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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

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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 fallibalism, 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 compulsive 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.

There are people who suffer a sense of loneliness so profound and fundamental that it is violated by its very expression. To reach to communicate is to deny its truth, its being. Extreme loneliness taxes our capacity to meet our patients. This is so, I think because profound loneliness is closely linked with degradation.

When people are degraded, they are treated as if they are subhuman. In my experience clinically, and with supervises, I have noticed that although severe shame states can be met, tolerated, and embraced, we have trouble surrendering to, and embracing, degradation. We have compassion, we have heartbreak, but from a psychological distance. We are reluctant to join them in the class of people who can be degraded. I do not want the concrete experience of being subhuman, unworthy of human connection. I have had such experiences, which tells me they are survivable, but just barely.

I think having our own encounter with what degradation feels like is part of what we put at risk when we try to meet the aloneness of extreme loneliness. I think to name what the German woman experienced as *loneliness* may be a slight misnomer. I think of it as profound *aloneness*. Aloneness is loneliness that is so prolonged, pervasive, encompassing, that it has become a loneliness grown weary of longing for otherwise. What the depth of such aloneness has in common with degradation, is that degradation and aloneness both take us to the edge of our sense of being human. If *to be* is *to be related*, then profound aloneness puts us beyond the human pale. So, along with degradation, the utter, unspeakable loneliness-of-aloneness also puts us into the nonhuman category. I believe that those who suffer this aloneness also suffer degradation, because they are failing at that which defines us as human beings.

Of course, many who suffer in this way came to their loneliness consequent to experiences with degradation. But I am also saying that the experience of such loneliness can also be degrading in itself, and is an element of why it is that embrace of profound loneliness is such an aversive challenge to our capacity for inclusion. Nonetheless, if we can embrace and mourn the limits of our embrace together, we honor and help add substance to that which we are not able to meet directly.

Finding shame, finding dignity

Schneider (1977), writes broadly of two types of shame: "before the act: shame as discretion" and "after the act: shame as disgrace" (pp. 19, 22). Shame as disgrace is the experience of shame proper, with which we are already familiar. The shame before the act could easily be called *tact*. It is a disposition, rather than an emotional experience of shame. It is the sensitivity to the possibility of shame—yours or others—that guides you to be attuned to other people's dignity, as well as your own. And you cannot develop such tact unless you also are familiar with states of shame.

Schneider also makes the point that dignity requires that we be only partially revealed at any given moment. A sense of privacy and a sense of choice about what to reveal are two components of dignity. When one lacks such discretion, we think of them as shameless. So it was with Lucinda.

Lucinda bounced. She bounced into my office. She bounced through life, bounced into people, bounced back, and did it again. She was very bright, creative, and full of enthusiasm. Our therapy proceeded relatively smoothly at first. But after several months, I started to withdraw. She began talking about trouble in her friendships, and I began to see that my withdrawal matched the trouble she was having in her friendships (and may well have been how her friendship troubles came to be of interest to her).

I decided to tell her what was going on for me. I told her that at first I found our conversations easy and smooth, in part because she seemed to be so free and unself-conscious. But after a while I found her lack of self-consciousness about highly personal and intimate details of her life a bit disturbing. And alongside that, she seemed to have an expectation that I be as easily open and self-disclosing. I gave her a few examples of what I meant, and she was taken aback.

This was a moment of shame as disgrace. It was an unexpected and disorienting intrusion on her ordinary way of being. She thought that being open and free could only be a good thing. She was injured by my preference for greater reticence. She thought I was a fuddy-duddy, too prim and

proper. While responding gently to her woundedness, I held my ground that there was something worth exploring. What I did not say to her at the time is that I had come to think of her self-exposure as shameless, as if she had no care for her dignity.

It turned out my guess about giving her dignity away was not far wrong. It turned out she was bartering it. We found this out by a process of paying close attention to the moments just preceding any of her self-exposing comments. We tracked it together in the office, and she tracked it with her friends. What emerged as we began to put the bits and pieces of momentary experiences together was the discovery that she used her revelations like glue. They were meant to guarantee that the other person would be tied to her. If she confided in the other person, and especially if she could seduce the other into confiding also, then a bond of loyalty was established.

Much ensued from this realization. For one thing, she had never experienced a sense of privacy, or a sense of tact or sensitivity to shame. At first, the idea of keeping something about herself private frightened her: How could anyone want to connect with her if she did not offer herself up in this way? That anxious question opened the door to her experiencing shame for the first time that she was aware of. First we explored her shame about her insufficiently interesting self, a shame that required that she reveal all in the hopes that something would stick.

The realization also led to new explorations about her relationship with her mother. She could see now that her mother assumed that privacy meant that Lucinda was abandoning her. Lucinda began to have a sense that by sharing everything about herself with another person, she was left in an odd kind of aloneness. She had given herself away and had nothing for herself. It was not that she must keep a specific thing private to have a sense of having herself, but she realized that by not having a choice to keep something private, she was acting shamelessly. She was now learning about shame as discretion. As she began to change and she looked back on her bargaining with her dignity; she felt ashamed of her shamelessness.

Buechler writes about such potentially revelatory shame experiences:

> Paradoxically, there is much narcissistic gratification to be gained from honest self-confrontation. That is, if we are willing to brave the narcissistic injuries inherent in seeing ourselves clearly, we can develop self-respect for having integrity. It takes courage to face one's cowardice. The analyst must help the patient learn to respect herself for facing herself. [Buechler, 2010, p. 122]

Lucinda's shame over her shamelessness was a particularly poignant time. She allowed herself the experience of shame that could be inspirational, rather than toxic. The shame she felt over bargaining her dignity away could now be a touchstone to remind her that it was better to tolerate her anxious uncertainty about connecting with others than to try to tie down the relationship through a bad faith bargain. She found new relationships that had a density she had not known before. They were based more on recognition of her wholeness than on *quid pro quo*.

As we engaged in these explorations together, my sense of Lucinda changed. She seemed more three-dimensional, more substantial, and, especially, more complex. She sensed the same thing, and she even started moving at a bit more graceful pace.

The last year of our therapy was spent with our mourning that I could not be more like her mother, with whom she felt utterly transparent, which she had equated with a feeling of great intimacy and closeness. At the same time that she mourned the loss of transparency, she gained a greater connection to the dignity that comes with being more than can be fully known by anyone. And she found that I recognized her wholeness more, even if I knew her less.

This experience of walking through her shame together with no eye toward expunging it, but rather with an eye to using it inspirationally, is well described by Buechler again (Buechler, 2008). She avers:

> I prefer the concept of balancing, rather than diminishing, shame (and other painful feelings) as a treatment goal. I have often found that, if my patients and I can become curious enough and proud of the courage to face ourselves, curiosity, courage, and pride can modulate our shame. [p. 103]

Shabad (2007), writing about the trap of shaming self-blame, cautions us against forgetting how shame can also be a pathway toward responsibility: "In our attempts to provide patients with an analytic love and rescue them from their shame, we forget to *respect* the sacred essence of each person to create his or her own life, for better or worse" (p. 603, emphasis added).

This is the path that Lucinda and I walked. We were not insensitive or unsympathetic to her shame. But we were able to differentiate the dignity-destroying shame that arose consequent to her family dynamics, from the more existential—hence motivating or inspiring—shame that called for her to claim her dignity.

Not quite human: An unchosen life

Stanley arrived in my office very anxious, an anxiety that I sensed was an expression of desperation. He was reluctant to begin therapy. He didn't like talking about himself, and in fact he knew very little about his own experiential world. He had almost no childhood memories, almost no awareness of feelings, or of bodily sensations, and no capacity for reflecting on his experience and behavior. He had no optimism that therapy could help him. His experiential world was remote, inert, and uninteresting to him.

His anxious desperation was the glue that would have to hold us together until other ties developed between us, and toward his therapeutic project. He was desperate because his wife of almost 30 years had discovered—for the second time—that he was having frequent sex with many male escorts for several years. She demanded that he join her in couple's therapy and also that he get into his own therapy. If he refused, she would leave him. One of the few things he knew about himself was that he did not want to lose her.

The situation was ironic, in that his lack of self-awareness made almost no room to explore what it was like for him to accede to a project that had no meaning to him. Only after he had developed some capacity to notice feelings and use them as a guide were we able to ask the question: Was complying with his wife's demands without protest a path that he actually wished to take?

Stanley lacked two things that are necessary for a sense of a life of dignity. He lacked any sense of having chosen his life, any sense of agency. Also, he lacked narrative coherence: a sense of meaning or purpose in his life, a story to tell about how he got to where he was and where he might want to go from here. He saw himself as having simply fallen into his life, never really choosing anything. Obviously, these two elements, the lack of narrative coherence and the lack of a sense of agency, interweave each other.

Joye Weisel-Barth (2009) has written a clear exposition about the tension between agency and determinism, in which she endeavors to contextualize a sense of agency as a kind of slippage that exists within the larger umbrella of the abstract determinism of complexity theory and its cousins. My own perspective on that tension—similar to Weisel-Barth's—is that because we live in and between many subcontexts, emergence arises from the interplay of many competing, conflicting, and supportive forces. That emergent process existing on the explanatory level, is experienced as having choice, or having to choose. We need not answer the question of whether choice actually exists; we only need know that a sense of agency, the experiential sense of choosing, matters.

A sense of agency matters for a few reasons. First, it helps in the development of a coherent story about your life and is a support for living according to aims, desires, values and ambitions. Second, having a sense that one can choose enables one to see more possibilities amidst the constraints in one's world, which makes one's experiential world more hopeful and richer. Taken together, these constitute a component of a sense of dignity.

Stanley did not choose his career. It was a default career, something he knew would not displease his parents. He did not choose his marriage. While attending separate colleges, Carla thought it would be a good idea if they went out with other people. Stanley never had a second date with any other woman, for fear of experiencing an humiliating, awkward uncertainty about what to do next. It also never occurred to him to date a man, and occasionally he wonders what that would have been

like. After college, Carla and Stanley started seeing each other again, and at some point it just seemed right that they had been dating long enough; it was time to marry. It is not a loveless marriage, by any means. Nor is it truly chosen.

It took quite a while for Stanley to even understand the concept of choosing his life. Now he has frequent spells of mourning his having spent so many years sleepwalking through his life.

The dignity of a story

Stanley and I have woven together many stories about what we have been able to mark as "choice points" in his life. That is, we have begun to think of ways to understand his behavior as more chosen than his previous thoughts about it. Many of his apparent choices were fear-based. He has developed some skill at recognizing his frightened moments, and finds he is frightened of being left feeling embarrassed, ashamed, or humiliated.

Many of our stories are woven from just a very few threads. His capacity for self-reflective thought has developed to quite an extent—and now he even enjoys trying to make sense of his current and past experiences—yet he still has few memories of the process of his life. Nonetheless, we spend time together building stories about his life that prove useful for him.

Carlo Strenger's (1986) discussion of coherence is well suited to the various ideas that Stanley and I have developed. Strenger points to two types of narrative coherence that, when taken together, can suffice as psychoanalytic understanding. The first is internal coherence, "the intelligibility an interpretation confers on some material, for example a patient's associations" (p. 259). The second is external coherence, a reference to the plausibility or aptness of the interpretations within the cultural context. A sense of dignity is not possible if one cannot be recognized as someone who has the potential to be understood. One needs a means of conveying something of their world of experience. That is one function of a story.

The idea of coherence is quite useful because we have such little grasp of Stanley's experiential world. He remains remarkably obtuse to both of us. He and I have had many, many explorations of his 17 years of sex with the escorts, for instance. We have tracked how it began and what various meanings might be. At first he and his wife and the couple's therapist wanted to know if Stanley was gay or straight. Stanley dutifully wondered. But over time, it became clear to him it was not an interesting, or even an apt, question. So we have woven various narratives about his behavior, some of which have been useable to us and to his wife and in their joint sessions.

For instance, given his dread of judgment from others, and his life-long commitment to "being a good boy," we look at his sexual behavior as his "underground life," a place where he could do something he wanted, instead of just complying with everyone else in his life. This has been useful for him as a support for being more open with his wife (which terrified him at first, and still frightens him) about his fears and disappointments in life. He now recognizes that if he keeps those things to himself, he would be going back underground.

When our therapy began, Stanley was obsessed with how his body looked. He exercised obsessively, restricted his calorie intake, went to tanning salons frequently, and shaved his body hair. Right from the start, Stanley spoke freely about his obsessional preoccupation with his body; the accompanying behaviors; and his sexual behavior with his wife, Carla, and with the escorts. He showed no signs of embarrassment. He was merely reporting dutifully what he thought I needed to know to help him. A stray remark he made led me to understand that he spoke that way because he assumed I had no feelings at all as I listened to him. He was a piece of machinery to be fixed, and I was a mechanic. I mentioned that metaphor to him, but at the time that metaphor felt apt and unremarkable.

Many of our early conversations revolved around his preoccupation with his body. He was concretely defective and ugly, because he didn't have a perfect body. He was sure that the escorts that he had sex with, who had perfect bodies, also had perfect lives. Our early conversations were highly repetitive. He tended to obsess and ruminate. We might have had a discussion that seemed to

mean something to him, for instance, a new way of understanding some of his preoccupations or behavior or even perhaps some feelings, but often by the next session it was as if those discussions had not happened. We seemed to be starting over again quite frequently. Eventually, however, our explorations of his feelings during the visits with the escorts began to open the door to exploring some fundamental feelings of shame and inadequacy.

Now that he has no interest in sex with escorts, he looks back and scratches his head with wonder. How could it have been so intense? So frequent? He had had no idea at the time how absorbing it was. But during his therapy, he and his wife went through his e-mails together. There were e-mails about thousands of appointments. We have taken to describing it as an "addiction bubble." In it, his life-sustaining fantasies of becoming perfect through osmosis by having sex with these perfect bodies was untouchable. Then when he got STDs, the bubble burst and he tried to kill himself. That is when his wife threatened him with divorce, and in an odd way, that gave him hope because it meant she was not going to just turn on her heels and leave.

We have woven many theories about how men's bodies became so fetishized, and how he made the progression from observing bodies, to going to online escort sites, to making the first call, to becoming addicted. None of them address the question of whether he is straight or gay. Importantly, whenever we are able to build a story that makes sense and is one that he can use heuristically, or as a support for feeling more whole, or as a doorway to some emotional process, he finds himself able to be more forthright with his wife, and also to hold his own against her tendency to criticize him and find him wanting whenever she is distressed. For instance, although he enjoys sex with his wife, he rarely initiates it. He is embarrassed to initiate it. His wife faults him for not initiating. After a long time of feeling guilty and ashamed that he is not satisfying her by "manning up," he was able to tell her that if she insists on waiting him out, she will be depriving herself of the sex that both he and she want. He is not going to bend himself into a pretzel anymore to try to initiate sex. He feels more worthy of being heard.

We have also woven a workable story about his lack of empathy. He told me stories about how Carla pointed out that he seems uninterested in her emotional experiences. Even worse, he was unresponsive to her at times when she has been ill. Carla and the couple's therapist have taught him about the concept of narcissistic personality. He finds resonance with that description, and yet he is dismayed by it. He wishes he could be more empathically sensitive, but he feels lost. He is not without remorse and sadness for what his wife has to endure as a result of his infidelities, but still, he does not attend to her emotional life.

At one point, Carla found an online Asperger's syndrome survey. Stanley's score was suggestive of Asperger's. This proved to be a boon to Stanley and to Carla. Carla had been morally indignant about Stanley's narcissistic self-absorption and his limited interest in and capacity for empathy towards her. She now saw his limits in a different light. Stanley and I talked about whether or not he wanted to get tested for Asperger's. He was content just to be able to think that maybe he was wired differently, as opposed to being morally defective. If he were tested he might find out differently.

This decision was his second decision to abandon a search for a final, all-inclusive truth, and rather, to settle on what William James (1907) would see as a useable truth (the first being surrendering the quest to determine if he is "gay or straight"). It seemed to lift a mantle of shame. He could now work toward being better attuned without expecting himself to be as astute and caring as Carla is. Recently, when his wife underwent surgery, Stanley took a week off from work without being asked to do so. He felt very good about the fact that he took care of his wife without any feelings of resentment. It felt natural to him.

The dignity of choosing one's life

A few years ago, Stanley read a novel in which there was a deeply sentimental, romantic, and loving man named Wilson. Stanley told me how much he wished he could feel the rush of feelings that Wilson described. And he lamented that even if he were able to feel those feelings,

he would be too embarrassed to share them with his wife. For him, almost any feeling was a source of embarrassment. Only children have feelings, not grown-ups. Wilson has been a topic of conversation off and on throughout his therapy. It is a touchstone for his longing for access to his feelings.

Sadness is one of the feelings he has begun to be able to access. He feels sadness and regret—sometimes to the point of tears—for what his wife suffered and suffers because of his years of sex with the escorts. Shame is a feeling he has in very tiny glimpses. Embarrassment is closer to the surface, but is something he avoids whenever possible.

He has learned that his thoughts and feelings have meanings. He often starts a session saying he noticed he had a reaction to something Carla said, and that then he spent some time wondering what his reaction might tell him about a feeling he might be having. He is excited about his newfound capacity for, and interest in, self-reflection.

It has been during this period of awakening to his feeling world and to his capacity for self-reflection that we had some sessions that seem to mark an emerging tipping point. The series of sessions began with his return from a partnership meeting in New York.

He started by telling me that, as often happens, he felt the disdain and disappointment from his New York partners about how Stanley's Los Angeles office was not pulling its weight. Stanley felt like the poor cousin. He lamented that he was having feelings—such as embarrassment, anger, and humiliation—that little boys have. In the past, we had talked about a little 8-year-old boy that lived inside his skin. Perhaps now, given his heightened emotional state, we might actually be able to explore that experience!

We ended up doing an imaginative experiment. He could picture the little boy sitting on the back steps of his childhood home, in his striped tee shirt, doing what he often did. He had spent many hours as a child drawing maps of trains, roads, and airplane flight paths (he still loves knowing about airplanes, and all kinds of transportation, even having memorized local bus lines). I asked if he had any feelings about his little boy self. To my surprise, he said he felt tenderness. As we went on, he said he wanted to go and put his arm around the boy's shoulder and tell him that things would be ok. He said the boy was sad and lonely.

We were both moved by that session. And unlike so many other sessions, it seemed to have some staying power. He referred back to it in subsequent sessions. Several weeks later he told me a story that brought tears to my eyes. He was quite consciously describing what was, for him, a new experience.

He had attended a one-man show at the Hollywood Bowl, a large amphitheater in Los Angeles. The performer was someone with whom he had a friendly professional relationship, so he was invited to meet with the performer on stage after the show. Stanley went to the stage but the performer was nowhere in sight. Stanley asked the stage manager about it. The stage manager said, "You know how terribly shy he is. He is still downstairs in the dressing room. Why don't you go down and bring him up?" Stanley found the performer sunk in a chair. Stanley gently spoke his name and asked what the problem was. The performer said, "There are so many people! I am terrified." Stanley told me that he spontaneously went over to the performer, and just as he imagined doing with his little boy, he draped his arm around the performer's shoulder and said, "Come on. We will go upstairs together." And off they went.

A few weeks later, he was walking from a restaurant to the car with his now frail father, and for a brief moment he held his father's hand. He described both of these events as spontaneous and natural. They seemed to represent to him that he was starting to live his life, instead of just passively coping with it. After all, he had initiated action.

The last session in this series was the *coup de grace*. We were coming up on the Jewish high holy days, and Stanley and Carla were having a discussion about whether to continue their membership in their *Shul* (synagogue) or whether to just buy seats for the two major holy days. Carla even said that perhaps they could just stay home and reflect by themselves on those days. Stanley was not sure what he wanted, but he thought that he ought to go to *Shul*.

Our exploration started with an examination of the word *ought*. He worried what others would think of him if he did not go. But that worry seemed thin to me, and I pressed for more. I had understood from him that he is an atheist, and yet I had a sense that religious stirrings were afoot. I said that if he did not believe in God, I wondered what a service could hold for him. He actually began speaking with some intensity about what it means to him to be Jewish. It matters to him to belong to the community of Jews. Going to synagogue on those days meant he could feel and demonstrate his communion. He went on to say that standing together with other Jews on those days was an affirmation that Jews were still standing, despite millennia of persecution and hatred.

And then, speaking specifically of Yom Kippur, he said that in past years he knew he was faking it on Yom Kippur, the Day of Atonement. He was cheating on his wife, and was not atoning. Now that he could feel more, he felt ready to atone. At that point, he realized that he also wanted to pay the membership fee again. He said the membership fee made it possible for other, less wealthy, Jews to stand with him. He was choosing how to affirm his Jewish life.

He looked at me with bright eyes, and we both said, almost simultaneously, that he was choosing his life! And he let out a brief, excited laugh.

The dignity of being received giving

There is a facet of dignity that is often overlooked in the consulting room: the dignity of having something to give to the other. For many of our patients, the fact that we are gratified by their gift of allowing us to contribute to their lives, and the fact that we take pleasure in being with them, may never require comment. It is a background substrate that dignifies our work in the therapeutic relationship. But there are some patients for whom such an experience is remarkable.

For one patient, objectified and dismissed as a "worthless piece of shit," my obvious interest in her and my pleasure and admiration for her self-reflective capacity was a surprise. At first, she dared not trust her experience, but over time it became something she relied on, even when we were struggling with each other.

Another patient, someone with whom I had been meeting for a few years, was seeing me at a time when I had suffered a sudden and quite painful loss, a death of someone dear to me. This patient knew, from other sources, about my loss.

She was reluctant, at first, to inquire as to how I was faring. She cared deeply for me, but experienced herself as a toxic presence, and she did not want to intrude. In a session in which we were talking sadly about her belief that she offered nothing positive to her newborn son, she finally—tentatively and with embarrassment—spoke of her concern and caring for me. I could not hide how moved I was, nor would I have wanted to. I was moved by the risk she took, but also by her care for me. That moment became a touchstone for our further explorations about her doubts concerning whether she had anything to give to another.

I don't think we should expect our patients to give to us, but I do think it vitally important that we be able to be vulnerable enough, and confident enough, to be open to receiving from our patients. Given how the process of therapy has so much indignity in its structure, I hope our patients come to know what a gift they give to us just by allowing us to sit with them.

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