to target these underlying factors and embed explicit discussions of humility within an integrative perspective tailored to specific clients. At the same time, humility and mentalization demand we hold conceptualizations somewhat loosely and stay receptive to clients as co-constructors in treatment.

We must also recognize that clinicians with divergent approaches to therapy will strive to foster humility in different ways. Clinicians who take the position of "expert" may have confidence they can acquire a thorough understanding of the client and use this understanding to alleviate client distress. For example, both classic psychoanalytic approaches and certain forms of cognitive therapy boldly use the therapist's conceptual framework and underlying assumptions to try to help clients deal constructively with their human limitations. Highly structured approaches to therapy attempt to formulate specific strategies for helping clients cultivate interpersonal and intrapersonal skills, and this skills focus could be consistent with cultivating humility through ongoing practice (e.g., Lavelock et al., 2014). Alternatively, our own preference is for relational approaches to therapy, which are less focused on clinical authority or

predetermined interventions than with the quality and dynamics within the therapeutic alliance. This relational approach is characterized by receptivity to the client and the modeling of humility by the therapist (Paine et al., 2015). From a relational perspective, one of the clinical challenges is that differing clients will need different relational experiences, which requires strong capacities for mentalization and relational flexibility by therapists. We view humility as a valuable intentional goal for clinicians, but also as an implicit dynamic that may emerge without direct intentionality in the therapy relationship. In the next section, we discuss this dialectic of humility as both a virtue to be developed and a gift to be received.

### Humility as a Virtue and a Gift

Humility may contribute to the therapeutic process as a virtue to be developed for both clients and therapists. "Virtue" may be understood as an evolving disposition of the self that is oriented to the right action and "the Good" (Aristotle, trans. 2004). Aristotle described virtues as particular dispositions that are essential for living a flourishing life. Openness to the relational process of therapy, being willing to perceive oneself accurately, and acknowledging strengths and limitations are all compatible with client factors that are necessary to make meaning of struggles and pursue change in therapy.

We have also argued that humility is a virtue supportive of best practice that might be actively developed among psychotherapists (Paine et al., 2015). Humility as a virtue is distinct from a clinical skill or technique. Although skills are critically important, we prefer to understand humility as a way of being with clients. In the context of psychotherapy, humility represents the developmental progress of clinicians toward accurate understanding of one's skills and limitations as a healer. Humility also involves a strong commitment to other-orientedness in the context of the work. The pervasiveness of the medical model in mental healthcare and clinical training places significant emphasis on practitioner expertise, authority, and technical knowledge. However, the complexities of therapy often present situations where a humble approach may be more effective and beneficial. We have previously suggested and illustrated with clinical vignettes that several dimensions of practice, including multicultural competence, the therapeutic alliance, the use of client feedback, collaborative care, and professional consultation, may be significantly enhanced through the cultivation of therapist humility (Paine et al., 2015). Cultivating an internal disposition to humility both serves the individual client and enhances relational dynamics in the clinical systems in which care is delivered. For example, clinicians who engage in regular peer consultation characterized by both support and rigorous self-examination are likely to find it enhances the quality of their

work and may inject some professional humility into the organizational climate of their clinics.

Aristotelian conceptions of virtue emphasize individual effort and personal action in the cultivation and acquisition of virtues. One becomes virtuous through intent, training, mastery, and discipline (Aristotle, trans. 2004). Although experience, theory, and empirical research support this proposal (Peterson & Seligman, 2004), there is another perspective on the acquisition of virtue. Within classical philosophy, it was proposed that virtue is not only achieved but *received*; not only a *goal* but also a *gift* (Plato, trans. 2009). For Plato, virtues were both cultivated by individuals and received as gifts from the Divine. Without making theological claims, we suggest it is useful to reflect on the experience of virtue as gift and explore the ways in which therapy is a vehicle receiving virtues such as humility. Thus, opportunities to experience humility may emerge for both clients and therapists independent of specific intentions or strivings. It may even be the case that the struggles, fluctuations, disappointments, and ruptures in the relational process drive the acquisition of humility as much, if not more so, than the individuals themselves. In the following sections, we draw on clinical experience to describe the role of humility in relational therapy. In particular, we focus on the tensions between these active and passive dimensions of humility within therapists and the associated power dynamics. We also seek to describe the experience of humility as a virtue and a gift, using clinical examples to demonstrate how therapist striving *and* receptivity may lead to growth in the virtue.

## Humility and Clinical Power Dynamics

Some approaches to psychotherapy place therapist humility at the foundation of their philosophies and therapeutic techniques. Many post-modern theories of psychotherapy (e.g., intersubjective and relational psychoanalytic approaches, feminist and liberationist therapies, narrative therapies) employ a careful analysis of power dynamics and view psychotherapist "expertise" with some caution. To be sure, within these systems of thought and practice practitioner competence is a basic expectation of any responsible therapist. However, the therapist as "expert *about the client*" is eschewed in deference to respect for the uniqueness of the client and the ethical assertion that the therapist should be willing to differentiate their experience and perspective from that of the client. This ideology represents the importance of an actively pursued humility on the part of the therapists. Such mentalizing efforts may be directed toward empathy and intersubjective "joining," which can serve as healing bridges between human beings. This active other-orientation may allow a therapist to accurately understand a client's emotions, behavior, history, meaning system,

unconscious conflicts, and suffering. Nevertheless, it is commonplace in therapy that well-intentioned efforts toward empathic attunement with the client sometimes fall short. Knowledge of "what is best for the client" may be occluded by the personal limitations, therapist values, cultural differences with the client, unconscious enactments, or a myriad of other factors. In such cases, therapeutic ruptures may force therapists to confront the limits of their understanding, as well as offer opportunities for new ways of relating. In this sense, humility may be emergent rather than pursued.

Therapeutic approaches rooted in the theory and empirical observations of human attachment systems also recognize that healthy growth and development is facilitated, inhibited, or thwarted by interactive processes between subjects. The nature of the dance between caregiver and infant, teacher and student, societal institution and citizen is a crucial factor in whether or not the child, student, or citizen will thrive. So too, the multifaceted interactions that occur between therapist and client have a great impact on the outcomes of psychotherapy. From this vantage, we believe the therapist's effectiveness does not typically come about through the transmission of expert opinions or the provision of wise interpretations. Rather, healing and growth are fostered limbically through the building of a secure relationship that is constructed, in part, through the recognition of both mutual and differentiated needs, experiences, and roles. Given this reality, the therapists do well to actively attend to their own personal subjectivity with due humility, because subjectivities and associated behaviors inevitably affect the client. Concretely, this leads us to affirm one of the basic practices of psychoanalytic traditions in valuing regular opportunities to process our own countertransference as therapists in dialogue with other clinicians. We would add that it is crucial for these professional relational "holding environments" for consultation to be diverse in order to foster awareness of differences and checks against various forms of prejudice and bias.

In relational psychotherapy, collaboration is privileged as part of cultivating humility. If the therapist recognizes their knowledge and insight into the client will be limited, then it is wise and caring to cultivate a collaborative partnership with receptivity to client inputs and feedback about the process. Psychotherapists are competent partners to their clients by (a) actively honing their knowledge of human psychology and their skills as counselor and (b) keeping their self-importance and attachment to their own expertise in check. A humble therapist can mentalize by offering ideas, perspectives, authentic responses, deep listening, and thoughtful questions without becoming overly attached to the outcomes of their offerings. Humble therapists will also be able to stand aside at times, acknowledging error, and even apologizing when appropriate. But a humble therapist may also take a stand at times. They may assert, confront,

interpret, address, or make suggestions when they believe they have something genuinely valuable to contribute. For some therapists, these active or confrontive stances will be ego-syntonic, whereas other therapists will need a certain form of humility to do what is needed and make an active intervention even if it is ego-dystonic. When their offerings are dismissed, rejected, or ignored, the humble therapist will nevertheless strive to understand why this is so, respecting the perspective and self-determination of their client.

Therapists may also be offered the gift of humility in the guise of therapeutic ruptures, "stuck" clients, and unsatisfactory outcomes. Those with a humble disposition are not immune to these developments, which may be received as opportunities to reframe the relational processes of therapy and, indirectly, grow deeper in humility. Clinicians who have neglected the active cultivation of humility may undervalue collaboration and find themselves comfortable in the role of expert for a time. However, they, too, will face the inevitable disappointments of the therapeutic process. Such frustrations, though unpleasant, may be construed as potentially transformative, both in the trajectory of care and the personal formation of the therapists. If clinicians are receptive to what such moments call for (collaborative repair rooted in a recognition of limits), they may achieve new ways of relating in therapy and enhance their inclinations toward humility. However, clinicians may not recognize the opportunity and/or not receive the gift. Therapists may also take a defensive position, placing responsibility for therapeutic disruptions on the client and become entrenched in their own perspective. In the next section, we explore concrete ways in which humility serves the objectives of both client and therapist in treatment. In describing the nature and impact of therapeutic strategies involving humility, we witness both the benefits of an already acquired disposition and the deepening of virtue that takes place in the context of the client–therapist relationship.

## Intervention Strategies for Psychotherapeutic Humility

In this section, we explore the ways in which humility both advances the therapeutic endeavor and manifests in the process. We focus on using humility as a reframe, not knowing, and attending to rupture and repair dynamics.

### *Humility as a Reframe*

Although it is true that people sometimes learn humility through hard experience and painful lessons, there are moments when humility may be a source of refuge and hope. This is especially true when a therapist or client needs to manage and reduce shame or recover from a serious mistake. Shame and regret may be triggered in different ways, ranging from abuse by others to facing the

consequences of our own limits, vulnerabilities, or capacity for evil. Whatever the source, shame often generates paralyzing dysregulation and intense self-loathing. Humility in various forms can metabolize shame by acknowledging the shameful situation while also conveying a basis for constructive action and self-respect.

Shame is powerful, in part, because there seems to be no escape from what feels awful. Humility-based interventions try to acknowledge shame while softening its impact. This may occur in different ways. In normalization, humility reframes the struggle by locating it within a larger community. One may feel less "alone" or uniquely exposed by relinquishing a sense of being different or above the common struggle. Permission giving is another type of reframe. Permissions may take different forms—for example, permission to be a learner, permission to make amends, and permission to be self-compassionate, among others. These interventions integrate acceptance with specific intentions grounded in a humility-based value or perspective. A learning reframe combines not knowing with trying to learn. Amends reframes encourage responsibility through acknowledgment of mistakes or wrongdoing and taking positive action for repair. Self-compassion invites kindness in the face of vulnerability or failure.

In our view of therapy, these permissions are most meaningful when they operate at the limbic level of interpersonal experience rather than neocortical rationality. In practice, reframes almost always start with acknowledgement. Establishing emotional contact with the problem grounds the conversation in the struggle or dilemma. Moreover, attending to how a person came to feel shame, remorse, regret, and other emotions can be a way of honoring that person's conscience and values. Reframes also try to offer a path or way to be constructive despite what has been destructive. These offerings are most effective when they resonate for the person involved because they connect to present or emerging values or have some narrative, poetic, or metaphorical power to inspire.

Consider the following example: Michael was a 58-year-old Orthodox Turkish-American man who struggled with treatment-resistant depression and loneliness. He had been in therapy for over five years, something most of the people in his life could not understand. Michael was engaged in treatment and made use of various resources such as medication, groups, and exercise. He had grown in various ways, including becoming more accepting of self and others and developing new coping strategies. Nevertheless, depression returned periodically. In those moments, Michael became especially distressed by "my failure to get better, my failure to solve this after all these years [of therapy]." Efforts to note progress were met with heartfelt complaints about what was still

not right. Affirmations from others were too infrequent to make a difference, and "besides, they don't know the real story, but I do." The therapist struggled with the unspoken reality that Michael's complaint indicted himself but also the treatment. Had she failed as a therapist? Both felt defeated.

However, defeat became less toxic once they began to explore the situation from a reframe of human limitation and resilience, a frame of acknowledging that some situations cannot be overcome by human effort and that each person has unique strengths and limitations. Michael recalled spiritual and cultural stories that affirmed this view. Once these beliefs were introduced, new possibilities for appreciating what had been accomplished emerged, as well as grief for the on-going struggle and self-respect for "continuing the good fight." The therapist's willingness to acknowledge the limitations of treatment created relational space for Michael to develop a new, edifying narrative of persistence in humility.

### *Not-Knowing Stances*

Another potential expression of humility in psychotherapy is adopting a stance of *not knowing*. Professional therapists must practice within their scope of competence, but competence in psychotherapy involves many elements, including respecting the client's perspectives, preferences, and autonomy. Psychotherapy research provides useful knowledge on processes of change, but psychotherapists work with a complex reality that includes each client's unique background, stressors, resources, emotional states, and immediate and developing relational dynamics with the therapist. Clinical practice grows even more complex when considering the array of potentially helpful interventions in any given moment. In the face of such complexity, relational therapists who value humility tend to emphasize tolerance of ambiguity, flexibility, and responsiveness rather than certainty or prescience.

At the core, *not knowing* involves the paradox of remembering that the client may see things differently and may know better than the therapist in any given moment. This awareness invites humility in the form of ongoing listening to what the client communicates in direct and implicit/nonverbal ways. Ironically, this kind of listening and observing may be most difficult to practice precisely when it is most needed—for example during an enactment, after a rupture, or when a client is struggling and only partially aware of his or her contribution (but quite clear on the therapist's contribution). It is the practice of returning to a listening or mentalizing stance, of being willing to stop and look again, that manifests the humility of *not knowing*.

Approaching humility as openness and attentiveness grounded in this kind of not knowing may help with the related dangers of becoming proud of being

humble or adopting a merely passive stance. Therapeutic not knowing as we are commending presupposes responsibility and professional competence; otherwise, it is merely an excuse for sloppy work. Moreover, therapists move in and out of awareness, so it is unlikely that any therapist could hold a humble attitude at all times. Perhaps it is better to think of recovering, returning to, or being receptive to humility. The opposite danger—passivity and deference to avoid being prideful—raises other concerns, most notably the possibility of leaving certain clients too alone in their struggles or failing to provide scaffolding for growth and change. It is our experience that many clients have been dissatisfied with previous therapists who "just listened," and most clients want contact with the therapist as a person actively engaged in the relational process.

So what might humility in this look like in practice? Consider the following examples: After reaching an initial agreement on a client's concerns and an appropriate treatment plan, a client then introduced several other topics in the next few sessions. At first glance this seemed like avoidance, but the therapist came to understand that there were other meanings, such as an attempt to help the therapist understand the larger context, a request for help with pressing situational factors, and sharing additional concerns. The therapist learned about these meanings by engaging the client with curiosity and adjusting his expectations.

Another client told many stories about how others had failed her by being neglectful, controlling, or simply unhelpful. She complained that that treatment was not helping either and responded to questions seeking her input on the treatment with, "Am I supposed to know how to help myself? I thought you would have some expertise." Although many factors implicated the client in this impasse, the therapist wrestled with his own participation and eventually recognized a tendency to be passive and deferring in moments of potential conflict. This awareness enabled him to face his own anxiety and take a more active role in structuring the treatment for a period of time. Later in the therapy, several instances of what could be seen as noncompliance signaled the need to adjust again, in this case by taking a more passive stance to honor the client's increased wish and readiness to initiate.

In another case, an adult client with significant childhood trauma struggled with a recurrent sense of being victimized and an underlying sense of low self-worth and distrust of her own experience. Her therapist provided empathy, acceptance, and help with affect regulation. When the client began to express a need to make progress, the therapist invited consideration of choices and action steps, but the client said it was "too hard." Efforts to help the client muster courage or find a manageable first step were unsuccessful. Continued exploration led to recognition of a complex dynamic around "ease and struggle"

and a need for more experiences of nonstriving before attempting to attain concrete life goals. The therapist reduced focus on life goals and asked more questions about striving and nonstriving. This eventually helped the client to acknowledge her fear that making progress would lead to losing the consolation and connection she had felt with the therapist around her pain.

### *Rupture and Repair*

Our relational approach to psychotherapy also values rupture and repair processes that have been empirically supported to represent another way clinical humility may manifest in psychotherapy (Safran & Kraus, 2014). These processes involve some kind of disruptive interaction that leads to withdrawal or confrontation, hopefully followed by efforts to re-establish the therapeutic alliance. A key element in repair is willingness to recognize one's impact on another and make active efforts to re-establish a sense of connection.

Rupture and repair processes may take many forms and sizes. Small ruptures probably occur in every therapeutic hour in subtle ways. Imagine a therapist making a comment that does not feel quite right to the client, who says "It's more like this . . . . " and offers a different version. If the therapist is able to receive the clarification with simple acknowledgement (e.g., a nod and "I see"), the dyad may proceed with minimal disruption despite the initial misunderstanding. Sometimes clients do not speak about such discrepancies, but alert therapists may notice nonverbal cues and inquire, for example, "How did that sound to you? I'm not sure it really fit."

Larger ruptures may be implicit or explicit. Implicit ruptures are sometimes described as enactments, interactions in which both parties feel trapped or coerced and neither party is fully conscious of their participation. Escaping and repairing enactments usually requires finding new freedom to act (Wallin, 2007), owning previously disavowed thoughts or feelings (Bromberg, 2011), or adopting a new relational stance that eludes the complementary power positions of "doer or done to" (Benjamin, 2004). These actions exemplify humility in various ways such as openness; willingness to own one's own vulnerability, mistakes, and limitations; and attention and concern for the other. Consider the case of a middle-aged White Lutheran female client in long-term treatment for depression who began to complain on a regular basis that her middle-aged White male agnostic therapist was not helping enough. The therapist made efforts to clarify the client's concerns and adjust the treatment plan, but nothing changed. Transference interpretations were rejected, and efforts to find adjunctive resources fell flat. The therapist felt more and more defensive and helplessness as the client felt alternately blamed and abandoned. This stalemate began to ease only after both parties were able

to incorporate previously unacknowledged material and take new risks. For the therapist, this involved acknowledging his ineffectiveness, offering to help the client find a new therapist if she wished, and asking the client to be less avoidant in certain ways during the session. For the client, this meant recognizing and expressing her frustration that they were not talking more about religious themes and voicing fears of potential invalidation if religious issues were engaged. These offerings broke the impasse and opened new threads of conversation.

Major ruptures may be explicit and painfully clear. In one case, an adult Indian-American male client repeated stories of being overburdened at home and at work. After several months of exploring concerns and possibilities, his White male therapist commented that the client seemed unwilling to make a change in either situation. The client retorted, "I can't make a change, can't you see that? I'm paying you to help me find meaning in all of this." Poignantly, this was the first time the client's dilemma had been framed in this way or seen this way by the therapist. The therapist acknowledged his mistake and the client's perspective, but the client dropped out soon afterward. In this case, therapeutic humility meant reflecting on lessons learned and sending referrals for other therapists.

## Conclusion

Humility may manifest in psychotherapy through intention or by emergence and receptivity. Both clients and therapists may draw on humility to reframe suffering, accept finitude, and repair alliance ruptures. We emphasize humility as a resource for relational psychotherapy, but believe this virtue/practice/gift may enrich other approaches in similar or distinct ways. There is a place for humility in receiving feedback and managing rupture–repair dynamics across orientations. However, humility may also be relevant to distinct approaches in more specific ways. For example, a client engaged in dialectical behavior therapy may exercise humility by consistently completing homework and skills practice outside of session, even when one does not feel particularly competent at that work. Clinicians rooted in cognitive behavioral therapy (CBT) exhibit humility when they are not excessively attached to particular strategies for reducing symptoms and are willing to let client experiences inform their technique. Humility is an integral foundation of some therapeutic modalities, especially humanistic-based approaches like motivational interviewing. More broadly, we believe humility can contribute to effective practice within various orientations, as awareness and management of inequitable power dynamics is always crucial. The capacity for mentalization and mature reflection on diverse conceptions of the virtue bolsters the practical fruits of humility in diverse settings. More

clinical research on humility in psychotherapy will support best practices, leading to improved client outcomes.

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