

Clarifying Human Dignity in Forensic Practice

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The notion of human dignity remains a relatively complex concept that has roots in classical Greek and Roman antiquity and links to religious teachings and Kantian philosophical notions. From the Latin *dignitas*, human dignity means worth and implies excellence and distinction. Human dignity, also found in 20th century constitutions and international declarations, has been considered in bioethics, general medicine, and psychiatry. The application of dignity to forensic psychiatry practice has received less attention. Through a review of texts in medicine and related fields, such as philosophy and anthropology, we aim to clarify the concept of human dignity and its application in forensic psychiatry practice. We first outline the historical origins of the term. We then consider several varieties of human dignity applied in medical ethics and psychiatry. We review individuals' lived experiences of indignity and dignity's place in forensic practice in different loci. We present recent scholarship related to human dignity and highlight the importance of dignity in forensic practice. Focusing on dignity in evaluator-evaluated and doctor-patient relationships should improve forensic work. Training in dignity-imbued forensic practice should remind us of the human dimensions of those we serve in the forensic arena.

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In the *New York Times* of October 13, 2022, Glenn Thrush¹ reported that a federal judge in Florida had severely criticized prison officials and prosecutors for their professional conduct toward Frederick Bardell, a prisoner. Mr. Bardell was sentenced in June 2012 to a prison term of 151 months for distributing pornography of adolescents. Doctors determined that Mr. Bardell had colon cancer. His first application for compassionate release in November 2020 was rejected because of the claim by prosecutors that his condition was not terminal. Mr. Bardell submitted a second petition supported by an oncologist in February 2021. The prosecutor claimed to have a report stating that there was no malignancy. On this occasion, the judge ordered that the Bureau of

Prisons prepare a court-approved plan for Mr. Bardell's release. The Bureau discharged Mr. Bardell, but reportedly did so without a plan. He died nine days later at a relative's home. Thrush stated that the judge held the Federal Bureau of Prisons and a prison warden in civil contempt of court orders intended to guarantee the humane treatment of Mr. Bardell. The judge noted that although Mr. Bardell was a convicted child pornographer, he still deserved humane treatment. Thus, the Bureau of Prisons had been indifferent to the human dignity of an inmate in its care.

Pless and colleagues² have reminded us that "it is the irony of dignity that its relevance becomes most obvious once it is violated and undermined in the most extreme ways" (Ref. 2, p 224). That is why we described Mr. Bardell's experience here. The judge seemed to understand that dignity came into play through the glaring visibility of the indignity. He also seemed to have appreciated that labeling the inmate as a convicted child pornographer within the court and prison systems may have contributed

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to his inhumane treatment. From the news report, one might conclude that the prison personnel and government lawyers likely helped undermine Mr. Bardell's self-esteem and identity. The personnel may have rendered less humane the systems in which Mr. Bardell was caught. Pless and colleagues² suggest that those systems are the organizational cultures, workplaces, and relationships encountered in courts and prisons.

The ethics scholar Edmund Pellegrino³ has referred to human dignity as estimations of our personal worth and worthiness. All of us regularly carry out these evaluations of ourselves and of others. We make imputed judgments of value and worth, knowingly and unknowingly. Furthermore, it is in our interactions with others that we gain knowledge of others and ourselves, which makes the experience an intersubjective phenomenon. Alec Buchanan⁴ noted the connection between human dignity and the vulnerability of those who seek the services of forensic mental health specialists. He remarked that these individuals' problems with indignity are partly related to the "nature of courts and prisons and the incapacities which are a part of mental illness" (Ref. 4, p 15). Ruth Macklin⁵ has clearly stated her dislike for the concept of human dignity. She urged that it be abandoned, as it is no more than respect for persons or respect for autonomy. In addition, it is difficult to define. In a publication on human dignity produced by the President's Council on Bioethics in 2008,⁶ several of the contributors⁷⁻⁹ argued against abandoning the concept and agreed that it would be worthwhile to clarify the concept further to make it more readily useful in practice.

Our objective is to shed light on the concept of human dignity and consider its application in forensic psychiatry practice. We review first the conceptual and historical development of dignity in medical ethics and then explore the fundamental varieties of human dignity and their applications in biomedicine. We draw on the scholarship from other disciplines that has recently contributed to the continuing elucidation of dignity. We ultimately offer guidance to forensic practitioners to help them understand better the notion of human dignity and its application to practice. We illustrate how dignity should be used by forensic professionals in their practice within two important loci: in clinical work

within secure psychiatric facilities and in the task of forensic evaluations. We note our omission of carceral institutions as a focus in this article. That is because those facilities are structurally and intrinsically more complicated, with ubiquitous emphasis on the power differential between inmates and officers, and a rigid focus on security. This contrasts with the attention to care in the other settings through the patient-caregiver relationship. So, the implementation of dignity-imbued care in the prison setting is especially complex. Nevertheless, what we say here about dignity applies to the incarcerated in large measure. We hope this clarification of dignity leads to changes of attitudes and behaviors in forensic specialists and development of dignity-imbued work.

Historical Perspective on Human Dignity

Examining literature about the origins of the concept of human dignity often reveals controversies and debates about what Pellegrino described as "humanity's claims to a unique dignity and to the moral entitlements such a status entails" (Ref. 3, p 513). Pellegrino was concerned about the encroachment of biotechnology's influence on "reshaping what it is to be human and what human being is" (Ref. 3, p 513). It seems that it is within these debates that consideration is given to what constitutes humanity.

Adam Schulman⁷ suggested that there are at least four sources of human dignity that deserve mention. The first source is classical (Greek and Roman) antiquity, which produced the Latin term, *dignitas*, that is the basis of the word dignity, meaning worth, and implying excellence and distinction. This is readily associated with rank and social status. While the Stoics in classical antiquity are mentioned as part of this first source, they emphasized possession of reason. Schulman⁷ described a second important source of dignity found in biblical religion. This form conceives of humans as having a type of dignity that is sacred and godlike, inherent, and inalienable, linked to the notion that we are made in God's image. David Gelernter⁸ supported the importance of religion's influence in the conceptualization of human dignity. He argued that it was difficult to claim a "unique set-apartness of man without turning to religious characteristics such as the sacredness of man and the linkage to God's image" (Ref. 8, p 395).

The third source of human dignity was attributed by Schulman⁷ to 18th century Kantian philosophy. It

was Immanuel Kant who argued that all persons possess human dignity because of their rational autonomy, “their capacity for free obedience to the moral law of which they themselves are the authors” (Ref. 7, p 5). The fourth source highlighted by Schulman is the common use of human dignity in 20th century constitutions and international declarations. This refers to a class of human dignity that is inviolable and entitles us to basic human rights and freedoms. It is based on the notion that all humans are born free and equal in dignity and rights.

Schulman⁷ stated that the forms of dignity derived from these different sources all have weaknesses. The classical conception (source #1), referring to the dignity of rank or merit, is problematic because of its “ambiguous relationship to technological progress and in part because of its aristocratic and inegalitarian tendencies” (Ref. 7, p 6). The biblical form of dignity (source #2) evokes opposition from those who resent the connection to religion. It is also not clear, for example, how it should be applied to the problem of destroying human embryos and to other technological innovation. Kant’s idea of human dignity (source #3) has had limited use in bioethics because its emphasis on rational autonomy gives little guidance on what to do with infants and individuals with dementia who lack rational autonomy. Twentieth-century constitutions and international declarations (source #4), while often relying on the concept of human dignity, rarely define its meaning. Schulman articulated these criticisms but concluded that human dignity still has been reasonably functional and “served liberal democracy well, fostering tolerance, freedom, equality, and peace” (Ref. 7, p 7). As a practical matter, we will be most interested here in the first, third, and fourth sources of dignity.

Classifications of Human Dignity

Daniel Sulmasy¹⁰ recommended usage of three broad categories of human dignity. They were intrinsic, attributed, and inflorescent dignity. He maintained that “to speak of human dignity, then, is to say something about the worth, stature, or value of a human being” (Ref. 10, p 938). We have previously encountered this practical working definition of dignity in the introduction, used by Pellegrino.³ Sulmasy explained that “Intrinsic dignity is the value that human beings have simply by virtue of the fact that they are human” (Ref. 10, p 938). This is not related to any biopsychosocial, economic, or political

conditions. Neither is it connected to any talents, skills, or power of the individuals. This form of dignity is supported by sources two and four mentioned earlier.

Attributed dignity (supported by source #1) refers to “worth, stature, or value that human beings confer upon others by acts of attribution” (Ref. 10, p 938). Sulmasy explained that attributed dignity is a created value. “We attribute worth or value to dignitaries, those we admire, those who carry themselves in a particular way, or those who have certain talents, skills, or powers” (Ref. 10, p 938). Inflorescent dignity refers to “the worth or value of a process that is conducive to human excellence or to describe the worth or value of a state of affairs by which an individual human being expresses human excellence” (Ref. 10, p 938). Thus, dignity may be used in an inflorescent way to describe people who are flourishing as human beings and living lives that express the assumed existence of intrinsic dignity of humans.

Sulmasy¹⁰ demonstrated how his definitions should be employed. As an example, he explained how in discussing patients one might say that all the patients in a hospital ward should be treated equally because of their (intrinsic) dignity, which cannot be lost or diminished. One may say, too, that some patients, by virtue of disfigurement by their illnesses, have lost their (attributed) dignity. Or one could also draw attention to how some patients have coped well with the intense experience caused by their illnesses and demonstrated (inflorescent) dignity.

We turn now to contemplate how Jeannette Pols, a medical anthropologist, viewed dignity as related to ideas about what it means to be human and how to treat people humanely.^{11,12} She noted that there are generally two types of dignity: *humanitas* and *dignitas*.^{11,12} She defined *humanitas* as what is also known as intrinsic dignity or the dignity of being human. She pointed out that *humanitas* is also considered as a founding category for the universal rights of people. It refers to ethics and juridical principles such as freedom, equality, autonomy, and independence. Pols referred to them as “citizen values” (Ref. 12, p 188). For Pols, *humanitas* has a universal normative claim that reposes on the principle of equality that is the cornerstone of a just society.

She further refined her definition of *dignitas*.^{11,12} This is social dignity or dignity of merit. She understood Sulmasy’s view of it as attributed dignity.

Nonetheless, she worried about the use of attributed dignity to diminish the equality among individuals, or to legitimize inequalities. She did not emphasize merit in *dignitas*, but accentuated esthetic values or social values that organize people. “Aesthetic values, in mundane situations, then, refer to different conventions of what is proper, tasteful, stylish or pleasant” (Ref. 12, p 187). This form of *dignitas* is, in practice, a reference to “an enactment of a particular aesthetics of what people in a certain (sub)society find proper or admirable rather than to expressions of merits or rights” (Ref. 12, p 187). Pols saw *dignitas* as the engagement of individuals in the esthetic genres of sociality they value. “Aesthetic genres are orderings in which one or more aesthetic values are central, referring to what people value or admire, find proper, stylish or tasteful” (Ref. 11, p 953).

Pols applied *dignitas* to the examination of clinical care. She observed that nurses, respecting patients’ privacy to make their own decisions, relied on the value of *humanitas*. Other nurses defended the value of cleanliness for patients’ bodies, utilizing *dignitas*. In considering the examples, we find it useful to reiterate that Pols’ view of *humanitas* emphasized it as useful for “thinking about the value of being human and about protecting humans” (Ref. 12, p 189). In contrast, *dignitas* refers to esthetic values as “values that organize (sub)genres of aesthetic practices . . . their normativity is permissive, not prescriptive” (Ref. 12, p 190). Having helped us to appreciate the differentiation of *humanitas* and *dignitas*, of intrinsic and attributed dignity, Pols then used her observations of nursing care on psychiatric services to caution us about sticking rigidly to definitions that in practice may lead to complications in caregiving. She made use of the principle of keeping patients clean as an example. Pols encountered nurses insisting that respect for privacy meant that they should not interfere with patients’ refusals to wash themselves. She pointed out, however, that this rigid approach to protecting a patient’s privacy could result in failure to recognize the patient’s bedsores.

The philosopher Jill Hernandez¹³ discussed moral dignity. That form of dignity, while interesting to philosophers, has received less attention in medical arenas. Roberto Andorno¹⁴ has argued that it applies to behavior and not to people. It is also “not possessed by all individuals in the same degree (an honest man has more dignity than a pickpocket)” (Ref. 14, p 45). We shall not mention it further. We have

encountered one other set of terminology in the literature (absolute and relative dignity) utilized by Gustafsson and colleagues.¹⁵ Absolute dignity is readily understood as intrinsic dignity; relative dignity is attributed dignity. As we move to the clinical arena, we find it preferable to employ the classification of Sulmasy or Pols, while remembering Pols’ insistence that we avoid rigid use of the terminology in clinical work. Pols’ concern about the inequities generated using dignity of merit or rank remains important.

Patients’ Experiences of Human Dignity

We now consider dignity in medical practice, particularly through patients’ feelings of having experienced indignity. Pellegrino³ formulated the notion of the lived experience of human dignity, defined as “the way human dignity is perceived by human beings as they respond to the valuations of their worth and worthiness by others or by themselves” (Ref. 3, p 514). Pellegrino³ asserted that it is difficult to appreciate fully the concept of human dignity unless it is grounded in our lived experiences, on a personal or collective basis. He was especially concerned about how human beings react in the routine context of sickness and in the role of patient. What patients feel is often connected to concern about a loss of status or identity compared with what they experienced when healthy or not in the patient-clinician situation. These medical patients, under stress, may believe that the experience is related to their own worth or inherent dignity. It should be an important therapeutic objective to reassure patients that intrinsic dignity is enduring and inviolable. Pellegrino agreed, that in the context of sickness or the patient-clinician relationship, there are common challenges that provoke feelings of self-deprecation and unworthiness, which may run deep enough to induce ideas that one has lost inherent dignity. He emphasized that undergoing such experiences is “to experience a loss of only our imputed dignity” (Ref. 3, p 516).

The indignities linked to patient status may produce feelings of guilt, shame, and a sense of being inferior to the physician. Sadness may come at the exposure of one’s body and after having revealed personal life stories. Or it may follow contact with hospital procedures and mandatory questioning. Feelings of humiliation may be evoked by a variety of factors. Pellegrino concluded that caregivers have

an obligation to use the information about human dignity to preserve individuals' self-worth and to prevent indignity. Many of his examples are like those presented by Rebecca Dresser¹⁶ in her discussion of medical conditions in which questions about dignity arise.

The 2008 contributions of Pellegrino³ and Dresser,¹⁶ to the understanding of the connection between disease states and dignity or indignity, were published about a year after the contribution by Harvey Chochinov.¹⁷ Still, there is complementarity in their work. Chochinov¹⁷ noted the connection between patienthood and dignity, relying on research findings showing that cancer patients report feelings of being a burden to others and a sense of losing respect. Thus, Chochinov¹⁷ advanced four elements as the basis of what he called dignity-conserving care. They were: attitude (how the clinicians' attitudes enable them to establish open and empathic relationships with patients); behavior (clinicians' behavior toward patients should be based on kindness and respect); compassion (suggests a deep awareness of the patient's illness linked to the desire to relieve it); and dialogue (which refers to the interpersonal exchange of information and conversation between clinician and patient that should verify the patient's personhood beyond the illness). These factors are of course now familiar to many clinicians. This work also led to development of dignity therapy, which Chochinov and colleagues¹⁸ intended as a therapeutic intervention to combat distress at the end of life. The effect on bolstering a sense of meaning and purpose while reinforcing a continued sense of worth within a supportive and nurturing framework was salutary.¹⁸ Chochinov and colleagues also pioneered the Patient Dignity Inventory, a tool for detecting patients' subjective perceptions of dignity.¹⁹

One of the authors (V.G.), a physician and medical anthropologist, recently conducted a qualitative study of endometriosis,²⁰ a chronic disease well known for its debilitating and painful effects on women. She noted how the disorder steals "women's dreams, careers, relationships, friends, right to decent lives" and how it "also negatively affected their pleasure from food, dance, and sex" (Ref. 20, p 9). This impact on their collective sense of self can lead to an illness experience that creates a basis for "solidarity among members of the endometriosis community" (Ref. 20, p 10). The resultant diminution of self-

worth caused by the disease and interactions with medical personnel have produced complaints about clinicians' negative attitudes, and the "trauma and depression experienced by the women after negative experiences with clinicians" (Ref. 20, p 11). These observations confirm how the experience of a sustained serious illness complicated by negative interactions with caregivers can lead to feelings of diminished personal worth.

In this section, we have demonstrated how clinicians commonly encounter the notion of dignity, as they confront patients' experiences of indignity. We reemphasize that individuals' disease states regularly provoke reactions of stress and induce feelings of indignity. This is in addition to the kinds of clinic and hospital-based interactions that may catalyze negative reactions in patients. We have also pointed out that differentiating the type of dignity involved can influence the direction of the treatment intervention. This discussion will be helpful as we move to dignity in forensic facilities, since there are some commonalities that characterize the reactions between patients and clinicians in medical and forensic psychiatric facilities.

Human Dignity in Forensic Facilities

It is readily acknowledged that the forensic inpatient psychiatry unit is different from those that deliver general medical and psychiatric services. This is because the forensic service is characterized by an ambience of involuntariness and a mission of custody that competes with the care mission. There is, too, close observation of patient behaviors and heightened concern about violence and possible attempted suicides. We may worry that the dignity of patients who have committed violent crimes is diminished in the eyes of caregivers, who may knowingly or unknowingly be displaying horror or anger in front of the patients. The clinicians may be outraged by the gravity of the crimes their charges have committed. Thus, the clinician-forensic patient relationship becomes an important and practical locus for the experience of indignities. The status of being a forensic inpatient may be determinative of how the patient is treated; staff may find it hard to see humanity in the patient. Their reactions of fear, disgust, and anxiety may result in incomplete forensic examinations, excessive use of medications, and unnecessary deployment of restraint and seclusion that in turn bias their reports to external agencies.

The study by Gustafsson and colleagues¹⁵ provided three main thematic findings related to maintenance of patient dignity, using focus group interviews of nurses in a Swedish forensic hospital. In the first finding, nurses confirmed that the patients had the right to things that others in the society enjoyed; additionally, patients were encouraged to make clear what they wanted or did not want. The second finding was focused on nurses' expression of respect for patients. This required teaching patients about creating respect without resorting to destructive actions that attract attention and about expecting respect in interactions with others in the hospital. The third theme was linked to nurses' displaying of care for the patients as human beings, through behaviors that increased patients' sense of worth. This was executed through nurses' taking additional time with patients and giving them extra space. The result was described by the authors as an attitude or posture of meeting the patients with dignity. We suggest that this effort at transforming the attitude of nursing staff should apply to all personnel encountering patients on a forensic service. The staff's behaviors should be based on a foundation of inherent and attributed dignity that is separate from the explicit therapeutic interventions taught in biomedical institutions.

Gustafsson and colleagues¹⁵ concluded that the themes they elicited, in this study of nurses, were connected to both intrinsic and attributed dignity, thereby reminding us of Jeannette Pols' theorizing,^{11,12} as well as the previous commentary by Pellegrino.³ We are referring to the possible conflating of different types of dignity when medical and forensic patients repeatedly experience indignities that make them feel that their intrinsic dignity is diminishing. Especially in the forensic context, there may be reinforcement from staff and others that these patients are intrinsically worthless; however, it should be clear that attributed dignity is involved here. This suggests that the staffs' behavior is the element in need of modification, through repeated training exercises, review of incidents on the unit, and other didactic measures. Gustafsson *et al.*¹⁵ argued that the important first step is to provide experiences to these forensic patients that maintain and strengthen their self-image, which is to say, their extrinsic dignity. After all, it is ultimately the staff who must work to protect the forensic patients from situations that are embarrassing, humiliating, or shameful.

In addition, there are other scholars, such as Gwen Adshead²² and Jacob and Foth,²³ who studied ethics violations related to patients in forensic facilities. Adshead²² commented on nonparticipation in treatment planning and lack of access to reading and video materials. These are two excellent examples of methods that emphasize dignity-enhanced interventions. Other models, commonly visible in well-run units, assure that patients have access to telephonic communication with family and have a say in certain leisure activities on the unit. Jacob and Foth²³ described the application of biopower by medical staff to establish zones of invisibility on clinical units to contend with patients whom staff disliked. This relates to staff behavior that favors some patients over others and the use of techniques to sequester patients. It may also be linked to excessive supervision of patients and inappropriate use of restraints. A dignity-oriented approach to care management emphasizes normalization of unit activities that promote patient independence and choice and input into leisure activities where possible. The balance is always with the requirements imposed by attention to safety and security.

A subsequent study by Askola and colleagues²⁴ addressed forensic psychiatric patients' perspectives on their care. This research was centered on the notion that patients' needs should be the focal point of their care. The work was carried out in a Finnish forensic psychiatric hospital with eight patients, six inpatients and two outpatients, between age 30 and 50 years. The patients were interviewed about their treatment in the hospital, how they worked through their offenses, and their feelings about both types of experiences. The patients found "the criminal offense, the mental health examinations, the diagnosis of mental illness, and commitment to forensic psychiatric care to be distressing, traumatic, and chaotic experiences" (Ref. 24, p 67). Coercive acts (restraint, seclusion, and forced medication) were clearly recalled, as were events of humiliation experienced by fellow patients. Some research subjects also described how staff laughed at patients. The subjects found it difficult to describe the offenses that caused their hospitalization; however, they acknowledged that the shame and guilt were attenuated over time. They recalled the experiences of being accused and judged by staff concerning their crimes, which contributed to the feeling that their hospitalizations were too long. These examples of

humiliating events provide illustrations that complement the factors discussed earlier by Gustafsson *et al.*¹⁵ Both studies suggest a need to help patients look to the future and to be reassured about retaining inherent dignity even as the staff help them rebuild attributed dignity.

Eventually, the research subjects adapted to their situations and understood better their mental illnesses and why the events had occurred. At the final stage of treatment, they envisaged a future, defined by increased self-esteem and responsibility for their illnesses. By then, too, the staff had become helpers and no longer villains. The subjects saw themselves as active participants in their rehabilitation, with hope for their future lives. Not all the patients recounted this narrative of recovery. The authors concluded that studying these patient narratives was an important task for staff and should lead to changes in the attitudes and behaviors toward patients in these forensic contexts of care. The patients' narratives were struggles for dignity in a context of discrimination and rejection.²⁴ We refer interested readers to another qualitative study of dignity in forensic psychiatric inpatient care from the patients' perspective²⁵ and yet another one dealing with carers' experiences in a maximum-security forensic psychiatry setting.²⁶

Forensic Psychiatrist-Evaluee Relationship

In 2018, Michael Norko²⁷ published a paper that underlined several ideas: the importance of forensic work as a vocation, serving others, and seeking the common good. Also included were the notions that we need one another and have a shared responsibility for others. (This should evoke Pols' thinking about the value of being human and about protecting humans.) Building on these values and principles, Norko enunciated elements that should characterize forensic work: presence, critical curiosity, humility, compassion, empathy, centering, and respect for human beings. Norko has certainly been a catalyst of this turn in forensic psychiatry activity, which prompts the question of whether there is a link in his ideas to our thoughts about dignity. We point out that Norko's mention of respect for persons, compassion, empathy, and critical curiosity are core elements in Chochinov's distillation of what constitutes dignity-imbued care. Norko also brought up the matter in his discussion of Simone Weil's Statement of Human Obligations, when he outlined Weil's

thoughts about the irreducible societal obligations laid on us to respect all human beings and be concerned about their needs (Ref. 27, p 17). Norko's contributions also connect to reexamining and refashioning the evaluator-evaluee interaction.

Other scholars have participated in this extension of elements, concerning the close evaluator-evaluee relationship, to discussions of dignity. For example, Candilis and Martinez,²¹ reviewing the evolution of forensic ethics, noted the role of robust professionalism in ensuring the dignity of forensic evaluees and referred to the "unifying ideas of culture, professionalism, dignity, and social goods" (Ref. 21, p 571). Richard Dudley and Pamela Leonard²⁸ discussed the life story, the pursuit of facts and circumstances of the evaluee's life and the crime that "encourages values of accountability over retribution, grace over vengeance and life over death" (Ref. 28, p 961). Dudley and Leonard also advised evaluators to see the evaluee "through the lens of people who know him as a person rather than solely as a criminal" (Ref. 28, p 971). This accentuates attention to seeking information from third parties about the evaluee. These are certainly references to intrinsic and attributed (esthetic) dignity, and to the search for humanity in others. Glancy and colleagues²⁹ reconceptualized the notion of empathy, one of Norko's elements and relevant to the forensic context, because of their fear that empathy might sometimes restructure the relationship between evaluator and evaluee by diminishing the emphasis on objectivity in the clinical examination. We worry that Glancy and colleagues may be encouraging a reduction in curiosity about the evaluee. When curiosity is reduced, the evaluator tends to close inquiry about the evaluee too early.

Recent contributions from psychoanalysts have developed from a broader societal concern about racism and oppression. They have been exploring questions about whether their unique branches of psychiatry and psychology should be interested in the role that psychoanalysis has played or not played in the perpetuation of this scourge in the United States. These concerns have also led to reconsideration of the basic relationship between the analyst and patient that should be of interest to forensic psychiatrists. For example, the psychoanalyst Anton Hart³⁰ focused on increasing clinicians' empathic availability to their patients across terrains of difference. Hart advocated that clinicians learn how to become undefended when interacting with patients and clients

who are different from them along racial, ethnic, and cultural axes. Hart described it as a stance of noticing, questioning, and relinquishing presumptions about oneself and the other. We suggest that such openness, applied in the forensic context, is fundamental to the structure of the relationship and interaction between forensic evaluator and evaluatee. Listening with openness is akin to recognition of the other and is dignity-enhancing. Hart argued that racism should logically symbolize a failure of curiosity.³⁰

Hart had recommended that clinicians “aspire to being open rather than to being neutral” (Ref. 31, p 340). He emphasized that openness means interacting with the evaluatee. He underlined what he called receptivity or taking the other into account, which approaches the notion of recognizing the other. Pellegrino³ made clear that intersubjective recognition enhances attributed dignity while reinforcing intrinsic dignity. This, too, is dependent on how much struggle over power enters the evaluator-evaluatee relationship. Véronique Griffith²⁰ described the complexity of these power relationships in medical clinics, seeing them as methods utilized by both clinicians and patients to safeguard their dignity. She examined the doctor-patient relationship in the context of chronic illness and illustrated examples of indignity that occurred both inside and outside the medical clinic. Clinic staff’s collectively agreeing quietly to label an individual as a difficult patient resulted in the patient’s extrusion from the clinic and referral back to the primary care physician. Griffith²⁰ also described how patients, feeling ignored and not listened to within the clinic, sometimes resorted to developing a symptom diary that they could use to defend themselves against the opposition of the caregivers. Noteworthy is that this often resulted in souring the doctor-patient relationship, turning it into a bilateral power contest.

The psychoanalyst Lauren Levine³² talks about the historic moral injury, related especially to race and gender in our society, that requires our participation in its dismantling. We do so by seeking frank and open dialogue with our patients and evaluatees, which requires that we be willing to engage affectively with them. Levine discussed plainly the “indignities and exhaustion of racial battle fatigue” and the “long overdue White reckoning with American racism” (Ref. 32, p 104). Here, we are expressly pointing out the applicability of these new developments to forensic psychiatry. Following Levine’s thinking,

we argue that we should, within the context of the forensic evaluation, reflect on how discrimination and privilege affect us. Then, we can appreciate better Dudley and Leonard’s notion of the evaluatee’s life story.²⁸ We will more effectively bear witness to evaluatees’ life trauma and ferret out its relation to the legal conundrum in which they are enmeshed. Beverly Stoute, another psychoanalyst, stated that the physician-patient relationship is fraught with potential difficulty when she noted that “race in America defines psychosocial position” (Ref. 33, p 263). She pointed out that the official reality of everyday life is determined by power. When that power difference plays itself out in the dynamics of the evaluator-evaluatee relationship, it may affect the interactions negatively. Stoute highlighted the dynamics that may underlie Blacks’ rage reactions to their common encounters with oppression.

In thinking about our forensic work and this nettlesome relation of evaluator and evaluatee, we recommend that the forensic psychiatrist enter the workspace with a commitment to the principle of intrinsic human dignity. We must work constantly at remaining open and undefended as we display a radical curiosity about the other we are facing. Listening with openness helps us recognize the other, which in turn enhances that person’s attributed dignity. The other’s crime should not fracture our commitment. The persons before us are like us and we must focus on their humanity, regardless of what they have done. We should not make use of our esthetic preferences to impair our relationship with evaluatees. We want to shed light on the experiences that have led them to such a troubling place. We agree to contribute to their healing, when that is our task, even in the face of multiple impediments. We believe there is a tomorrow, even when we cannot see it. The cross-examiner’s insistence and the provocative press reports cannot be allowed to break our stride.

Conclusion

We hope we have shed light on the concept of dignity by emphasizing the definitions, establishing distinctive aspects of the varieties of dignity, and illustrating practical uses of the concept in loci where forensic psychiatrists do their work: forensic hospitals, and in settings where forensic evaluations are carried out. Regarding both central forensic spaces, we discussed values and practices that should undergird a framework for carrying out dignity-enhanced practice. We acknowledge that we did not explore

specific technical interventions of psychiatrists like psychotherapies and pharmacotherapies. They would be beyond the scope of this article. Forensic psychiatry's exploding interest in the ethics of forensic practice has led inexorably to how forensic work is practically executed.³⁴

We have also discussed the evaluator-evaluated relationship and the factors that affect it. We recognize that this unique relationship is at the center of the broader discussion of the knotty role that discrimination plays in the debasing, controlling, and dehumanizing of one another. That is why Pless and colleagues² have stated that dignity is a factor in the humanization of organizational cultures, workplaces, and relationships, in addition to having powerful influence in the sociopolitical arena. We return to the initial vignette about prisoners and their need for dignity-conserving care. Reginald Betts,³⁵ now a poet-lawyer and creator of Freedom Reads (a project for installing curated libraries in prisons), stated that "People don't understand how many of us sought to become more than our crimes or how many of us starved for lack of a conduit to the dignity that we sought."³⁵ Betts sees the delivery of a book to these individuals as a dignity-enhancing act.

References

1. Thrush G. Judge holds prison officials in contempt for treatment of terminally ill inmate. *The New York Times* [Internet]; 2022 Oct 13. Available from: <https://www.nytimes.com/2022/10/13/us/politics/florida-prison-cancer-release.html?smid=em-share>. Accessed October 14, 2022
2. Pless NM, Maak M, Harris H. Art, ethics and the promotion of human dignity. *J Bus Ethics*. 2017; 144(2):223–32
3. Pellegrino ED. The lived experience of human dignity. In *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*. Washington, DC: The President's Council on Bioethics; 2008 p. 513–39
4. Buchanan A. Respect for dignity and forensic psychiatry. *Int'l J L & Psychiatry*. 2015; 41:12–7
5. Macklin R. Dignity is a useless concept. *BMJ*. 2003 Dec; 327(7429):1419–20
6. The President's Council on Bioethics. *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*. Washington, DC: The President's Council on Bioethics 2008
7. Schulman A. Bioethics and the question of human dignity. In *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*. Washington, DC: The President's Council on Bioethics; 2008. p. 3–18
8. Gelernter D. The irreducibly religious character of human dignity. In *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*. Washington, DC: The President's Council on Bioethics; 2008. p. 387–405
9. Davis FD. Human dignity and respect for persons: A historical perspective on public bioethics. In *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*. Washington, DC: The President's Council on Bioethics; 2008. p. 19–36
10. Sulmasy DP. The varieties of human dignity: A logical and conceptual analysis. *Med Health Care Philos*. 2013; 16(4):937–44
11. Pols J. Through the looking glass: Good looks and dignity in care. *Med Health Care Philos*. 2013; 16(4):953–66
12. Pols J. Washing the patient: Dignity and aesthetic values in nursing care. *Nurs Philos*. 2013; 14(3):186–200
13. Hernandez JG. Human value, dignity, and the presence of others. *HEC Forum*. 2015; 27(3):249–63
14. Adorno R. Human dignity and human rights. In ten Have HA, Gordijn B, editors. *Handbook of Global Ethics*. Dordrecht: Springer Science; 2014. p. 45–57
15. Gustafsson LK, Wigerblad A, Lindwall L. Respecting dignity in forensic care: The challenge faced by nurses of maintaining patient dignity in clinical caring situations. *J Psychiatr Ment Health Nurs*. 2013; 20(1):1–8
16. Dresser R. Human dignity and the seriously ill patient. In *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*. Washington, DC: The President's Council on Bioethics; 2008. p. 505–12
17. Chochinov HM. Dignity and the essence of medicine: The A, B, C, and D of dignity conserving care. *BMJ*. 2007; 335(7612):184–7
18. Chochinov HM, Hack T, Hassard T, *et al*. Dignity therapy: A novel psychotherapeutic intervention for patients near the end of life. *J Clin Oncol*. 2005; 23(24):5520–5
19. Chochinov HM, Hassard T, McClement S, *et al*. The patient dignity inventory: A novel way of measuring dignity-related distress in palliative care. *J Pain Symptom Manage*. 2008; 36(6):559–71
20. Griffith VAS. *Healers and Patients Talk: Narratives of a Chronic Gynecological Disease*. Lanham, MD: Lexington Books; 2020
21. Candilis PJ, Martinez R. The evolution of forensic psychiatry ethics. *Psychiatr Clin North Am*. 2021; 44(4):571–8
22. Adsheed G. Care or custody? Ethical dilemmas in forensic psychiatry. *J Med Ethics*. 2000; 26(5):302–4
23. Jacob JD, Foth T. Expanding our understanding of sovereign power: On the creation of zones of exception in forensic psychiatry. *Nurs Philos*. 2013; 14(3):178–85
24. Askola R, Nikkonen M, Paavilainen E, *et al*. Forensic psychiatric patients' perspectives on their care: A narrative view. *Perspect Psychiatr Care*. 2018; 54(1):64–73
25. Olausson S, Danielson E, Johansson IB, Wijk H. The meanings of place and space in forensic psychiatric care – a qualitative study reflecting patients' point of view. *Int J Ment Health Nurs*. 2019; 28(2):516–26
26. Soderberg A, Wallinius M, Horberg U. An interview study of professional carers' experiences of supporting patient participation in a maximum security forensic psychiatric setting. *Issues Ment Health Nurs*. 2020; 41(3):201–10
27. Norko MA. What is truth? The spiritual quest of forensic psychiatry. *J Am Acad Psychiatry Law*. 2018 Mar; 46(1):10–22
28. Dudley RG, Jr, Leonard PB. Getting it right: Life history investigation as the foundation for a reliable mental health assessment. *Hofstra L Rev*. 2008; 36(3):963–88
29. Glancy GD, Chatterjee S, Miller D. Ethics, empathy, and detached concern in forensic psychiatry. *J Am Acad Psychiatry Law*. 2021 Jun; 49(2):246–53
30. Hart A. From multicultural competence to radical openness; A psychoanalytic engagement of otherness. *Am Psychoanalyst*. 2017; 51(1):12–5
31. Hart A. Neutrality as a "white lie": Discussion of Gabbard, Holmes, and Portugues. *J Am Psychoanal Assoc*. 2022; 70(2):335–49

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32. Levine L. Interrogating race, shame and mutual vulnerability: Overlapping and interlapping waves of relation. *Psychoanalytic Dialogues*. 2022; 32(2):99–113
33. Stoute BJ. Black rage: The psychic adaptation to the trauma of oppression. *J Am Psychoanal Assoc*. 2021; 69(2): 259–90
34. Griffith EEH, editor. *Ethics Challenges in Forensic Psychiatry and Psychology Practice*. New York: Columbia University Press; 2018
35. Betts RD. The search for beauty in a prison cell. *The New York Times* [Internet]; 2022 Nov 25. Available from: <https://www.nytimes.com/2022/11/25/opinion/prison-books-library.html>. Accessed July 20, 2023