Moral Features of the Therapeutic Relationship with Adults: Dignity, Trust, Autonomy, Vulnerability, and Resilience

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ABSTRACT

Using dignity as a foundational value of morality, this article defines trust, autonomy, vulnerability, and resilience in relational terms. A fictional narrative illustrates these attributes as well as solidarity and care, two core tenets of relational ethics. Medicine and rehabilitation are described as moral enterprises with respect for persons at the core of our professional obligations to patients—namely, duties of care, trustworthiness, and loyalty. Clinically, promoting autonomy, decreasing vulnerability, and fostering resilience are encouraged, with particular emphasis on avoiding words or actions (or inactions) that could cause patients to feel discouraged or depersonalized. In conclusion, the purpose of our work with persons with aphasia and other communication disorders is to help them live their lives as fully as possible, despite their life-changing losses. Viewing our therapeutic relationships with them in relational moral terms can enhance our work.

KEYWORDS: ethics, morality, dignity, therapeutic relationship, relational ethics

Learning Outcomes: As a result of this activity, the reader will be able to: (1) distinguish respect for persons from respect for autonomy; (2) define relational ethics; (3) explain why the therapeutic relationship is fundamentally a moral relationship; (4) list the duties of the health professionals in relationship to their patients; (5) define resilience.

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Two guiding principles have informed our work with adults with communication disorders over many years. The first is “Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally…” 1 (Code of Ethics, Principle I). The second is treat patients with “unconditional positive regard.” 2 Espoused by psychologist Carl Rogers, unconditional positive regard means that the humanist therapist “accepts and loves the person” for who he or she is. 2

Work by prominent aphasiologists such as Byng et al,3 LaPointe,4 Sarno,5,6 Worrall,7 and others8–16 suggests we might not be living up to these ethical responsibilities. Patients report that by careless words and actions, some clinicians inadvertently devalue and depersonalize them17 (see Table 1).

The goal of this article is to discuss the moral dimensions of the therapeutic relationship, thereby helping us avoid ethical mistakes and uphold our promise to persons with aphasia to hold their interests paramount. This article will develop the idea that all persons have dignity, including those with compromised cognitive or communication abilities, and that the apparent shift in emphasis in bioethics from respect for persons to respect for autonomy 18 deserves scrutiny. To accomplish this, a model referred to as relational ethics will be defined and adapted to help us understand the moral basis of, and some of the dynamics within, the therapeutic relationship. Therefore, the purposes of this article are:

1. To define relational ethics.
2. To apply concepts of dignity, trust, autonomy, vulnerability, and resilience to the therapeutic relationship.
3. Using a fictional case study, to illustrate the power of therapeutic relationships in helping persons with aphasia reclaim a sense of dignity (self-identity, self-worth), agency (self-determination), and optimism.

### RELATIONAL ETHICS

According to Jennings,19 relational ethics is a philosophy based on the idea that health and human flourishing (moral goods) are achieved by moral agents in relationships of solidarity and care. Solidarity is “the practice of affirming the moral standing of others—their rights, freedom, dignity, and membership in the community.”

### Table 1 Depersonalization and Stigma Associated with Therapy for Individuals with Aphasia

<table>
<thead>
<tr>
<th>Things patients say3,11,14</th>
<th>Things clinicians say to and about patients15</th>
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<tbody>
<tr>
<td>“No one would speak to me—they would always speak to people around me”</td>
<td>“I understand”</td>
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<tr>
<td>“What am I doing, where am I going, where do I go from here?”</td>
<td>“Poor historian”</td>
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<tr>
<td>“I don’t know what they call it but they had to do games and things”</td>
<td>“Unremarkable”</td>
</tr>
<tr>
<td>“You’re a forgotten person”</td>
<td>“Normal”/“Abnormal”</td>
</tr>
<tr>
<td>“Nobody told me about anything”</td>
<td>“Difficult patient”</td>
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<td>They said you can get better on your own”</td>
<td>“I just can’t fathom it out, it’s like a mystery to me”</td>
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<table>
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<tr>
<th>Stigma attached to aphasia</th>
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<tbody>
<tr>
<td>Society’s intolerance6</td>
</tr>
<tr>
<td>Offering therapy that some patients describe as demeaning, irrelevant, patronizing, unachievable7</td>
</tr>
<tr>
<td>Not seeing the individual “as a whole person”11</td>
</tr>
<tr>
<td>Labeling patients as “difficult” which focuses on patients’ deficiencies13</td>
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<tr>
<td>Status loss16</td>
</tr>
<tr>
<td>Lack of empathy17</td>
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community[y]."19 Care is “the practice of attentiveness and attending to the moral (and mortal) being of others—their welfare, suffering, need, and vulnerability.”19 These definitions resonate with feminist scholar Gilligan’s observation that “we know ourselves as separate only insofar as we live in connection with others.”20

Thus, the character and quality of our relationships matter because it is only in relation to others that our identity and our ethical responsibilities lie. The core features of these relationships are dignity, trust, vulnerability, autonomy, and resilience (see Table 2).

Dignity

That humans have dignity—that they are worthy of respect—is a foundational principle of humanism and human rights. According to Basic Ethical Principles in European Bioethics and Biolaw:

“[D]ignity is defined both as an intrinsic value and as a matter for constructive morality in human relationships.... It refers to the inviolability of individual human life, ... [H]uman dignity expresses the intrinsic worth and fundamental equality of all human beings.”21

Human dignity is at the core of Kant’s duty-based philosophy as reflected in his Formula of Humanity:

“Act in such a way that you treat humanity, whether in your own person or in the person of any other, never merely as a means to an end, but always at the same time as an end.”22

This formula grounds the principle of respect for persons.23,24 According to Byers,25 the reason Kant established human dignity (respect for persons) as a fundamental, unconditional imperative of morality is because dignity is an intrinsic value of persons as ends in themselves. Dignity designates the value of persons in their own right; it is why a person “matters.”25 “A person’s ends, individuality, autonomy, and so on matter because the person matters. This ‘mattering’ is a person’s value, or his or her dignity.”25

Rodríguez-Prat and colleagues26 conducted a meta-analysis of studies addressing patients’ perceptions of dignity during catastrophic illness. Some patients reported feeling useless, burdensome, uncertain, fearful feelings exacerbated by loss of physical and personal independence (i.e., increased dependence on others). A key finding was how dignity varied “in relation to how patients perceived they were seen by others”26 and “the quality of interactions with others.”26 For example, if individuals felt they were treated like objects, they felt ashamed; if they felt useless and incapable, they felt valueless; if they needed help with personal hygiene and eating, they felt humiliating.26 These findings remind us of Sarno’s observations of how aphasia affects a person’s “identity,” including her “sense of self,” her “purpose,” as well as the “meaning of [her] life” and that of her family.5 In summary, “[t]o respect another means to regard her or him highly—to esteem, honor, value in his or her uniqueness or distinctiveness, to make space for the person to be him- or herself.”18 To illustrate these ideas, a fictional story27,28 told in the voices of a person with aphasia and her husband can be found in Table 3.

To further understand relational ethics, it is necessary to explore the importance of “Self”

Table 2 Definitions of Relational Features of Morality Relevant to Therapeutic Relationships

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
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<tbody>
<tr>
<td>Dignity</td>
<td>Respect for oneself and for others stems from the finitude and irreplaceable value of human life; an unconditional attribute of every person.</td>
</tr>
<tr>
<td>Self</td>
<td>A self-reflective (self-conscious) person.</td>
</tr>
<tr>
<td>Other</td>
<td>A self-reflective (self-conscious) person.</td>
</tr>
<tr>
<td>Trust</td>
<td>Justified expectation that one can depend on another person’s promise, commitment or responsibility.</td>
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<tr>
<td>Relational autonomy</td>
<td>Relationships with others are essential for individual freedom and human flourishing.</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>A common feature of all human beings that may be ameliorated or exacerbated by personal traits and life challenges.</td>
</tr>
<tr>
<td>Resilience</td>
<td>Thought to have its origin in genetic makeup, nurturance, and experience, resilience is an antidote to life’s adversities.</td>
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</table>
and “Other” as conceptualized by Tauber29 (see Table 2). In his philosophy of medicine, Tauber explains that I (the “Self”) discover my humanity through two interrelated processes, one is through self-reflection (an attribute unique to man) and the other is by contemplating you (the “Other”). The figurative space between us is a “moral space”29 in which I develop my sense of self (my individuality and agency) in relation to you (relational autonomy), and vice versa. Furthermore, it is in this moral space—in the relationship itself—that I recognize my ethical obligations to you. Ethical responsibility arises in this context because “ethical responsibility with regard to others rests on the recognition that in acting on the world one inevitably changes it for others, as well as for oneself.”29

As conceptualized, personhood is relational, autonomy is relational, and morality is relational. These dynamics occur when I engage with you because I become other-regarding (rather than merely self-regarding); your vulnerabilities become apparent to me; and, recognizing your intrinsic worth and dependency, I willfully adopt ethical responsibilities toward you.

In the first century AD, Pellegrino reminds us, Scribonius Largus, physician to Emperor Claudius, said, “the aim of the physician, the end of medicine, was humanitas … humanity, a love of mankind.”30 Guiding principles such as

Table 3 Hypothetical Case: Vulnerability, Relationships of Care, and Resilience

**Week 1: Vulnerability**
My wife Em, a middle-aged woman, has been in the hospital for a week. Normally a “can-do” person—a business woman, loving wife, and mother—she is now lying helplessly in bed. We are still in shock. A few days ago, she staggered and fell and could not speak. Now she struggles to express herself, but I do not understand her (and don’t even recognize the sound of her voice). The emotion on Em’s face, in her eyes, is fear. I try to encourage her, but I am not sure what to say. When I visit, she clutches my hand and struggles not to cry.

**Week 2: Relationships of Care**
(Em’s voice) If I could keep a diary, these are some of things I would write. A few days ago, I was terrified to even think about the future. I find myself becoming more calm and confident as each day passes—to the credit of all the people caring for me. The first professional I see each day (on morning rounds) is my physician. To my surprise, she does not show disgust or disappointment at my drooping face or garbled words. She sits on the edge of the bed, looks me right in the eye, and speaks to me in a normal way. Next is my nurse. He is all business! He expects me to feed myself and take care of my own hygiene. He helps me, of course, and he’s very kind. I think he wants to foster my “can-do” attitude (the “old me”). Physical therapy is first on my therapy schedule. My physical therapist always has a smile and, gratefully, she explains how the stretching and strengthening exercises are preparing me to stand and maybe (hopefully) walk again. I also meet with the occupational therapist, who is helping me use my left arm and hand, and do as many “functional” things for myself as possible. Last but not least, I see a speech-language pathologist twice each day. She is very sensitive to my strengths and weaknesses and is providing therapy tasks to stimulate all my “modalities.” We spend most of our time on building phrases—1 word, then 2, then 3 in a string. Unison speech with her and lots of repetition help me “elaborate” each response. Sometimes I get frustrated by how hard it is, but most of the time, I feel good about my progress.

**Week 3: Resilience**
(Em’s husband’s voice) This morning at the family conference with the rehab team, we’ve learned that Em’s meds are working and her recovery is “slow-but-sure.” Now using a word-plus-picture pointing board, gestures, and 1–3 word phrases, Em is able to explain her emotions and express basic ideas. The professional staff explain the goals of nursing and therapy care, and explain how they counsel Em, while dutifully soliciting and respecting her preferences whenever possible. Today, everyone offered Em (and the whole family) their personal words of encouragement and reassurance. Em and I are deeply grateful that everyone is competent, trustworthy, and loyal to Em’s best interests. Truly, each member of the rehab team is a gift of hope. With their help, we are beginning to reimagine our future. Despite a long road ahead, Em now smiles when she clutches my hand.
beneficence and respect for autonomy are “product[s] of the primary relational commitment.” The healing relationship between patient and health professional is, thus, a relational moral commitment based on respect for patients’ humanity; it is fundamentally a relational commitment to the “humanity of the ill.”

“At its heart, medicine is a moral enterprise: the relation between the one seeking help and the professional offering it is based on profound human values, including the relief of suffering, bonding with others in the community, being at risk for vulnerability, alterations in one’s social and familial roles, and the value of existence itself.”

**Trust**

The bonding agent in the moral space between health care providers and patients is trust. As Wolfensberger and Wrigley explain, trust is qualitatively different from confidence, reliance, hope, and belief in; trust is a justified expectation based on the characteristics of those being trusted and the nature of their commitments.

“At its ethical and humanistic core, professionalism is the commitment of health professionals to be deserving of this trust—in other words, to be trust-worthy.”

In health care relationships, we trust professionals to fulfill the following obligations: duty of care (competence), duty of trustworthiness (honesty and good faith), and a duty of loyalty (always acting in patients’ best interests).

If professionals neglect or betray the trust that is placed in them, they undermine patients’ dignity—in effect, depersonalizing them. As Pellegrino noted, “If there is any meaning to professional ethics, it must revolve around the obligation of fidelity to trust.” If the commitment is breached, we feel betrayed. In Baier’s words, “it is uncontroversial that the betrayal of trust … is a grave moral wrong.”

**Autonomy**

In Kant’s philosophy, one determinant of dignity is autonomy (auto- self, nomos rule), but it is important to note that our obligation to respect persons (the dignity principle) is separate from and conceptually prior to respect for autonomy. Evidence of the priority of respect for persons is found in The Belmont Report (1979):

“Respect for persons—Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection.”

Thus, in The Belmont Report, respect for persons (dignity) is the first principle; in Beauchamp and Childress’ “principlism,” autonomy is the first principle. In both models, autonomy is composed of “… liberty (independence from controlling influences) and agency (capacity for intentional action)” and “[T]raits of the autonomous person include “capacities of self-governance such as understanding, reasoning, deliberating, managing, and independent choosing.” Beauchamp and Childress explain that “[o]bligations to respect autonomy do not extend to persons who cannot act in a sufficiently autonomous manner” but that such individuals are owed moral respect nonetheless.

What, then, is our ethical obligation when a person is determined to be “nonautonomous”? What should we do when a patient is chronically ill and debilitated, yet makes demands such as “I want to go home?” Or, what should we do when persons who, although fully competent prior to their illness, now are unable to communicate their wishes and lack, or are misperceived as lacking, decision-making capacity? In both examples, there is a tension between respect for persons and respect for autonomy—a tension that is particularly poignant and consequential when considering persons with communication impairments.

To help us with this problem, let’s consider Cassell’s aesthetic interpretation of autonomy in his essay entitled “Life as a Work of Art” in which he explains that it is the act of choosing, not necessarily the choice itself, that matters. Cassell observes that “to focus on the ethical as the narrow pursuit of rights, autonomy, and self-determination misses the reason for ethics.” Cassell’s thesis is “autonomy is not important in itself, but rather for its function in the self-creation of a person, of a lived life.” Using
the creation of a tapestry or the playing of a concerto as metaphors, he asks us to imagine the contribution of each stitch or note to the beauty of the whole.

“It is here in the moment-by-moment choices that determine the person that autonomy has true meaning. Choice is the essence of the process.”

Cassell’s aesthetic vision of autonomy is an important counterweight to the unfortunate yet prevalent notion idea that “the free or autonomous choice is more important than the true worth of what is chosen.” Thus, exercising choice simply for the sake of choosing, or exercising choice in isolation from or in disregard for relationships, is a futile exercise of autonomy—“like random chords on the piano, or a life without a purpose.”

Vulnerability

The first sense of vulnerability is inherent vulnerability—a “universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social responsibility.” In the context of medicine as a moral enterprise, Thomasma explains that “the vulnerability of the sick is grounded in human finitude, and because we all share that finitude, we are duty bound to address it in all of our relationships, including the universal one of illness, decay, and death.” Thomasma’s corresponding principle of vulnerability is “if there are inequities of power, knowledge, or material means, the obligation is upon the stronger to respect and protect the vulnerability of the other.”

Relational vulnerabilities arise from or are exacerbated by socially unjust situations—namely, situational vulnerability, and its subset, pathogenic vulnerability. Situational vulnerability arises from social, political, economic, or environmental factors, for example, unemployment, housing, or food insecurity. Pathogenic vulnerability arises from “prejudice or abuse in interpersonal relationships and from social domination, oppression, or political violence.”

An additional example of pathogenic vulnerability is depersonalization, meaning that vulnerability can be exacerbated if people (family, strangers, health professionals) say or do things that are construed as alienating, demeaning, or stigmatizing (see Table 1). Depersonalization can take the form of ignoring someone in need, taking advantage of another to advance one’s own interests, arbitrarily overriding a person’s choices or preferences, treating someone as useless or incapable, failing to inform them about matters of vital interest, disregarding their feelings, or labeling them as “difficult” rather than providing encouragement and opportunities for them to overcome challenges. Finally, health professionals should be sensitive to the fact that merely labeling individuals as vulnerable can invite others to view them as “worthy of pity,” helpless, needy, or victimized.

Resilience

Resilience, a form of positive adaptation to illness and other adversities, is a human attribute or capacity with presumed origins in genetics as well as biopsychosocial dynamics. Resilience has been defined as “[a] capacity to confront, absorb, withstand, accommodate, reconcile, and/or adjust to conditions of adversity, setback, and challenge in the pursuit of desired or desirable goals or states.” Rather than conceptualizing resilience as a single concept, Lotz defines it as a “suite or cluster of skills, attitudes, and resources.” In their accounts of resilience, Haglund et al propose these attitudinal and behavioral elements: optimism and sense of humor, active coping, cognitive flexibility, moral compass, physical exercise, social support, and role models, while Robertson and Cooper include adaptability, confidence, social support, and purposefulness.

Thus, a triad of overlapping strategies is available to clinicians in therapeutic alliance with patients during their recovery: promoting autonomy, mitigating vulnerability, and fostering resilience. Lotz explained:

“Recognition of vulnerability does not in itself obviate duties of respect for vulnerable persons as fully autonomous; and efforts aimed at reducing or overcoming vulnerability must at the same time serve wherever possible to promote the autonomy of the vulnerable.”

“Em’s Story” (see Table 3) was written to highlight how an acute illness—in this case a stroke—can, in a matter of moments,
demoralize a person and debilitate her “rational, emotional and relational agency.” In Part 1, we hear Em’s story through her husband’s anguish. In Part 2, Em’s (imagined) voice describes her personal growth through her relationships, and Part 3 (in her husband’s voice) captures her resilience. Throughout the story, between the lines, we understand that the rehabilitation team understood and honored its relational ethical commitments. (Some suggestions for clinicians to enhance therapeutic relationships are listed in Table 4.)

SUMMARY AND CONCLUSION
Using dignity as a foundational value of morality, this article has defined trust, autonomy, vulnerability, and resilience in relational terms. A fictional narrative illustrated these attributes as well as solidarity and care, two core tenets of relational ethics. Medicine and rehabilitation were described as moral enterprises with respect for persons at the core of our professional obligations to patients—namely, duties of care, trustworthiness, and loyalty. Clinically, promoting autonomy, decreasing vulnerability, and fostering resilience were encouraged, with particular emphasis on avoiding actions (or inactions) and words that could cause patients to feel discouraged or depersonalized.

In conclusion, the purpose of our work with persons with aphasia and other communication disorders is to help them live their lives as fully as possible, despite their life-changing losses. Viewing our therapeutic relationships with them in relational moral terms can enhance our work.

“To rehabilitate is to restore the power or capacity for living, where living does not signify merely biologic life, and function, but takes on a qualitative dimension. It is the restoration of the power of living well, living meaningfully, that rehabilitation essentially seeks.”

CONFLICT OF INTEREST
None declared.

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Erratum: This article has been corrected in accordance with the Erratum published on October 23, 2020. The last paragraph on page 218 was meant to be a quotation.