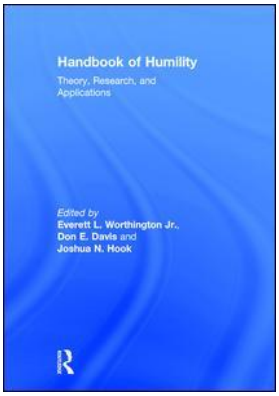

Handbook of Humility
Theory, Research, and Applications

Everett L. Worthington, Don E. Davis, Joshua N. Hook

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Loren L. Toussaint, Jon R. Webb
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THE HUMBLE MIND AND BODY

A Theoretical Model and Review of Evidence Linking Humility to Health and Well-Being

Loren L. Toussaint and Jon R. Webb

This chapter offers a theoretical model for how humility is connected to health and reviews evidence relevant to the model. We begin by considering the nature of humility and offer a definition. We then provide a theoretical model and review the scant scientific literature on humility and health. Given the dearth of work in this area, we consider limitations; outline research questions and recommendations for future work; and conclude with a discussion of practical implications for health, healthcare, and the broader public.

Definition

The study of humility and health begins with a clear definition of humility. Buddhist, Christian, Hindu, Islamic, and Jewish teachings are replete with encouragement to be humble (Hook & Davis, 2014; Jeste & Vahia, 2008; Porter et al., in preparation; Shah-Kazemi, 2014), and virtually all world religions hold humility in high esteem (Hook & Davis, 2014; Woodruff, Van Tongeren, McElroy, Davis, & Hook, 2014). Likewise, ancient and modern philosophers have discussed, explicitly or implicitly, the role, relevance, and importance of humility in ethical, virtuous, and healthy life (Hull & Peikoff, 1999; Kaufmann, 1970; Lebell, 1995; Norton & Norton, 2000; Tredennick, 1976). Early luminaries in the field of psychology also acknowledged and discussed the inherent value of humility (Frankl, 1986; Fromm, 2006; James, 1994). Consequently, humility has strong connections to religious/spiritual, philosophical, and psychological traditions. This has naturally led to several contemporary accounts of humility within the field of positive psychology.

Tangney (2000, 2009) was an early contributor in outlining key theoretical features of humility. Accordingly, Tangney suggested that humility consists of an accurate view of oneself, including one's abilities and achievements. One must acknowledge limitations and imperfections but not be overly focused on

these aspects of the self so as to negatively influence self-image. Openness to others' perspectives and being other-oriented are also key features.

Peterson and Seligman (2004) partially share Tangney's (2000, 2009) view arguing that humility is an accurate self-evaluation including both strengths and weaknesses. Peterson and Seligman also suggest that perfect accuracy in self-evaluation is not critical, but openness toward accurate information aids self-awareness, and this quality may allow humble individuals to be teachable. Davis et al. (2013) similarly agree that humility involves having an accurate view of oneself and the ability to inhibit self-focused and promote other-focused emotions and behaviors.

Critical to an accurate definition of humility is an understanding of what humility is not (Tangney, 2009). As with many positive psychology concepts, it is tempting to think of humility as simply the opposite end of an otherwise logical continuum—in this case, narcissism. However, the absence of narcissism doesn't necessarily imply that an individual has the characteristics of humility. The lack of a pathologically broken self-system doesn't necessarily imply an accurate view of oneself and being other-oriented. Modesty is also commonly confused with humility. Although modesty may be one facet of humility, it is generally too narrow a concept that focuses on one's presentation in social circumstances. Finally, humility is sometimes conflated with self-esteem. Humility does not imply low self-esteem. Self-deprecation, self-loathing, and holding a low opinion of oneself suggest that one's view is negatively biased and not accurate, and hence, are contrary to many notions of humility where an accurate view of oneself is a core aspect of the definition. Indeed, humility may arguably be a necessary (but not sufficient) component of high self-esteem (Rosenberg, 1989).

Based on this review of conceptual notions of humility, we have identified two fundamental commonalities that inform our definition. The first hallmark feature of humility is an accurate view of oneself. The second is the quality of being selfless *and* other-oriented.

A Theoretical Model of Humility and Health

There are several reasons why humility should be related to mental and physical health, and Figure 12.1 offers a theoretical model. First, as a construct antithetical to narcissism, humility by its very definition should be composed of characteristics that directly ease mental and physical burden and allow for better health (see Figure 12.1, path A). Chancellor and Lyubomirsky (2013) review many of the hallmark characteristics of humility that would facilitate better health status, including such things as decreased tendencies toward rumination about the self, secure and accepting identity, modulation of negative emotions, and openness to experience. Much of the present research supports the direct correlations between humility and mental and physical health outcomes, and this will be reviewed later.

Indirect routes of humility's influence on health should not be overlooked as research and theorizing on important mechanisms is rapidly developing. Key indirect routes by which humility should be related to mental and physical health are through stress and social support (see Figure 12.1, path B). Narcissism has been linked to greater stress (Orth & Luciano, 2015), and humility is often considered a construct with an inherent prosocial focus (Davis et al., 2013). As such, humility should reduce stress and promote social integration and support and defend against loneliness. Stress and social support (see Figure 12.1, path C) are major contributors to both mental and physical health (Contrada & Baum, 2011).

Although the indirect paths through stress and support displayed in Figure 12.1 clearly connect humility and health, there are critical midstream mediators of the connections between humility and stress and social support themselves that should be examined (see Figure 12.1, paths D and E). These variables are key to understanding the most proximal mechanisms that facilitate the connections between humility and stress and support health. That is, it is important to consider how humility is related to variables such as forgiveness, gratitude, and self-regulation (Davis et al., 2013)(see Figure 12.1, path D) as they serve to decrease stress and increase social support, and forgiveness, gratitude, and self-regulation variables may also have independent and direct associations with health (see Figure 12.1, path F).

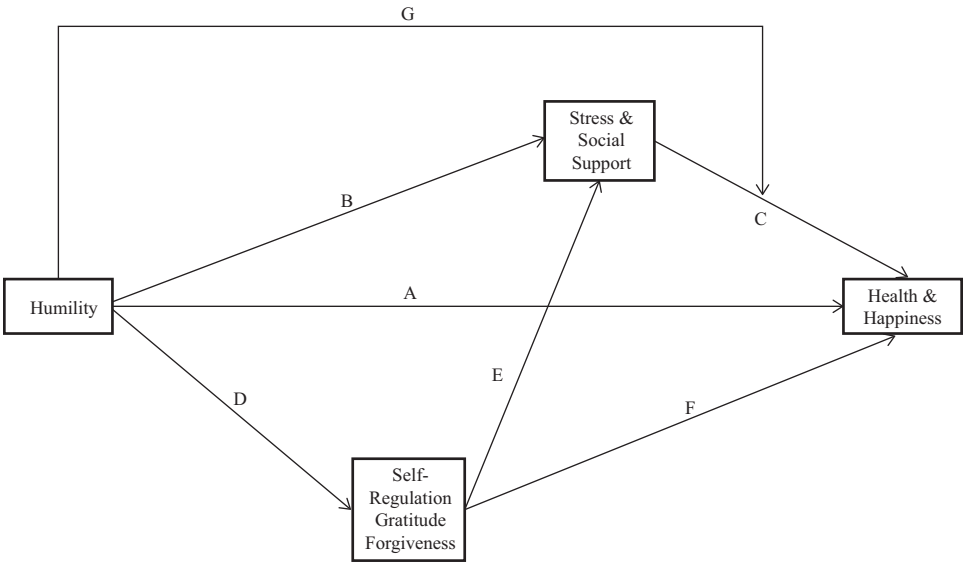

Figure 12.1 **Theoretical model of associations between humility and health and well-being and sequential mediating mechanisms of: a) self-regulation, gratitude, and forgiveness, and b) stress and social support. Unique effects labeled A-G.**

A final aspect of this model focuses on the extent to which humility might act to buffer individuals from the effects of stress on health (see Figure 12.1, path G). Early evidence (Krause, 2014), exists to support this hypothesis in a religious context, and it could be the case that humility may act more broadly as a moderator of stress–health relationships. Especially where interpersonal stress is concerned, humility may act as a buffering mechanism that reduces the impact of interpersonal stress on health. This may be because humble individuals more accurately assess their own, often imperfect, role in interpersonal conflict and stress, have greater concern for others in social relationships, and therefore experience less stress and more support that defend against depression or physical ailments. Furthermore, humble individuals may perceive interpersonal stress as less severe, be equipped with better coping responses, or be capable of avoiding stressful circumstances altogether (Orth & Luciano, 2015).

In summary, the present model integrates research and theorizing about humility and health into a broad model that offers several hypotheses and lines of investigation. Researchers should continue to build from the small empirical database to establish the generalizability and robustness of the direct connections (see Figure 12.1, path A) between humility and health. They should also examine direct effects of humility on health-promoting variables such as decreased stress and social support (see Figure 12.1, path B). Finally, researchers should consider mediating mechanisms and be attentive to mediation processes that occur both in parallel and serial fashion. For instance, some researchers may choose to examine the benefits of humility for stress reduction and social support (parallel mediators) and its indirect connection through these constructs to health (see Figure 12.1, path C). Others may choose to examine how humility promotes forgiveness (see Figure 12.1, path D), which in turn promotes social support or decreased stress (serial mediators, see Figure 12.1, path E), which then promotes health (see Figure 12.1, path C). It is hoped that the model offers direction and flexibility in creating research questions and hypotheses that can guide work aimed at understanding the humble mind and body. Next we review the literature bearing on this model. Incomplete as it is, the existing research offers beginning support for several lines of investigation building from the proposed model.

Literature Review

Method

The literature search was conducted on February 1, 2016, using three databases: (a) PsycINFO, (b) PubMed, and (c) GoogleScholar. Searched terms included "humility and heal*" or "humble and heal*". Title searches for these key phrases yielded 7 studies in PsycINFO, 19 studies in PubMed, and 29 studies in

GoogleScholar. Subject term searches revealed 23 studies in PsycINFO. MESH major topic searches showed 22 studies in PubMed. Searching the phrase "humility and health" and the phrase "humble and health" anywhere in an article turned up 11 studies using GoogleScholar. PsycINFO searches produced the most focused and useful results returning empirical studies of humility and health. PubMed and GoogleScholar searches tended to overinclude studies focused more broadly on issues of provider humility and cultural humility in healthcare. Studies of humility and general mental and physical health were the focus of this review. Studies examining humility and personality disorders (e.g., psychopathy, Machiavellianism, schizotypy, etc.) were excluded.

Results

Only a handful of the aforementioned studies met our inclusion criteria for review; that is, measurement of humility, not just self-esteem or narcissism, and mental or physical health. Type of measurement, sample, and design were allowed to vary. This resulted in 14 empirical studies of humility and health available for review.

Five studies contain data on the direct correlation (see Figure 12.1, path A) of humility and mental health (Jankowski, Sandage, & Hill, 2013; Kesebir, 2014; Krause, 2014; Quiros, 2008; Rowatt et al., 2006). Four of these studies are correlational and one is experimental (Kesebir, 2014). Three of the correlational studies show a consistent negative association (rs = –0.13 to –0.46) between humility and depressive symptoms (Jankowski et al., 2013; Krause, 2014; Quiros, 2008). One study shows a similar negative association (r = –0.24) between humility and anxiety (Quiros, 2008). Krause's (2014) study also shows that humility acts to buffer (see Figure 12.1, path G) the relationship between stressful interactions with church members and depressive affect. Kesebir's (2014) experimental studies show that humility protects against (see Figure 12.1, path G) fear of death under mortality salience priming and that humility priming itself is sufficient to reduce death anxiety (rs = .23–.27; see Figure 12.1, path A). Rowatt et al.'s (2006) study was the only one of the five not to show a connection between humility and mental health (|rs| = .01–.09). These five studies were conducted with undergraduate and graduate student samples and middle and older aged American adults. Sound psychometric assessments of both humility and mental health were used. Based on this small handful of studies, it appears that humility may have a negative association with symptoms of depression and anxiety and may moderate the effects of stress on these mental health outcomes.

Eight studies offer data on the direct correlation (see Figure 12.1, path A) between humility and happiness, and four of these studies were published by the same research team (Aghababaei, 2014; Aghababaei & Arji, 2014; Aghababaei

et al., 2015; Aghababaei, Mohammadtabar, & Saffarinia, 2014). Aghababaei and colleagues have consistently measured humility using the HEXACO honesty-humility subscale and happiness using measures of life satisfaction, subjective happiness, and multidimensional aspects of psychological well-being as defined by Ryff and Keyes (1995). A distinctive feature of this emerging body of work is that the participants originate from areas that are underrepresented in the psychological literature (e.g., Iran, Poland, Malaysia). A consistent theme in these four studies is that humility is unrelated, or very weakly related, to subjective happiness and life satisfaction ($|rs| = .03–.20$). Stronger associations ($|rs| = .14–.33$) are found between humility and Ryff and Keyes' (1995) aspects of psychological well-being (e.g., autonomy, self-acceptance, positive relations, mastery, purpose, and growth). The honesty-humility subscale of the HEXACO measures broad aspects of personality that extend beyond humility, and as such, has been criticized as a measure of pure humility (Davis, Worthington, & Hook, 2010). The measures used to assess happiness are standard ones and psychometrically sound.

Four other studies were identified that examined humility and happiness (Dangi & Nagle, 2015; Park, Peterson, & Seligman, 2004; Pollock, Noser, Holden, & Zeigler-Hill, 2016; Rowatt et al., 2006). Park et al. (2004) used large Internet samples and the Values in Action (VIA) humility subscale to examine the connection between humility and life satisfaction, and associations were small to nonexistent ($|rs| = .00–.05$). Opposite findings were reported by Rowatt et al. (2006) who used a humility semantic differential scale and showed a significant correlation with life satisfaction ($r = .28$). Two other studies correlated the HEXACO honesty-humility subscale with happiness. Pollock et al. measured mood and life satisfaction and found small, nonsignificant correlations with the HEXACO honesty-humility subscale ($|rs| = .02–.13$). Dangi and Nagle used Ryff and Keyes' (1995) assessment of happiness and found the subscales of self-acceptance ($r = .42$) and purpose in life ($r = .37$) were significantly correlated with the HEXACO honesty-humility subscale in a sample of adolescents from India.

Overall, the relationship between humility and happiness appears a bit nuanced. The correlation between humility and affect, life satisfaction, and subjective happiness is quite small, if one exists at all. On the other hand, the correlation of humility and broader conceptualizations of happiness (Ryff & Keyes, 1995) is stronger. Perhaps the investigation of humility and happiness should focus more intently on how humility contributes to a rich and meaningful life through such things as autonomy, self-acceptance, positive relations, mastery, purpose, and growth and not simply how it relates to in-the-moment mood or evaluations of life. It is also important when interpreting findings in

this area to be mindful of differences in measures and samples across studies, as there is considerable variability.

Only three studies offer data on the direct correlation (see Figure 12.1, path A) between humility and physical health (Krause, 2010, 2012; Rowatt et al., 2006). Krause's (2010, 2012) two studies examine humility and health in a sample of Americans with an average age of 78. Both studies come from the larger *Religion, Aging, and Health Survey*. This impressive 15-year, five-wave, longitudinal project has offered numerous insights into religious and spiritual factors, including humility, and connections to mental and physical health. Krause's (2010) first study showed that humility was positively associated with self-rated physical health (β = .27), and Krause's (2012) second study offered evidence that as humility increases across time it is associated with similar increases in self-rated physical health over the same time span (β = .11). In both studies, confounding variables such as sociodemographics and religiousness were controlled. The third study (Rowatt et al., 2006) offers relevant evidence, though sampling, measurement, and control of confounds are not as rigorous. Nevertheless, Rowatt et al.'s (2006) study showed that measures of humility, both a single item (r = −0.22) and a semantic differential scale (r = −0.21), showed negative associations with unhealthy physical symptoms. With few studies to draw from, it would be reckless to offer sweeping conclusions, but the evidence appears to lean in favor of the notion that humility is associated with better physical health.

Limitations of Existing Work

Before reaching any conclusions about the state of the evidence on the relationship between humility and health, it would be prudent to consider first the numerous limitations of this small body of work. First and foremost, the evidence base is quite small. Second, most of the samples are convenience samples of college students. Third, no established gold standard of measurement exists for humility. Measures used have shown some, but often not sufficient, evidence of psychometric soundness. Fourth, only one experimental study and one prospective population-based study have been completed. The rest are cross-sectional, correlational studies. Fifth, all measures of health are self-reported, and no objective health indices have been used.

Conclusions

The existing literature provides a foundation on which to base future work. The data offer a suggestion, though not yet well replicated, that humility might be positively related to both mental and physical health. The same might be said for the relationship between humility and some, but not all, kinds

of happiness. Associations between humility and mood, life satisfaction, and subjective happiness were not common, and when they did exist, were small in magnitude. Stronger associations were observed between humility and broader conceptualizations of happiness that included such things as autonomy, self-acceptance, positive-relations, mastery, purpose, and growth. A common mantra of positive psychologists is that the absence of the negative (e.g., narcissism) does not guarantee the presence of the positive (e.g., humility) (Tangney, 2009). But beyond that understanding, it may be important to consider that positive psychological traits and virtues may not facilitate all types of positive health and well-being end-states. That is, it might be that humility has inverse associations with poor mental health (e.g., depression) but is unrelated to some forms of happiness. We suggest this based on a few studies. Careful consideration of measurement issues and samples is important before drawing too strong of conclusions on the matter. Given the early state of the literature and the tentative nature of our conclusions, we turn to what future research might bring to bear on the question of if and how humility might be related to health.

Research Agenda

Because the research base is quite small at the present moment, much of the low-hanging fruit remains to be picked. Straightforward and methodologically sound studies can make considerable contributions to the literature. We consider several lines of research to address the humility and health connection.

Measurement

Brief humility measures are needed for use in health studies with sick or challenged patient populations. Efficient measures are also useful in health experiments and epidemiological studies where time and survey space are limited. Krause (Krause, 2010, 2012, 2014) has used an abbreviated four-item version of Peterson and Seligman's (2004) measure and shown scores with good estimated internal consistency and construct validity in divergence from other constructs. Likewise, the measures offered by Rowatt et al. (2006) are useful because of their brevity (one-item humility thermometer and seven-item semantic differential scale) and good estimated internal consistency. Regretfully, none of these measures have been subsequently evaluated in independent samples, but this verification could be done. Davis et al. (2011) have made a valuable contribution in developing a psychometrically sound assessment appropriate for health studies, and a brief five-item version is available. There are some good beginnings here in the measurement of humility for health studies. Investigators

should extend this work and more rigorously evaluate these assessments, keeping a keen eye to length.

Health

Presently, assessment of health outcomes is limited to self-report measures. Self-reports of health are valid predictors of physical health outcomes (Idler & Benyamini, 1997), but conceptualization and assessment of health could be expanded. For instance, often measures of pain, impairment, or functional status are relevant to health researchers because of what they indicate about health status and health-related quality of life. Health behaviors, including but not limited to, nutrition, exercise, sleep, and substance use, should be included. Finally, psychophysiological measures (e.g., blood pressure, heart rate), biomarkers (e.g. cortisol, adrenaline), and neural measures (e.g., functional magnetic resonance imaging [fMRI], positron emission tomography [PET]) of humility remain to be explored.

Sample

Much humility-health data come from college students. These samples are fairly idiosyncratic, being from Christian schools or from countries such as Iran, Poland, and Malaysia. The only two existing published population-based studies come from the same population of Americans with an average age of 78 years. Representative, population-based work investigating humility and health in young and middle-aged adults is simply absent despite the mounting evidence that lack of humility and growing narcissism are concerns not as much of the older generations but much more so for younger generations (Twenge, 2014). Growing narcissism in more recent generations could be resulting in poor health outcomes (Reinhard, Konrath, Lopez, & Cameron, 2012), but how humility is involved in health is unclear because it simply hasn't been studied in adolescents and young and middle-aged adults.

Cause and Effect

Presently just one study speaks to the *effect* of humility on health. Kesebir (2014) showed, in a humility priming experiment, that humility can protect individuals from death anxiety. Investigators would be wise to build from Kesebir's priming model to design experimental studies. The methodology used by Kesebir is straightforward and holds good promise for replication. Furthermore, it could be easily extended to examine the influence of humility priming on depressive affect, generalized anxiety, stress, and somatic and other symptoms of psychological distress. In addition, humility interventions could be used to

examine the effect of increases in humility on health. Interventions are sparse at the moment, but Lavelock et al. (2014) have developed and evaluated an approach that is efficacious in promoting humility. Intervention trials in both healthy and patient samples investigating the impact of humility promotion on health conditions would be valuable contributions to the literature.

Mechanisms of Action

Studies need to be designed to understand why humility might be linked to health. Our model outlines several mechanisms of the association between humility and health. Stress and social support are key mediators, but research suggests that so, too, are forgiveness (Davis et al., 2011), gratitude (Kruse, Chancellor, Ruberton, & Lyubomirsky, 2014), religiousness and spirituality (Krause, 2010), self-regulation (Davis et al., 2013), and positive and negative emotion (Davis et al., 2011). Our model also suggests that humility acts as a buffer against the untoward effects of negative affect and stress on health. Krause (2014) provided early evidence of this model, showing that the effect of stress from interacting with religious congregations on depression was buffered by humility. What other specific types of stress might be buffered by humility? Might the buffering effect of humility act more powerfully for religious versus nonreligious individuals or vary based on spirituality (see Webb, Toussaint, & Dula, 2014)? Might humility play a role in the relationship between temptation and health (see Webb, 2014) or the associations among spirituality, forgiveness, substance abuse, and suicidal behavior (see Webb, Hirsch, & Toussaint, 2015)? Might the role of humility be influenced by other factors such as age, gender, or socioeconomic status? Many questions remain in this area, and studies designed to specifically examine mediating and moderating models of the humility-health connection would be useful.

Practical Lessons

At the moment early studies favor the notion that humility might be healthy for body and mind, but studies are sparse. Consequently, considering the applications of this knowledge has to be done with a degree of considerable caution. Our ideas about practical applications are probably better framed in terms of what *might* be useful if continued, rigorous scientific studies bear out what early work promises. If that is the case, then there are many reasonable extensions of this knowledge into everyday areas of life. First, because religious communities are some of the earliest commentators and teachers on the topic of humility (Hook & Davis, 2014; Krause, 2010), it would prove useful to know that what is fitting with theological doctrine is also in alignment with good public service and public health. Many religious communities

are involved in health ministries either as direct outreach efforts (i.e., part of social outreach) or as supporting partners of healthcare facilities (i.e., founding or financially supporting partners in clinics and hospitals). Understanding the health effects of humility offers a unique intersection between religious teaching and health promotion in which multidisciplinary teams of chaplains, psychologists, physicians, and nurses can collaboratively work. Second, college campuses are being overwhelmed by students in need of mental health services (Kadison & DiGeronimo, 2004). Growing narcissism and entitlement in college students of today (Twenge, 2014) may be bringing with it mental health struggles. Humility, with its emphasis on accurate self-perception, selflessness, and other-orientedness, may be just what today's college students need. Facilitating conversations about humility between students and their professors, coaches, residence hall assistants, and other members of student-life teams may be especially useful. Undoubtedly, these conversations will have to be brief, but effective, and able to squeeze between all the commitments and challenges that college students face. Third, the Twelve-Step Model warns against self-centeredness as the crucible of addiction and stresses the critical role of humility in recovery (Alcoholics Anonymous, 2001). Empirical verification of this long-standing yet anecdotal observation will likely strengthen resolve in the recovery community. Finally, extensions to businesses, nonprofits, philanthropic organizations, and governments are warranted if the case for healthy humility can be made. Encouraging humility among employees and volunteers may not only bring organizational benefits by enhancing productivity, but it may also bring rewards in fewer sick days and health insurance claims and improved functioning in the workplace. The practical applications of humility and its end-game bonus to health seem almost boundless, and continued attention to this intriguing connection will bring greater understanding of when and why humility might bring health gains and in what contexts it is best to encourage it.

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