Short communication

Subjective dignity and self-reported health: Results from the United States before and during the Covid-19 pandemic

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A B S T R A C T

Aims: To describe disparities in depressive symptoms and self-rated health with a novel, individual-level measure of subjective dignity administered before and during the COVID-19 pandemic.

Methods: National survey data were collected across the United States by the Gallup Organization in Spring (2017) (n = 1459) and again in Spring (2021) (n = 1244). Subjective dignity is measured by self-reported perceptions of dignity in one's own life. Numerous demographic subgroups constructed across age, gender, race/ethnicity, education, income, urbanicity, labor force status, and political background are used to test for robustness of dignity-health associations within and across years.

Results: All demographic subgroups studied reported numeric decreases in dignity from 2017 to 2021, with many of these decreases being both large and significant. With few group-year exceptions, subjective dignity relates to lower levels of depression and higher self-rated health, with dignity-depression associations significantly increasing from 2017 to 2021.

Conclusions: Dignity, as a pluralistic moral concept, is purported to anchor legal, human rights, and cultural discourses on justice, equity, and social inclusion. This study provides timely, original evidence that subjective appraisals of dignity should be considered as a public health indicator, especially across periods of societal unrest or adversity. Given groupwise robustness of dignity-health associations as documented here, subgroup determinants and lay definitions of dignity may merit closer attention.

1. Introduction

Immanuel Kant distinguished "price" from "dignity": that which has dignity — such as human life — is priceless (Rosen, 2012). Tragically, however, the dignity of life does not guarantee its societal realization. In fact, the Universal Declaration of Human Rights (UDHR) in 1948 actively sought the "(social) recognition of the inherent dignity" of persons (Assembly, 1948). Since then, dignity conceptions have flourished across legal, constitutional, human rights, global health, and cultural discourses (Jacobson, 2007; Marmot, 2004; Misztal, 2013; Neal, 2014). In these contemporary usages, conceptions of dignity entail that each human should benefit from autonomy, a lack of abuse or humiliation, relief from poverty, protection of or a right to health, a realization of their capabilities, or some combination of these processes. Given how it typically foregrounds the sanctity of individual life, dignity could help constitute a unifying morality in pluralistic, democratic societies such as the United States (Dworkin, 2006; Neal, 2014).

Despite its proposed role in orienting modern political and legal regimes, however, dignity is quite difficult to define concretely (Mattson and Clark, 2011; Misztal, 2013; Neal, 2014), which in turn places a

premium on subjective or implicit understandings of dignity across societies, groups, and individuals (Goffman, 1959; Lamont et al., 2016; Lizardo, 2017). These lay understandings may have practical, meaningful consequences for how individuals evaluate their social standing or treatment (Goffman, 1959; Lamont et al., 2016; Lizardo, 2017; Mattson and Clark, 2011). Sir Michael Marmot asked, "if we cannot measure it (dignity), how will we know we are achieving it?" (Marmot, 2004). Marmot suggests that definitional stalemates about dignity across discourse communities have stalled the development of needed empirics on dignity. Similarly elusive concepts like happiness, compassion, or meaning-in-life have gained empirical progress by yielding to subjective measurement in view of philosophic quagmires yet undeniable conceptual resonance (VanderWeele et al., 2019), suggesting that a similar scientific path forward may exist for furthering empirical knowledge about dignity. Therefore, beginning to heed Marmot's call involves a consideration of new measurement opportunities for dignity.

In this study, we draw on two recent waves of national survey data collected in 2017 and 2021 by the Gallup Organization, to document levels of what we term 'subjective dignity' across the COVID-19 pandemic. Across diverse sociodemographic groups in America, we

track an innovative measure of whether individuals perceive or experience dignity in their own lives, thus relying on public understandings of dignity to capture important societal forces as instantiated within individuals' self-conceptions. We ask not only how subjective dignity levels have changed across groups defined by education, income, age, gender, race, marital status, urbanicity, labor force status, and political party, but also whether dignity associates with mental and physical well-being for these groups. Given how multifaceted structural inequalities interwoven with American capitalism shape dignity's meaning, we explore whether dignity serves as an efficient indicator capturing differing life situations, whether it matters for well-being across multiple social hierarchies, and how these levels and associations have changed from before to during the global pandemic.

2. Background

Group-based distinctions and legal rights are deeply, historically entwined with capitalism and its differential prioritization of individual lives (Flynn, 2021; Reynolds, 2021; Subica and Link, 2022). As as a transnational superstructure, capitalism interweaves and calcifies different institutions of inequality (e.g., colonialism, racism, classism, ableism, ageism, and sexism) by legitimating intergenerationally transmitted advantages in cultural and economic capital, especially for those who are male, white, physically able, shielded from occupational risk, and have minimal family or care obligations (Flynn, 2021; Grusky and Hill, 2017; Marmot, 2017). Viewed this way, dignity – anchored within intersubjective notions of morality, justice, and the reflected appraisals of others – has many profound, group-specific obstacles toward its societal realization.

In parallel, individuals in the U.S. are differentially prioritized in practice, if not in institutional principle, as observed through structured health inequities before and during the covid-19 pandemic (Freeman, 2021). Following #BlackLivesMatter and #StopAsianHate, for example, racial and ethnic minorities collectively protest cultural, legal, and social injustices. Meanwhile, Trump-era anti-immigrant legislation has devalued Latinx lives and placed them in search of sanctuary and respite from chronic stress (Barajas-Gonzalez et al., 2021). Among non-Hispanic whites especially, a college divide in occupational and income inequality, and substance use and morbidity, fuels well-documented deaths of despair (Case and Deaton, 2021). In general, the covid-19 pandemic has coexisted with many social inequities by race, gender, occupation, and socioeconomic status, such as through disproportionate disease, care, work, and financial burdens felt across America (Willen et al., 2017). As a byproduct of these deepened inequities, society creates "recognition gaps," or variations in perceived dignity at the group and individual levels, based in perceived discrimination, exclusion, overwork, exposure to occupational hazard, or social disenfranchisement (Lamont, 2019).

If a subjective measurement of dignity is to be pursued, group specificity is likely to matter fundamentally (Lamont, 2000; Lamont et al., 2016; Marmot, 2017). Systemic inequities inherent to pre- and during-pandemic American capitalism do not resolve a definitional pluralism of dignity, but rather provide a vivid context for appreciating its nature, as particular social groups rally for rights, recognition, and fair treatment (Flynn, 2021). Societies are structured in ways that lead to certain group-specific resources, discourses, or moral codes surrounding dignity and, beyond this, the concrete settings and resources within which meaning-making transpires in ways that either confirm or challenge dignity (Goffman, 1959; Jacobson, 2007; Lamont et al., 2016; Lizardo, 2017; Mattson and Clark, 2011). Existing qualitative research into dignity implies that it is defined, enabled, or achieved differently across social groups. These differing dignity conceptions reflect group-specific values, practices, or possibilities, among other structural factors, and different ways of anchoring self-worth across various social situations and communities. For instance, working-class dignification can be tied to manual or "honest" work, and middle-class dignification to

traditional economic success or mobility (Grusky and Hill, 2017; Lamont, 2000; Lamont et al., 2016). Similarly, dignity is constructed differently for younger individuals facing uncertain futures and competition for good jobs than for older individuals who navigate or exist within medical or caregiving infrastructures (Guo and Jacelon, 2014; Silva, 2013); and across gender, race and political ideology due to differing experiences of obligation, discrimination, marginalization, or solidarity (Flynn, 2021; Lamont, 2000; Marmot, 2017). Higher-status positions in society come with their own strains and difficulties, such as overwork or work-family conflict associated with professional occupations, as well (Schieman and Koltai, 2017). However, on balance, these stresses at the top of social hierarchies have a far lesser impact on health, disease, and early death in the aggregate than do markers of strain, humiliation, disadvantage, or risky environmental exposures in lower socioeconomic strata (Jacobson, 2007; Marmot, 2004, 2017; Reynolds, 2021; Subica and Link, 2022). Overall, a subgroup analysis should be placed at the forefront of any inquiry into associations between subjective dignity and individual health.

While social marginalization and discrimination stem from objective differences in life conditions across social groups (Case and Deaton, 2021; Crowley, 2014; Grusky and Hill, 2017; Lamont, 2019; Lamont et al., 2016; Marmot, 2004; Oeur, 2016), dignity itself is fundamentally cultural and intersubjective, hardly defined in any strict sense by material conditions (Lamont et al., 2016; Mattson and Clark, 2011; Rosen, 2012). That is, it stems from collectively shared meanings, resources, or norms within social groups and individual lives. While human rights and public health violations (Assembly, 1948; Rosen, 2012; Willen et al., 2017) and constitutional and criminal law (Dworkin, 2006; Mattson and Clark, 2011; Rosen, 2012) offer valuable points of departure for conceptualizing dignity, dignity must ultimately be understood and enacted by groups and individuals on an everyday or practical basis (Goffman, 1959; Lamont et al., 2016) if it is to have broader value for society. In recognition of this fundamental fact, we contend in this study that dignity can and perhaps should be measured subjectively, by appealing to the word "dignity" itself as an element of public and personal culture used with different motivations (Lizardo, 2017). Similar to how individuals deem themselves "happy" or as leading a "meaningful life" on the basis of how they personally understand happiness or life's meaning (VanderWeele et al., 2019), allowing individuals to interpret "dignity" for themselves circumvents philosophical, theoretical, and legal debates about the "true" meaning of dignity, towards a more pragmatic (Mattson and Clark, 2011), socially situated (Lamont et al., 2016), pluralistic (Dworkin, 2006), and group-differentiated understanding of dignity, as advocated by sociological scholars of the concept. Dignity might serve as an efficient, subjective indicator of moral and social integration (Marmot, 2004). As Michèle Lamont contends, there are many potential paths to dignity (Lamont, 2000, 2019; Lamont et al., 2016).

In this study, we take a group-based approach to establishing subjective dignity as a public health concern and a useful social indicator of broader societal events. Societal hierarchies are structured according to categorical memberships such as gender, race, education, age, geography, marital status, and other life-defining characteristics (Flynn, 2021; Grusky and Hill, 2017; Lamont, 2000; Marmot, 2017; Reynolds, 2021; Subica and Link, 2022), and ethnographic work on worker dignity and dignity across different hierarchical groups attests to the group-based structuring of dignity (Crowley, 2014; Lamont, 2000; Lamont et al., 2016; Oeur, 2016; Silva, 2013). Some assumed definitional correlates of dignity, such as abuse, violence, perceived discrimination, efficacy, autonomy, or mattering to others, have well-established associations with mental and physical health (Jacobson, 2007; Lamont, 2000; Reynolds, 2021; Schickedanz et al., 2018; Sherer and Adams, 1983; Subica and Link, 2022; VanderWeele et al., 2019; Williams et al., 1997), leading to the reasonable expectation that subjective dignity could be associated with group-level differences in mental and physical well-being across the covid-19 pandemic.

3. Methods

We draw on repeated cross-sectional, national survey data collected by Gallup Organization in 2017 and again in 2021, the Values and Beliefs of the American Public Survey. This survey offers a random sample of adults aged 18 and older, living in all 50 US states and the District of Columbia. In February 2017, Gallup randomly selected individuals to participate using an address-based sample (ABS) frame, mailing 11,000 surveys with a $1 USD cash incentive, with reminder postcards following about two weeks later. Collection of completed interviews ended on March 21st, with n = 1501 (AAPOR1 response rate = 13.6%). In 2021, surveys were sent to a separate, random ABS frame sample of 11,000 households. Respondents were allowed to respond to the survey on paper or via web. The survey was conducted from January 27 to March 21, in English and Spanish (n = 1248; AAPOR1 response rate = 11.3%). This research is deemed IRB-exempt by the Baylor University Institutional Review Board due to secondary data analysis, and the Gallup Organization administered the survey to freely consenting individuals of the American public.

3.1. Key variables

Well-Being: Depressive Symptoms Scale and Self-Rated Health. Across both years, a two-item depressive symptom index based on items from the Center for Epidemiologic Studies - Depression Scale is available. It asks respondents how often each of the following was true during the past week: "I felt depressed" and "I felt sad" (0 = "Never"; 0.33 = "Hardly Ever"; 0.67 = "Some of the time"; 1.00 = "Most or all of the time"; items averaged). Additionally, self-rated health is queried by a single item in both survey years: "In general, would you say your health is poor, fair, good, very good, or excellent?" We analyze responses to this question in terms of the full, five-point scale of increasing health (0 = poor; 0.25 = fair; 0.50 = good; 0.75 = very good; 1.00 = excellent).

Subjective Dignity Scale. Across Gallup survey administrations, the availability of subjective dignity items varied: "I feel that my life lacks dignity" (available in 2017 and 2021), "People generally treat me with dignity" (2017 and 2021), "I determine my own dignity" (2017 and 2021), "My dignity is not up to me" (available in 2017 only) and "I have dignity as a person" (2017 only) (for all items, 1 = strongly disagree, 2 = disagree, 3 = undecided/neither agree nor disagree, 4 = agree, 5 = strongly agree; reverse-scored as necessary to denote higher levels of dignity). We used all five items in 2017 to assess the proposed subjective dignity construct, because using only three items does not allow degrees of freedom for global fit testing of a confirmatory factor model. These items vary in the degree to which they characterize dignity as coming from within rather than without (i.e. "dignity-of-self" and "dignity-in-relation") (Jacobson, 2007), so we began with an exploratory factor analysis (Kline, 1998). In 2017, principle-components exploratory factor analysis identified one factor with eigenvalue = 1.688 (factor 2 eigenvalue = 0.144). All factor loadings ranged from 0.42 to 0.71. Confirmatory factor analysis with asymptotically distribution free (ADF) estimation to address response nonnormality and free covariances among conceptually similar items retained a one-factor solution against the observed covariance-variance matrix, $\chi^2(2) = 1.663$, $p = .44$, RMSEA = 0.000, CFI = 1.000, TLI = 1.008, SRMR = 0.011. Having established that a one-factor model was consistent with the observed data in 2017, we proceeded to treat all items as belonging to the same subjective dignity scale across both survey years. Specifically, we used the three items available across both survey years for all analyses in this paper. Latent factor scores were generated and normalized across both years using Stata 17.0. In 2017, the three-item latent score correlates highly with the five-item latent score ($r = 0.900$). Appendix Table 1 displays a polychoric correlation matrix for the five items (mean correlation = 0.478).

Sociodemographic Variables. We rely on sociodemographic variables to construct subgroups for the dignity analysis. Age is measured in years; current marital status is indicated, as is living with a partner (yes or no);

Table 1

Levels of subjective dignity in America, by demographic subgroups, Gallup surveys, 2017 and 2021.

POPULATION Group	Dignity in 2017		Dignity in 2021			
	n	Mean	n	Mean	% decrease	Diff p
College+	470	**0.653**	443	**0.596**	8.7	0.004
Black	150	**0.651**	138	**0.540**	17.1	0.017
Income 75 k+	699	**0.637**	653	**0.597**	6.3	0.042
Hispanic	202	**0.637**	180	**0.547**	14.1	0.044
Women	745	**0.631**	640	**0.538**	14.7	<.001
Working Full-Time	687	**0.630**	593	**0.576**	8.5	0.014
Urban	748	**0.627**	602	**0.547**	12.8	<.001
Democrat	525	**0.621**	501	**0.515**	17.1	<.001
Married	725	**0.617**	637	**0.570**	7.6	0.020
25–39 years	384	**0.614**	368	**0.565**	8.0	0.144
Working Part-Time	170	**0.609**	148	**0.508**	16.6	0.039
55–69 years	347	**0.607**	303	**0.538**	11.4	0.003
40–54 years	355	**0.603**	296	**0.534**	11.4	0.030
(ALL RESPONDENTS)	1459	**0.601**	1244	**0.529**	12.0	<.001
Republican	417	**0.598**	370	**0.538**	10.0	0.030
White	957	**0.594**	784	**0.526**	11.4	<.001
70+ years	179	**0.592**	185	**0.483**	18.4	<.001
<College	957	**0.583**	775	**0.487**	16.5	<.001
Asian	47	**0.583**	61	**0.565**	3.1	0.835
Not Working	602	**0.566**	502	**0.480**	15.3	<.001
Men	687	**0.574**	576	**0.522**	9.1	0.027
Am. Indian	50	**0.557**	48	**0.483**	13.3	0.408
Single	303	**0.552**	264	**0.472**	14.5	0.039
Income <$30 k	472	**0.550**	370	**0.397**	27.8	<.001
Rural	190	**0.538**	202	**0.513**	4.6	0.549
<25 years	84	**0.530**	66	**0.423**	20.2	0.232

Note. Dignity is normalized to range from 0 to 1. Groups are sorted in descending order based on 2017 dignity level. Sample sizes are weighted. Probability of between-year difference (Diff) based on within-group regression test for Year.

level of education is specified as highest degree attained; and last year's household income is midpoint-imputed within broad survey question brackets. Race and ethnicity is treated as self-identification as white, Black, Hispanic, Asian, or American Indian/Alaska Native. Urbanicity is queried on a four-point self-reported scale ranging from "a large city" or "a suburb near a large city" (classified as urban) to "a small city or town" or "a rural area" (classified as rural). Political affiliation ranged from "strong republican" to "leaning republican" (classified as republican) to "strong democrat" to "leaning democrat" (classified as democrat). Labor force status is treated as working full-time, working part-time, or not currently working.

3.2. Analytic strategy

We seek to characterize subjective dignity levels across different segments of society as defined by multiple social hierarchies. Relatedly, we also seek to document that the predictive value of dignity for well-being or health is not specific to certain groups but rather carries across groups and across years (2017 and 2021). A multivariate approach ultimately would mask this because it is structured around principles of average or net effects which are driven disproportionately by groups with larger sample representation. Moreover, there are substantial intercorrelations among memberships in the different sociodemographic groups we cover, and we cannot properly explore these intercorrelations without bringing in intersectional theoretical approaches beyond the scope of this paper. Therefore, we conduct most of our analyses using a within-group, bivariate approach to dignity and its association with well-being.

We begin by summarizing mean levels of subjective dignity for 25 distinct sociodemographic groups, as well as for the entire national Gallup sample, across 2017 and 2021. These survey-weighted group means are tabulated by year, along with their group-specific, year-

specific weighted sample sizes. Across years, we test for significant differences at the group level by pooling group-specific samples and then implementing a survey-weighted, within-group regression coefficient test for Year.

Next, we evaluate year-specific associations between subjective dignity and well-being for these same groups. We analyze the depressive symptoms scale and self-rated health separately. For each group-year combination, a bivariate, survey-weighted regression of well-being on dignity is estimated within a given group's subsample, and coefficients are reported. Between-year differences are tested by use of a Dignity × Year two-way statistical interaction term, which is added to the specification, along with a Year main effect, in a second, additional model that pools group-specific samples across survey years. Probability values from these Dignity × Year coefficient tests are reported in tables. To enable valid statistical comparison of association sizes between sample-wide and group-specific estimates, we employ linear modeling of depressive symptoms and self-rated health (Idler and Cartwright, 2018).

Finally, we estimate multiple regressions of depressive symptoms, and self-rated health, in which survey data is pooled from both years and sociodemographic covariates are held constant. Thus, these multiple regressions report adjusted or net associations for subjective dignity across the entire Gallup sample. Two regression equations are fitted for each well-being measure. The first equation treats the subjective dignity association as year-invariant, while a second equation specifies a Dignity × Year two-way interaction.

All regression models are weighted by the Gallup post-stratification weight variable to enhance national representativeness. In the multiple regression analysis, parameters are estimated by full-information maximum likelihood (FIML), which is an optimal procedure for dealing with missing data that is asymptotically equivalent to multiple imputation (Allison, 2012). FIML uses all available data from each case to estimate model parameters.

4. Results

Table 1 documents mean levels of subjective dignity across years and by demographic group. Groups are presented in descending order according to their 2017 dignity levels. Subjective dignity is normalized across years to a scale ranging from 0 to 1 (M = 0.570, SD = 0.301). In 2017, college-educated (mean = 0.653), Black (0.651), high-income (0.637), Hispanic (0.637), women (0.631), full-time worker (0.630), urban (0.627), and Democrat (0.621) respondents showed the highest quantitative levels of dignity, while respondents less than 25 years old (0.530), rural (0.538), low-income (0.550), single (0.552), American Indian (0.557), male (0.574), not working (0.566), Asian (0.583), and non-college-educated (0.583) respondents showed the lowest levels.

As shown in Table 1, levels of dignity generally are higher in 2017 compared to 2021, as evidenced by the fact that all groups showed percentage decreases in their dignity levels across these years (ranging from −3.1 to −27.8%). For most groups, these decreases are statistically significant at $p < .05$. The subjective dignity decrease across all Gallup respondents is 12.0% from 2017 to 2021 ($p < .001$). Groups with highest observed dignity losses from 2017 to 2021 were low-income (−27.8%, $p < .001$), <25 year old (−20.2%, $p = .23$), 70+ year old (−18.4%, $p < .001$), Black (−17.1%, $p = .02$), Democrat (−17.1%, $p < .001$), part-time worker (−16.6%, $p = .04$), non-college-educated (−16.5%, $p < .001$), not working (−15.3%, $p < .001$), and women respondents (−14.7%, $p < .001$), while those with the smallest decreases from 2017 to 2021 were Asian (−3.1%, ns), rural (−4.6%, ns), high-income (−6.3%, $p = .04$), married (−7.6%, $p = .02$), 25–39 year old (−8.0%, ns), full-time worker (−8.5%, $p = .01$), college-educated (−8.7%, $p < .01$), men (−9.1%, $p = .03$), and Republican (−10.0%, $p = .03$) respondents.

Fig. 1 visualizes group-specific means for 2017 and 2021, capped by their 95% confidence intervals. This visualization enables a quick comparison across groups, years, or both. Looking at 2017 group mean bars, which are depicted in light gray, no groups significantly differ from each
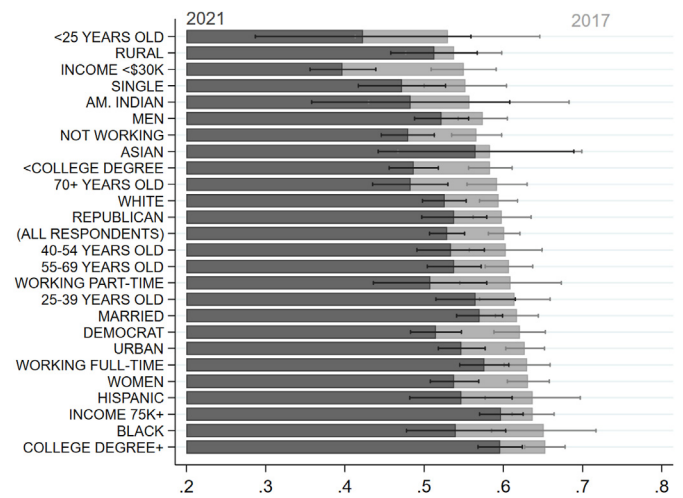

Fig. 1. Levels of Subjective Dignity (2017) to 2021, by Gallup Survey Demographic Group
Note. Dignity is normalized to range from 0 to 1. Means (averages) of subjective dignity shown by demographic group and by year. 95% confidence intervals shown.

other. However, in 2021, depicted in dark gray bars, some groups significantly differ from each other, such as low-income respondents (0.397) compared to college-educated respondents (0.596) or non-college-educated respondents (0.487) compared to married respondents (0.570). Comparing groups across years, numerous significant between-group differences are evident.

Table 2 reports group-specific coefficients between depressive symptoms and subjective dignity. Depressive symptoms are measured on

Table 2
Group-specific regressions of depressive symptoms, Gallup surveys, 2017 and 2021.

	Association of Subjective Dignity with Depressive Symptoms			
REGRESSION GROUP	2017	2021	% change	P
	b	b		
Rural	−0.347	−0.325	−6.3	0.871
Single	−0.342	−0.454	32.7	0.233
<25 years	−0.340	−0.336	−1.2	0.981
25–39 years	−0.334	−0.433	29.6	0.297
Hispanic	−0.328	−0.380	15.9	0.696
Men	−0.305	−0.328	7.5	0.726
Asian	−0.302	−0.421	39.4	0.478
College Degree+	−0.282	−0.290	2.8	0.886
40–54 years	−0.277	−0.343	23.8	0.452
Income <$30 k	−0.277	−0.387	39.7	0.178
Working Full-Time	−0.277	−0.337	22.0	0.333
(ALL RESPONDENTS)	−0.251	−0.364	45.0	0.010
White	−0.250	−0.366	46.4	0.032
<College Degree	−0.238	−0.404	69.7	0.006
Women	−0.234	−0.422	80.3	0.001
Republican	−0.230	−0.311	35.2	0.321
Not Working	−0.228	−0.345	51.4	0.111
Democrat	−0.219	−0.352	60.7	0.077
Working Part-Time	−0.198	−0.489	147.4	0.011
Income $75 k+	−0.194	−0.271	39.7	0.189
Married	−0.191	−0.321	68.1	0.030
Black	−0.187	−0.246	31.6	0.667
Am. Indian	−0.186	−0.395	112.4	0.251
Urban	−0.163	−0.333	104.3	0.004
55–69 years	−0.163	−0.369	126.4	0.003
70+ years	−0.100	−0.260	160.0	0.133

Note. Coefficients are from bivariate, within-group regressions. Groups sorted in ascending order based on 2017 coefficient. Between-year probability (*p*) based on within-group, survey-weighted Dignity × Year interaction term test. Dignity and depressive symptoms range from 0 to 1.

a scale of 0–1 (M = 0.376, SD = 0.268). These associations are organized in ascending order, by 2017 coefficient. In 2017, the largest associations are observed among rural, single, <25 year old, 25–39 year old, Hispanic, men, Asian, and college-educated respondents, while smaller associations are found for 70+ year old, 55–69 year old, urban, American Indian, Black, married, high-income, and part-time worker respondents. All coefficients are plotted with 95% confidence intervals in Fig. 2. A vertical, red line demarcates a point estimate of zero. Except for those who are 70+ years old and American Indians in 2017, all subgroups show significant associations in both years.

With the sole exceptions of rural and <25 year old respondents (−6.3 and −1.2%, respectively), associations strengthen from 2017 to 2021 for all other groups (+2.8 to +160.0%). However, these coefficient changes are statistically significant only for white (+46.4%; $p = .03$), non-college-educated (+69.7%, $p < .01$), women (+80.3%, $p < .001$), part-time worker (+147.4%, $p < .03$), married (+68.1%, $p = .03$), urban (+104.3%, $p < .01$), and 55–69 year old respondents (+126.4%, $p < .01$). Across all Gallup respondents, the association changes from $b = −0.251$ in 2017 to $b = −0.364$ (+45.0%; $p = .01$).

Table 3 reports group-specific coefficients between self-rated health and subjective dignity. Self-rated health is measured on a scale of 0–1 (M = 0.622, SD = 0.242). These associations are organized in descending order, by 2017 coefficient. In 2017, the largest associations are observed among single, 40–54 year old, low-income, white, Hispanic, 55–69 year old, women, <25 year old, and men respondents, while smaller associations are found for Asian, American Indian, 70+ year old, high-income, part-time worker, 25–39 year old, college-educated, married, Democrat, and urban respondents. All coefficients are plotted with 95% confidence intervals in Fig. 3. As before, a vertical, red line demarcates a point estimate of zero. Asian, American Indian, and 70+ year old respondents have 95% confidence intervals crossing this line in both 2017 and 2021, denoting statistically insignificant associations between dignity and self-rated health. Otherwise, most observed associations are statistically significant, especially in 2021.

Several groups showed quantitatively declining associations from 2017 to 2021: 40–54 year olds (−15.8%), low-income (−37.8%), 55–69 year olds (−5.6%), men (−8.0%), urban (−1.2%), college-educated (−3.7%), 70+ year olds (−17.3%), and Asian respondents (−10.9%). Across the entire sample, however, increasing coefficients were more common from 2017 to 2021 ($b = 0.204$ to $b = 0.248$, +21.6%, $p = .31$). No groups had significantly different coefficients across years, as all between-year probabilities are $p > .05$.

Table 3

Group-specific regressions of self-rated health, Gallup surveys, 2017 and 2021.

REGRESSION GROUP	Association of Subjective Dignity with Self-Rated Health			
	2017	2021	% change	P
	b	b		
Single	0.274	0.303	10.6	0.757
40–54 years	0.266	0.224	−15.8	0.638
Income <$30 k	0.249	0.155	−37.8	0.307
White	0.219	0.249	13.7	0.564
Hispanic	0.216	0.285	31.9	0.577
55–69 years	0.215	0.203	−5.6	0.893
Women	0.214	0.306	43.0	0.090
<25 years	0.207	0.349	68.6	0.407
(ALL RESPONDENTS)	0.204	0.248	21.6	0.312
Men	0.200	0.184	−8.0	0.825
Black	0.194	0.314	61.9	0.336
Not Working	0.190	0.238	25.4	0.508
Working Full-Time	0.189	0.204	8.1	0.802
Rural	0.184	0.265	44.0	0.626
<College Degree	0.176	0.254	44.3	0.197
Republican	0.170	0.251	47.6	0.321
Urban	0.168	0.166	−1.2	0.976
Democrat	0.164	0.258	57.3	0.178
Married	0.163	0.211	29.4	0.443
College Degree+	0.162	0.156	−3.7	0.910
25–39 years	0.155	0.318	105.2	0.075
Working Part-Time	0.149	0.258	72.8	0.323
Income $75 k+	0.118	0.213	80.5	0.075
70+ years	0.098	0.081	−17.3	0.834
Am. Indian	0.078	0.101	29.5	0.933
Asian	0.055	0.049	−10.9	0.978

Note. Coefficients are from bivariate, within-group regressions. Groups sorted in descending order based on 2017 coefficient. Between-year probability (p) based on within-group, survey-weighted Dignity × Year interaction term test. Dignity and self-rated health range from 0 to 1.

Finally, Table 4 reports estimated associations between well-being and subjective dignity, based on multivariable regression. According to Model 1, subjective dignity is associated with lowered depressive symptoms net of sociodemographic background ($b = −0.283$, $p < .001$), with this association becoming significantly larger in 2021 (Model 2: Dignity × Year $b = −0.085$, $p < .05$). Low-income respondents report greater levels of depressive symptoms ($b = 0.035$, $p < .05$), as do women ($b = 0.059$, $p < .001$), Democrats ($b = 0.040$, $p < .05$), and American Indians ($b = 0.070$, $p < .05$), whereas married
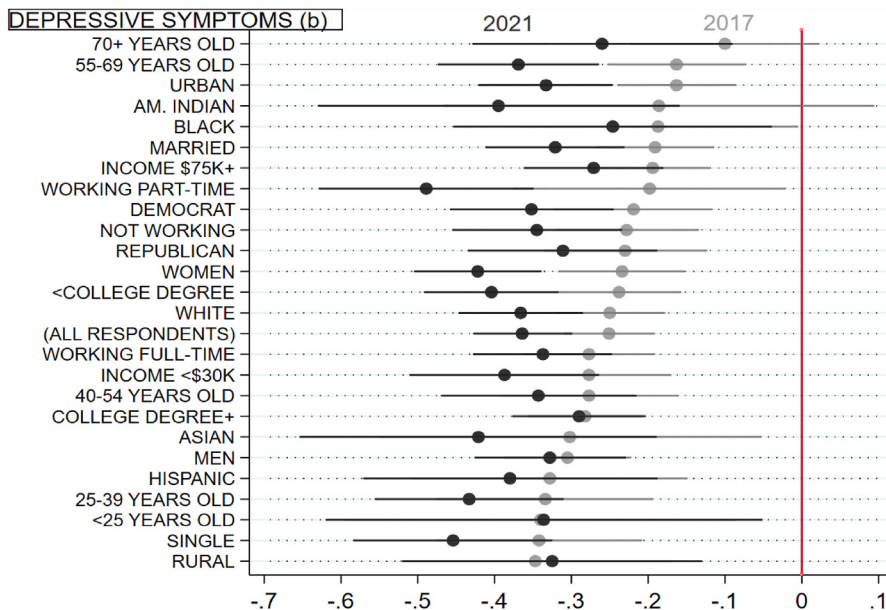
Fig. 2. Associations between Subjective Dignity and Depressive Symptoms, 2017 to 2021, by Gallup Survey Demographic Group

Note. Bivariate, within-group associations between depressive symptoms and subjective dignity shown by demographic group and by year. Estimated using Gallup survey weighting with linearized standard errors. 95% confidence intervals shown. Reference line drawn at 0 (to denote cutoff for non-significant association with alpha = 0.05). Dignity and depressive symptoms are normalized to range from 0 to 1.
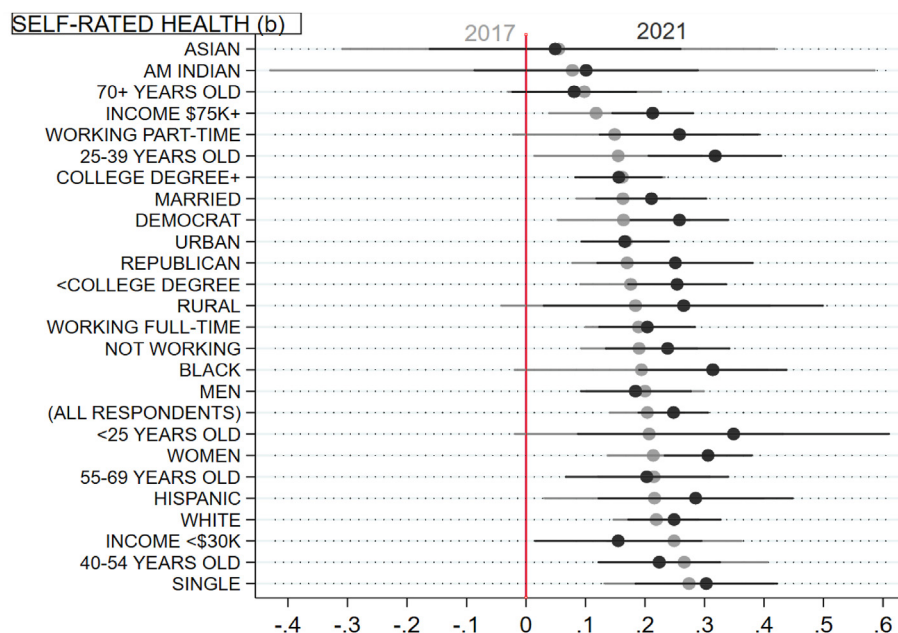
Fig. 3. Associations between Subjective Dignity and Self-Rated Health, 2017 to 2021, by Gallup Survey Demographic Group
Note. Bivariate, within-group associations between depressive symptoms and subjective dignity shown by demographic group and by year. Estimated using Gallup survey weighting with linearized standard errors. 95% confidence intervals shown. Reference line drawn at 0 (to denote cutoff for non-significant association with alpha = 0.05). Dignity and self-rated health are normalized to range from 0 to 1.

individuals ($b = -0.041$, $p < .01$) and Republicans ($b = -0.033$, $p < .05$) report fewer symptoms.

As also shown in Table 4, the association of dignity with self-rated health net of demographic background (Model 3: $b = 0.172$, $p < .001$) does not vary by survey year (Model 4: Dignity × Year $b = 0.009$, *ns*). College-educated ($b = 0.063$, $p < .001$), high-income ($b = 0.044$, $p < .05$), full-time worker ($b = 0.055$, $p < .001$), and part-time worker ($b = 0.075$, $p < .001$) respondents report greater levels of self-rated health, whereas low-income ($b = -0.047$, $p < .01$) and older (25–70+ years: *bs* $= -0.085$ to -0.116, $p < .001$) individuals report worse self-rated health.

5. Discussion

Although mired in intellectual or definitional debates, dignity serves as a cultural foundation for navigating modern individuality. Understood as an indicator of morally situated self-regard, dignity may be an important psychosocial resource for maintaining well-being within modern societies. In this study, we drew on two rounds of Gallup national data collected before and during the COVID-19 pandemic. This pandemic has induced substantial and sudden variation in resources, routines, and imagined futures, making it a meaningful point of departure for investigating variation in dignity. From 2017 to 2021, subjective dignity showed consistent — and significantly increasing — associations with depressive symptoms within the U.S. population across many demographic groups defined by education, income, gender, age, race, marital status, political party, and labor force status. Many of these same groups also showed consistent associations between subjective dignity and self-rated health. Our adjusted, multivariate estimates suggest that dignity associates with well-being at levels comparable to or exceeding income gaps, working full-time, college degree differences, race, or political affiliation, adding quantitative levels to a range of important qualitative treatments of dignity most often tied to work and social class, while suggesting arenas for further research.

Individuals from diverse social groups rely on situated and cultural meanings, norms, and resources to determine whether their lives are dignified, helping to explain both the overall decline and the increased heterogeneity in dignity levels that we documented from 2017 to 2021. Rather than impose an academic limit on the nature of dignity, our subjective dignity measure allows respondents to draw on their own situated understandings of self and morality.

In addition to these national associations with well-being across the pandemic, dignity as a term carries resonance and overlap with high-profile public health issues in multiple respects. However, these more conceptual interpretations will need to be explicated by future research. First, following epidemiological characterizations of deaths of despair (Case and Deaton, 2021), we find that low-income, rural, and non-college educated respondents report some of the lower or lowest levels of dignity, and sometimes increased associations between dignity and depressive symptoms from before the covid-19 pandemic. Second, while a Black-white paradox in mental health is well-documented (Erving et al., 2019), so too is the elevation of racial inequality in America across the pandemic due to staggering community and work-based differences in pandemic vulnerability. Perhaps accordingly, Blacks show a relatively high level of dignity before the pandemic and a marked decrease across the pandemic. Third, the burden of childcare, household tasks, and informal elder care has fallen disproportionately on women before and especially during the pandemic, as have psychological costs of opting out of full-time work (Langer et al., 2015), which is consistent with a near-doubled association between dignity and depressive symptoms for women from before to during the pandemic, as well as women's significant decline in dignity from 2017 to 2021 compared to men's. While a more compelling investigation of gender disparities in dignity would need to jointly account for marital status, spousal employment, coresidential children, and elderly parents, for example, gender inequality still is so pervasive across the domestic, parental, and work realms that these results may hardly be surprising. Fourth, adults aged 70 or older showed relatively high declines in dignity across the pandemic, consistent with the great tolls the pandemic has taken on those who live with health or mobility limitations, and perhaps the group least used to digital maintenance of social ties. This group also showed the highest increase in associations with depressive symptoms from 2017 to 2021 of all groups investigated, but this difference was not statistically significant due in part to a nonsignificant association observed in 2017. Fifth, associations between dignity and well-being were consistent across partisan lines, which falls in line to a universal valuation of individual rights even at a time of political polarization. Democrats showed a somewhat larger decrease in dignity across the pandemic than did Republicans, which could indicate their larger representation among or identification with socially vulnerable groups, although their dignity decrease (-17%) was not statistically different from the decrease observed among Republicans (-10%).

Table 4

Multiple regressions of subjective dignity, depressive symptoms, and self-rated health, Gallup surveys, 2017 and 2021.

	Depressive Symptoms		Self-Rated Health	
	(1)	(2)	(1)	(2)
Dignity	−0.283***	−0.243***	0.172***	0.168***
	(0.021)	(0.028)	(0.021)	(0.029)
Dignity x 2021		−0.085*		0.009
		(0.042)		(0.040)
Year: 2021 [1]	0.037**	0.035**	−0.049***	−0.049***
	(0.012)	(0.012)	(0.011)	(0.011)
College Degree+ [2]	0.008	0.008	0.063***	0.063***
	(0.013)	(0.013)	(0.011)	(0.011)
Income <$30 k [3]	0.048*	0.047*	−0.047**	−0.047**
	(0.022)	(0.022)	(0.018)	(0.018)
Income $75 k+ [3]	−0.023	−0.022	0.044**	0.044**
	(0.019)	(0.019)	(0.015)	(0.015)
Married [4]	−0.042**	−0.041**	0.023	0.023
	(0.014)	(0.014)	(0.012)	(0.012)
Working Full-Time [5]	−0.003	−0.004	0.055***	0.055***
	(0.017)	(0.017)	(0.015)	(0.015)
Working Part-Time [5]	0.002	0.001	0.075***	0.075***
	(0.021)	(0.021)	(0.019)	(0.019)
Urban [6]	0.000	0.000	−0.001	−0.001
	(0.014)	(0.014)	(0.012)	(0.012)
Rural [6]	0.02	0.021	−0.020	−0.020
	(0.021)	(0.021)	(0.019)	(0.019)
Republican [7]	−0.033*	−0.033*	0.020	0.019
	(0.016)	(0.016)	(0.014)	(0.014)
Democrat [7]	0.041**	0.040**	−0.017	−0.017
	(0.016)	(0.016)	(0.013)	(0.013)
Women [8]	0.059***	0.059***	−0.009	−0.009
	(0.013)	(0.013)	(0.011)	(0.011)
Black [9]	−0.026	−0.026	−0.016	−0.016
	(0.026)	(0.026)	(0.019)	(0.019)
Hispanic [9]	−0.026	−0.026	0.002	0.002
	(0.020)	(0.020)	(0.017)	(0.017)
Asian [9]	−0.012	−0.011	−0.012	−0.012
	(0.032)	(0.032)	(0.030)	(0.030)
American Indian [9]	0.070*	0.070*	−0.028	−0.028
	(0.034)	(0.034)	(0.037)	(0.037)
25–39 years [10]	0.027	0.027	−0.085**	−0.085**
	(0.036)	(0.036)	(0.030)	(0.030)
40–54 years [10]	0.033	0.033	−0.116***	−0.116***
	(0.036)	(0.036)	(0.030)	(0.030)
55–69 years [10]	0.011	0.011	−0.112***	−0.112***
	(0.035)	(0.035)	(0.029)	(0.029)
70+ years [10]	−0.025	−0.026	−0.114***	−0.114***
	(0.037)	(0.037)	(0.031)	(0.031)
Constant	0.317***	0.318***	0.681***	0.680***
R^2	0.191	0.194	0.211	0.211

Note. N = 2749. Coefficients shown are obtained under full-information maximum likelihood (FIML) with Gallup survey post-stratification weighting for national representativeness. Linearized standard errors shown in parentheses. Dignity, depressive symptoms, and self-rated health each are normalized to range from 0 to 1. *$p < .05$; **$p < .01$; ***$p < .001$ (two-tailed).

[1] Reference: 2017.
[2] Reference: Less Than College Degree.
[3] Reference: 30-74.9 k.
[4] Reference: Not Married.
[5] Reference: Not Working.
[6] Reference: Small City or Town.
[7] Reference: Independent.
[8] Reference: Men.
[9] Reference: Non-Hispanic White.
[10] Reference: < 25 Years Old.

Generally, associations between dignity and health were more reliable – and reliably increasing across the pandemic – for depressive symptoms than for self-rated health. This suggests that subjective dignity may bear a more direct association with mental health than with physical health, like what has been documented for psychosocial resources such as mastery, social support, and self-esteem (Jacobson, 2007; VanderWeele et al., 2019). In other research, we are examining the statistical and factor independence of subjective dignity against mastery, mattering, resilience, and other psychosocial constructs. Indeed, mastery and self-efficacy also carry strong associations with mental health.

While we cannot unpack all our tabulated findings piece-by-piece, our examples are meant as illustrative rather than exhaustive or conclusive. We recognize that some group trends might defy common expectations. For instance, the decline of only 3% in subjective dignity for Asian-Americans from 2017 to 2021 could be interpreted in terms of changing solidarity within this community or as a form of group-affirming boundary work at a time of historically high rates of anti-Asian violence in America (Lamont et al., 2016). The fact that subjective dignity correlates with well-being across a variety of demographic groups, even if declines in dignity seem unusual in view of objective atrocities confronting these groups, might signify a universalistic value of dignity for human flourishing that can be confirmed by future, longitudinal research into the topic.

Our organizing framework for subjective dignity, for which we have offered a preliminary exploration using national Gallup data, specifies that, because a variety of social science, legal, and public health scholars have advanced group-specific understandings of social inequities, dignity must: (1) remain flexible to group-specific or pluralistic senses of the term; and (2) remain flexible to the possibility that observed, group-specific levels of dignity reflect (i) objective social conditions; (ii) subjective interpretations of these same conditions; or (iii) socially constructed, possibly dynamic understandings of what dignity means. All of these points fit into our innovative approach to conceptualizing and measuring dignity as a subjective construct, which we argue is long-overdue given the socially constructed nature of dignity.

According to the wide distribution of dignity levels and associations between health and well-being that we observe across the 2017 and 2021 Gallup data, we believe that a fundamental tension exists between inherent dignity – the philosophically derived basis for democratic equality and citizenship – and its societal realization. These pre- and during-pandemic epidemiological findings add to ethnographic research into dignity as an intellectual, theoretical concept, which is separate from lay understandings of dignity within individual lives. While current conditions certainly can uphold a sense that one is in fact a whole or deserving person in society, it also is possible that dignity carries origins in a deeper, firsthand knowledge about systemic oppressions, gained by women, Blacks, and other marginalized individuals through continued dealings with discrimination or injustice (Morris, 2022; Oeur, 2016). Shifts in dignity could indicate dynamic shifts in political, economic, or social circumstances, which can be difficult to measure.

There are several limitations to this analysis of Gallup national data. First, while the 2017 Gallup survey confirmed that a one-factor subjective dignity scale is supported in a national sample, this does not rule out the possibility that specific dignity items may carry conceptual or empirical overlaps with perceived discrimination, self-efficacy, mattering, or other constructs discussed earlier. Second, the data are cross-sectional, leaving unclear the time ordering between dignity levels and levels of mental or physical health. For instance, feelings of worthlessness that are common with depression could lead to lower dignity scores, or serious health problems that are especially common among those with fair or poor physical health could lead to foregone autonomy or stigmatization due to disability or incapacitation (Jacobson, 2007). If lowered subjective dignity depletes self-rated health, it then is a risk factor for morbidity and death. If, reciprocally, new mental or physical health issues lead to lowered levels of dignity, through the compromising of bodily or physical functioning, then these associations may be self-reinforcing and especially important as an intervention target. Advocates of "dying with dignity" already have noted interconnections among bodily and psychological dignity (Guo and Jacelon, 2014).

Third, the group-specific or precise underpinnings of dignity remain unclear; a more comprehensive analysis — for example among the non-college educated, racial or ethnic minorities, women, or the elderly, as outlined above — could begin to disentangle dignity effects from the

broader social conditions supporting dignified lives. Fourth and finally, individuals exist at the intersection of their multiple group identities, making a reduction of group-specific findings to individual-level dignity levels in need of more theoretical development. The fruitful examination of intersecting dignity levels across multiple social hierarchies could be enabled by larger-scale data collection efforts.

6. Conclusion

By offering an efficient measurement of social and moral integration in American society, subjective dignity could enable new paths forward for population health research. Dignity offers a way of capturing felt inclusiveness, respect, or value in terms of how individuals relate to their social groups. Given the strengthening associations that we find between depressive symptoms and subjective dignity across the pandemic, it seems plausible that the covid-19 pandemic is a generalized stressor affecting the population for which dignity might serve as a mental health buffer.

If implemented as a public health measure, subjective dignity would allow for idiosyncrasies in the situated, social standards individuals use to determine their own sense of how they are treated socially despite, or because of, structural oppressions and resources. Asking individuals how they perceive particular issues, resources, norms, or relations within their lives does not in itself provide a holistic assessment of whether their lives are dignified, a point made by leading scholars on dignity. Given how subjective appraisals operate across time, biography, history, culture, and imagined futures, these brief dignity items hold promise of measurement flexibility across these immense inputs to subjectivity, while also offering a new avenue for relating diverse, social individualities to health inequities.

Even as situated understandings of dignity vary across individuals or social groups, we contend that dignity itself still can serve as an efficient social indicator (Marmot, 2004). As one way to begin rectifying deep social divisions in America, the eminent sociologist Michèle Lamont advocates for an "ordinary universalism" based in "breaking the wall to universal dignity." (Lamont, 2019). There are multiple pathways to defining oneself with dignity, and if members of disadvantaged groups can achieve a decent level of this person-focused indicator, they could stand a better chance of sustained mental or physical health advantages. Regardless of one's positionality, dignity indicates meaningful, personal responses to collective issues.

Declaration of competing interest

None.

CRediT authorship contribution statement

Matthew A. Andersson: Conceptualization, Data curation, Methodology, Formal analysis, Writing – original draft, Writing – review & editing. **Steven Hitlin:** Conceptualization, Data curation, Writing – review & editing.

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Appendix

Table 1
Polychoric Correlation Matrix, Subjective Dignity Items, 2017 Gallup Survey

	(1)	(2)	(3)	(4)	(5)
(1) Life Lacks Dignity	1.000				
(2) People Treat Me with Dignity	0.528	1.000			
(3) I Determine My Dignity	0.383	0.475	1.000		
(4) I Have Dignity as a Person	0.580	0.728	0.567	1.000	
(5) My Dignity is Not Up to Me	0.407	0.292	0.473	0.350	1.000

Note. Items reverse-scored such that higher levels indicate or suggest greater dignity.

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