

Acknowledging the Unavoidable: Addressing Dual Relationships in Massage Therapy

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In massage therapy, it is generally advised to avoid dual relationships because they are believed to be difficult to manage and cross professional and personal boundaries. However, dual relationships are difficult to avoid in small, rural, and other communities. This paper is written from the perspective of a massage therapist who lives and works in a rural town and who works within dual relationships regularly. It discusses ideas around the ethics, management, and benefits of dual relationships as well as the need for supportive ethical guidance informed by the realities of living and working in small or rural communities. Research is lacking in massage therapy around ethical issues and dual relationships; therefore, this paper draws in research from other areas of health care such as rural health ethics and rural health care. The aim of this work is to encourage contemplation, discussion, and research around dual relationships in massage therapy. Dual relationships should be further studied in massage therapy to better inform ethics education, practice standards, and guidance, which may positively impact patients and massage therapists.

KEYWORDS: Massage therapy; ethics; boundaries; therapeutic relationship; dual relationships; rural practice; ethical decision-making

INTRODUCTION

In 2012, I left my urban massage therapy practice and moved to a rural town. I was excited about integrating into a new community, getting to know my neighbors, and working for myself from my home. However, as I began to build my practice, I real-

ized that there would be no way to avoid dual relationships (DRs) with my patients. I was now living and working in a situation where I would naturally come to know my patients in many ways beyond the confines of the therapeutic relationship.

In massage therapy, participating in a non-sexual DR with a patient has been described as being unethical,⁽¹⁾ problematic, and better off avoided.⁽¹⁻⁴⁾ The intention behind avoiding DRs is to protect the patient from harm, prevent conflicts of interest, and preserve clinician objectivity.⁽¹⁻⁴⁾ The therapeutic relationship is the responsibility of the massage therapist (MT),⁽¹⁻⁴⁾ and good boundaries and communication skills help manage and negotiate this relationship and keep patients safe.⁽¹⁻⁸⁾

I understand the importance of properly managing the therapeutic relationship and preventing patient harm, and I take these issues seriously. However, the predominantly negative views around DRs and the lack of effective and supportive guidance for managing them have been challenging. Where I live and practice, there is a population of approximately 1,500 people⁽⁹⁾; furthermore, 41.1% of my province's population, Nova Scotia, live in a rural area.⁽¹⁰⁾ I work within DRs daily; they are not something I can easily avoid, nor do I feel it would always be appropriate to try to avoid them.

I have struggled to reconcile my experience of working in DRs with our current perspectives and guidance. Contrary to common beliefs, sharing a community and workspace with my patients has positively impacted and influenced my practice. I have experienced immense growth in developing and applying my communication and critical thinking skills around discussing and creating boundaries with

patients, in building and preserving trust, and in managing my dual roles. Yet, I struggle to find my experiences accurately reflected within our ethical teachings. This inspired me to further explore the topics of health ethics, rural health care, and DRs outside of the massage therapy literature. I found that other health care providers (HCPs) also struggle with their profession's negative perceptions of DRs and are frustrated with the scarcity of representative and supportive guidance.^(11–13) As such, I felt it necessary to offer a glance at the rural health ethics literature and my perspective as an MT who engages in DRs regularly. I believe it is time to challenge the common beliefs and negative views, and encourage research to better inform education, practice standards, and guidance in massage therapy around DRs.

This paper will describe non-sexual DRs between HCPs and patients mainly in the context of a small or rural practice environment.

DUAL RELATIONSHIPS

A DR occurs when an MT and their patient have both a professional and a personal or other relationship.^(1,4) When a DR overlaps in more ways than one, it is referred to as a multiple relationship (MR),⁽¹⁴⁾ for example, when an MT and their patient are friends and also members of a shared organization.

Although non-sexual DRs are not prohibited in massage therapy, they have been cast as a “boundary violation” and “ethically wrong and inappropriate.”⁽¹⁾ These relationships are thought to place the MT in a position where it is difficult, if not impossible, to remain objective, maintain boundaries and professionalism, and prioritize the needs of the patient.^(1–4) Specific types of DRs, for example, those involving friends and family, are considered more difficult to manage and thus may have more severe negative outcomes for the patient and MT.^(1–4) For example, the continuous role switching between MT, friend, and/or family member can cause “misunderstandings and stress”⁽³⁾ and these dual roles are thought to be incompatible with or to “compromise” patient-centered care.⁽²⁾

It is difficult to determine the level of ethics training MTs receive in their entry-to-practice education because private and

public college curricula are inconsistent across Canada.⁽¹⁵⁾ There is a lack of massage therapy-specific research around ethical issues,⁽¹⁶⁾ communication and professionalism, the therapeutic relationship,^(5,6,8) and the attitudes and beliefs that MTs hold around DRs.⁽⁵⁾ Although some massage texts do offer acknowledgment of and some guidance for managing DRs,^(3,4) typically in massage therapy,^(1–4) and in other areas of health care such as physiotherapy,⁽¹²⁾ medicine,⁽¹³⁾ and mental health,^(17–22) it is suggested to avoid DRs and MRs. Some provincial codes of ethics and standards of practice also advise using caution around DRs,^(23–26) or suggest avoiding them altogether.^(27–29)

UNAVOIDABLE DUAL RELATIONSHIPS AND CRITIQUES OF ETHICAL PRINCIPLES

Despite the above-noted concerns about the dangers of DRs, research outside of the massage profession shows that DRs are unavoidable, normal, expected,^(11–14,17–20) and even beneficial^(11–14,19) within small, rural, and remote communities. However, the rural practice environment is often noted as being misunderstood,^(11,12,14) and its contextual nuances infrequently inform ethical standards and education in practical ways.^(11,14,17,19) This may create difficulties for HCPs who try to adhere to their profession's ethical standards and also work within a context where DRs are inevitable.^(12–14)

In their book *Rethinking Rural Health Ethics*, Simpson and McDonald⁽¹⁴⁾ critique ethical principles such as rigid professional boundaries and avoidance of DRs as being urban-centric, that is, influenced by urban norms and disconnected from the ways in which health care operates in small, rural, and remote communities. Rural patients often prefer to receive care in their own communities by people they know or are familiar with.⁽¹⁴⁾ Values such as place, community, and relationships hold distinct and significant meaning to, as well as influence upon, health care decision-making for rural patients and practitioners.⁽¹⁴⁾ Simpson and McDonald⁽¹⁴⁾ argue that the unique, and largely overlooked, perspectives of rural health care should inform ethical guidance and education to provide more balanced and supportive guidance around common rural practice issues such as engaging in and managing DRs.

DRs are not just unique to the rural landscape in health care, they also occur within interconnected groups or communities within urban areas.^(14,20,21,30) Members of the deaf and blind community, spiritual and religious groups, and equity-seeking groups⁽³⁰⁾ may also experience or prefer working in DRs with their HCPs. Within both urban^(11,22) and rural^(11,19,22) Indigenous communities, DRs are also a common occurrence.

Tanya Dawn McDougall,⁽²²⁾ a First Nation educator and mental health provider who lives and works in her home community, notes that the principle of avoiding DRs is difficult to comprehend, incompatible with her practice environment, and represents a Western or Eurocentric ideal. She argues that this ethical value unjustly questions her personal and professional integrity and fails to recognize the importance of providing care for one's community from an Indigenous health perspective, exemplifying the need for culturally informed ethical standards and education.⁽²²⁾

MANAGEMENT OF DUAL RELATIONSHIPS

Although managing DRs is a part of everyday practice in small and rural communities,^(11,14) ethical standards and best practices for them are often ambiguous or non-existent.⁽¹¹⁻¹⁴⁾ Unfortunately, a lack of guidance can leave HCPs feeling isolated, without professional support, prone to leaving their practice,⁽¹¹⁻¹³⁾ and vulnerable in the case of disciplinary action.^(11,18) Nevertheless, HCPs develop advanced critical thinking and decision-making skills informed by professional, personal, community, and cultural values to manage DRs^(11-13,17-19) and foster a sustainable practice.⁽¹¹⁾

The rural context sometimes calls for a more human^(13,14) or relaxed⁽¹⁸⁾ approach to relationships. Rigid boundaries may appear rude, diminish trust, cause patient harm, and create a barrier to accessing care.^(11,12,14) This does not mean that boundaries are unimportant or carelessly trespassed, but they may be negotiated differently, or co-created by patient and HCP.^(12,14)

Developing ethical guidance around DRs informed by diverse practice contexts could benefit patients and HCPs.^(11-14,21) I believe this would be supportive in massage therapy as well. DRs are inevitable and unavoidable in certain practice contexts.^(11-14,17-22,30) The objective should not be to avoid DRs but to teach effective

navigation skills and offer HCPs support.^(11-14,17-20) Gingerich et al.⁽¹²⁾ note that as long as practice standards continue to be unclear and discourage or exclude support for managing "rural norms" such as DRs or MRs, rural HCPs will remain without proper support and feel that their practice is "always compromised."

Szumer and Arnold⁽¹¹⁾ created the ARAAR schema (Acknowledge, Recognize, Assess, Act, and Reflect) to support HCPs with ethical decision-making around DRs. Briefly, the authors suggest that HCPs *acknowledge* that overlapping relationships are normal, manageable, and can be a positive experience; *recognize* and address one's thoughts and feelings about DRs; *assess* the risks and benefits, practice context, ethical principles, and seek guidance when needed; *act* by discussing and documenting the relationship, creating boundaries, or referring the patient elsewhere when needed; and *reflect* on challenges and successes and share knowledge to help support other rural HCPs.⁽¹¹⁾

Although we have inadequate data about managing DRs in massage therapy,⁽⁵⁾ an MT's practice is centered on providing holistic^(7,8) client-centered care.^(5,7,8) We have more time for assessment and treatment^(5,7) and a concern for effective communication,⁽⁵⁻⁸⁾ establishing boundaries, building trust, and developing the therapeutic relationship.^(5,6,8) These skills are well suited to successfully manage DRs and are worth exploring further. As the profession of massage therapy continues to grow and evolve through research and self-inquiry, the unique experiences of patients and MTs engaging in DRs should be sought out to better inform education, ethical guidelines, standards of practice, and policy.

Recently, the Massage Therapists' Association of Nova Scotia introduced a new guideline which recognizes that DRs are unavoidable in some scenarios.⁽³¹⁾ This is a first step in acknowledging and supporting DRs, and this guideline offers some practical guidance in managing boundaries rooted within the associations code of ethics and standards of practice.

BENEFITS OF DUAL RELATIONSHIPS

The ethics of DR are commonly situated within a fear-based or risk-versus-benefit discourse.^(11,14,22) The risks are often clearly

stated, but the benefits may be absent, unclear, or deemed not to outweigh the risks.⁽¹⁴⁾ Possible risks of harm toward the patient may include boundary violations and role confusion due to blurred boundaries,^(1-4,11,14) conflicts of interest and exploitation,^(1,3,4,11,14) an increase in opportunity for breaches in confidentiality, and impaired clinician objectivity.^(1-4,11,14) Although these issues are serious and ask HCPs to be vigilant in their care, the rural context offers us an opportunity to perhaps suspend our fear that DRs will inevitably lead to harm and instead try to understand how these relationships are being successfully managed⁽¹⁴⁾ and how they might positively affect patient and practitioner.^(14,19) Broscious et al.⁽¹⁹⁾ note that DRs might be better understood through a “strengths perspective” analysis which recognizes that HCPs already have and can effectively use their skills to engage in DRs, and the benefits are recognized.

Participating in DRs in small communities is often expected and considered socially acceptable by community members.⁽¹¹⁻¹⁴⁾ When patients see their providers being active in their community, it can foster trust, reduce barriers to accessing health care, and may improve patient care and treatment outcomes.⁽¹¹⁻¹⁴⁾ Patients may be looking for HCPs with specific traits or characteristics with which they can identify.^(20,21,30) Some may self-match⁽²⁰⁾ with HCPs whom they feel share similar values, experiences, or culture,^(20,21,30) and this can be especially common among equity-seeking groups^(20,21,30) and those who have experienced trauma.⁽³⁰⁾ DRs may be initiated by patients for reasons of eliciting comfort and safety from the therapeutic relationship and may be frequent in small communities.^(20,21,30) Benjamin and Sohnen-Moe note that a DR may benefit a hesitant or fearful patient as they may feel safer and more willing to access care from a friend who is also an HCP.⁽⁴⁾

The well-being of HCPs must also be considered in this discussion because avoiding DRs in small and rural communities may contribute to stress and social isolation.^(11-14,18) This is particularly important for MTs as it has been noted that we already work within an isolated profession.^(8,15,32) HCPs who live and work alongside patients need to feel supported not only in their work, but also in cultivating friendships and integrating into and contributing meaningfully to shared communities with

patients.⁽¹¹⁻¹⁴⁾ HCPs are more visible in shared communities, and they often seek services or assistance from community members who are also patients.⁽¹⁴⁾ Feelings of power and vulnerability may be experienced by both parties which may help to reduce or balance negative outcomes associated with power and vulnerability and benefit the therapeutic relationship.⁽¹⁴⁾

Researchers feel that a great opportunity exists to gain extensive knowledge by exploring the intricate interactions and unique spaces where patients and HCPs engage in DRs, and this knowledge could benefit education around ethics, communication, and the therapeutic relationship.^(11,12,14)

LIMITATIONS AND DISCUSSION

It is important to note the limitations of this work as it is derived from my personal experience, perspective, and understanding of the referenced literature. Yet, it is my hope that this paper encourages MTs, researchers, educators, and regulators to broaden their understanding of DRs to better support those of us working in circumstances where DRs cannot and, perhaps, should not be avoided.

Working in a rural town has both challenged and rewarded me over the years, but ultimately, my practice has been enhanced by living and working alongside my patients. DRs are something I must manage, they are a normal and expected part of delivering health care where I live, and I embrace my role as an MT, friend, and community member.

CONFLICT OF INTEREST NOTIFICATION

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