

Exploring virtue ethics in psychodynamic psychotherapy: latent changes in humility, affect regulation, symptoms and well-being

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Abstract

A rising interest in virtues in psychotherapy has spurred empirical exploration of their influence on both mental health symptoms and well-being. As such, we explored the virtue ethics premise that growth in the virtue of humility may ameliorate mental health symptoms and promote well-being. We also examined whether change in experiential avoidance was a mechanism of these changes. Using a multiple simultaneous latent change score model, we analysed latent changes among humility, experiential avoidance and the outcomes of symptoms and social well-being in a sample of clients ($N = 778$; $M = 31.56$ years of age; 59.4% female; 78.1% White) who received outpatient contemporary relational psychotherapy at a community mental health training clinic. Results indicated that change in humility corresponded to changes in symptoms and social well-being through change in experiential avoidance. Clinical implications centre on clinicians attending closely to client experiences of oscillation between self-abasement and self-superiority and utilising *small ways* within the therapeutic encounter to foster humility.

KEYWORDS

humility, psychodynamic psychotherapy, virtue ethics, well-being

1 | INTRODUCTION

A virtue ethics premise is that flourishing cannot be achieved solely through symptom reduction, but, rather, is inextricably connected with the development of 'qualities of human character and excellence which enhance the capacity to live well' (Sandage & Hill, 2001, p. 243). Sometimes also described as character strengths, virtues are grounded in motivational, affective, cognitive, relational, behavioural and contextual dimensions of human functioning, and thus hold important implications for therapists' clinical formulation and treatment approaches. Virtues orient clients to reflect on who they *are* and *are becoming* in relation to others (McMinn et al., 2016). While numerous virtue-based interventions exist (e.g. keeping a

gratitude journal), considerably less attention has been given to understanding the complex and often implicit psychotherapeutic processes that promote or impede virtue development (Jankowski et al., 2020). Rowden and colleagues (2014) described a shift from 'focusing exclusively on what people do in relationships (action oriented or skills training approaches) to addressing who people are (character, affective, and motivational domains)' (p. 380). It is this focus on who people are in relation to others that is consistent with a psychodynamic understanding of virtue development (Akhtar, 2019; Summers & Barber, 2010), and frames our current study.

Recent psychotherapy research suggests the importance of dual-factor models that attend to both mental health symptoms and well-being (Fosha & Thoma, 2020; Rusk et al., 2018; Trompeter

et al., 2017). As such, we responded to calls for research examining how change in virtues might be associated with changes in mental health symptoms and well-being (Jankowski et al., 2020). We used a practice-based research design, a supplement to efficacy research (e.g. randomised controlled trials), which offered the opportunity to examine the effectiveness of psychotherapy to promote growth in virtuousness in a real-world treatment context, with greater ecological and external validity (Halvorson et al., 2020; Henton, 2012). Specifically, we tested the theoretical premise that growth in the virtue of *humility* could facilitate changes in mental health symptoms and social well-being through decreased affect dysregulation. Put another way, we explored change in clients' humility in psychodynamic psychotherapy and a mechanism of this change. We proposed experiential avoidance (EA) as an intervening variable explaining how humility influences mental health symptoms and social well-being. EA is an affect regulation strategy generally associated with maladaptive outcomes, with affect regulation broadly defined as 'an attempt to influence emotions' (Naragon-Gainey et al., 2017, p. 385). We examined our proposed model of change in the context of an outpatient urban community mental health clinic in the United States (US) that utilises contemporary relational psychotherapy (CRP), a pan-theoretical framework integrating psychoanalytic, psychodynamic, experiential dynamic and relational approaches (DeYoung, 2015; Sandage et al., 2020).

2 | INTRA- AND INTERPERSONAL DIMENSIONS OF HUMILITY

Humility is a multidimensional construct, with both intra- and interpersonal components, that involves balancing or transcending the polarities of servility and arrogance (Haggard et al., 2018), masochism (i.e. self-defeating) and narcissism, and 'self-deflation and self-inflation' (Akhtar, 2019, p. 120). Like the many heads of Hydra in Greek mythology, lack of humility can take multiple forms, 'Whether beaten down by self-doubt or puffed-up by pride, we are suffering from an obsession with ourselves... The middle way is something new, free of narcissism, something more like play, ready to be surprised, ready for the unthinkable, spontaneous, and authentic' (Weber, 2006, p. 218). Intrapersonally, cultivating humility can involve developing an accurate view of oneself, 'an intrinsic and non-comparative sense of worth and goodness inherent to the individual', including non-judgemental self-awareness of both personal strengths and limitations (Rowden et al., 2014, p. 381). In Western society, humility can be wrongly equated with low self-esteem, shyness and being reserved (e.g. feeling humiliated, embarrassed), what Weidman et al. (2018) identified as a self-abasing form of humility, in contrast to a self- and other-appreciative form of humility; the latter of which includes an interpersonal dimension.

Ultimately, humility enables us to move beyond ourselves as we recognise our place in the larger order of things, resulting in 'an increase in the valuation of others, not a decrease in the valuation of one's self' (Means et al., 1990, p. 214). Humility also involves

'unshackl[ing] the ego from self-serving drives' (Akhtar, 2019, p. 116), which seems most tied to the dimension of lack of self-superiority, defined as an 'open rather than superior stance towards ... other individuals', and identified as the most frequently assessed dimension of humility (McElroy-Heltzel et al., 2019, p. 394). Lacking self-superiority also refers to resisting the normative tendency to judge self as 'better-than-average' (Kruse et al., 2017, p. 413), and resisting this self-enhancing tendency has been labelled *hypo-egoism*. Evidence suggests that *hypo-egoism* may be the central defining feature of humility and, in particular, resisting the belief that one is 'entitled to be treated special' because of personal accomplishments or characteristics (Banker & Leary, 2020, p. 738).

Banker and Leary (2020) stated that 'people who view their accomplishments or characteristics as superior may naturally assume that they are worthy of special treatment' (p. 745). They found that greater *entitlement* (i.e. lower *hypo-egoism* or humility) correlated with higher ratings of the motivation 'making sure that one is getting more and better outcomes than other people' (p. 746). Thus, transcending self-enhancement and a preoccupation with status through a humble relational stance facilitates greater openness and receptivity to others. Humility also involves a posture of lifelong learning or teachability, rather than needing to be 'right' or 'prove' oneself to others (McElroy-Heltzel et al., 2019). From a psychodynamic perspective, a humble relational stance is difficult so long as an individual's intrapersonal sense of self lacks differentiation between the ego and self-aspects, or internalised relational experiences. Kohut (1977) described the necessity of meeting human developmental needs for empathic mirroring, relational connection and self-other identification to help individuals develop healthy self-love rather than narcissism, and a cohesive, differentiated, stable sense of self.

3 | LINKS BETWEEN HUMILITY AND AFFECT REGULATION

Emerging evidence suggests a link between lower humility and greater affect dysregulation. Sandage and colleagues (2017) theorised that clients exhibiting narcissism, an inverse of humility, 'lack[ed] the internalized and differentiated capacities to self-regulate shame, anger, and other distressing emotions related to disappointments in self and other' (p. 4). Research involving clients in outpatient mental health treatment found that greater grandiose narcissism was associated with lower social well-being through greater affect dysregulation (Bell et al., 2019), and greater vulnerable narcissism was associated with lower humility through lower affect regulation capacities in a graduate student sample (Sandage et al., 2017). In multiple experimental studies, Tong and colleagues (2016) found greater humility to predict greater self-regulation capacity, and Lerner and colleagues (2020) reported that humility was positively associated with adolescents' ability to 'set goals and recruit resources to work toward those goals' (p. 2). Additionally, in couples' conflicts, Perkins (2019) found that greater humility correlated with lower expression of negative emotion, more attentive

listening and more supportive responses. Taken together, these findings suggest that gains in humility may strengthen clients' ability to regulate difficult emotion.

Difficulty regulating emotion is a common feature of mental health problems. While affect dysregulation has been conceptualised from a variety of angles, we focus here on *experiential avoidance*, described as 'unwillingness to remain in contact with distressing internal experiences along with the attempts to control or avoid distressing internal experiences' (Hayes-Skelton & Eustis, 2020, p. 115). Empirical evidence points to EA as a transtheoretical mechanism of change in the treatment of anxiety, depression, substance use disorder, eating and borderline personality disorders, with additional implications for increased well-being (Boettcher et al., 2019; Eustis et al., 2016, 2020). Building on this affect regulation–mental health symptom link, we tested a virtue ethics informed model that considered the influence of humility, not only on affect regulation and symptoms but also on social well-being.

3.1 | Applications to contemporary relational psychotherapy

Of particular interest in the context of this study are the ways that humility might emerge within CRP. Benjamin (2018) suggested that humility is central to psychoanalytic psychotherapy, and particularly the clinician's stance within the therapeutic alliance, which can open space for client exploration and adaptive meaning construction. CRP is grounded in three premises: (a) conceptualising clients within their historical, familial and sociocultural contexts, (b) understanding distress as stemming from maladaptive intra- and interpersonal patterns, and (c) prioritising a here-and-now focus within the therapeutic relationship as a primary change mechanism (e.g. Huang et al., 2016; Jankowski, Sandage, Bell, Rupert, et al., 2019; Schore, 2018). Yet, CRP approaches have focused not only on alleviating symptoms, but also on promoting flourishing, with recent attention given to the cultivation of virtues (McMinn et al., 2016) and positive emotion regulation and well-being (Fosha & Thoma, 2020). While a growing body of research examines therapists' humility when engaging diverse clients and navigating therapeutic ruptures to facilitate improvement (e.g. Paine et al., 2015; Watkins & Mosher, 2020), scant attention has been given to the other side of the treatment dyad. However, Rowden and colleagues (2014) contended that *client* humility is 'at the heart of successful relational therapy' (p. 388). Thus, from a CRP perspective, humility is a relational quality, with therapist *and* client contributing to its emergence during the therapeutic encounter, and this quality may facilitate change in affect regulation, symptoms and well-being.

4 | THE PRESENT STUDY

The present study utilised a practice-based research design, involving routine, non-manualised treatment occurring in a naturalistic

setting (Henton, 2012). We explored self-reported humility, experiential avoidance, mental health symptoms and social well-being over time in clients receiving CRP treatment. Previous research has suggested a link between humility and affect regulation capacities (e.g. Perkins, 2019; Tong et al., 2016), and reducing affect dysregulation has been identified as a transdiagnostic mechanism of change, which in turn reduces symptoms and promotes well-being (Eustis et al., 2016, 2020; Sloan et al., 2017). Humility has demonstrated associations with greater affect regulation, lower symptoms and greater well-being (Jankowski et al., 2019). Further, greater humility has shown associations with lower vulnerable and grandiose narcissism, whereas both greater grandiose and vulnerable narcissism have shown associations with higher levels of mental health symptoms and lower well-being (Bell et al., 2019; Jankowski, Sandage, Bell, Ruffing, et al., 2019). The present study synthesised existing empirical evidence with the theoretical premise that developing virtues reduces symptoms and promotes well-being (i.e. enhances flourishing). Specifically, we hypothesised that clients' growth in humility would exhibit a salutary influence, lowering symptom levels and increasing social well-being, and that clients' decreased reliance on experiential avoidance would mediate the association between humility and symptoms, and humility and well-being.

5 | METHOD

5.1 | Participants

Between 2008 and 2019, data were collected from clients receiving outpatient treatment at a mental health training clinic in a large urban area of the north-eastern United States. From these archival data, we selected a subset of clients ($N = 778$; $M_{age} = 31.56$; $SD = 11.10$; range = 12 – 74) who had completed an initial assessment (time 1) and then a second assessment later in treatment (time 2). The sample was 59.4% female (34.3% male). A majority identified as heterosexual (81.7%) and single (74.4%). Participants identified as 78.1% White, 5.8% Black/African American, 7.1% Asian and 5.9% Hispanic. Most selected their employment status as employed full-time (44.5%; 13% employed part-time, 31.4% full-time student), and most identified as religiously affiliated (59.4% Christian, 4.6% Jewish, 1.4% Hindu, 7.6% other and 21.3% none).

5.2 | Treatment

One hundred and three licensed clinicians, and masters-level, doctoral/post-doctoral interns/fellows receiving training in CRP provided the treatment. Training occurred via monthly professional development sessions, weekly group seminars, and weekly individual supervision and/or biweekly group consultation. Supervision focused on the trainee–client therapeutic alliance, and specifically (a) building trust and collaboration, (b) assessing and treating clients' relational patterns and struggles, (c) exploring clients' values and

meaning-making processes, and (d) addressing ruptures and repairing the alliance.

5.3 | Measures

Data were collected using the Treatment Outcome Package (TOP; Kraus et al., 2005), a 'widely used measure ... [in] naturalistic, real-world treatment settings' to assess multiple symptom and life functioning domains (Kraus & Castonguay, 2010, p. 155). Participants completed the adolescent or adult version, and responded to items using a 6-point scale (1 = *all* to 6 = *none*). We constructed raw scores for each measure using items common to both adolescent and adult versions of the TOP, except for experiential avoidance items which were unique to the adult form ($n = 657$, 84.4% at time 1; $n = 687$, 88.3% at time 2). Nevertheless, data were determined to be missing completely at random (MCAR), as assessed by a nonsignificant Little's test ($\chi^2(220) = 236.81, p = .21$).

5.3.1 | Humility

We used a single item (i.e. 'felt you were better than other people') to assess lack of self-superiority. Similar worded items appear on brief multi-item measures of humility (e.g. Kruse et al., 2017). Lower self-superiority has correlated with greater empathy and lower grandiose narcissism (Davis et al., 2011; Kruse et al., 2017; McElroy-Hetzel et al., 2019), and evidence supporting the reliable and valid use of single-item measures for both empathy and grandiose narcissism has been offered (e.g. Konrath et al., 2014, 2018).

Construct validation evidence for our measure of humility was derived from a subset of client data ($N = 190$; Sandage, 2019) for whom we had other measures than the TOP. Our single item correlated with the low concern for status subscale of a multidimensional measure of humility (Hill et al., 2015). Lower self-superiority corresponded to lower concern for status ($r = 0.21, p = .01$) and correlated most strongly with the low concern for status item 'Getting special attention from others is important to me' ($r = 0.39, p = .005$).

Factor analytic evidence can also be used to establish the use of a single item as a 'best' indicator of a construct. Specifically, use of a single item can be justified if it loads most strongly on the unidimensional measurement of a construct, and the squared factor loading is greater than 0.49 (i.e. factor loading [Hayduk & Littvay, 2012; Kline, 2011; Wanous & Hudy, 2001]). Individual items explicitly measuring self-superiority have met these criteria (e.g. $\lambda = 0.82$; 'To be completely honest, I feel that I am better than most people'; Chusniyah et al., 2020; $\lambda = 0.85$; 'Acts superior'; DeBlare et al., 2019, p. 93; $\lambda = 0.86$; 'My intellectual ideas are usually superior to others' ideas'; Krumrei-Mancuso et al., 2020, p. 156). Taken together, there seems to be sufficient evidence to suggest that lack of self-superiority may be measured by a single item. Higher scores on the single self-superiority item represented greater humility.

5.3.2 | Experiential avoidance

We used two items to assess EA (i.e. 'had to do something to avoid anxiety or fear' and 'avoided certain situations due to fear or panic'; $\alpha = 0.76$ at time 1, $\alpha = 0.80$ at time 2). Again, using our construct validation subset of client data noted above ($N = 190$; Sandage, 2019), our two-item EA scale demonstrated construct validity through theoretically consistent associations with other indicators of affect regulation. Specifically, lower EA correlated with greater affect regulation, along intra- ($r = 0.35, p < .001$) and interpersonal ($r = 0.25, p = .002$) dimensions, and lower adult attachment avoidance ($r = -0.31, p < .001$) and anxiety ($r = -0.48, p < .001$). Higher scores represented less experiential avoidance.

5.3.3 | Mental health symptoms

We used nine items that assessed anxiety and depression symptoms (i.e. 'worried about things'; 'felt little or no interest in most things'; $\alpha = 0.92$ at time 1, $\alpha = 0.91$ at time 2), with higher scores representing lower symptom levels.

5.3.4 | Social well-being

We assessed positive interpersonal functioning by using the three-item social functioning subscale ($\alpha = 0.80$ at time 1; e.g. 'felt someone else had too much control over your life'; $\alpha = 0.76$ at time 2). Positive interpersonal functioning is a dimension of eudaimonic well-being (Huta & Waterman, 2014; Ryff & Singer, 2008), and in the subset of client data we used for construct validation ($N = 190$; Sandage, 2019), better social functioning correlated with greater general well-being ($r = 0.22, p = .01$) and correlated most strongly with the item 'You had warm and trusting relationships with others' ($r = 0.31, p = .001$). We modelled these correlations in the context of structural equation modelling, with well-being measured by the general well-being factor in a bifactor model of the Mental Health Continuum-Short Form (Longo et al., 2020). Thus, construct validation evidence points to the social functioning subscale as a measure of well-being. In the current study, higher social functioning scores indicated greater social well-being, that is, more positive interpersonal functioning.

5.4 | Data analytic procedure

We examined treatment effectiveness by modelling dynamic change among humility, EA and the outcomes of symptoms and well-being. Specifically, we used a multiple simultaneous latent change score (LCS) model (Henk & Castro-Schilo, 2016; Kievit et al., 2018) using Mplus (version 8.4; Muthén & Muthén, 1998–2019; estimation = maximum-likelihood estimation with robust standard errors; missing data were handled using full-information maximum-likelihood

estimation). We used the model constraint command to test the significance of the product of coefficients comprising the indirect effects (Muthén & Muthén, 1998–2019), with 5,000 bias-corrected (BC) bootstrapped samples and 95% confidence intervals (CI; Selig & Preacher, 2009).

6 | RESULTS

First, we fit separate univariate proportional change LCS models (i.e. direct effect from time 1 score to the latent change variable; Kievit et al., 2018). Results indicated that change in humility ($\Delta_i = 3.45$, $SE = 0.20$, $p < .001$; $R^2 = 0.36$) was conditional upon initial levels of humility ($B = -0.63$, $SE = 0.04$, $p < .001$), with lower initial scores corresponding to higher change scores. Similarly, change in EA was conditional on initial levels ($B = -0.58$, $SE = 0.03$, $p < .001$), with significant change ($\Delta_i = 3.14$, $SE = 0.15$, $p < .001$; $R^2 = 0.39$). Change in symptoms was conditional on time 1 symptoms ($B = -0.54$, $SE = 0.03$, $p < .001$), with significant change ($\Delta_i = 2.57$, $SE = 0.12$, $p < .001$; $R^2 = 0.36$), and similarly, change in well-being was conditional on initial levels ($B = -0.67$, $SE = 0.04$, $p < .001$), with significant change ($\Delta_i = 3.19$, $SE = 0.16$, $p < .001$; $R^2 = 0.38$).

We then linked the separate univariate change models in a multiple simultaneous LCS model and examined whether change in humility corresponded to changes in EA, symptoms and social well-being. We modelled time lag as a covariate on initial levels of the variables and latent change scores, given that we had time unstructured data (e.g. initial assessment corresponded to the treatment began date for 70.94% of the sample), which is typical of longitudinal designs (Van De Schoot et al., 2017). Initial time lag (i.e. difference between treatment began date and initial assessment; $M = 6.23$ months,

$SD = 22.21$; range = 0.00 – 272.76) was not a significant predictor of time 1 scores. However, treatment time lag (i.e. elapsed time between assessments; $M = 12.74$ months, $SD = 12.11$ months; range = 0.43 – 84.93 months) was associated with EA latent change scores. Greater elapsed time during treatment predicted lower EA change scores ($B = -0.01$, $SE = 0.003$, $p = .02$). Time 2 represented the end of treatment for 50.3% of the clients. Study designs that depict change but which do not necessarily involve termination data have been referred to as *progress research* (Knobloch-Fedders et al., 2007). The final model, with treatment time lag predicting change in EA, fit the data ($\chi^2(12) = 18.38$, $p = .11$; Comparative Fit Index [CFI] = 0.993, Root Mean Square Error of Approximation [RMSEA] = 0.026, 90% CI [.00, 0.049], Standardised Root Mean Square Residual [SRMS] = 0.024; see also Figure 1). There were significant indirect effects, as greater change in humility corresponded to greater change in EA, which in turn corresponded to greater change in symptoms ($B = 0.07$, $SE = 0.02$, BC 95%CI [.03, 0.11]) and social well-being ($B = 0.04$, $SE = 0.01$, BC 95%CI [.02, 0.07]).

6.1 | Alternative models

We tested alternative models in an attempt to discern whether change in humility or change in EA was 'the leading variable' in the association with change in symptoms and social well-being (Klopack & Wickrama, 2020, p. 104). As a first step, we conducted non-nested model comparisons of our proposed model (model A; Figure 1) with a parallel change model (model B) and a model with the direction of associations reversed (model C). Based on Bayesian information criteria (BIC) comparisons (i.e. lower BIC value = better fit; Henk & Castro-Schilo, 2016), our proposed

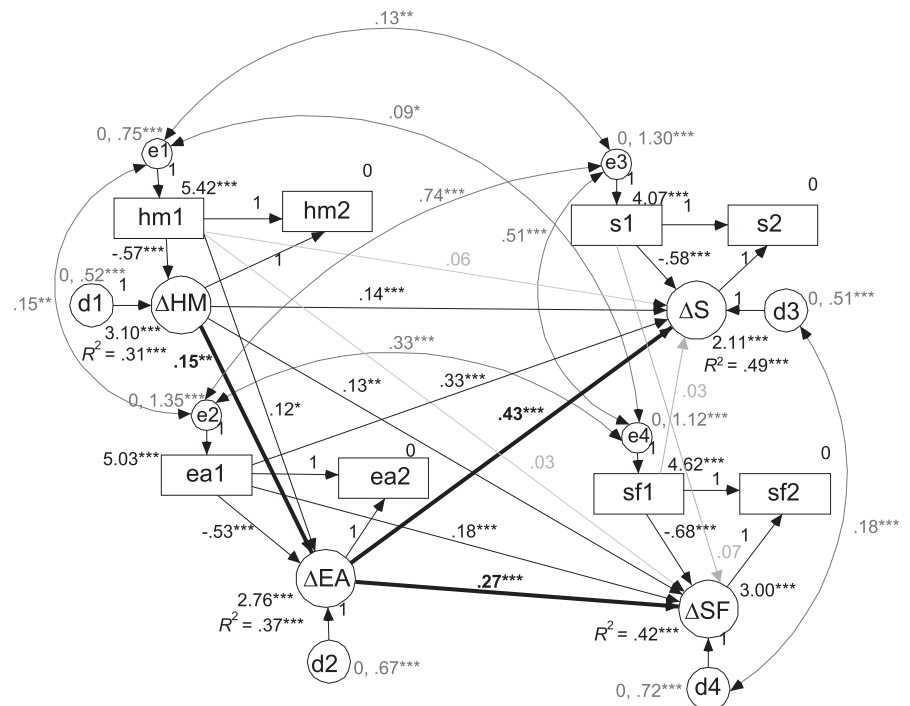


FIGURE 1 Diagram of the multiple simultaneous latent change score model
 Note: Covariate of treatment lag not depicted. Δ = latent change score variable, HM = humility, EA = experiential avoidance, S = symptoms, SF = social functioning. 1 = time 1, 2 = time 2.

model (BIC = 15,088.56) yielded better fit relative to model B (BIC = 15,113.69) and model C (BIC = 15,191.47). Second, we conducted nested model comparisons by estimating a model that had the coupling from time 1 humility to change in EA set to 0, the coupling from time 1 EA to change in humility set to 0, and a correlation between change in humility and change in EA (model 1; Klopock & Wickrama, 2020). We then compared model 1 with a model with humility at time 1 as the leading variable (model 2), and then a model with time 1 EA scores as the leading variable (model 3). We then compared models 2 and 3 with a model with the coupling paths from time 1 variables to latent change variables estimated (model 4). We compared models based on $\Delta\chi^2$ (Klopock & Wickrama, 2020). Results of the model comparisons were all non-significant, suggesting equivalence among models. A Wald test comparing the two leading paths in model 4 revealed that the two paths did not differ ($\Delta\chi^2(1) = 0.01, p = .89$). We then proceeded to use model 1 and compared a model with a path from change in humility to change in EA (model 1a) to a model with a path from change in EA to change in humility (model 1b). Model 1a yielded somewhat better fit (BIC = 15,088.16) with a significant path ($\beta = 0.08, SE = 0.04, p = .03$) relative to model 1b (BIC = 15,090.95), which had a nonsignificant path ($\beta = 0.06, SE = 0.03, p = .07$). Last, despite sample size limitations beyond time 2 (see also Limitations section below), we extended our proposed model by adding time 3 data ($N = 387$) to explore time 1 to time 2 treatment change predicting concurrent/simultaneous changes, and predicting time 2 to time 3 changes. A model with humility as the leading variable fit the data ($\chi^2(26) = 27.27, p = .40$; CFI = 0.999, RMSEA = 0.01, 90% CI [.00, 0.03], SRMS = 0.03; BIC = 18,432.52), and fit better than a model with EA as the leading variable (BIC = 18,456.79). There were significant indirect effects, from change in humility through change in EA to change in symptoms ($B = 0.93, SE = 0.55, BC\ 95\%CI [.37, 4.55]$), which in turn then predicted change in social well-being ($B = 0.37, SE = 0.33, BC\ 95\%CI [.10, 4.28]$). Taken together, results seem to suggest that the coupling between humility and EA is better represented by a model with humility as the leading variable.

6.2 | Invariance test

We explored the influence of treatment status (i.e. those who ended and those who continued treatment beyond session 2) by conducting multigroup comparisons (i.e. unconstrained versus constrained model comparison; Kievit et al., 2018). Results indicated that our proposed model (Figure 1) did not differ by treatment status ($\Delta\chi^2(33) = 28.40, p = .70$).

7 | DISCUSSION

The current study documented latent changes across time in non-manualised psychodynamic treatment within a naturalistic setting,

empirically testing a virtue ethics premise about change. We found significant indirect effects in a model with concurrent changes in humility predicting concurrent changes in symptoms and social well-being through concurrent changes in EA. We also observed significant indirect effects in an exploratory model with concurrent changes in humility and EA predicting later treatment changes in symptoms and social well-being. As such, results offered initial support for the notion that clients' growth in humility in psychotherapy may foster human flourishing (Jankowski et al. 2020). Our findings also replicated prior research demonstrating parallel change processes between affect regulation, social functioning and mental health symptoms (Jankowski, Sandage, Bell, Rupert, et al., 2019), adding further support for dual-factor models of treatment and change (e.g. Trompeter et al., 2017). We found evidence for EA as an explanatory factor by which humility may exert a salutary influence on both symptoms and social well-being, which is consistent with other research suggesting EA is a transdiagnostic mechanism of change (e.g. Eustis et al., 2016, 2020). Clients' growth in managing distressing internal experiences appeared to stem from growth in humility. However, much remains unknown about exactly how humility promotes affect regulation.

Results pointed to the effectiveness of CRP in a real-world context and the importance of considering ways that virtues such as humility may catalyse therapeutic change. In the absence of humility, clients' sense of self may oscillate between deflated-inadequacy and superior-grandiosity, depending on the current relational context. This unstable self-structure involves 'an intense need for mirroring and validation from others' (Bell et al., 2019, p. 27), which leaves clients vulnerable to drastically shifting emotional states. The primacy of others' positive feedback to maintain one's psychological integrity can create dilemmas amidst the inevitable strains and stressors of relationships. In situations of difference or conflict, these individuals may ward off overwhelming emotions through defensive coping processes, turning on others (e.g. devaluation, entitlement rage) or themselves (e.g. lapsing into self-hatred; Pincus et al., 2014). In contrast, humility represents the development of ego strength, becoming less sensitive to positionality (e.g. superiority, dominance) and more accepting of oneself 'warts and all'. Our findings support the notion that humility may strengthen clients' ability to regulate difficult emotions, rather than cope through experiential avoidance.

The current study expanded previous work on the contribution of therapists' humility to treatment effectiveness by documenting the influence that clients' humility can have on treatment outcomes and, specifically, enhanced flourishing. CRP does not manualise an overt focus on humility, but does prioritise relational work in the here and now, including emphases on attunement, mirroring and optimal responsiveness in moment-to-moment communication, with the aim of facilitating coregulation, identification, internalisation and integration of self-deprecating and grandiose self-states (Kohut, 1977). Our findings also support the psychodynamic model of Summers and Barber (2010), positing virtues as

mechanisms of change that influence symptoms and interpersonal growth.

7.1 | Clinical implications

While humility appears to have the potential to catalyse change, we caution practitioners against assuming that just talking about humility in sessions will bring about change. Language is only one means through which therapeutic action occurs (Schore, 2014), and it seems that humility is more likely to be indirectly nurtured within the treatment dyad. In fact, we suggest that humility may not (or even primarily) emerge as an explicit topic for discussion, since few clients seem to present for treatment with an explicit goal of increasing humility. However, many people describe wanting to better manage difficult emotions. Understanding the link between humility and affect regulation can guide clinicians in attending more closely to how virtues influence behaviour within the therapeutic relationship and, with humility specifically, how clients may oscillate between self-deprecating and self-aggrandising states in the clinical encounter.

Further, humility is also more than a behavioural skill to be practised, despite evidence that virtue-based behavioural interventions can foster growth in virtuousness (Jankowski et al., 2020). In fact, we are not saying humility cannot be explicitly talked about nor practised during treatment, but rather that humility may also be a spillover effect of change in affect regulation as a result of processes within the alliance between clinician and client. Use of the alliance in CRP remains distinctively psychoanalytically informed, involving transference-countertransference processes, albeit with clinician and client collaboratively constructing the relational experience. Nevertheless, viewing the alliance in terms of transference-countertransference processes is a hallmark of CRP relative to other treatment approaches that also emphasise the alliance as a key mechanism of change (Jankowski, Sandage, Bell, Rupert, et al., 2019).

Specifically, humility can potentially be forged in the crucible-like quality of the alliance, evolving as therapist and client work through moments of discord and rupture towards surrender and mutual recognition. CRP involves *implicit relational knowing* as a primary site of therapeutic action, which is 'automatically or implicitly updated in small ways with each relational encounter rather than as operating primarily through explicit narrative exchanges' (Boston Change Process Study Group, 2005, p. 715). According to Bion (1967), '[B]y the time you are able to give a patient an interpretation which the patient understands, all the work has been done' (p. 11). These *small ways* in each relational encounter may foster humility and could involve a self-compassionate response to awareness of a limitation within the self, an expression of appreciation for the other, or 'attending to self and other with honesty, approaching one's relationship with dignity and respect, being willing and open to change, taking responsibility, and being benevolent' (Rowden et al., 2014, p. 388). Further, these *small ways* would ideally occur while engaging in authentic communication of here-and-now experience with an empathic, attuned other, which can permit staying in contact with

a wide range of affect and noticing how experience fluctuates in response to different self and other actions.

7.2 | Limitations and future research directions

First, we did not conduct a randomised controlled trial, which limits our ability to attribute change directly to the CRP treatment. Nevertheless, we did observe change, and future research could build upon our use of flexible longitudinal analyses to examine dynamic change processes among constructs. Replication of the ordering of variables in our proposed model is needed, particularly given some evidence that parallel change between humility and EA fit the data, albeit not quite as well as our proposed model in this sample. Future research could also focus on replication with alternative treatment approaches. Second, our sample was predominantly White, heterosexual and female, which could limit the translation of our findings about the effectiveness of CRP to some contexts. Future research should strive for greater diversity, with attention to cultural influences (e.g. acculturation) on virtues and treatment effectiveness. Third, sample size limitations constrained our ability to conduct detailed analyses beyond two time points. Future research should involve more time points with greater frequency of data collection, as this would clarify mechanisms of change from early (e.g. times 1 and 2) to mid-treatment (e.g. times 2 and 3) and then later treatment (e.g. times 3 and 4). Last, while we offered evidence of construct validity for our measures in the current study, future research should employ multiple methods of data collection for the constructs, including therapist *and* client humility. Isolating dimensions from multidimensional measures of humility is also needed to clarify change processes; for example, what influence does lack of self-superiority play relative to the dimensions of receptivity to others' feedback or concern for others' well-being.

8 | CONCLUSION

We tested a theoretical premise of virtue ethics, namely that growth in the virtue of *humility* could facilitate changes in mental health symptoms and social well-being through decreased experiential avoidance. Findings offered initial support for this theoretical premise in the context of examining the effectiveness of CRP in real-world clinical practice at a community outpatient training clinic. From the perspective of CRP, humility is an emergent quality of the therapeutic encounter between clinician and client, with the primary implication of this notion that clinicians attend closely to client experiences of oscillation between self-abasement and self-superiority and utilise *small ways* within the encounter to foster experiences of humility.

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