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What is Humility Good For? A Meta-Analysis of Humility, Health, and Well-Being

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Abstract

Humility, the organizing virtue of multicultural frameworks in counseling psychology, has traditionally been framed to be positively associated with health and well-being and negatively associated with mental illness. Despite lauded benefits, however, scholars have cautioned that humility may not always be of benefit. To examine these associations, we conducted a meta-analysis to clarify the magnitude of the associations between humility and physical health, mental illness (i.e., depression, anxiety), life satisfaction, and eudaimonic well-being (i.e., meaning in life, purpose in life), in addition to testing moderators. The final sample included 65 studies, with results yielding small to medium associations (*r*s ranged from −.06 to .20) between humility and examined outcomes. Results suggest that the size and direction of

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associations depend on methodological choices and cultural contexts. Implications for studying the cultural context of humility are discussed.

Keywords
humility, health, well-being, meta-analysis, positive psychology, multiculturalism

Significance of the Scholarship to the Public
This meta-analysis on the associations between humility and physical health, mental illness, and well-being suggest that existing claims about the benefits of humility may be overstated, amplifying the need to integrate multiculturalism and positive psychology within counseling psychology. This work provides rationale calling for further empirical work on examining humility within specific multicultural contexts.

Humility is a virtue that is esteemed as essential, if not central, to popular multicultural frameworks in counseling psychology (e.g., cultural humility; Davis et al., 2018). Over decades of work, humility has established a firm research base positing a host of benefits to relationships, physical health, well-being, and protection against mental illness (Van Tongeren, Davis et al., 2019). At first glance, there seems to be no question: cultivating greater humility promotes health and well-being. However, a closer examination of humility research seems to tell a more complex story; some research suggests small to nonsignificant findings (e.g., Aghababaei & Arji, 2014) or even deleterious effects of humility (e.g., humility in the workplace may disadvantage women; Priebe & Van Tongeren, 2021). Such findings align with critiques of positive psychology that suggest that the study of virtues has faced difficulties involving small effect sizes (Davis et al., 2016) and lack of generalizability across cultures (van Zyl et al., 2024).

Given the centrality of human strengths within counseling psychology to sustain work towards justice (e.g., French et al., 2023), counseling psychologists are well-positioned to address interdisciplinary tensions emerging from work on character and virtue. In the current article, we use scholarship on humility as an example of how conceptual work within positive psychology may have traditionally over-simplified narratives about the benefits of virtue and character strengths such as humility. As an initial step, we meta-analytically synthesized work on the associations of humility with physical

health, mental illness, and well-being to examine whether the strength of associations are as strong as claimed by mainstream theories. We provide implications for future research to examine the effects of humility within specific cultural contexts, such as those for marginalized groups.

Defining Humility

Intrapersonally, humility is conceptualized as having an accurate view of oneself—not too high or low—as well as an other-oriented stance, focused on valuing others to strengthen relationships rather than prioritizing one's own interests and needs (McElroy-Heltzel et al., 2019). The behavioral expression of humility is defined as having three aspects: (1) accurate self-presentation and an attitude of teachability, (2) modest self-presentation, and (3) being oriented towards the betterment of others (Worthington & Allison, 2018). Psychologists have studied humility as a trait (e.g., Honesty-Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness, Openness to Experience (HEXACO); Ashton & Lee, 2009), a virtue (e.g., intellectual humility; Krumrei-Mancuso & Rouse, 2016), and a sociocultural value (e.g., humility as an Asian value; Kim et al., 2005). Scholars have tended to simplify measurement of humility by focusing on its behavioral expression within specific social roles (e.g., leadership; Owens et al., 2013) and relational contexts (e.g., humility towards one's values and beliefs; humility regarding culture, Hook et al., 2013). Accordingly, definitions of humility are often contextualized to specific kinds of roles and social problems, which in turn lead to measures contextualized to different roles or situations (e.g., intellectual humility, political humility, cultural humility; McElroy-Heltzel et al., 2019).

Humility has been examined within the context of various indicators of physical health, mental illness, and well-being. In this meta-analysis, we examine the associations between humility and four broad indicators of well-being: physical health, mental illness, life satisfaction, and eudaimonic well-being.

What is Humility Good For?

Most of the research on humility has generally lauded its benefits to health and well-being (see Van Tongeren, Davis et al., 2019 for a review). The humility-health hypothesis (Toussaint & Webb, 2017) suggests that people higher in humility will engage in a range of intrapersonal and interpersonal behaviors that contribute to better physical and mental health. Intrapersonally, humility eases one's mental and physical burdens through mechanisms such as less

rumination, greater ability to cope with negative emotions, greater openness to experience, and greater security in sense of identity (Chancellor & Lyubomirsky, 2013; Toussaint & Webb, 2017). Interpersonally, humility is theorized to increase the quality of social relationships and support through the social bond hypothesis (i.e., promoting and strengthening relationships; Van Tongeren, Hook, et al., 2019) and social oil hypothesis (i.e., buffering the cost of conflict in relationships; Van Tongeren, Hook et al., 2019). Research has supported such claims: humility has been associated with better physical health (Krause et al., 2016), life satisfaction (Chen et al., 2023), meaning in life (Aghababaei et al., 2016), and purpose in life (Tong et al., 2019), as well as less depression (Van Tongeren, Davis et al., 2019) and anxiety (Powell et al., 2021).

Recent critiques and research on humility, however, have suggested that humility may be detrimental to health and well-being in certain contexts. Greater attention has been placed to the potential need to contextualize discussions of humility (and its application to multicultural challenges within psychotherapy) to the power dynamics that exist within broader society. For example, research examining humility in the context of gender suggests that there is an expectation that women express greater humility than men. This may result in women paying a penalty relative to men for expressing 'arrogance' (i.e., the same behavior) in workplace negotiations (Priebe & Van Tongeren, 2021). Within the context of counseling, clinicians of color may experience unique vulnerabilities to applying cultural humility with clients, particularly when there is a power difference due to race (i.e., clinician of color working with a White client; Choe et al., 2024; Moon & Sandage, 2019). In such cases, using virtue language such as humility may create a structure for maintaining social advantages (e.g., such as allowing someone to act more selfishly or assertively without being labeled arrogant) or perpetuating existing systems of privilege and oppression. In fact, some have suggested that humility is a "burdened virtue" (Tessman, 2005), where others are benefited at the expense of giving up one's own self-interest. Liberation psychologists and theologians have carefully examined these kinds of constructs for potential abuses of power (Floyd-Thomas, 2020).

Meta-analytic strategies have often been used to estimate overall effect sizes across studies when a body of literature presents with conflicts and inconsistencies in theory and research. Such techniques can help to identify moderating factors and to provide direction for future research. To our knowledge, no research has meta-analyzed the body of research linking humility to its associations with physical health, mental illness, and well-being. As such, we seek to aggregate effect sizes across empirical work on humility to identify contextual and boundary conditions that impact the

strength and direction of associations of humility on physical health, mental illness, and well-being.

Contextual Factors on the Impact of Humility

Given initial reviews that suggest both salubrious and deleterious effects of humility, it is important to clarify contextual factors that explain when humility is beneficial or costly to physical health, mental illness, and well-being. As such, we identified several moderators that may begin to identify important boundary conditions that impact the strength of associations: domain of health, measurement of variables, sample characteristics, sampling strategy, nation/cultural context, and religious/existential context.

Domain of Health and Well-Being. In this study, we examined the associations between humility and four broad domains of health and well-being: (1) physical health, (2) mental illness (i.e., depression, anxiety), (3) life satisfaction, and (4) eudaimonic well-being (i.e., meaning in life, purpose in life). Surely, humility may show stronger associations with some indicators of well-being over others. For example, in what we may call the humility-well-being hypothesis, Aghababaei and colleagues argue that humility is more strongly and consistently related to indicators of eudaimonic rather than hedonic well-being (Aghababaei & Arji, 2014; Aghababaei et al., 2016). Furthermore, research examining the effects of humility on physical health have been small (Krause et al., 2016; Yoon et al., 2022) compared to mental illness (Mosher et al., 2019; Suh et al., 2020).

Measurement of Humility. How humility is defined and measured may moderate the associations between humility and health/well-being. Various assessments have been created to measure humility as a trait, sociocultural value, and as a virtue. Additionally, specific measures have been developed across various contexts, including in relational contexts, cultural contexts, and existential contexts. For example, given that eudaimonic well-being focuses on an individual's sense of alignment with values and visions of a life worth living (Ryan & Deci, 2001), it is possible that humility measured as an intellectual construct may not have as strong of an association compared to when it is measured as an existential construct.

Measurement of Health and Well-Being. Similarly, how health and well-being are defined and measured may moderate the strength of associations. There are a diversity of measures to capture any one construct; for example, physical health may be measured as a general feeling of physical energy and strength or

may be measured through reports of specific somatic experiences. Whether eudaimonic well-being is measured as "meaning" or "purpose" may also impact results, given that literature distinguishes these as two distinct constructs (George & Park, 2013). Furthermore, specific constructs may be measured by context. For example, anxiety may be measured as a state, a trait, or in the context of an interview, when driving, or related to existential contexts.

Sample. Whether humility is examined among student samples compared to community samples may moderate the degree to which humility is associated with health, well-being, and mental illness. Research has suggested that there is a difference in characteristics and demographics between these two samples, and each may have strengths and limitations in the quality of data and degree of validity (Novielli et al., 2023).

Nation/Cultural Context. The cultural and national context of where humility is studied is an important moderator to examine. Humility is defined and functions differently across contexts. For example, humility in Asian cultures is considered a sociocultural value where there may be social consequences (i.e., alienation, exclusion) for failing to demonstrate such a value (Suh et al., 2020). Further, research suggests that associations may look different depending on the country. McLaughlin et al. (2023) observed through latent profile analyses that groups of individuals with higher levels of intellectual humility reported higher levels of anxiety and negative affect in the United States and Hong Kong, but not the Netherlands.

Religious/Existential Context. Whether the study was conducted within a religious/existential context (i.e., religious participants, research question associated with religion/existential themes) was coded as a moderator in this meta-analysis. Recently, more research has suggested that humility may cause disadvantages in times of existential uncertainty (McLaughlin et al., 2023; Van Tongeren et al., 2023). When engaging existential doubts, humility towards one's beliefs, values, and worldview (i.e., intellectual humility) might undermine existential security (called the trade-off hypothesis of humility; Van Tongeren et al., 2016). For example, in a set of two studies, Van Tongeren and Colleagues (2023) observed that existential humility predicted greater death anxiety and lower levels of religious well-being. Thus, we expected that the association between humility and health/well-being would be negative in religious/existential contexts.

The Purpose of the Present Review

Although scholars often sing the praises of humility and its many benefits (e.g., for a narrative review, see Van Tongeren, Davis et al., 2019), our goal was to meta-analytically synthesize the magnitude and consistency of humility's positive association with well-being or its negative association with mental illness. As such, the body of research on humility on physical health, mental illness, and well-being is ripe for an examination using meta-analytic techniques. Humility research has proliferated over the past few decades, and researchers have called for greater synthesis of existing research (McElroy-Heltzel et al., 2019). Meta-analyses help to estimate overall effect sizes across studies and to identify inconsistencies in the findings. Such techniques can help to identify moderating factors and to provide direction for future research. Thus far, no research has meta-analyzed the body of research linking humility to its associations with physical health, mental illness, and well-being.

We sought to answer a fairly basic question: to what degree is humility associated with benefits to physical health, mental illness, and well-being? If effect sizes are small, the field may need to be more cautious about their claims on the benefits of humility. Alternatively, it may be that humility only provides health benefits under certain conditions. Indeed, theory linking humility with physical health, mental illness, and well-being is nuanced and conflicting. This warrants critical attention as counselors, supervisors, and educators have been attending to humility more closely as a target for intervention. Thus, the aim of these meta-analyses were to (a) examine the overall association between humility and physical health, mental illness, life satisfaction, and eudaimonic well-being; and (b) explore potential moderators of these associations. Given that this study is the first of its kind, hypotheses regarding moderators and directionality of associations were exploratory.

Method

Inclusion Criteria and Literature Search

Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines were followed to ensure best practices in conducting meta-analyses (Page et al., 2021). We set several inclusion criteria for our meta-analysis. First, we only included studies that were empirical and reported an effect size (e.g., Pearson's r); theoretical articles and case studies were excluded. Second, we only included articles that were written in English and contained (a) a measure of humility and (b) one or more measures of physical health, mental illness (i.e., depression, anxiety), life satisfaction, meaning in

life, and purpose in life. Type of measurement (e.g., self-report, other report, behavioral), sampling method (e.g., random, convenience, snowball sampling), and study design (e.g., cross-sectional, experimental, longitudinal) were allowed to vary. Both published and unpublished (e.g., preprints, dissertations, theses) studies were eligible for inclusion.

Defining Outcomes. For the purposes of this study, we narrowed our inclusion criteria to specific constructs of physical health, mental illness, and well-being. We examined physical health, which encompassed self-reports of general health status (e.g., poor, fair, good, excellent; DeSalvo et al., 2006) or somatic symptoms (e.g., pain, fatigue, physical functioning; Hays et al., 2009). We examine mental illness through measures of depression (e.g., depression, anxiety, and stress scales; Ali et al., 2021) and anxiety (e.g., Beck Anxiety Inventory; Beck & Steer, 1993) as these are two of the most common mental illnesses diagnosed in the United States (National Alliance on Mental Illness, 2023). We also examined life satisfaction, which is defined as the cognitive and affective evaluations that an individual makes of their overall life (Diener et al., 1985). For eudaimonic well-being, we examined meaning in life (i.e., sense of significance) and purpose in life (i.e., sense of goals, aims, and direction in life; George & Park, 2013).

Due to the scope of this study, we excluded several measures that may otherwise fit constructs of humility, physical health, mental illness, and well-being. We excluded measures of modesty, as humility researchers distinguish these as different concepts or suggest that modesty is only one subdomain of humility rather than encompassing the whole construct (McElroy-Heltzel et al., 2014). For mental illness, we excluded all conditions other than depression and anxiety, including stress and burnout. For eudaimonic well-being, we excluded measures of flourishing, happiness, and positive/negative affect. The defining of constructs were specified in this way to achieve a deeper understanding of associations between humility and physical health, mental illness, and well-being.

Screening Process. The screening process occurred in multiple steps (for an overview, see Figure 1). Initially, papers that included a measure of humility were identified. A search on PsycINFO and ProQuest was conducted for all empirical studies that included the term "humilit*" on January 31, 2024. The date range was not restricted for the search. This process yielded 7,179 articles, which were imported into Covidence Systematic Review Software (2024), a web-based collaboration systematic review software that streamlines the production of systematic reviews. Of these, 2,325 papers were removed as duplicates, leaving a total of 4,854 abstracts to be screened. Coders consisted

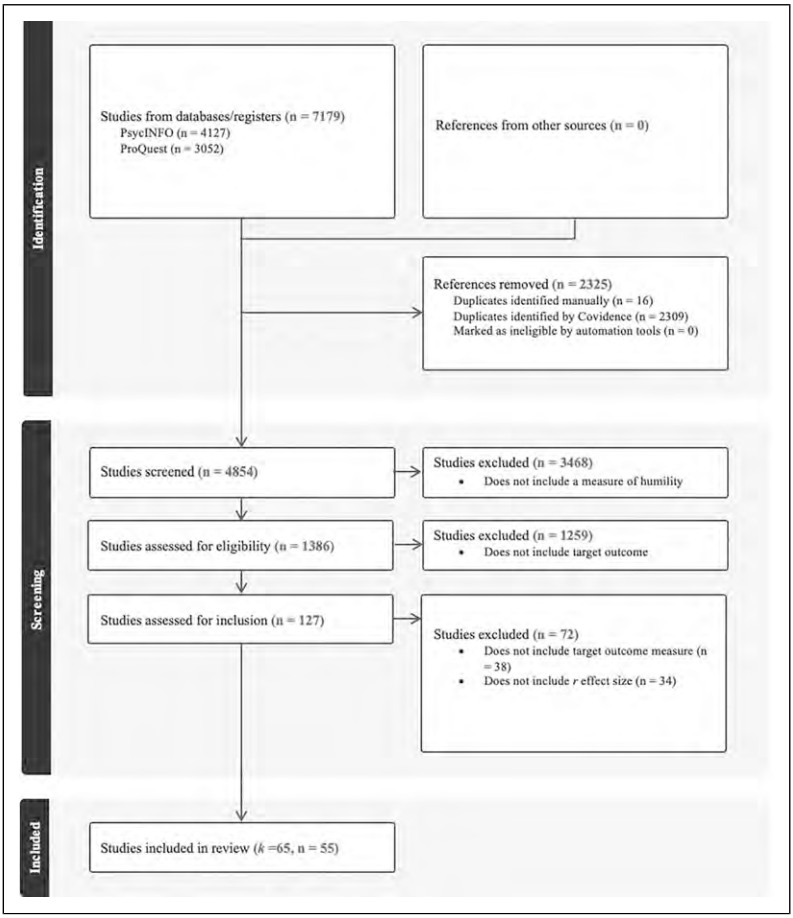


Figure 1. Flowchart of screening process

of a team of two counseling psychology doctoral students, a postdoctoral research associate, and two masters' level students in programs for mental health counseling. The first author of this study and a counseling psychologist with expertise in meta-analysis trained coders and provided feedback for the screening and coding process. Team members were provided a codebook and attended training meetings to practice coding until consensus became consistent. The team of coders met weekly to discuss progress of the coding and to settle disagreements or questions that arose in the process. Two or more coders had to agree on the inclusion decision for the article to pass the initial phase of

screening. Through this process, 3,468 papers were excluded. In total, 1,386 articles were subjected to a second round of screening, where they were examined for measures of physical health, depression, anxiety, life satisfaction, meaning in life, and purpose in life. Twenty-five percent of articles ($n = 350$) were double coded by the first author to examine reliability. Cohen's kappa coefficient was $k = .86$, $p < .001$, indicating strong agreement. Disagreements in coding were resolved by establishing consensus among coders through weekly meetings. After removing ineligible studies, 127 studies were eligible for full-text review.

In the full-text review, conducted by the first author, articles without specific target outcome variables and effect sizes were excluded. Data was extracted from final inclusion articles. The first author met with a counseling psychology professor weekly during this process where decisions about inclusion/exclusion were discussed. Another member of the research team (i.e., counseling psychology doctoral student) extracted data for 25% of the articles to examine reliability. Cohen's kappa coefficient indicated that interrater reliability ranged from substantial agreement ($k = .73$, $p < .001$) to near perfect agreement (range: .82–1.00, $p < .001$). Any discrepancies in coding were resolved through discussion until a consensus was reached. This process yielded a total of 65 independent studies across 55 articles for final inclusion. References and overviews for all included studies (i.e., study characteristics and summary of key findings) and analytic code can be found at OSF (Open Science Framework; Lee, 2024). This meta-analysis was not preregistered.

Data Coding

A total of 186 effect sizes ($k = 65$ studies, 55 articles) were included in the meta-analysis. We coded effect sizes for the individual outcome variables: physical health, mental illness (i.e., depression, anxiety), life satisfaction, and eudaimonic well-being (i.e., meaning in life, purpose in life). Effect sizes for physical health, life satisfaction, and eudaimonic well-being were coded in the positive direction (e.g., greater scores indicate greater health and well-being) and effect sizes for mental illness were coded in the negative direction (e.g., higher scores indicate greater symptoms of illness) as most scales measured depression and anxiety in this direction. Separate meta-analyses were conducted to examine each of these variables.

Moderators. Several moderators were examined to explore whether there were boundary conditions on the relations between humility and physical health, mental illness, and well-being. Measures that did not have three or more effect

sizes were not used in moderation analyses (Goh et al., 2016). The full list of measures can be found in Supplemental Table 1.

Measure of Humility. There is substantial variability across self-report measures of humility. Different conceptualizations of humility (e.g., trait, sociocultural value, virtue) may moderate the associations between humility and physical health, mental illness, and well-being. Measures that examined humility as a trait included the HEXACO Personality Inventory (HEXACO; Ashton & Lee, 2009; ES = 45, k = 19) and Values in Action Inventory (VIA; Peterson & Seligman, 2004; ES = 12; k = 5). Measures that examined humility as a sociocultural value included the Asian Values Scale (AVS; Kim et al., 2005; ES = 15, k = 5). Humility as a virtue was measured using the Dispositional Humility Scale (DHS; Bollinger, 2010; ES = 4, k = 1), Experiences of Humility Scale (Davis et al., 2017; ES = 6, k = 3), Expressed Humility Scale (EHS; Owens et al., 2013; ES = 8, k = 3), Humility Inventory (HI; Brown et al., 2013; ES = 10, k = 2), and Humility Scale (Krause, 2014; ES = 4, k =1). As a virtue, humility was also measured across specific domains (e.g., intellectual, cultural, relational, existential). Intellectual humility was measured using the Comprehensive Intellectual Humility Scale (Krumrei-Mancuso & Rouse, 2016; ES = 17; k = 2), Specific Intellectual Humility Scale (SIHS; Hoyle et al., 2016; ES = 3, k = 2), and an unpublished cognitive broadening scale (Santos & Grossmann, 2021; ES = 3, k = 1). Cultural humility was measured using the Cultural Humility Scale (CHS; Hook et al., 2013; ES = 3, k = 2), relational humility was measured using the Relational Humility Scale (RHS; Davis et al., 2011; ES = 10; k = 3) and existential humility was measured using the Existential Humility Scale (IH-E; McLaughlin et al., 2023; ES = 13, k = 2).

Measure of Physical Health, Mental Illness, and Well-Being. There is substantial variability across self-report measures of physical health, mental illness, and well-being. Thus, we assessed health outcome domain (e.g., physical health, mental illness, life satisfaction, and eudaimonic well-being) and specific outcome measures as moderators in our analyses.

For physical health, the following measures were coded: Brief General Health Index (Rowatt et al., 2006; ES = 5, k = 1), General Self-Rated Health (GSRH; DeSalvo et al., 2006; ES = 3, k = 2), and Patient-Reported Outcomes Measurement Information System (PROMIS; Hays et al., 2009; ES = 8, k = 1). For mental illness, the following measures were coded: Beck Anxiety Inventory (BAI; Beck & Steer, 1993; ES = 4, k = 2), Cascades of Mental Health Assessment (Thalmayer et al., 2021; ES = 4, k = 1), Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977; ES = 19, k = 9), Depression, Anxiety, Stress Scales (DASS; Ali et al., 2021; ES = 17; k = 3), Interview

Anxiety Scale (Tross & Maurer, 2008; ES = 5, k = 1), Measure of Anxiety in Selection Interviews (MASI; McCarthy & Goffin, 2004; ES = 4; k = 2), Patient Health Questionnaire (PHQ; Kroenke et al., 2009; ES = 5, k = 4), and State Trait Anxiety Inventory (STAI; Spielberger, 1983; ES = 5, k = 4). For life satisfaction, the following measures were coded: General Life Satisfaction Scale (GLSS; Ye, 2007; ES = 6, k = 2), Midlife in the U.S. Scale (MIDUS; Brim et al., 1999; ES = 3, k = 1), and Satisfaction with Life Scale (SWLS; Diener et al., 1985; ES = 42; k = 22). For eudaimonic well-being, the following measures were coded: Group-Meaning Measure (GMM; Zhang et al., 2018; ES = 3, k = 2), Meaning in Life Questionnaire (MLQ; Steger et al., 2006; ES = 16, k = 4), Psychological Well-Being Scale (PWB; Ryff & Keyes, 1995; ES = 10, k = 4), and Sense of Purpose Scale (SOPS; Yukhymenko-Lescroart & Sharma, 2020; ES = 4, k = 1).

Study Characteristics. Study characteristics were examined as moderators. Research has suggested that the associations between humility and physical health, mental illness, and well-being may differ across sampling strategies (Krause et al., 2016), religious/existential contexts (Van Tongeren et al., 2023), and cultures (Suh et al., 2020). The following study characteristics were coded for as moderators: study population (i.e., student, community, mixed), nation (i.e., predominate nation > 50% sample), and existential/religious context (i.e., yes/no).

Data Analytic Plan

All analyses were conducted using the metafor package in R (Viechtbauer, 2010). This package is a free add-on in R which can be used to calculate meta-analytic effect sizes, fit various effects models to the data, conduct moderator analyses, and create meta-analytic plots (i.e., forest plots). More information about this package can be found at The Metafor Package (2021).

Main Effects. Correlations were transformed using Fisher's r-to-z transformation to normalize the sampling distribution, and effect sizes were weighted according to sampling error. A three-level random-effects model with restricted maximum likelihood estimation was used, which models effect size sampling variation (Level 1), within-sample variation (Level 2), and between-sample variation (Level 3). This model accounts for the dependence caused by including multiple effect sizes from the same sample (Van den Noortgate et al., 2013). We calculated meta-analytic models for each of the four response variables (i.e., physical health, mental illness, life satisfaction, eudaimonic well-being) with ks (studies) ranging from 9 (physical health) to 25 (mental illness) and Ns (sample size) from 2,463 (physical health) to 15,466 (life satisfaction).

Moderator Analyses. For each moderator, a three-level random-effects model was fitted to the data to examine whether there were any differences between groups. Results were interpreted if there was a significant omnibus F-test (Viechtbauer, 2010). T tests were conducted to compare each level of the moderator to determine significant differences.

Sensitivity Analysis: Outliers and Publication Bias. Sensitivity analyses were conducted around publication bias and outlier bias. We created datasets without outliers by excluding data points above the 99th percentile of the standardized residuals distributions. If results remained unchanged after removing outliers, complete datasets were used for the analysis. For publication bias, we used the precision-effect test (PET; Stanley & Doucouliagos, 2014), where effect sizes are predicted from their standard errors and weighed according to precision estimates. If PET was significant, then we conducted the precision-effect estimate with standard error test (PEESE; Carter et al., 2019), where effect sizes are predicted from their squared standard errors. In addition to the PET-PEESE analyses, we also included a binary categorical variable in the moderator analyses.

Certainty Assessment: Heterogeneity and Prediction Intervals. Certainty assessment was conducted by examining several factors, including heterogeneity and prediction intervals. Heterogeneity was quantified using Cochrane's Q statistic, I^2 statistic, and H^2. The Q statistic approximates a chi-squared distribution with $k - 1$ degrees of freedom. The I^2 statistic reflects the percentage of variation due to true heterogeneity beyond chance. Within-sample variation was calculated in Level 2 and between-sample variation was examined in Level 3. We also calculated H^2, which allows for comparisons between meta-analytic models. H^2 was interpreted according to Higgins and Thompson's (2002) guidelines: $H^2 = 1$ indicates that the population of studies is homogeneous whereas $H^2 > 1.5$ indicates that heterogeneity is present. Prediction intervals (PI) were examined to assess certainty. Where confidence intervals (CIs) quantify accuracy of the mean, PIs represent the actual dispersion of effect sizes about true effects distributed around the mean effect. We include the 90% prediction intervals; if this interval contains zero, then associations among variables may not be significant.

Results

Full outputs and forest plots can be found at https://osf.io/zmpux/ (Lee, 2024). Following guidelines from Gignac and Szodorai (2016) for effect size

benchmarks in individual differences research, Pearson's r was interpreted as small (r = 0.1), medium/typical (r = 0.2), and large (r > 0.3).

Study Characteristics

There were 65 independent studies (55 articles) and 183 effect sizes (N = 27,892) included in the meta-analysis. The studies were conducted between 2003 and 2023. Of the 55 articles, 52 were published and 3 were unpublished. Most studies included samples from the United States (S = 38), followed by Iran (S = 6) and Canada (S = 5). More studies recruited from student samples (S = 36) than community samples (S = 28). Twenty-one studies considered the context of religious/existential research questions, whereas 43 studies did not. Among outcomes, mental illness was most frequently assessed (S = 75), followed by life satisfaction (S = 51), eudaimonic well-being (S = 34), and physical health (S = 23).

Outliers and Publication Bias

Estimates of effect were not sensitive to outlier bias or publication bias. Specifically, the results remained largely unchanged after removing outliers at the 99th percentile. Additionally, there was no evidence for publication bias (e.g., PET-PEESE test, moderation analyses). Subsequently, all models were conducted using the full data set for each meta-analytic model. Results from datasets with outliers removed are available at https://osf.io/zmpux/ (Lee, 2024).

Main Effects and Moderator Results

Main Effects. Main effects, 95% confidence intervals, prediction intervals and heterogeneity statistics are presented in Table 1. Forest plots are presented in Supplemental Figure 1.

Physical Health. There was a small positive association between humility and physical health (r = .13, p < .001), indicating that humility was correlated with better physical health. The population of studies had a small degree of heterogeneity (H^2 = 1.49). Between-sample heterogeneity tended to be small relative to within-sample variation ($I^2_{(3)}$ < 1.0%).

Mental Illness. There was a small negative association between humility and mental illness (r = −.06, p = .039), indicating that higher humility was associated with less mental illness. The population of studies tended to be

Table 1. Study Characteristics, Meta-Analytic Estimates, and Heterogeneity Statistics

Construct	*k*	S	ES	*N*	*r*	95% CI	90% PI	H^2	*Q*	$I^2_{(2)}$	$I^2_{(3)}$	τ^2_1	τ^2_2	τ
Physical health	9	9	23	2463	**.13**	[.09, .17]	[−.01, .26]	1.49	57.31	61.83%	< 1.0%	.006	.000	.08
Mental illness	25	28	75	10263	−.06*	[−.12, −.01]	[−.35, .23]	8.80	735.16	52.37%	38.08%	.017	.013	.17
Life satisfaction	24	30	51	15466	**.12**	[.09, .15]	[−.05, .29]	5.45	328.86	82.12%	2.85%	.010	.001	.07
Eudaimonic well-being	13	16	34	6384	**.20**	[.15, .25]	[−.03, .42]	5.44	231.74	38.71%	45.58%	.008	.009	.09

Note. Bold indicates $p < .001$, italicized indicates $p < .01$, and $^*p < .05$. *k* = number of studies; *S* = number of samples, ES = number of effect sizes; CI = confidence intervals; PI = prediction intervals.

heterogeneous ($H^2 = 8.80$). Between-sample heterogeneity tended to be small relative to within-sample variation ($I^2_{(3)} = 38.08\%$).

Life Satisfaction. There was a small positive association between humility and life satisfaction ($r = .12$, $p < .001$). The population of studies was heterogeneous ($H^2 = 5.45$). Between-sample variation tended to be small relative to within-sample variation ($I^2_{(3)} = 2.85\%$).

Eudaimonic Well-Being. There was a medium positive association between humility and eudaimonic well-being ($r = .20$, $p < .001$). The population of studies tended to be heterogeneous ($H^2 = 5.44$). Between-sample heterogeneity tended to be larger relative to within-sample variation ($I^2_{(3)} = 45.58\%$).

Moderator Results. Descriptive statistics for each moderator are reported in Table 2. Moderation results are provided in Supplemental Tables 2-5. Below, we discuss results from moderation models with both a significant omnibus *F*-value and a significant follow-up *t*-test. The full moderation results are available at https://osf.io/zmpux/ (Lee, 2024).

Health and Well-Being Domain. The domain of health moderated the association between humility and physical health, mental illness, and well-being, $F(4, 181) = 21.27$, $p < .001$. Mental illness ($b = -.06$, $p = .007$) showed a smaller association compared to physical health ($b = .13$, $p = .001$; $t[181] = 4.78$, $p < .001$), life satisfaction ($b = .13$, $p < .001$; $t[181] = -6.09$, $p < .001$), and eudaimonic well-being ($b = .20$, $p < .001$; $t[181] = -6.86$, $p < .001$).

Humility Measure. The specific construct of humility moderated the associations between humility and mental illness, $F(8, 53) = 7.09$, $p < .001$. Relational humility (RHS; $b = -.23$, $p = .001$) showed a stronger negative relationship with mental illness compared to humility as a trait (VIA; $b = -.03$; $p = 672$; $t[53] = 2.12$, $p = .039$) and intellectual humility (CIHS; $b = -.04$, $p = .049$; $t[53] = -2.28$, $p = .027$). Humility as an Asian value (AVS; $b = .08$, $p = .179$) had a stronger positive relationship with mental illness compared to cultural humility (CHS; $b = -.21$, $p = .007$; $t[53] = -3.08$, $p = .003$), general humility (DHS; $b = -.20$, $p = .0276$; $t[53] = -2.64$, $p = .011$), humility as a personality trait (HEXACO; $b = -.10$, $p = .0148$; $t[53] = -2.59$, $p = .013$), and relational humility (RHS; $t[53] = -3.51$, $p < .001$). Finally, existential humility (IH-E; $b = .22$, $p < .001$) had a stronger and positive association with mental illness compared to cultural humility (CHS; $t[53] = 4.69$, $p < .001$), intellectual humility (CIHS; $t[53] = 3.63$, $p = .001$), relational humility (RHS; $t[53] = -2.28$, $p = .027$), dispositional humility (DHS; $t[53] = 4.06$,

Table 2. Moderator Descriptive Statistics

	Publication status		Sample		Religious/ Existential				
Construct	Pub	Unpub	Com	Stud	Yes	No	Nations	Humility measure	Outcome measure
Physical health	21	2	7	16	0	23	America = 20	HI = 8; VIA = 5	PROM = 8; BGHI = 5; GSRH = 3
Mental illness	70	5	29	46	26	49	America = 59; Canada = 7; Namibia = 4	CIHS = 16; HEXACO = 13; AVS = 10; RHS = 7; IHE =5; DHS = 4; VIA = 3; CHS = 3	CESD = 19; DASS = 17; PHQ = 5; STAI = 5; IAS =5; BAI = 4; MASI = 4; MHA = 4
Life satisfaction	49	2	19	32	11	40	America = 28; Iran = 9	HEXACO = 23; VIA = 4; AVS = 3; EHS = 3; cogb = 3	SWLS = 42; GLSS = 6; MIDUS = 3
Eudaimonic well-being	34	0	12	22	20	14	America = 22; Iran = 5	HEXACO = 8; IHE = 8; EHS = 3; SIHS = 3; EXHS = 5; Krause = 4	MLQ = 16; PWB = 9; SOPS = 4; GMM = 3

Note. Only measures and nations that had 3 or more effect sizes were included in the table; Pub. = published; Unpub. = unpublished; Con. = community; Stud. = student; HI = Humility Inventory; VIA = Values in Action Inventory; CIHS = Comprehensive Intellectual Humility Scale; HEXACO = HEXACO Personality Inventory; AVS = Asian Values Scale; RHS = Relational Humility Scale; IHE = Existential Humility Scale; DHS = Dispositional Humility Scale; CHS = Cultural Humility Scale; EHS = Expressed Humility Scale; COGB = cognitive broadening; SIHS = Specific Intellectual Humility Scale; EXHS = Experiences of Humility Scale; Krause = Humility Scale; PROM = Patient-Reported Outcomes Measurement Information System; BGHI = Brief General Health Index; GSRH = General Self-Rated Health; CESD = Center for Epidemiologic Studies Depression Scale; DASS = Depression Anxiety Stress Scales; PHQ = Patient Health Questionnaire; STAI = State Trait Anxiety Inventory; IAS = Interview Anxiety Scale; BAI = Beck Anxiety Inventory; MASI = Measure of Anxiety in Selection Interviews; MHA = Cascades of Mental Health Assessment; SWLS = Satisfaction with Life Scale; GLSS = General Life Satisfaction Scale; MIDUS = Midlife in the U.S. Scale; MLQ = Meaning of Life Questionnaire; PWB = Psychological Well-Being; SOPS = Sense of Purpose Scale; GMM = Group-Meaning Measure.

$p = .001$), and humility as a trait (HEXACO; $t[53] = 4.83$, $p < .001$; VIA ($t[53] = 2.12$, $p = .039$).

Measure of humility was also a significant moderator of the relationship between humility and eudaimonic well-being, $F(6, 27) = 24.60$, $p < .001$. Specifically, intellectual humility (SIHS; $b = -.06$, $p = .404$) had a weaker association with eudaimonic well-being compared to existential humility (IH-E; $b = .21$, $p < .001$; $t[27] = -3.45$, $p = .002$), humility as a personality trait, (HEXACO; $b = .14$, $p < .001$; $t[27] = -2.58$, $p = .016$), and humility as a virtue as measured by the Expressed Humility Scale ($b = .25$, $p < .001$; $t[27] = -3.57$, $p = .001$), Experiences of Humility Scale ($b = .22$, $p < .001$; $t[27] = -3.31$, $p = .003$), and Humility Scale ($b = .41$, $p < .001$; $t[27] = -5.68$, $p < .001$) measures. Additionally, Humility Scale (Krause, 2014) showed a stronger association to eudaimonic well-being compared to the Experiences of Humility Scale ($t[27] = 2.74$, $p = .011$) and when measured as a personality trait (HEXACO; $t[27] = 4.44$, $p < .001$), intellectual humility (SIHS; $t[27] = -5.68$, $p < .001$), and existential humility (IH-E; $t[27] = 3.29$, $p = .003$).

Outcome Measure. Outcome measure moderated the association between humility and eudaimonic well-being, $F(4, 29) = 23.12$, $p < .001$. Sense of purpose (SOPS; $b = .41$, $p < .001$) had a stronger association with humility compared to meaning experienced in a group (GMM; $b = -.06$, $p = .495$; $t[29] = 4.46$, $p < .001$), meaning in life (MLQ; $b = .19$; $t[29] = 2.95$, $p = .006$), and psychological well-being (PWB; $b = .19$, $p < .001$; $t[29] = 2.85$, $p = .008$). Meaning experienced in a group had a weaker association with humility compared to psychological well-being (PWB; $t[29] = 2.65$, $p = .013$) and meaning in life (MLQ; $t[29] = 2.85$, $p = .008$).

Study Characteristics. Whether the study topic was religious/existential moderated the association between humility and mental illness, $F(2, 73) = 8.32$, $p < .001$. Humility was positively and significantly related to mental illness in religious/existential contexts ($b = .11$, $p = .057$) but weakly and negatively associated with mental illness in other contexts ($b = -.13$, $p = .002$), $t(73) = 3.76$, $p < .001$. Moreover, study population moderated the association between humility and life satisfaction ($F[2, 49] = 30.39$, $p < .001$); community samples ($b = .17$, $p < .001$) showed a stronger effect than student samples ($b = .09$, $p = .001$), $t(49) = -2.27$, $p = .028$.

Discussion

In the present meta-analysis, we sought to synthesize extant research on the benefits of humility for health, mental health, and relationships. Building on

impressive work in other applied contexts (Kelemen et al., 2023), counseling psychologists have focused on the importance of humility for multicultural counseling (Davis et al., 2018), but scholars have warned about the need to consider power dynamics (Moon & Sandage, 2019) or other boundary conditions in which humility could be good, but not good for you (Kelemen et al., 2023). As conversations about multiculturalism as an ethical imperative come to the forefront of conversations within psychology (Knapp & Fingerhut, 2024), critical examination of positive psychology literature has clarified the importance of considering cultural dynamics that affect whether a virtue is good or potentially exploitive.

Although fully exploring the nuances of power in the expression of humility is beyond the scope of this paper, a basic starting place is to examine the magnitude and consistency of the hypothesized benefits of humility for physical health, mental illness, life satisfaction, and eudaimonic well-being. Overall, results indicated that effect sizes were small ($r = -.06$ to .13) for physical health, mental illness, and life satisfaction and medium ($r = .20$) for eudaimonic well-being. We also examined moderators of associations, including domains of health/well-being, measurement of humility and health/well-being, and study characteristics. Below, we provide a summary of key findings and outline future directions, calling for the need for greater integration of multiculturalism within positive psychology.

The Boundary Conditions of Humility

Although it may be preferrable if our results supported a clear story that humble people are rewarded with good health, our results did not provide strong support for the humility-health hypothesis (Toussaint & Webb, 2017). Moderators associated with the domain of health affected the relationship between humility and benefits. Compared to other domains, mental illness (i.e., depression and anxiety) showed the weakest overall correlation with humility, although there was considerable variability, and some studies did show large effect sizes. These results suggest that effect sizes differ based on type of humility and context of health.

The way humility was measured also moderated associations between humility and its benefits. Relational humility (i.e., RHS) had a stronger negative association with mental illness compared to other constructs of humility. These results align with theories suggesting that humility contributes to better relationships by facilitating commitment to a relationship (i.e., social-bonds hypothesis) and buffering the negative impact of conflict in relationships (i.e., social-oil hypothesis; Van Tongeren, Davis et al., 2019). On the other hand, when humility was examined within the context of existential

uncertainty (i.e., IHE-12) or measured as an Asian value (i.e., AVS), humility had a stronger positive association with mental illness. These findings align with prior theory on costs of practicing humility in the face of existential anxiety (Van Tongeren et al., 2016) or in sociocultural contexts where humility is associated with less social reward (Suh et al., 2020).

Implications of our review are that there are likely important nuances in understanding the associations between humility and well-being (i.e., life satisfaction, eudaimonic well-being). In early reports, some scholars reported stronger correlations of humility with eudaimonic rather than hedonic well-being (Aghababaei & Arji, 2014; Aghababaei et al., 2016), but our findings suggest that scholars may need to proceed with patience, as we clarify scientific knowledge of how humility works in a range of situations, roles, and cultures. There seem to be contextual factors that interact with the magnitude and direction of associations. Our results showed that study characteristics moderated the association between humility and life satisfaction; there were stronger associations when measured in community samples compared to student samples. Furthermore, specific kinds of humility, rather than humility in general, may provide benefits to eudaimonic well-being. For example, existential humility had stronger associations with eudaimonic well-being compared to intellectual humility. Humility also had stronger associations with sense of purpose compared to meaning in life. These results suggest the importance of distinguishing the mechanisms that sometimes connect humility to benefits to well-being. Taken together, our results suggest that theory on the benefits of humility may be overstated—or at least underqualified. We need to know more about the social consequences of humility. Sometimes people may decide to act humbly, even if it involves sacrifice of their own well-being, but this raises challenging normative questions that are not easily addressed with social science methods alone (Grzanka & Moradi, 2021; Levitt, 2024). We call for the need to explore the benefits and risks of humility within a broader interdisciplinary conversation between psychologists, communities from marginalized groups, and other disciplines with expertise on evaluating normative claims (Moon & Sandage, 2019). With that caution in mind, we discuss implications for theory, research, training, advocacy, and practice.

Implications for Theory and Research

Our results call for a refinement of existing theoretical claims that assumes the universality of benefits of humility for health and well-being. Although previous theories, such as the humility-health hypothesis, have largely assumed humility to be beneficial across contexts (Van Tongeren, Hook et al., 2019), our results

suggest that benefits of humility depend on a range of relational and cultural factors that are not fully understood. A good next step is to explore different theorized mechanisms of when and how humility can strengthen relationships and thereby confer benefits. Until more is known, psychologists can practice a form of humility about knowledge, aware of how much remains unknown about this mysterious virtue. Not only do we not know when and how humility helps the most, but we also know very little about when it might cause harm or even spark escalation of conflict in a system (e.g., ruptures involving fierce disagreement over epistemic norms; Johnson, 2021).

More research is needed to examine under what conditions humility is salubrious or deleterious, particularly in relation to broader multicultural contexts. Our work aligns with recent critiques of positive psychology that have accumulated over the past decade (for a review, see van Zyl et al., 2024), spanning from basic scientific issues involving small effect sizes (Davis et al., 2016) to the lack of generalizability (low external validity) across cultures. The typical framing of virtues and strengths tend to focus on benefits of a virtue for the individual's health, mental health, relationships, and spiritual life. However, not only does this individualistic focus ring hollow without sufficient normative grounding (Wong et al., 2024), but it also fails to contextualize virtues to broader power dynamics (i.e., sociocultural and structural factors such as systemic oppression, and racism) experienced by marginalized groups (Floyd-Thomas, 2020). Future research on humility needs to consider boundary conditions in which humility is potentially contraindicated, including gender, race/ethnicity, culture, and based on cultural minority status. Such research may also be conducted longitudinally and experimentally to better establish causal mechanisms underlying these associations. We strongly advise scholars to consider key cultural nuances in research and clinical work within counseling psychology in light of issues of privilege, power, and social justice in the expression of humility.

Implications for Training and Education and Advocacy

Our results highlighting the contextual considerations of humility provide implications for tailoring multicultural training for clinicians in training. Cultural humility is a virtue that is esteemed as essential, if not central to popular multicultural frameworks in counseling psychology (e.g., Multicultural Orientation Framework; Davis et al., 2018). However, cultural critiques of cultural humility (Moon & Sandage, 2019) have highlighted the unique vulnerabilities or sacrifices that clinicians with marginalized or oppressed identities might be asked to make when working with clients with privileged identities (i.e., clinician of color working with a White client; Choe et al., 2024). Thus, to

be good and just, humility likely must be balanced with other language, such as courage, critical consciousness, or hope (French et al., 2023), and we can revisit principles related to refusing to engage in coercion or abusive use of power (i.e., encouraging professional acculturation, but stopping short of dynamics of assimilation or alienation; Handelsman et al., 2005). We suggest that true humility involves striving to become trustworthy in how one handles power—one can be counted on not to abuse power. Our results also carry implications for advocacy, particularly in challenging a "one-size-fits-all" approach to virtue-based interventions. Counseling psychologists are well-positioned to advocate for examining positive psychology within cultural contexts. This may look like calling for increased funding and support for research that examines the study of virtues, flourishing, and resilience within non-Western and marginalized populations. Furthermore, ethical practice is closely tied to the study of virtue and strengths, which involves a commitment to social justice (Knapp & Fingerhut, 2024). Listening for clients' dreams for their lives, and understanding how their cultural background informs those dreams, is a key cultural opportunity (Lee et al., in press). Counseling psychologists could contribute to a positive psychology that builds trustworthy institutions rather than amplifying the already distorted preoccupation with virtue as something that can be practiced in private (Wong et al., 2024). Counseling psychologists know that many goods, like justice or hope (French et al., 2023), are things we procure together. This approach attends to the environmental factors that affect people's lives (e.g., racism, global warming, etc.), and as such, proves more sustainable and sensitive to diversity (Steger, 2024).

Clinical Implications

Our results inform how humility may be understood within clinical contexts. In particular, humility could increase stress when practiced in the context of existential uncertainty. Clients seek help from psychologists in a state of distress, often with wounded visions of what makes their life worth living. They may present to therapy after having experienced violations of their preexisting worldviews, giving rise to existential questioning, which may even lead to religious change (Sandage & Stavros, 2023). Results from our meta-analysis align with prior work suggesting that humility may be associated with greater mental health symptoms when exercised in the face of existential uncertainty (McLaughlin et al., 2023; Van Tongeren et al., 2023). Given the role of cultural worldviews for mitigating existential anxiety, holding such beliefs too loosely may undermine the degree to which such commitments may provide existential security (Van Tongeren et al., 2023). Holding existential commitments somewhat firmly (i.e., a balance of devotion

and flexibility) may be psychologically salubrious. Until we know more, clinicians may want to proceed with patience when helping clients address existential distress, given the power dynamics of psychotherapy and the risk of cultural paternalism (Jadaszewski, 2017). These results indicate the importance of attuning to clients' needs and identities systemically, rather than blindly imposing the values of mainstream culture.

Limitations and Future Research Directions

Our review had several important limitations. First, this study was limited in scope, as we only searched for studies including the term "humility" and specified only a few outcome variables to examine (i.e., physical health, anxiety, depression, life satisfaction, meaning in life, purpose in life). As such, we were unable to examine humility's association with other important constructs such as hedonic well-being (e.g., positive affect) or relationship quality. Second, this study examined only a few moderators and did not examine important identity factors such as race/ethnicity, gender, or sexual orientation. Third, most studies in our review included Western samples that were associated with educational privilege. As such, our study provides limited information regarding how results compare across countries. Fourth, the studies in our review used methods that do not allow strong evidence for causal inference (e.g., Van Tongeren, Hook et al., 2019); cross-sectional correlational designs preclude causal or temporal statements, obscuring whether humility precedes physical health, mental illness, and well-being.

In future work, examining other indicators of physical health, mental illness, and well-being (e.g., relationship quality, stress, burnout, happiness) may be informative to clarify additional contextual factors. Additional empirical work needs to be conducted to examine the unique experiences of humility among marginalized populations. To identify when and for whom humility provides benefits versus risks to well-being, researchers may utilize targeted sampling based on race/ethnicity, spirituality, disability, sexual orientation, gender, or nationality. We also call for richer methodological development within humility research, moving beyond correlational studies to include experimental, longitudinal, daily diary, experience sampling, physiological, and behavioral paradigms to examine mediators through which humility is associated with physical health, mental illness, and well-being.

Conclusion

Research within the field of positive psychology has traditionally oversimplified narratives about the benefits of virtue and character strengths

such as humility. This meta-analysis explores humility and its benefits and suggests a more nuanced understanding is likely in the future. Sometimes, humility may foster strong, committed relationships that contribute to personal flourishing. At other times, particularly in relationships marked by untrustworthy or harmful behavior, humility may lead to sacrifices. In such situations, individuals may require wisdom to discern whether these sacrifices are worth making or worth walking away from because they are externally imposed by another kind of abuse of power (some refer to this as virtue bypass; Captari et al., 2023). Counseling psychologists surely have an important role in understanding how humility functions within multicultural relationships and in advancing efforts to build more just and trustworthy systems.

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Supplemental Material

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