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EDITORIAL

Staying Grounded: Humility as an Aim in Psychiatry Education and Practice

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Humility is an underappreciated concept in psychiatric practice and education. It is perhaps commonplace to be overconfident about our abilities and to overestimate our expertise [1]. In one systematic review, self-assessment of competence was compared with external measures of competence among physicians, and the lowest accuracy in self-assessment was among those who were the least skilled and those who were the most confident [2]. A small sample of 129 mental health care professionals viewed themselves to be at the 80th percentile in terms of clinical skills compared with peers, and none thought they were below the 50th percentile [3]. Ironically, physicians may even tend to believe they are above average in their capacity to make accurate self-assessments [1]. These are characteristics that can also apply to groups. As a profession, psychiatry has done an enormous amount of good, but sometimes with painful overconfidence in our diagnoses and treatments and in enthusiasm for whatever is new in our field. This overconfidence can potentially lead to inadvertent harm [4]. As a new wave of interventions (including psychedelics and various forms of brain stimulation) are being actively launched, this is a fitting time to reflect on issues of confidence and, therefore, humility.

This editorial calls attention to the importance of humility in psychiatry and the implications for the future of training. Its goals are to describe concepts of humility, highlight aspects of psychiatry most in need of humility, discuss how to build humility into our curricula, and consider how we might help our trainees by striving to model humility ourselves.

Concepts of Humility

Humility is described in a variety of philosophical traditions throughout the world as a virtue that is rooted in having the appropriate perspective on oneself or, especially in Eastern traditions, in a need to let go of the self to connect with a greater reality. One text describes humility as a professional virtue and defines it as the habit of recognizing the limits of one's ethical and professional judgments while working persistently to improve them [5]. This concept includes an openness to new evidence and willingness to change one's mind as required by the strength of evidence [5]. Religious traditions have associated humility with submission to a greater power and with the ability to see others as worthy of love and compassion [6]. As Thomas Aquinas wrote, "Truly, the virtue of humility consists in this, that one keep himself within his own limits" [7]. This sense of perspective is suggested by the etymology of *humility*, which derives from the Old Latin *humilis*, meaning "lowly" or "on the ground" and which, in turn, is traced to *humus*, or "earth."

Humility has sometimes been cast in a negative light, as a kind of abnegation of the self. An online dictionary [8] defines being *humble* as "(1) not proud or arrogant; modest… (2) having a feeling of insignificance, inferiority, subservience, etc. … (3) low in rank, importance, status, quality, etc.; lowly… (4) courteously respectful." Although respectfulness and modesty are desirable in physicians, we do not want our trainees to learn a feeling of insignificance or inferiority. This is especially important in psychiatry, where stigma against psychiatric illness, psychiatric patients, and psychiatrists as physicians can be a prevalent challenge. Humility does not mean self-castigation. Thus, the discussion of humility in psychiatric

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education requires a careful balancing act. It requires an openness to seek other opinions and to value and respect the views of colleagues, particularly in the face of uncertainty. One might consider that maintaining humility offsets the tendency for arrogance and rigidity of opinions. It implicitly acknowledges that we are all fallible and are open to embracing the observations and considerations of our work by trusted peers. In this sense, it adds an important trait to professionalism.

The concept of humility is known and understood across languages and cultures. In Hawai′i, where one of the editors (APSG) lives and works, the state legislature specifically identifies *ha'aha'a*, or "humility, to be expressed with modesty" as a component of *Aloha*, which in turn incorporates "warmth in caring with no obligation in return"; is "the essence of relationships in which each person is important to every other person for collective existence"; and is intended to guide the actions of public leaders [9].

For the purposes of this editorial, humility means being grounded in an accurate perspective—not only appreciating our successes but also embracing our fallibility and limitations and finding balance and flexibility in our self-assessment. Humility, as the dictionary notes [8], helps us avoid arrogance, but it is equally essential that we not fall into humiliation.

Aspects of Humility to Teach in Psychiatry

Five aspects of psychiatry particularly call for humility and specific action by educators. First, we remain uncertain about the nature of the illnesses we treat and their treatment. Second, there is a moral dimension that pervades our clinical work and cannot be resolved with science. Third, we acknowledge that discrimination and disparities of mental health care persist in our field and that we ourselves may be subject to implicit bias. Fourth, our ability to change the outcomes of serious mental illness remains limited. Fifth, our ability to modify the major social factors that contribute to the etiology of mental illness is also limited, though we have an ethical obligation to inform the public about social forces that may influence psychiatric disorders and their treatment.

"Epistemic humility" is the term Hyman [10] proposed for the problem of what we truly know about our illnesses. Although the advance in reliability since the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) III was real, it was expected that it would lead to increasing success in defining discrete illnesses with clear boundaries. Instead, a patient with a DSM-5 diagnosis is likely to meet criteria for several other diagnoses, present with phenomenology starkly different from another patient with the same diagnosis, and have a course of illness that is highly variable. Our diagnostic situation is at least consistent with what we have learned about the genetics of serious mental illness in that thousands of genes contribute very small increments of increased risk, and the same alleles may increase risk for multiple different illnesses. In sum, we have been unable to demonstrate that DSM diagnostic categories correspond to underlying biologic realities [10]. In the face of this disconnect, the National Institute of Mental Health launched the Research Domain Criteria program to open new avenues for exploration [10]. However, we should hesitate before thinking that our diagnostic problems will be resolved by a new focus on circuit neuroscience. The multi-level causation of psychiatric illness, including the social determinants of mental health, individual trauma, and other psychological factors, and brain development, among other factors, suggests we rein in our enthusiasm for paradigm-shifting theories and accept an incremental accretion of complex explanations [11, 12].

In order to teach epistemic humility, journal club curricula that review emerging literature with both enthusiasm and caution are needed. It is difficult to teach residents to a level of comfort in translational neuroscience that will allow them to independently read and critique, for example, developments in neurostimulation or the impact of psychedelics. Yet that is what we will need. The enthusiasm of experts and their investment in their work have repeatedly contributed to the idea that psychiatry is on the verge of a paradigmatic breakthrough, which has sometimes led to bubbles of overenthusiasm that eventually burst. We should instead emphasize that most new advances—as is true in all medical specialties—will fail to be replicated or to hold up in effectiveness trials and that there are considerable lags between initial uptake of new treatments by our field and the appreciation of the full impact of adverse effects.

Humility, however, is not only a matter of recognizing the current limits of our knowledge, since psychiatry has moral dimensions that scientific progress cannot resolve. Many of our patients' symptoms are not discrete instances of pathology, like a blocked artery or a tumor, but represent many factors leading to a final common pathway. They are toward the extremes on a continuum with "normality," and where we place the thresholds of pathology, with impulsivity or grief, as examples, are determined in part by current societal values. There is also a moral element as we teach our trainees to make judgment calls about admission, discharge, and involuntary treatment decisions, which require thoughtful consideration when balancing benefits over harms. Trainees may experience distress when we fail to acknowledge the potential harms of treatment. An involuntary dose of medication may be experienced as a terrifying assault or a demoralizing sacrifice of dignity. How much relative weight to give to protection from danger versus freedom and autonomy are moral and social judgments, not simply matters of science.

To achieve moral humility, residents should learn that we cannot rely on expertise only from within our profession, since doing so leads to blind spots and echo chambers that

downplay our uncertainties. Effective and equitable patient care, especially when based on psychosocial assessments or psychosocial interventions, also requires significant introspection and self-awareness, which in turn requires a willingness to acknowledge potential biases and errors. Our curricula should include learning from scholars outside the medical profession, including sociologists, anthropologists, and ethicists. Along with their specific content expertise, these disciplines can teach us about how to best use qualitative methods that provide a rich understanding of the patient's narrative and experience. Just as important, residents should learn directly from people with lived experience of serious mental illness, supplemented by formal teaching sessions and additional readings when possible. Many excellent books complicate the usual narratives of psychiatry with alternative perspectives, including two recent ones [13, 14].

Our trainees also have to learn structural humility, an understanding that psychiatric illnesses can be shaped by cultural forces that are external to the patient but embedded in the institutions of our society. When we teach the history of psychiatry, we should include the ways that bias and discrimination have distorted our profession's achievements. Several years ago, for example, the American Psychiatric Association apologized for its history of institutional racism [15], and it would be tempting, but inaccurate, to think such problems were entirely in the past.

Residents need to learn that research has demonstrated, for example, that Black patients are more likely to be overdiagnosed with psychosis [16], more likely to experience involuntary restraint in emergency settings [17], and less likely to have clozapine prescribed [18]. Recent work on diversity, equity, and inclusion for our workforce and our trainees has been crucial, but academic psychiatry departments should also focus on teaching residents how to measure disparities in their individual clinical systems and how to correct them. And, at a personal level, assessment of our own implicit bias should be taught to our residents, for a deeper understanding of our internalized and largely unconscious attitudes toward our patients.

Another area of humility has to do with our outcomes in psychiatry—therapeutic humility. There are some disturbing realities when we look at population health. Patients with serious mental illness continue to have a profound loss of life expectancy, and US suicide rates rose by 33% between 1999 and 2019 [19]. The reasons are complex and include social determinants such as poverty and isolation driving many deaths of despair and a lack of access to mental health care for many. And while we doubtless prevent many deaths in the patients we reach, the loss of even one patient to suicide can be crushing to the psychiatrist and lead to shame and demoralization if not properly supported.

We should also appreciate that the profession's ability to shape the social forces that contribute to mental illness is limited. Major social issues confronting us include homelessness, poverty, access to care, trauma and interpersonal forms of violence, pervasiveness of alcohol and substance use, deeply rooted cultural problems related to the ready access and use of firearms, and climate change. Yet aiming to address these social problems is certainly consistent with our identity and roles and responsibilities [20]. We need to teach our residents that though they may feel limited as individuals to ameliorate the social determinants of mental health, individual advocacy is strengthened with organizational commitment and support [21].

We also need to teach our residents to accept that clinical work in psychiatry defies prediction and that bad outcomes do happen. For example, morbidity and mortality conferences are valuable in providing academic departments a means to learn from our losses and also to support each other in the intrinsic uncertainty of clinical work. An effective morbidity and mortality conference can teach transparency in acknowledging our limitations and fallibility. None of us can be expected to individually know everything, and consultation with each other, textbooks, and online resources is critical. Our aim should be to foster a culture that does not shame its members but, instead, supports them in the challenge of treating dangerous and complex illnesses.

Modeling Humility

What we demonstrate to our trainees has more impact than what we say. There are many opportunities for program directors, medical student educators, chairs, administrators, and other faculty to illustrate humility through our actions and to promote an organizational culture of humility. These are opportunities that also apply to the accrediting bodies that govern our training environments, and the professional organizations that provide thought leadership and direction.

First, we ought to not only be open to respectful and constructive criticism from trainees, but we should invite and embrace it. As an example, on the local level, it is common for medical students to raise concern or express discomfort about the involuntary treatment of a patient. It is a natural response that our first inclination may be to explain why it is justified and is the right decision. But it is hard to imagine that, in every judgment call, we find the optimal balance, or that the balance points remain the same across different cultures and different generations. Instead, we might begin by asking the trainee, "Tell me how you see the situation. How might you manage this differently?" Fresh eyes may see things that are currently in our blind spots. Acknowledging that a budding professional, such as a medical student or resident, has a perspective, that we are eager to hear about their views, is an example of modeling humility in practice.

Next, we should remember that valid criticism can come from unexpected sources. It is understandable that leaders may be most interested in feedback from those who are flourishing and performing at a high level in their programs and departments. But sometimes it is the person struggling who is most in touch with something we need to change. This person could be one of our trainees. Their own areas of sensitivity or vulnerability can allow them to serve as the proverbial canary in the coal mine. Differences of view or conflicts between individuals and groups must then be handled with civility, since this is an indispensable professional responsibility [22].

Finally, we should share our experiences of bad outcomes with our trainees. Many of us have had the experience of our fallibility leading to a mistake. We can model both the pain of owning our mistakes and the ways that ownership can lead to growth. We should share our practices of lifelong learning and consultation, particularly when these have led to modification of our care based on new research evidence or lack of progress in a patient's treatment.

But many bad outcomes—perhaps most patient suicides—do not have any identifiable mistakes. Much of the shame we feel around bad outcomes is connected to an illusion that we have more control than we do, and it is indicative of a loss of accurate perspective. We do not ultimately determine whether a patient adheres to a medication or calls in a crisis. Our role is to invite the patient to do these things, and there is skill to be learned in how to offer that invitation most effectively. But in the end, it is only an invitation. This aspect of humility has to do with being able to accept the limits of our profession's ability. Faculty can be crucial models for how we support each other in living with the limitations of our influence.

An accurate and balanced understanding, therefore, of both the strengths and vulnerabilities of our profession can and should be a goal for training and an aspiration of educators and leaders in academic psychiatry. Humility, in this sense, can allow psychiatrists the grace to learn from failure, to be open to constructive criticism and to new evidence, and to develop the resilience to persevere in our uncertain, but vital, work.

Declarations

Disclosures On behalf of all authors, the corresponding author states that there is conflict of interest.

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