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On Dignity, a Sense of Dignity, and Inspirational Shame

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ABSTRACT
The word dignity encompasses more than we can say of it. It is difficult to define, and yet we work with it every day in our offices. I explore various ideas about dignity, and then examine the place of dignity in the process of analysis and therapy. I draw out psychological components of dignity that are often strong themes in our psychoanalytic work. Many patients come to therapy as a result of assaults on their dignity, or from the effects of family situations that are so corrosive that they never developed a sense of their own dignity. For these patients, I think of therapy as a process of either finding or restoring dignity.

I was walking to a local restaurant to order a sandwich that I would take back to the office with me. Sitting on the sidewalk about 20 feet from the restaurant door was a man without a home to go to, and who was most likely, given his rheumy eyes and disheveled appearance, alcoholic. He asked me for some money.

I don't give money to people whom I think will use it to buy alcohol. My mother died from her alcoholism. It is really not my place to decide how someone else should spend the money they might be given, and yet for my personal reasons, respectful of my personal limits, I just will not do it.

We had the following conversation:

Me: Sir, I'm sorry. I won't give you cash. But I'm about to go into the deli to get myself a sandwich. Can I get you one as well?
Him [making a sour face]: Oh. Well, okay. What kind of sandwiches do they have anyway?
Me [with a bit of irritation in my voice]: Geez, I don't know! It's a deli. You know, stuff like roast beef, turkey, chicken. I'm going to have a turkey salad sandwich.
Him [making another sour face]: Okay, a turkey salad sandwich.
I nodded my head and began to turn away and walk toward the restaurant door. After a step or two he spoke again.
Him [grumpily]: What comes with it? What kind of sides?
Me [shaking my head in frustration, moving back toward him and speaking a bit shrilly]: I don't know! [Speaking more calmly] Well, I suppose potato salad, carrots, pickles, maybe coleslaw. I'm getting carrots and pickles.
Him: I want pickles and coleslaw.
Me: Pickles and coleslaw it is. Okay, I'll be out in a few minutes.
I took a few more steps toward the restaurant. He spoke again.
Him [speaking in a surly tone]: Hey wait, what kind of bread?
Me [showing my frustration again]: Damn, I don't know! I would think they have white, wheat, rye, I don't know what else. I am having white.
Him: I want wheat.
Me: OK.
And then a funny thing happened. I took another step or two, still feeling my irritation and frustration. And without thinking about it, suddenly without irritation, I spontaneously turned to him and asked:
Me: Toasted or plain?

In the years since that conversation took place, I've thought about it many times. It is dense, open to multiple interpretations of meanings. I think the man did not want to have a sandwich as much as he wanted the money. And at first he may have been trying to wear me down. For my part, I was...
annoyed that my willingness to offer him something, even if it was not what he wanted, was met with such surliness.

And yet, I think something more profound was occurring. The man came up against limits of what was possible with me. But by asking the questions he did, by asserting that he still wanted a choice in the matter, perhaps it could be said that he was asserting his right to be treated with dignity. And by my participation, I was agreeing with him.

It is ironic, because my participation was not eager, nor particularly openhearted. And yet in the end, I became his server. By asking if he wanted "toasted or white," I surrendered my resistance against serving him. I moved from being charitable to being his servant. The matter of who was paying had receded, overpowered by our negotiations about whether or not this man who apparently had so little in his life could at least have some choice as to how he might receive something from me.

I begrudged his surliness, but not his dignity.

What do we mean by dignity?

The word dignity appears to be used predominantly in two ways. The first is dignity as a description of living in a dignified manner. People with an intact and resilient dignity tend to be assured of their right to be treated with dignity, even when they may be treated poorly. A famous example of dignity is in the comportment of the students who engaged in lunch counter sit-ins during the early days of the civil rights movement. Such people also have a sense of reticence and centeredness, and they are committed to living according to their values even in the face of adversity. They are also respectful of others' dignity, such that they do not manipulate others for their own ends, as that would degrade both themselves and the others.

I think of this usage of dignity as both an ideal toward which we aspire, and also as a description of people whose developmental context supported certain psychological and emotional processes that inhere in the development of dignity. It does not mean that such a person is always aware of, or thinking about, living with dignity. More, it reflects psychological and emotional resources that have cohered in such a way as to make living with dignity a given.

The second, and perhaps most common, use of the word is as an ethical precept that affirms that human beings warrant dignity, and that warrant is part of what defines us as human. We may not be accorded dignity, but it is our due. It is more of a philosophical, moral, or ethical concept than it is a psychological concept.

However, all that said, the word dignity encompasses more than we can say of it. It is difficult to define, and yet we work with it every day in our offices. I explore various ideas about dignity, and then examine the place of dignity in the process of analysis and therapy. I draw out psychological components of dignity that are often strong themes in our psychoanalytic work. Many patients come to therapy as a result of assaults on their dignity, or from the effects of family situations that are so corrosive that they never developed a sense of their own dignity. For these patients, I think of therapy as a process of either finding or restoring dignity.

Ethics of dignity

Dignity as an ethical precept has its roots in philosophy. It is linked with what philosopher Charles Taylor calls "our orientation towards the good" (Taylor, 1989, p. 42).

Taylor and other philosophers have provided useful guidance for psychoanalysis, especially in recent years (see for example, Jacobs, 2008; Orange, 2009; Cavell, 2011). George Hagman (2000), in "The analyst's relation to the good," draws on Taylor, who "argues that self-experience is grounded in intersubjectively constructed moral frameworks" (p. 67, italics added).

Taylor believes that we are "selves" only insofar as we find our "orientation towards the good," and it is through language that we "articulate the nature of the good" and thus become ourselves. He further states that, "one of
the most basic aspirations of human beings, is the need to be connected to, or in contact with, what they see as good, or of crucial importance, or of fundamental value. This orientation in relation to the good is essential to being a functional human agent." [Taylor, 1989 p. 42, cited in Hagman, 2000, p. 67]

Hagman's idea that our consulting rooms are a place where our patients can find their way to what constitutes their orientation to the "the good," bears similarity to what Marcia Cavell (2011) describes as, "leading a life" (p. 596). She draws from philosopher Richard Wollheim (1986), who argues that the concept of self is not useful, and instead he recommends the notion of "leading a life." Leading a life has singularity, a personal idiom, in that only you can live your life. And it has aims and directionality, based on your vision of your future, in combination with your values and your contact with your present reality (Cavell, 2011, p. 599). These analysts and philosophers are pointing to the idea of dignity, although without addressing it directly.

Philosopher Peter Baumann draws a very direct connection between dignity and psychology, and his ideas are worth some elaboration here. He does not try to define dignity, but he makes a distinction between dignity simpliciter and human dignity (Baumann, 2000). Simpliciter pertains to moments when we might lose our dignity, or even behave in ways that go against our dignity. This is usually a temporary loss in a particular situation. It is not global, and can be repaired. An example might be the necessary indignity of undergoing genital medical examinations. Human dignity, Baumann says, is "something that can be violated, but it cannot be lost. Racist discrimination violates human dignity but it would be extremely misleading to say that the victim has lost human dignity" (Baumann, 2000, p. 6). That is, the dignity we think of as an inherent warrant of our being human is not gone, even when others violate the covenant by ignoring our dignity. He is distinguishing here between dignity and a sense of dignity.

Baumann is pointing to the claim—central to our understanding of what it means to be human since the enlightenment era—that as human beings, we have a right, or worth, to be treated with respect for our uniqueness and autonomy. But Baumann thinks there is something more fundamental than the argument of our right to be treated with respect, and here he dovetails with our psychoanalytic project. Using an empiricist perspective, he asserts that the importance of dignity as a value is simply that we need it.

We are social animals in the sense that we need recognition by other people. We need to have self-respect and our self-respect depends on the recognition we get from others. I do not mean relativized recognition here, that is, recognition as this or as that (as a parent, as a professional, etc.); the recognition I have in mind is rather basic. ... If we lack this very basic kind of respect by others, we suffer serious psychological damage and, in the extreme case, are not able to live a normal life. To say that we have human dignity roughly means that we should get the basic kind of respect from others that we need so badly. [Baumann, 2000, p. 12]

When Baumann says that self-respect depends on the recognition we get from others, he is affirming that it is violations of dignity that most likely bring patients to our consulting rooms.

Dignity in the consulting room

Baumann's ideas about dignity remind me of Koichi Togashi's (2014) article, "A sense of 'Being human' and twinship experience." Togashi provides a succinct history of some of the psychoanalytic theorizing about human beings in their wholeness. His particular interest is in how traumatized patients often suffer from the experience of not feeling human. He avers that Kohut's self-psychology, and specifically the twinship experience, provides a pathway by which we can navigate such an anguished sense of life with our patients. I believe that a "sense of being human" is fundamental to having a sense of dignity.

My understanding of a twinship experience is that the patient has a sense that the analyst and patient are more alike than not, in the sense that they are both all too human. Furthermore, the analyst welcomes the patient to share this all-too-human life-world. Both are vulnerable human beings engaged in a most intimate dialogue.
Kohut’s emphasis on an empathic listening perspective that Togashi (2014) describes is one example of a clinical attitude that supports a sense of dignity and humanness. The relational turn in psychoanalysis has spawned many discussions of various clinical attitudes that might valuably inform our work and enhance our sensitivity to what it means to be human. Each of those clinical attitudes is an ethical attitude, in part because all human behavior is inescapably ethically situated. That is a condition of being human that applies to every moment of engagement with our world. It is most obvious in our relations with other people, and is writ large in our consulting rooms.

For just a few examples, Donna Orange has written about fallibilism, clinical humility, and clinical generosity, as well as other welcoming attitudes (Orange, 2011). Elizabeth Corpt emphasizes an attitude focused on the “ethics of human relating, timing, tact, and the care of a particular patient” rather than a focus on technique (Corpt, 2011). Doris Brothers has written about the necessary humility required to tolerate uncertainty, thereby allowing both patient and analyst to be open to surprise (Brothers, 2008), and Max Sucharov embodies an antireductionist approach in his writing on dialogue, experiential complexity, and complex experiencing (Sucharov, 2009).

Each of these attitudes embodies an openhearted intent to learn from the patient and from the emergent dialogue. They also caution against reductionism and dichotomies, and instead they valorize finding useable meanings that are flexible and open to revision rather than seeking any foundational truths. They see the patient as a partner in the process, and one who can make meaningful choices about the direction of the work. All of these attitudes, directly or indirectly, are sensitive responses to the foundational issue of human dignity, or what it means to be human. They are all attitudes of welcome. Attending to our clinical attitudes is important, it seems to me, because an attitude is something we can intend. We can cultivate it, we can analyze our resistances to it when we are struggling with a patient, we can work our way back to the attitude of welcome. We cannot legislate our feelings; we cannot make ourselves love a particular patient, but we can have a loving, or welcoming, attitude. And sometimes that attitude may lead to love where it could not be found before, but that is not as essential as the attitude itself.

I have written about a Buberian I-thou,” or dialogic, attitude (Jacobs, 2009), in which emotional attunement “serves as recognition of the wholeness of the patient. The therapist, in attempting to attune to the patient’s emotional life and to understand it in the context of this patient’s history and present life, is recognizing a unique and yet understandable person” (p. 108). There is a difference between being perceptive about a patient and being attuned to the patient in his or her wholeness. Attuned recognition involves awareness of the patient as a separate center of initiative and is also accompanied by specific perception of the patient’s particularity. Most importantly, it involves an embrace, an openhearted welcoming, of the patient’s otherness, including the idea that the patient is always more than what you know of them.

Martin Buber placed recognition within the context of what he called “dialogic relation” (Buber and Friedman, 1969, p. 150)—although his term for recognition was confirmation—and it has a thicker presence than recognition. Engaging another in dialogue accords the other a respect and dignity that confirms him. Buber asserted that psychological suffering was a direct result of being alienated from dialogic relations. In writing about psychological problems, Buber (Buber and Friedman, 1969) said, “Sicknesses of the soul are sicknesses of relationship” (p. 150).

George Kunz (2007) asks the question, “What is therapeutic about therapy?” His answer was, “Ethical responsibility.” Inspired by Levinas, he writes:

The fundamental expression of the face of the patient says, “Do not do violence to me; do not reduce me to your structures, help me. Bracket your obsessive categories, your compulsion techniques, and your need to have good feeling about being a psychotherapist.” Without speaking, the patient asks a psychotherapist to be ethically responsible, to use the freedom invested in her by the patient to attend to him. Speaking in psychotherapy is primarily speaking to someone and, secondarily, speaking about something. [p. 632]
Dignity and a "sense of dignity"

Just as Togashi (2014) beautifully described the difference between merely "knowing" that you are human, and having a "sense of being human" (pp. 265–266), we use the word *dignity* to point both to dignity as an ethical stance toward another, and as a felt sense of dignity or lack thereof.

Aspects of a sense of dignity include such things as a sense of worth, a sense of autonomy and choice, a sense of being human among fellow humans, a sense of meaning or purpose, and a sense of having a personal idiom, or uniqueness. Dignity is also tied to having a confident sense that our bodies will perform properly (something that people who are ill or have disabilities know quite intimately). It also points to being able to manage one's emotional life within a culturally acceptable range, and that one has sense of psychological integrity (that is, they are not consistently chaotic, fragmented or shattered) and also a sense of behavioral integrity, reflected in their respectful treatment of others.

When interacting with others, we generally intuitively respect the others' separate centers of gravity or initiative, their autonomy, and their bodily integrity. We might also attend to the others' worlds of meanings their and emotions as expressions of their personal idioms and desires. We are likely to be attentive to the potential to shame them by objectifying or ignoring them.

Thus, we ordinarily treat people with sensitivity to their dignity, which means we treat them with sensitivity to qualities that we think inhere in human life, such as those listed previously. Sometimes, we interact with people with the commitment to dignity, even if it is somewhat of an abstraction to do so because we do not directly experience the dignity of the other. We accord people dignity just by virtue of the fact that they are human. If we take my earlier example, it is an instance in which we could say I treated him—relatively—with the dignity he was due. I did not pass by as if I did not hear his request. Even a refusal, a spoken "no," would have meant that I at least had heard his voice, his assertion of his initiative.

Attuned sensitivity to another's dignity may support dignity to remain intact even in embarrassing, shameful, or other difficult situations. For instance, a man fell while crossing a street. Another pedestrian and I helped him up with a very matter-of-fact attitude, as if we were just doing what we always do when crossing the street. His embarrassment was mitigated, to some degree, by our casual attitude. For others, perhaps even for the man with whom I negotiated about a sandwich, sensitivity to their dignity may afford a rare experience of a sense of dignity, something that has been virtually nonexistent in their lives. When we don't see people as meriting dignity, we participate in impinging on their dignity, and for most of us, our sense of dignity is a vulnerable, fluid experience, reactive to impingements.

Dignity under assault

Finally, defining dignity is a bit like Justice Potter Stewart's (*Jacobellis v. Ohio, 1964*) famous statement about pornography: You can't define it but you know what it is when you see it. In the case of dignity, maybe we cannot define dignity, but we know it when it is under assault!

For instance, we know indignity when our bodies betray us and we trip and fall in the middle of the street. Or when we are arrested. Or when someone touches us inappropriately. Or when another demeans us. Or when we mistreat another person. We know it when we are at a medical facility and our bodies become a focus of objectifying attention.

When Arnold Beisser, a quadriplegic psychiatrist, first contracted polio and was utterly helpless, he wrote:

> At times I felt as if I had lost my human qualities, and did not belong to the species *Homo sapiens* any longer. ... As an inanimate object, I was in constant need of attention and care from human beings. My most private and personal functions rested in the hands of others. I was a Martian dependent on the earthlings for my survival. [Beisser, 1989, p. 33]
Andrew Morrison wrote similarly about the experience of receiving dialysis treatments as “an appallingly degrading and strange experience. ... The setting of the dialysis unit is otherworldly, alien, and alienating. In there, I was just another body attached to an artificial kidney machine” (Morrison, 2008, p. 77).

It is no surprise that Togashi (2014) used literature from people who wrote about the care of the elderly and dying to explore what it means to be human. Indignities of illness and aging are probably universal, and they pose severe challenges to our narcissistic equilibrium and to our sense of being human.

In ways large and small, we comport our lives, largely without noticing it, in ways that are meant to reduce the likelihood that we—and those with whom we participate—will suffer indignity.

Indignity and shame

Many of our patients know indignity all too well. They enter our office suffused with shame, sometimes conscious, sometimes not. And just the fact that they are seeking our help is another indignity.

Shame in its many forms, from embarrassment to mortification to humiliation, can be considered the primary emotion of indignity, and our patients may well feel ashamed that they have not been able to solve their life problems using their own resources. Instead, they must bare their souls to a stranger, someone who may or may not welcome their fears, their longings, their vulnerabilities, their failures, and their shame.

A patient’s sense of dignity is never far from my mind when I’m having conversations with my patients, or when I am bearing witness, or even when I am arguing with them. There is an overall felt sense that all of our conversations are navigations through the waters of dignity and indignity. I am alert to whether the conversation feels like it is voluntary; that is, is the patient saying or doing what feels right to them to say or do, even if it puts us at odds? That sense of choiceful conversation respects a patient’s sense of agency, which is a component of dignity.

I remember a difficult, yet quite affirming, event of being at odds in my last analysis. My analyst had suffered a severe head injury. At one point in his recovery process, he invited me back to his office to recommence my analysis. But it was clear from our meeting that he was not yet ready to return to work. A colleague who was shepherding my analyst’s patients agreed with my assessment, and, in fact, it was a few more months before my analyst did return to work, at which time we were able to continue our work together quite fruitfully.

I met with him a final time during that aborted first attempt to resume our treatment.

I said that I knew I was going to have to discontinue our meetings for now, despite how much we both wanted to keep meeting, and that I would leave whether or not I had his blessing, but I hoped he could understand and give his blessing. His integrity came shining through, despite his serious impairment. He paused and then said that when people come to a decision that feels true to themselves, he is excited by it, even if he does not like the decision. [Jacobs, 2007, p. 410]

Shame as the fulcrum for finding dignity

Analysts are very familiar with our patients’ experiences with shame and with various shame dynamics. The literature on shame has exploded in recent years. It is now taken for granted that shame is to be described as a complex emotional state. Susan Miller points out that, broadly described and defined, shame is a “family of feelings” and this “loosely bounded category of experiences” serves a variety of functions (Miller, 2013, p. 7). We know about devastation and toxic, annihilating shame. Sometimes, of course, there is the direct experience of being ashamed, generally called shame proper. And then there is the direct experience of humiliation that is often described as being shamed. And there are attitudes about shame: fear, dread, reactive rage, wishes to minimize it, etc.
However, little has been written about the positive potential of shame, what minister and therapist Carl Schneider calls the *revelatory* capacity of shame (Schneider, 1977). For instance, not all shame is toxic. Sometimes shame is inspirational and motivating. I think of this as a kind of existential shame. When I fall short of living in a way that is congruent with a cherished value, the wash of shame I suffer, even though unpleasant, provides me with a chance to reexamine the value and decide if it still suits me. If it does, then my shame is a touchstone. I generally feel a rueful compassion toward myself, and a renewed commitment to live aligned with my values. If not, I have the option of reorienting myself to values more in keeping with my life aims and capacities.

Helen Lynd, a sociologist, has also written about the emancipatory power of daring to face one’s shame in her seminal study of shame, *Shame and the Search for Identity* (1958). Even the most devastating experiences of shame have the potential for increasing our sense of compassionate humility toward ourselves and others when our shame experiences can be received, held, understood, even embraced. Such an experience leads to a chance to reevaluate one’s life aims, as well as to the restoration of dignity. For Lynd, Frieda Fromm-Reichmann was an exemplar of someone who could reach across to a terribly shame-riddled and isolated patient. She had the attitude of welcome and openness required to accompany someone in her shame.

I give some instances of the process of finding dignity in a few examples of therapeutic dialogue that do not represent the heroic reach of Fromm-Reichmann’s example. These instances only required of me that I be welcoming and willing to be affected, be vulnerable with an open and present attitude, and to not turn away.

**Almost beyond human: An experience worthy of respect**

One of the most alienating of shame experiences is degradation. It can trigger perhaps the most fundamental shaming self-appraisal, “I am unfit for human company.” About 6 years ago, I ran a workshop for therapists in Germany. The topic was a relational perspective on the process of shame in therapy. One of the participants became excruciatingly mournful as she recounted a story of her extreme degradation at the hands of her father, her alienation from her unsupportive mother, and her consequent life-long severe mistrust and isolation. I was heartbroken as I listened. She then went on to describe a current difficulty with her therapist. She appreciated much of what had transpired in their work together. With him, she had begun to gain some trust of others; some respect for herself, and her crust of defensive isolation had cracked to the point where she now experienced loneliness and longings, instead of the deadening sense of aloneness that she had lived in for many years.

But currently she felt emotionally abandoned by him. She wanted him to join her down at the bottom of her well—the terrible dark cave where her traumatized existence dwelled, so that they could climb out together. She could only sense him as coming part way down the well. As we continued to explore together, I told her that, in relation to my own experience of traumatic degradation, I had come to realize that no one else could truly meet me at the bottom of the well. There would always be a gap, in part because the lived experience is one of annihilation, so there are no words, no sense of a human connection. What I had come to appreciate were experiences with therapists who could mourn that gap with me.

She felt heartened by my statement, joined by me in her mournfulness, and was empowered to speak about our conversation with her therapist. I privately hoped that he, too, would be able to join her in her mourning the gap. Two years ago, the same woman showed up at another workshop of mine. Much to my surprise and relief, she told me our previous experience together has gotten her therapy back on track, and, in fact, had allowed her and her therapist to face together her shame over her desperate, rageful “neediness.” That process loosened the grip of her quest to be perfectly met and held, and she now was even living with a man, a romantic partner. She had a sense that her dignity existed now in mourning the gap, not transcending it. By mourning, together with her therapist, the experience of traumatic degradation he could not reach, the experience became more real, more worthy of respect in and of itself.