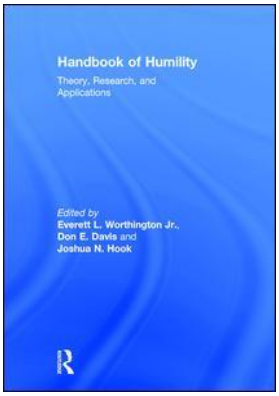

Handbook of Humility
Theory, Research, and Applications

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HUMILITY INTERVENTION RESEARCH

A Qualitative Review

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Thomas Aquinas defined virtue as *ultimum potentiae*, or the highest potential a person could achieve (Alvarez-Segura, Echavarria, & Vitz, 2015). The positive psychology movement has long supported the promotion of virtue-based flourishing, both in the presence and absence of adversity (Peterson & Seligman, 2004; Seligman & Csikszentmihalyi, 2000). In this chapter, we define humility and consider its role in psychopathology, making the promotion of humility of interest. Next, we review the few existing studies that explore how one might work to increase one's level of humility and consider the extent to which the promotion of humility is adaptive. We then highlight the sparse amount of humility intervention research and propose future research directions.

What Is Humility?

Humility is a warmth-based virtue involving intrapersonal and interpersonal qualities. Intrapersonally, humility is characterized by an accurate view of the self, understanding one's strengths and weaknesses, and acknowledging one's limitations. Interpersonally, humility involves presenting oneself modestly and sensitively and maximizing one's orientation to others above the self, fostering connection while "transcend[ing] egotistical concerns and the attendant urge for defensive, self-serving maneuvers" (Davis et al., 2011; Hook & Davis, 2014; Kesebir, 2014, p. 611; Worthington et al., 2015). When people worry less about their own needs or interests, freedom exists to care for the needs and interests of others (Van Tongeren, Davis, & Hook, 2014).

Humility, Mental Illness, and Psychotherapy

Radical individualism in Western society makes humility a challenge. Sentiments such as "look out for number one," and "you do you" emphasize the primacy

of the self in today's world. Although some attention to the self is important and adaptive, radical glorification of the self engenders a culture of narcissism, entitlement, overcompetitiveness, attention seeking, and self-obsession (Gilbert & McGuire, 1998; Myers; 2000; Putnam, 2000; Twenge & Campbell, 2009). For example, in a pair of studies examining American books published in the twentieth century, usage of terms related to Christian values, such as humility, patience, kindness, gratitude, and charity, significantly decreased over time (Kesebir & Kesebir, 2012). This decrease may be in a parallel decline with religious affiliation, which has traditionally supported the idea of a disciplined ego and a greater focus on the public good (Chaves, 2011) and is consistent with the burgeoning *Zeitgeist* of self-interest.

In this normatively egocentric paradigm, psychotherapy is rarely pursued for the sake of promoting humility (Worthington, 2007). Moreover, clients in psychotherapy rarely make humility an explicit treatment goal, despite humility's implications for positive relationship functioning (Davis et al., 2013). Nonetheless, humility plays a central role in the psychotherapeutic relationship (see Davis & Cuthbert, this volume; Drinane, Owen, Hook, Davis, & Worthington, this volume; and Sandage, Rupert, Paine, Bronstein, & O'Rourke, this volume). For example, the very act of seeking help through psychotherapy requires humility, because the patient acknowledges his or her limitations and accepts help from another person. The patient is also willing to be vulnerable, acknowledge his or her role in causing or maintaining his or her problems, and learn and take assistance from another person (Rowden, Harris, & Wickel, 2014). Conversely, narcissism in patients has been implicated in poorer treatment outcomes relative to humble comparisons (Hart & Huggett, 2005).

The success of psychotherapy is also contingent upon the humility of the psychotherapist (Sandage, Chapter 21, this volume; Owen, Chapter 22, this volume; Worthington, 2007). The ethical psychotherapist humbly enters the patient's value system and exercises cultural and intellectual humility, allowing not only tolerance and acceptance of the patient's differences, but also facilitating growth and positive change within the patient's cultural context (Gregg & Mahadevan, 2014; Hook et al., 2013). A patient is often sensitive to a psychotherapist's humility. When clients view their therapists as humble, this allows the client to risk greater vulnerability, which leads to better outcomes in psychotherapy (Owen et al., 2014).

Self-Focus, Shame, and Low Humility

One reason humility may be important to promote is that pathology often involves various forms of low humility (e.g., egocentric cognition, emotions, and motivations and narcissistic vulnerability; Alvarez-Segua et al, 2015; Book, Visser, & Volk, 2015). For example, narcissism and paranoia have obvious links to self-focus, whether it is a defensive and grandiose love of self or whether it

involves an uncomfortable concern that others show care for them more than the others really do (Dwiwardani, 2012; Exline, Baumeister, Bushman, Campbell, & Finkel, 2004). Social anxiety charades as concern about others, but it is more likely concern for how others perceive the self. Depression can be considered a heightened focus on one's own sadness, making it difficult to know or connect with anyone or anything beyond the suffering of the self. Patients suffering from obsessive-compulsive disorder tend to burden themselves with the idea that the fate of self and others depends on their rituals. Disordered eating centers around self-image and self-doubt. Substance abuse and impulsivity are born of the need to find relief or feel good *right now*. Grief desires departed loved ones, and existential identity issues involve struggling with the self's physical demise (Kesebir, 2014). Trauma strands the self in a shameful past (Andrews, Brewin, Rose, & Kirk, 2000), whereas anxiety ruminates on the self's future. Borderline personality insists that others are the problem and never themselves; histrionic personalities crave attention to the self; dependent personalities insist that others care for the self; and antisocial personalities lack the capacity to empathize with others beyond the self. Almost by definition, pathology involves various ways of addressing the needs of the self in ways that have been deemed problematic for social living. Thus, we might conceptualize much of the psychotherapeutic enterprise as an exercise in ameliorating various forms of self-focused thoughts, feelings, and behaviors that make a person less fit to contribute to society, let alone flourish personally or interpersonally.

Most people do not set out to get entrenched in ineffective strategies of balancing their own personal needs with the needs of others. Rather, self-focus often develops somewhat unconsciously, and the fire is accelerated by shame. Shame—a quiet devaluation of the self—begs not to be seen (Lewis, 1987). Behavior appraised as bad becomes an indication of the bad self (e.g., if people really knew who I am, they would harshly judge me). Shame is painful and sometimes leads to maladaptive behaviors (e.g., moral disengagement, avoidance, withdrawal, secrecy, compartmentalization of the self; Shapiro & Powers, 2011).

If the heart of coping with shame involves moral disengagement (Fossati, Pincus, Borroni, Munteanu, & Maffei, 2014)—or numbing oneself to the pain of being judged as morally bereft and thus unfit for close relationships—then it makes sense for humility to facilitate moral engagement after shame. Humility may help to free the self from the debilitating effects of shame on human personality. For example, humility helps people become aware of defenses that socially isolate the individual and preempt the potential for healing and social integration, including strengthening of social bonds and the give-and-take of help and compassion within a healthy relational system. Humility allows one to see what has been intolerable to see and connect that which shame has

disconnected. Thus, humility exposes the self to the self, vulnerably and accurately, and allows the person to see beyond shame to correctively experience connection to others. Shapiro and Powers (2011) thus note, "It is only when shame reaches the light of day that the healing process can begin" (p. 125).

Interventions Designed to Promote Humility

Humility has only recently gained empirical attention, and relatively limited work has focused on promoting humility. Recent research supports the importance of secure attachment style in early childhood as a predictor of humility (Dwiwardani et al., 2014). Psychotherapeutic modalities that emphasize corrective emotional experiences related to establishing secure relationships can benefit patients who developed shame as a result of insecure attachments during formative years. Relatedly, mentalization, or "the ability to attend to the mental states of self and others" (Worthington & Sandage, 2016, p. 190), is born of security and may lead to humility.

But what of specific interventions designed to promote humility? A PsycINFO search of "humility" conducted on November 18, 2015, yielded 1,483 results; further refinement using the search term "intervention" winnowed results to 47. Of these, three related to the direct promotion of humility using a targeted intervention. The first of these, "wisdom therapy" (Robins, 2008), was introduced as a method for facilitating humility, well-being, mindfulness, and ultimately wisdom. Wisdom therapy combines cognitive behavioral, mindfulness-based, and humility-driven techniques to ameliorate anger, anxiety, depression, antisocial personality behaviors, and narcissism. Narcissism was specifically targeted in wisdom therapy, with the fearful aspect of narcissism being addressed using cognitive behavioral therapy (CBT) and the grandiosity aspect of narcissism being addressed with humility. The humility portion of the intervention treats humility as an appreciation that one's perceptions are limited, and the intervention aims at loosening any rigid assumptions and expectations that attend certainty of one's rightness. A second aspect of the intervention was to induce awe and respect for the size and complexity of the universe. A third aspect of the intervention was to undermine certainty that what we see is real. Visual illusions were used to undermine confidence in one's visual perceptions.

This intervention is a limited humility intervention. The stated goal of the intervention is to help people develop more wisdom through increasing humility. We note several weaknesses in this research. First, the available research was never adjudicated by peer review. Second, no process research was done that demonstrated that (a) humility was actually promoted by the intervention or (b) that people achieved some measure of wisdom to the degree that they attained humility. In fact, one dissertation study found that wisdom therapy did

not promote humility more than rational emotive behavior therapy in a sample of substance-dependent clients (McCulloh, 2009). Thus, although the claims relate to humility, the supporting evidence for this as an evidence-based intervention for promoting humility specifically is limited.

Second, a workbook intervention to promote humility (Lavelock, Worthington, & Davis, 2012; available at www.EvWorthington-forgiveness.com) was created in response to a need for a protective buffer of humility against mental illness, as well as to a call for mental health resources that could be widely disseminated (Kazdin & Rabbitt, 2013). Early conceptual research informed the workbook content, including (a) acknowledging accuracy regarding self-strengths and limitations, (b) inducing states of awe for things greater than or beyond the self, (c) performing menial tasks, (d) seeking forgiveness for one's transgressions, (e) recording thoughts of gratitude daily, and (f) furthering close relationships (Peterson & Seligman, 2004). Grounded in these tenets, the 80-page workbook guides participants through five steps to promote humility, forming the acrostic PROVE: **P**ick a time when you were not humble, **R**emember your abilities within the big picture, **O**pen yourself, **V**alue all things, and **E**xamine limitations (for a detailed description of the workbook, see Lavelock et al., 2014).

Initial research has supported the efficacy of the humility workbook (Lavelock et al., 2014). Between pre-test and a follow-up two weeks after workbook completion, 26 undergraduates in the workbook condition reported significantly greater increases in trait humility than did the 33 undergraduates in the control condition, who did not change in humility over time. Participants in the humility condition also saw gains in trait forgiveness and trait patience and decreases in trait negativity; the participants in the control condition did not. Neither religious commitment nor spiritual transcendence predicted increased humility as a result of the workbook, demonstrating the accessibility of humility for both religious and nonreligious individuals (Lavelock et al., 2014).

The initial study had notable weaknesses. First, the number of participants was small, and the population was undergraduate students at a public university. Second, only trait or dispositional measures were used, and the time of follow-up was only two weeks. Longer-term assessment is needed to ensure that the results are replicable. Third, all intervention research is specific, despite the claims to promote changes in its focal construct (in this case humility). However, just because a treatment claims to promote humility does not mean that is what is happening. Though randomized controlled trials seek to control for effects of repeated assessment, there is no guarantee that the retested control condition controlled for demand characteristics associated with participating in any intervention.

However, further analyses have compared the humility workbook to additional workbooks. Each workbook was designed to promote a particular virtue (e.g., forgiveness, patience, self-control) (Lavelock et al., 2016). These three workbooks each resulted in significant improvement for their target virtue, and importantly to the contention that virtues are interrelated, each workbook showed significant improvement among other trait virtues as well. Participants who completed the humility workbook, however, reported the most statistically significant improvements compared to other workbooks. Participants in the other workbook conditions did not report improvements in humility. This might be interpreted that humility might be a higher-order virtue that promotes a variety of other virtues. The main conclusion after the study by Lavelock et al. was that replication and further analyses were needed, especially given that the results still could have been shaped by demand characteristics.

The humility workbook was then revised to refine and clarify concepts and minimize redundancy. The revised version (Lavelock, Worthington, & Davis, 2013) yielded an identical constellation of outcomes as in the primary efficacy trial, with improvements in trait humility, trait forgiveness, and trait patience and decreases in trait negativity (Lavelock et al., 2016). This exact replication minimizes the threat of demand characteristics as the primary agent behind these results. Importantly, the major difference between the two versions of the workbooks was not in number of outcomes or average completion time, but in effect size; the effect size of the revised humility workbook was .86, compared to .35 for the original (Worthington et al., 2014).

The third intervention to promote humility was an art intervention, called Shibboleth, intended to promote humility and self-awareness and prevent hubris in leaders (Romanowska, Larsson, & Theorell, 2014). In this intervention, 20 leaders and 64 subordinates provided written responses and participated in guided group discussion after witnessing a 60- to 70-minute art performance representing multiple genres, media, and moods. These participants were compared on several leadership measures to another group of 20 leaders and 66 subordinates who participated in a more conventional leadership training seminar. Leaders in the art group improved self-awareness, humility, and stress coping and demonstrated a style of leadership less characterized as laissez faire. Romanowska et al. (2014) posit that the performance's inclusion of topics of genocide, suffering, and injustice may have been important factors in this change. We note that this intervention does not explicitly target humility. Furthermore, leadership, rather than humility, was the target of the intervention.

In conclusion, the intervention workbook to promote humility (Lavelock et al., 2013) appears to be the only existing intervention to specifically target the cultivation of humility. Although there is preliminary evidence of its

efficacy, much more research is needed. This includes use of state measures of humility as well as dispositional measures, careful process research on what elements of the workbook are active treatment ingredients, and use of alternative conditions that control for demand characteristics. In addition, it is possible to critique the content of the workbook in light of the definition we advanced. We noted six elements of the workbook earlier. These were (a) acknowledging accuracy regarding self-strengths and limitations, (b) inducing awe for things beyond the self, (c) performing menial tasks, (d) seeking forgiveness, (e) gratitude, and (f) furthering close relationships. According to our three-part definition (i.e., accurate view of self, modest self-presentation, and other-orientation), the intervention covered accurate self-appraisal in element 1 and other-orientation in elements d, e, and f. However, little attention was given to modest self-presentation. Thus, more could be done to strengthen the PROVE Humility intervention.

Humility in Moderation

Scholars have recently argued that virtues can have a "dark side" when used in excess or in inappropriate circumstances (McNulty & Fincham, 2012). In fact, almost every virtue examined in positive psychology has generated studies examining how the benefits of that virtue may have important boundary conditions. For example, forgiveness is generally thought to be an important virtue. However, for a person who is a victim of physical abuse, perhaps the virtue of courage, leading to behavior that prioritizes seeking safety for oneself and one's children, should be prioritized over forgiveness. After safety is achieved and one has established appropriate boundaries, one can then perhaps consider forgiveness. Indeed, virtuous behaviors require appropriate balance with other virtues. Thus, despite the many theorized and some empirically supported benefits of humility (Davis & Hook, 2013; Kesebir, 2014), it might be wise to consider the adage, "all things in moderation," in application to humility.

As such, there are likely limitations and boundary conditions to humility as well. For example, humility involves an accurate view of self and modest self-presentation. However, there may be situations in which it is adaptive for one's mental health and well-being to have a positive illusory bias (Taylor & Brown, 1988), and years of research on self-esteem demonstrates that it is possible to take awareness of limitations and modest self-presentation to the point of low self-esteem or fragile high self-esteem (Baumeister, Campbell, Krueger, & Vohs, 2003). Also, humility involves an interpersonal stance that is other-oriented rather than self-focused. However, we acknowledge that contexts indisputably occur in which it is important for individuals to prioritize one's own needs and wants rather than defer to the needs and wants of others.

Additionally, situations certainly exist when it is important to stand firm to one's convictions, even if it differs markedly from the convictions of others. In these ways, a moderate exercise of humility, as seems to be the case with other virtues, may be merited. And yet, humility is hallmarked by its accurate *and* moderate view of the self. One who is truly humble embodies this moderation, so to be too humble may not be possible.

Future Directions and Practical Lessons

Humility research has flourished in recent years; yet, because humility is relatively new to the empirical scene, far more work must be done to explore the construct, its implications and relationships to other constructs, and how it can be predicted and cultivated. The evolving definitions and measurement strategies for studying humility have presented a challenge for humility intervention research thus far, but as basic humility research advances, applied research and practical applications can follow.

Predictors of *who* benefits from humility intervention remain elusive, as little predictive research has been conducted to determine what personality traits and factors may lend themselves best to noticeable improvements in humility. For example, the role of attachment in the development of virtues should continue to be explored (Dwiwardani et al., 2014). Additionally, though a workbook to promote humility has evidence supporting its efficacy in healthy populations, the utility of humility and interventions to promote it in clinical samples represents an exciting area for future research and application. Given the implication of maladaptive self-focus in a number of diagnosable pathologies, future research should explicitly assess the efficacy of humility interventions for treatment of specific psychological disorders. Such research would also shed light on the utility of humility for acute stressors relative to more chronic concerns.

Predictors of *when* humility intervention is necessary and most successful have also yet to be examined. For example, it may be that promoting humility is most necessary or successful during a depressive episode, following an argument, or in the aftermath of a traumatic experience. Alternatively, it may be during times of stability or following a meaningful accomplishment. Future research should examine the life circumstances under which humility intervention is the most needed and effective. This line of research may also reveal whether the presence of other virtues (e.g., forgiveness following conflict, gratitude following an accomplishment) facilitates humility or perhaps whether it is humility that facilitates other virtues.

When considering the *who* and *when* of humility intervention, modality (i.e., the *where*) is an important and yet relatively unexplored factor in humility intervention. Given that humility is a multifaceted construct, composed

of intrapersonal and interpersonal factors, certain components may be more effectively promoted in specific contexts. For example, the group psychotherapy modality may lend itself well to interpersonal humility promotion (e.g., increasing in other-orientedness), as group psychotherapy is a shared environment where shame is often addressed interpersonally. This could have a strong propensity for both increased humility, as well as a corrective emotional experience (Shapiro & Powers, 2011). Alternatively, a more private, self-directed experience may lend itself well to intrapersonal humility promotion (e.g., accurate self-appraisal). Workbook interventions such as Lavelock et al. (2013) capitalize on the participant's self-reflection, a powerful agent of change according to a number of therapeutic orientations. Future research would do well to examine the growth of specific components of humility across a number of modalities (individual psychotherapy, group psychotherapy, self-directed intervention, etc.); in particular, process research on the humility workbook intervention can illuminate exactly which exercises are effective for which components of humility.

An important practical application of humility and its research is greater understanding and acknowledgement of *why* humility is a vital in the therapeutic process. Cultural and intellectual humility should be emphasized in training programs and in continuing education (Hook et al., 2013; Owen et al., 2014). Further research is necessary to examine patient perceptions and outcomes related to the humble clinician, as well as the role of humility as a mechanism of positive change in psychotherapy. Qualitative methods may be especially helpful for detailing the process of successful psychotherapy, both in specific humility interventions and in more general interventions provided by the humble therapist. In general, greater reliance on multiple methods, rather than simply self-report, will also supplement findings in future studies testing humility interventions on wider, and potentially clinical, contexts; specifically, behavioral measures of humility can add an accurate and nuanced view of humility and why it is can be effective for clinical treatment (Davis et al., 2011; Dorn, Hook, Davis, Van Tongeren, & Worthington, 2014).

Conclusion

Leary (2004) writes that the self is both our greatest ally and our worst enemy. Humility may yield the optimum relationship with the self; one which knows and acknowledges the self, while disabling shame and self-focus and diminishing the need for defenses that can escalate to mental illness. We conceptualize humility as therapeutic for mental health, yet very little research has sought to promote humility with specific interventions. The impact of interventions to promote humility is far from fully realized; thus, it is essential

that researchers continue to seek ways to promote humility and implement them in clinical practice.

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