Registered Massage Therapists' Association of Ontario

RMTAO Sexual Assault and Harassment Survey Summary

Contents

Introduction

In September 2025, the RMTAO surveyed 2,495 Registered Massage Therapists and students in Ontario regarding their experiences with sexual harassment and assault. This data provides a vital window into the professional challenges and safety concerns facing the massage therapy community today.

Purpose

The purpose of this survey was to gather the perspectives of Ontario RMTs to better understand these issues and to help inform the development of programs, policies, and resources that promote safer practice environments across Ontario.

For the purposes of this survey, the following definitions apply:

Sexual harassment is defined as any sexual or sexually suggestive comments or behaviours from a patient that are perceived as offensive, intimidating, or uncomfortable.

Sexual assault is defined as unwanted sexual contact from a patient that occurred without your consent or against your will.

Complete Results Summary

Key findings from the survey

Note: In some questions, respondents could select multiple answers for each question; as a result, percentages reflect the proportion of respondents selecting each option and **do not sum to 100%.**

Respondents were primarily women (81%), with men comprising 17% and approximately 2% identifying as transgender, non-binary, gender diverse, or other. Most were between ages 45–54 (32%) and 35–44 (30%). Experience levels were generally high, with 26% reporting over 20 years of experience and 20% reporting 6–10 years. This matches the overall demographics of RMTs in Ontario.

54% of respondents felt confident responding to sexual assault or harassment, while 39% felt somewhat confident and 7% did not feel confident. Despite this, 69% reported never receiving training on how to handle sexual assault or harassment. Among those who had received training, most received it through massage therapy school (77%), with fewer through professional development opportunities (28%) or their employer (24%).

Sexual Harassment

- Nearly three-quarters of respondents (73%) reported experiencing sexual harassment during their training or practice, most often verbal (85%), followed by physical (48%), phone (19%), and online harassment (12%).
- Slightly more than half experienced 1–3 incidents (55%), and 14% reported more than 10 incidents.
- Incidents occurred primarily during treatment (92%), with fewer happening after (37%) or before treatment (30%).
- Incidents were most common in multidisciplinary clinics (54%) and massage therapy clinics (48%).
- 66% of respondents discharged the patient following an incident.
- Decisions not to discharge were most often due to:
    - Patient's behaviour was ambiguous (69%). *Ambiguous patient behaviour refers to actions or responses that are unclear or open to more than one interpretation*,
    - Fear of patient pushback (34%)
    - Concerns about not being taken seriously (29%).
- Most respondents disclosed the incident to someone (83%), typically a colleague (76%), clinic owner (60%), or spouse/partner (41%), and 84% of those who disclosed felt supported.
- Among those who did not report the incident, common barriers included:
    - Patient's behaviour was ambiguous (54%). *Ambiguous patient behaviour refers to actions or responses that are unclear or open to more than one interpretation*
    - Uncertainty about responding within CMTO regulations (40%)
    - Lack of knowledge about reporting processes (32%).
- As a result of these experiences, 71% became more cautious, 32% increased screening, 24% took no action, and 17% implemented new policies.
- Sexual harassment also led to changes in interactions with patients, students, and instructors (70%), increased stress and anxiety (58%), consideration of leaving the profession (21%), and a need for mental health support (17%).

Sexual Assault

- 21% of respondents reported experiencing sexual assault. Among those assaulted, physical assault was most common (89%), followed by verbal assault (53%). 65% experienced between 1 and 3 assaults, while 12% reported ten or more.
- Assaults most often occurred during treatment (88%) and were most common in multidisciplinary clinics (54%) and massage therapy clinics (46%).
- Following an assault, most respondents discharged the patient (74%).
- Of those who did not discharge, the reasons were primarily due to:
    - Ambiguous patient behaviour (52%). *Ambiguous patient behaviour refers to actions or responses that are unclear or open to more than one interpretation*
    - Fear of pushback from the patient (49%)
    - Concerns about meeting CMTO requirements (47%).
- Most respondents disclosed the assault to someone (83%), typically to a colleague (74%), clinic owner (63%), or spouse/partner (47%). 75% felt supported after disclosing.
- Barriers to reporting included:
    - Uncertainty about responding within CMTO regulations (49%)
    - Fear of retaliation from the patient (44%)
    - Fear of not being believed (42%).
- After the assault, 81% of respondents became more cautious, 38% increased screening, 23% implemented new policies, and 14% took no action.
- Many reported lasting effects from the incident(s), including changed interactions with patients, students, or instructors (72%), increased stress or anxiety (69%), consideration of leaving the profession (32%), and a need for mental health support (31%).

The survey and referenced resources were reviewed and verified for accuracy by:

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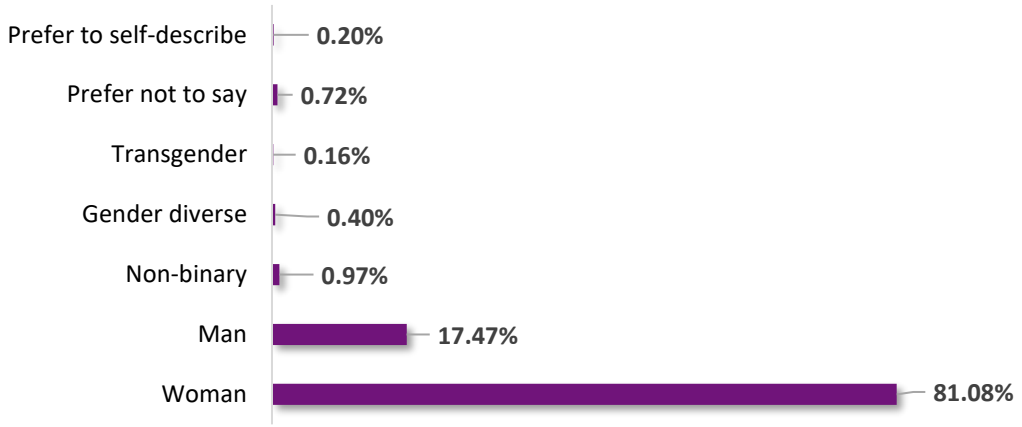
Survey Data Results

A summary of the complete survey data is included below.

Demographics

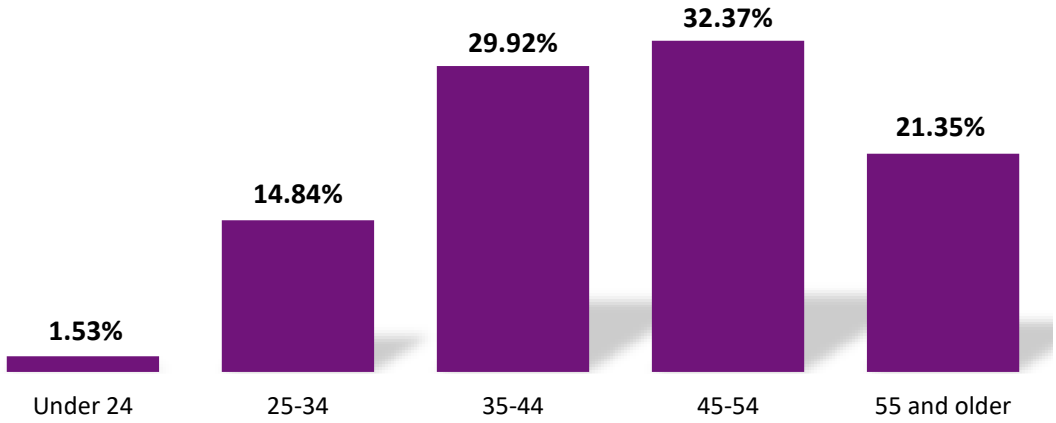
Gender Identity

Most respondents were women (81%), with men making up 17% and a small number identifying otherwise.



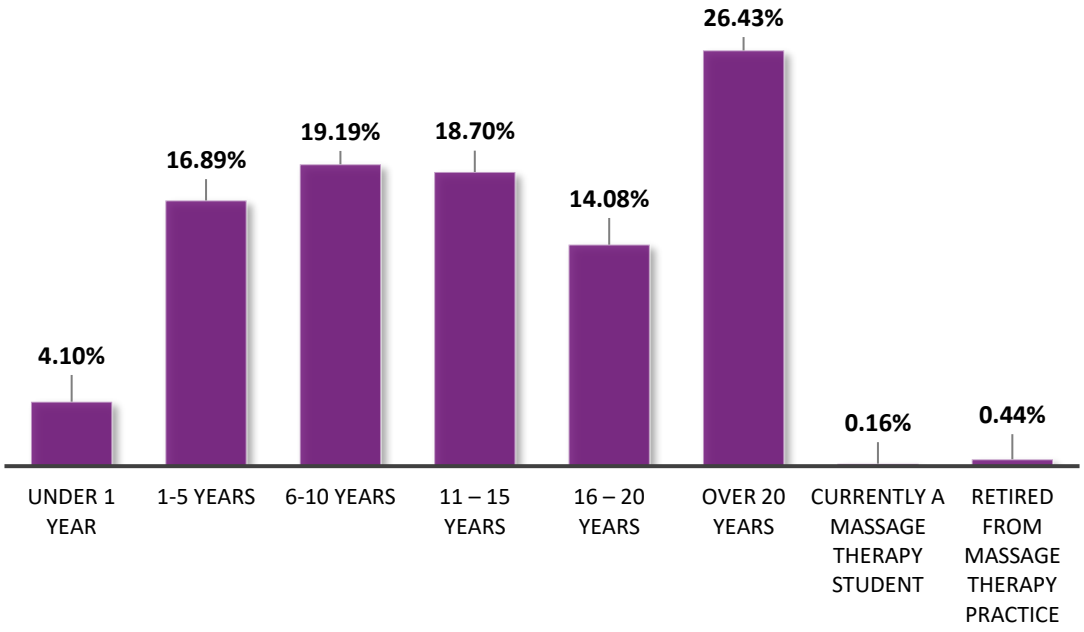
Age Range

Most respondents were between ages 45-54 (32%), followed by 35-44 (30%), 55+ (21%), 25-34 (15%), and under 24 (1.5%).



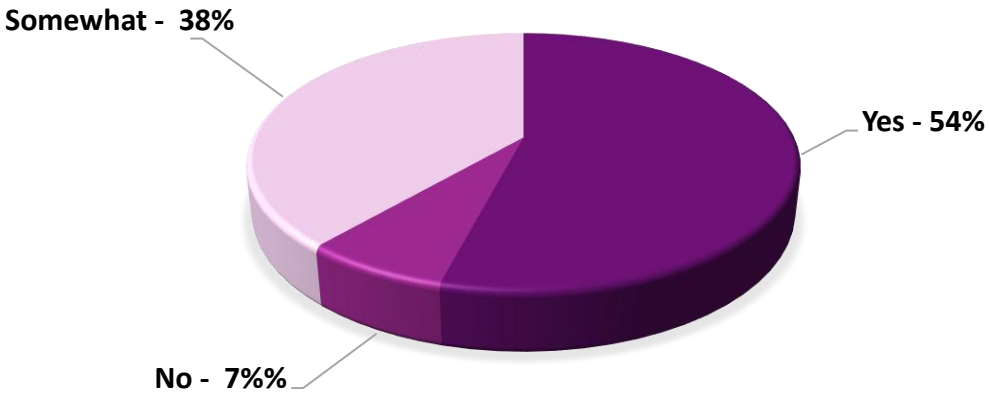
Years in practice

Most respondents have over 20 years (26%) of experience. 20% have 6-10 years, 19% have 11 - 15 years, 17% have 1-5 years, and 4% have under 1 year.



Confidence in knowing how to respond if sexual assault or harassment happens

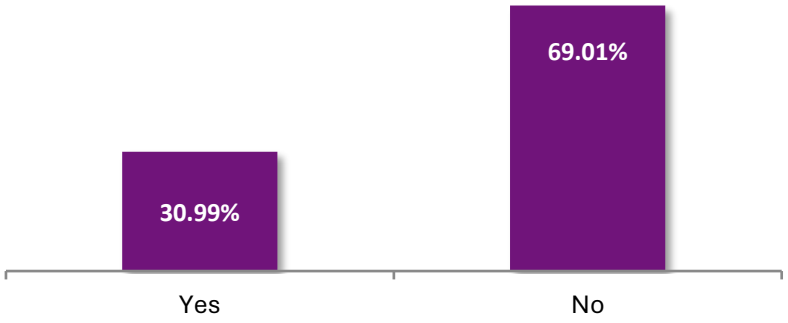
54% of respondents said they feel confident responding to sexual assault or harassment, while 39% feel only somewhat confident and 7% do not feel confident.



- The comments indicated that while many respondents understand how to respond to sexual harassment or assault in theory, they often struggle to apply this knowledge in real situations.
- Shock, fear, and fight-flight-freeze responses commonly interfere, leading to self-doubt, delayed reactions, or freezing in the moment. Many respondents emphasized that knowing what to do does not mean being able to do it under stress.
- For many, confidence in setting boundaries was not a result of formal training but was instead learned through years of experience or the necessity of surviving multiple past assaults.
- A strong concern across responses is fear of retaliation, particularly patient complaints or disciplinary action from the CMTO. Many respondents feel the system prioritizes protecting patients over practitioners, which discourages boundary setting and reporting. This fear is compounded by unclear guidance, inconsistent support, and past experiences of feeling blamed or dismissed by regulatory bodies or employers.
- Most respondents felt poorly prepared by their education, noting that training focused on preventing therapist misconduct rather than protecting therapists from abuse. Confidence generally increased with experience, but often only after repeated or traumatic incidents. Physical safety, lack of workplace safeguards and unsupportive clinic cultures further complicate responses.
- Overall, respondents stressed that each situation is highly contextual, unpredictable, and difficult to manage without stronger education, clearer rights, and better institutional support.

Training received to handle sexual assault or harassment

Most respondents (69%) reported never receiving training on how to handle sexual assault or harassment.



- In the comments, most respondents reported receiving little, outdated, or insufficient training on sexual harassment and assault, usually limited to brief discussions in massage therapy school. When addressed, the focus was largely on patient protection and ethics, with minimal practical guidance on therapist safety, rights, or real-world responses.
- Many said their most useful training came outside the profession, through previous careers, self-defence, therapy, personal experience, or workplace policies.
- Overall, respondents agreed that current education is inadequate and called for updated, trauma-informed training with clear protocols, realistic scenarios, and stronger institutional support to better protect therapists.

Where respondents received sexual assault or harassment training

Among those who had received training, it most often came from their massage therapy school (77%), with fewer receiving training through professional development opportunities (28%) or their employer (24%).

Most respondents reported gaining training or awareness outside of massage therapy, through previous careers, self-defence or martial arts, therapy, lived experience, or self-directed learning. Some referenced using CMTO or RMTAO resources.

Overall, preparation in this area was largely informal and self-initiated. Many noted that existing guidance focuses on preventing practitioner misconduct rather than protecting therapists and noted a significant gap in training for RMT safety.

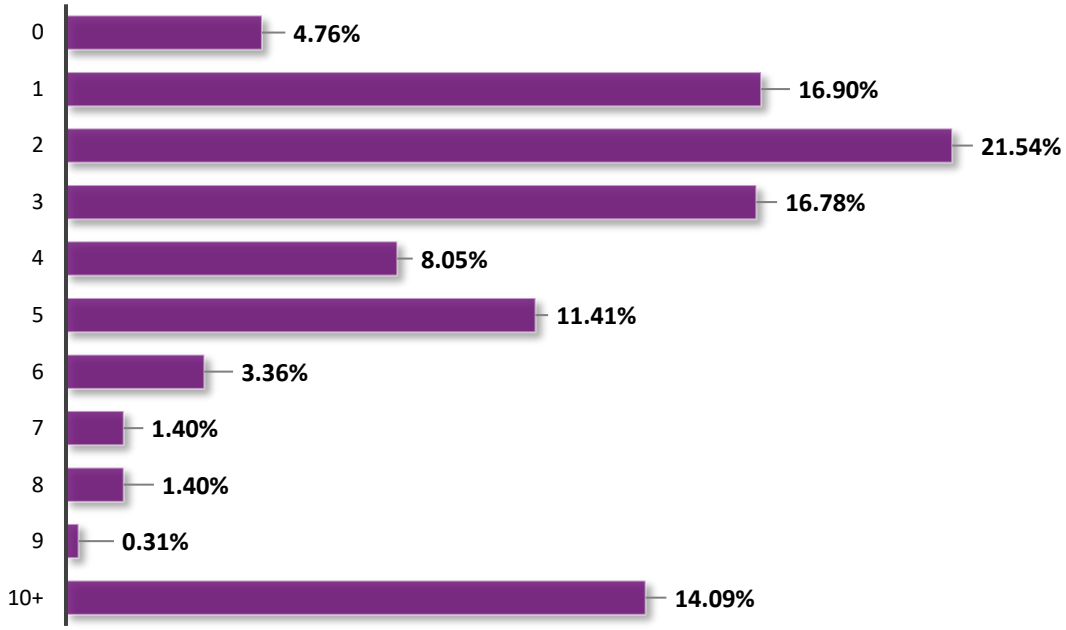
Sexual Harassment

73% of respondents reported experiencing sexual harassment during their training or practice. Of those who experienced sexual harassment:

- 85% experienced verbal harassment
- 48% experienced physical harassment
- 19% experienced phone harassment
- 12% experienced online harassment

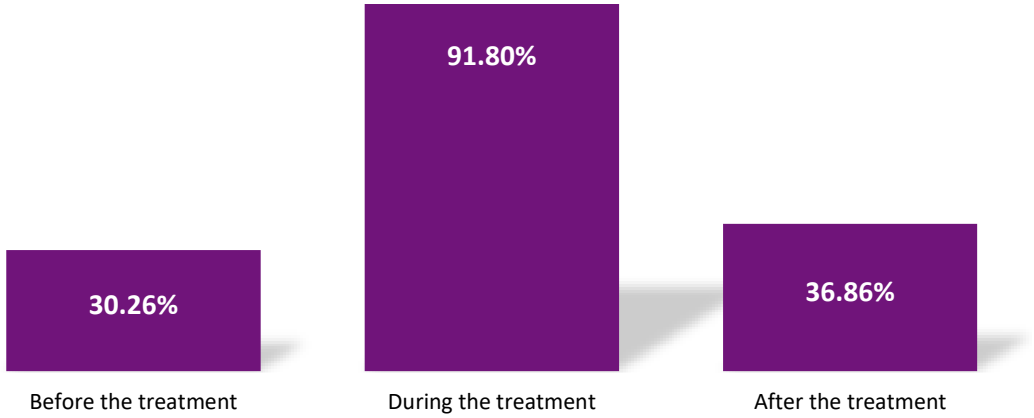
How often respondents experienced sexual harassment by patients or at school.

Most respondents report experiencing 1-3 incidents (55%), with 14% experiencing 10+ incidents.



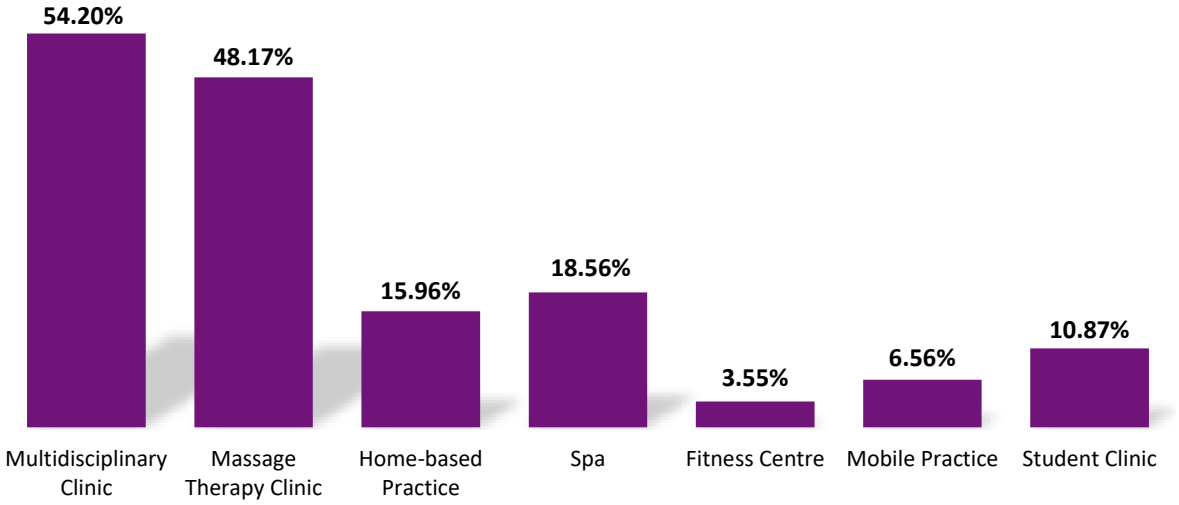
When sexual harassment incidents occurred

Incidents occurred primarily during treatment (92%), with fewer happening after treatment (37%) or before treatment (30%).



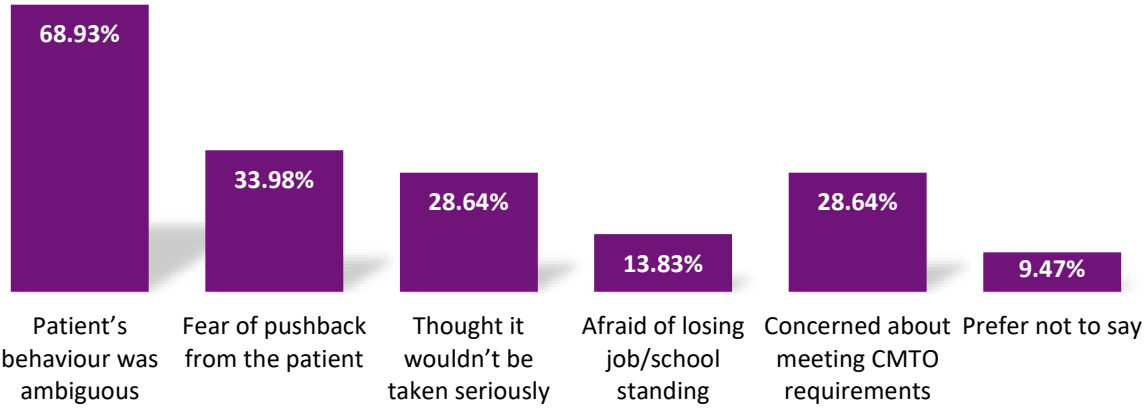
Where sexual harassment incidents occurred

Incidents most frequently occurred in multidisciplinary clinics (54%) and massage therapy clinics (48%).



Discharge of the patient

After the incident, 66% of respondents discharged the patient, whereas 34% did not. Discharge of the patient was often avoided due to ambiguous patient behaviour (69%), fear of pushback from the patient (34%), and concerns they wouldn't be taken seriously (29%).



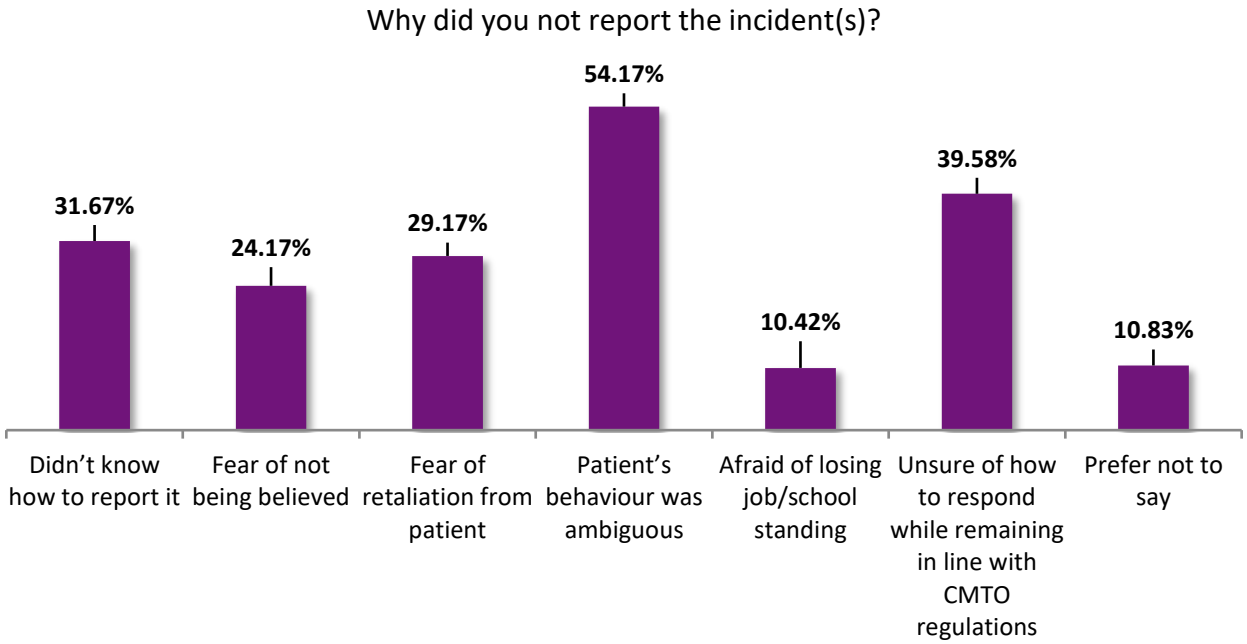
- Respondents described a range of inappropriate patient behaviours, from suggestive comments and requests for sexualized services to physical harassment.
- Early-career therapists often felt shocked or unprepared, while more experienced therapists acted assertively. Responses varied by setting, severity, and support from management.
- Respondents addressed this behaviour by setting verbal boundaries, redirecting patients, adjusting treatment, referring to another therapist or formally discharging patients.
- Many documented incidents, flagged patients in booking systems, or contacted authorities when necessary.
- Minor incidents were often resolved through discussion, while repeated or physical harassment usually led to discharge.
- Safety measures included having other staff present or scheduling sessions during busier hours.
- Challenges included unclear CMTO guidelines, inconsistent managerial support, and risks of complaints when enforcing boundaries.
- Outcomes varied, most patients did not re-book after boundaries were set, while serious violations resulted in formal discharge.
- Respondents emphasized that clear communication, boundary-setting, documentation, and supportive policies are essential for maintaining safe practice.

Reporting the incident

Most respondents (83%) disclosed the incident, while 17% did not.

Of those who disclosed the incident, most told a colleague (76%), clinic owner (60%), or spouse/partner (41%). The majority of respondents felt supported (84%) after telling someone about the incident, whereas 16% did not.

Among those who did not report the incident, common barriers included that the patient's behaviour was ambiguous (54%), uncertainty about how to respond while remaining in line with CMTO regulations (40%), and lack of knowledge about reporting processes (32%).

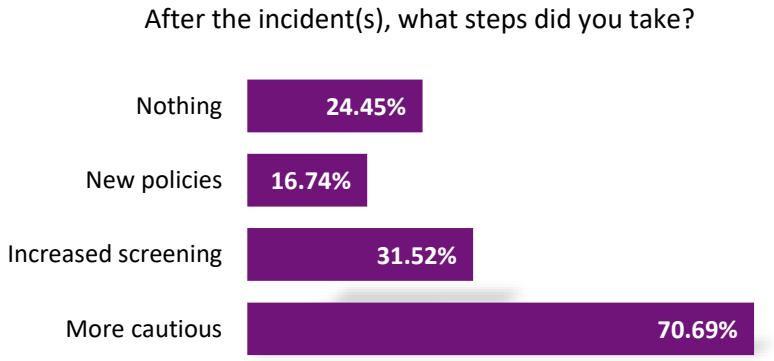


- Most respondents disclosed incidents informally to colleagues or trusted contacts rather than through formal reporting channels, which were seen as confusing, discouraging, or retraumatizing. As a result, many incidents were managed in the moment through boundary-setting, patient education, warnings, and documenting the incident, approaches that were often effective, with patients correcting their behaviour or not returning.
- Formal discharge was typically reserved for repeated, escalating, or physical incidents, though hesitation was common due to fear of conflict, income loss, limited managerial backing, and unclear regulatory guidance.
- Emotional support was most consistently found among colleagues, peers, friends, and partners, particularly those with shared experiences.

- In contrast, support from clinic owners, schools, regulatory bodies, and police was inconsistent and frequently perceived as dismissive or focused on business or procedural concerns rather than therapist safety.
- Overall, respondents described a culture in which harassment is normalized, support systems are inadequate, and therapists are often left to manage incidents on their own.

After the incident

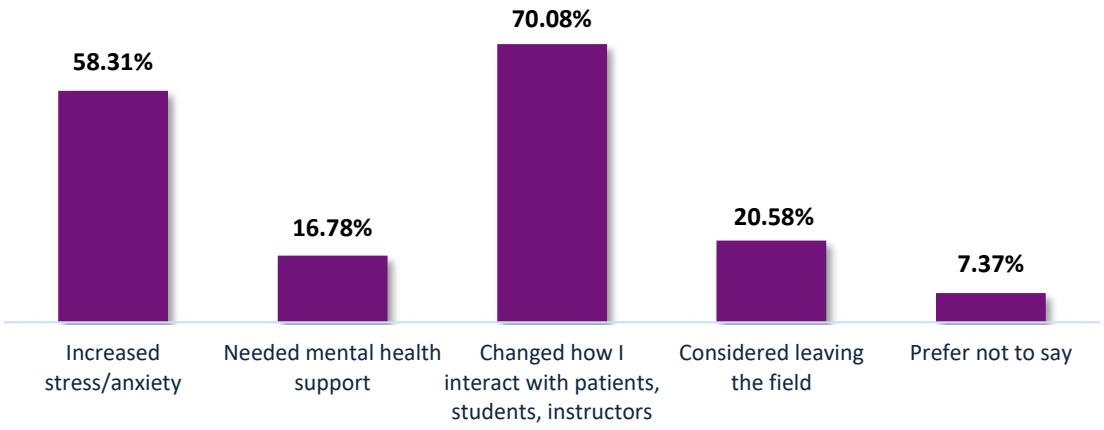
Following the incidents, 71% became more cautious, 32% increased screening, 24% did nothing, and 17% implemented new policies.



- Respondents described a range of self-protective strategies after experiencing harassment, including stronger documentation, clearer boundaries, rehearsed scripts, stricter draping and intake procedures, zero-tolerance policies, and more clinical language.
- Many adjusted scheduling to avoid being alone, flagged or discharged patients, relied on referrals, removed personal information from websites, and limited or refused male patients. Some changed clinics, relocated, or left the profession temporarily or permanently.
- Emotionally, experiences led to greater caution and confidence for some, but ongoing anxiety, hypervigilance, or trauma for others. Many emphasized they did nothing to cause the incidents and noted that harassment cannot always be prevented, highlighting the reliance on individual strategies and the lack of consistent workplace or systemic support.

How sexual harassment affected the RMT

Sexual harassment incidents led to changes in interactions with patients, students, and instructors (70%) and a heightened stress and anxiety (58%). Some considered leaving the profession (21%) or felt they needed mental health support (17%).



- Responses varied widely, but most therapists reported becoming more cautious, vigilant, and proactive in setting boundaries after incidents.
- Many increased patient screening, adjusted intake procedures, clarified draping and treatment protocols, and discharged patients who crossed boundaries.
- While some experienced only short-term stress or discomfort, others reported heightened anxiety, fear, anger, or burnout, with some limiting their practice, changing workplaces, or considering leaving the profession.
- Over time, some respondents grew more confident and assertive, developing skills to manage inappropriate behaviour and implementing measures such as referral-only patients or enhanced workplace safety.
- A smaller group experienced significant and long-lasting emotional distress or PTSD triggers, highlighting gaps in systemic support and training.
- Overall, respondents emphasized learning from incidents, trusting their instincts, and reinforcing professional boundaries. While some respondents adapted, these experiences frequently impact safety, mental well-being, and career choices, especially when support is lacking.

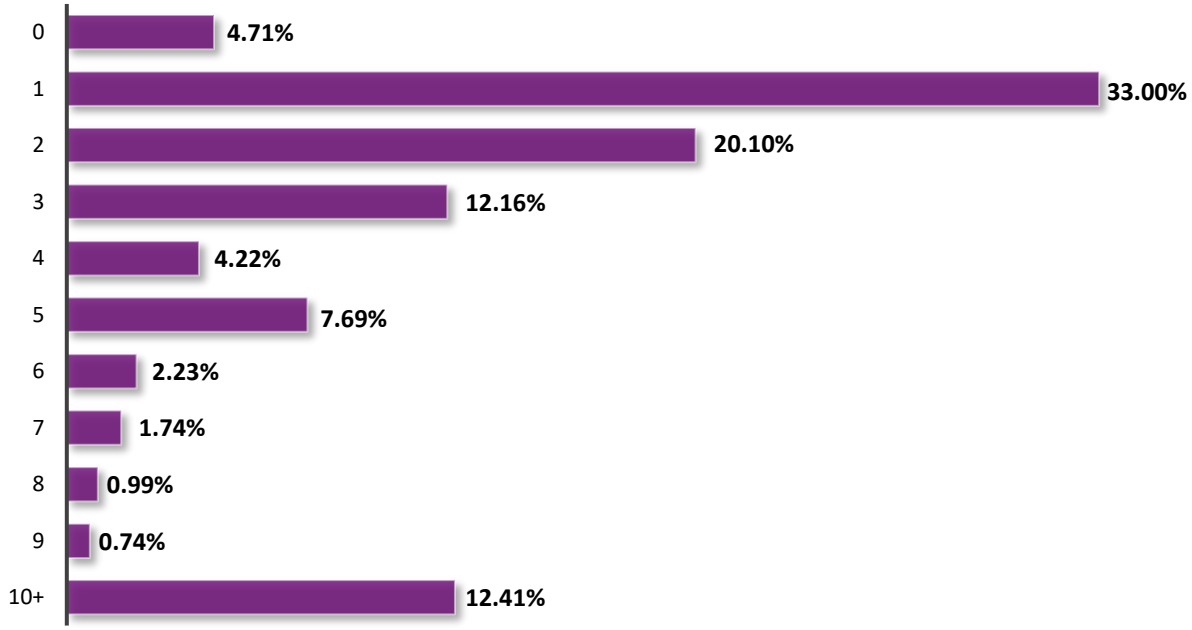
Sexual Assault

21% have experienced sexual assault in practice or school, and 79% have not. Of those who experienced sexual assault:

- 89% experienced physical assault
- 53% experienced verbal assault
- 13% experienced phone assault
- 8% experienced online assault

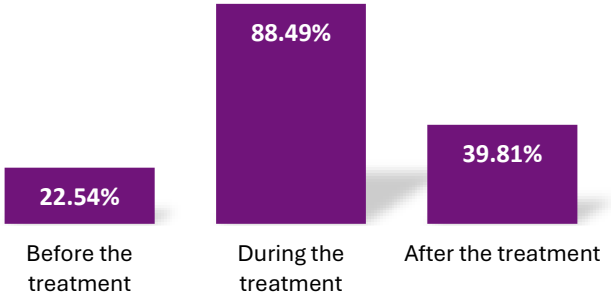
How often respondents experienced sexual assault by patients or at school.

53% of respondents experienced one or two assaults, whereas 12% reported experiencing 10 or more incidents



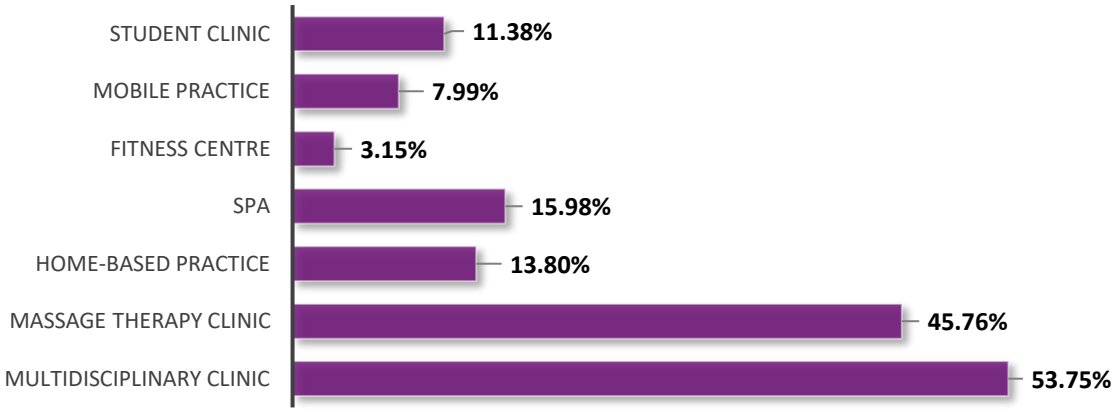
When sexual assault incidents occurred

Sexual assaults most often occurred during treatment (88%), with 40% occurring afterward and 23% beforehand.



Where sexual assault incidents occurred

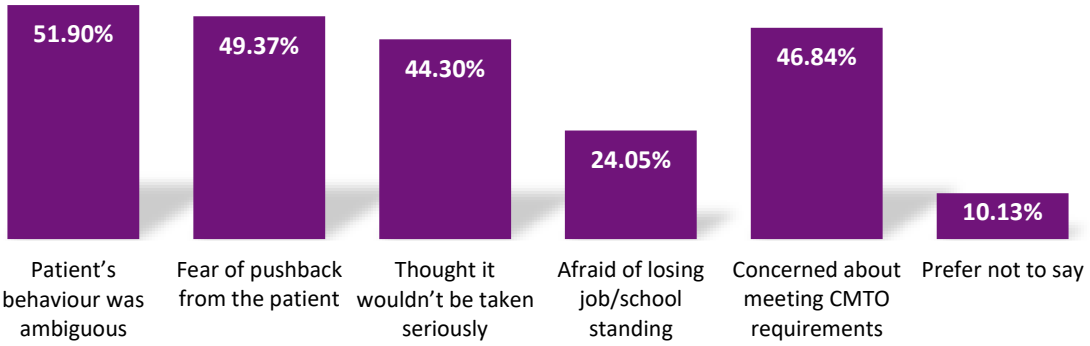
Assaults were most frequently reported in multidisciplinary clinics (54%) and massage therapy clinics (46%)



Discharge of the patient

Following an assault, 74% of respondents discharged the patient, while 26% did not. The primary reasons for not discharging included:

- Patient's behaviour was ambiguous (52%)
- Fear of pushback from the patient (49%)
- Concerns about meeting CMTO requirements (47%).



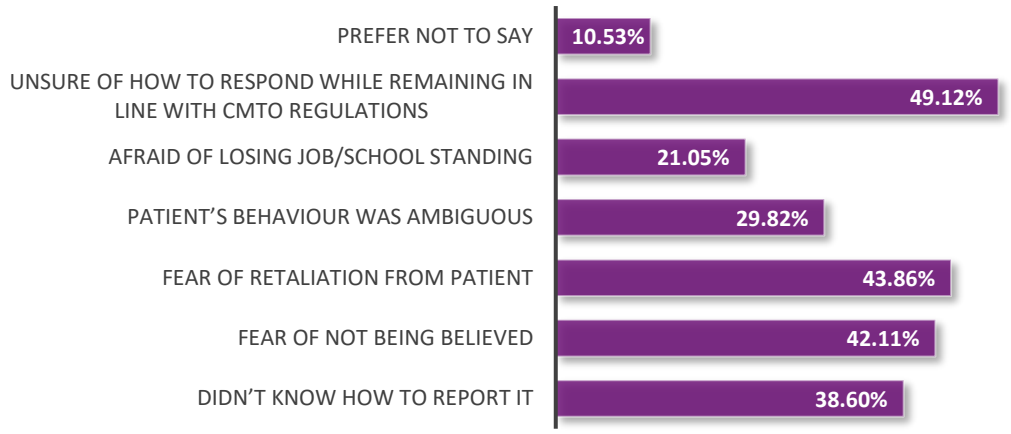
- Respondents reported a range of inappropriate patient behaviours, including unwanted touching, exposure, sexualized comments, and harassment.
- Many felt unsupported by supervisors or regulatory bodies, leaving early-career therapists and students uncertain or fearful of acting.
- Responses varied from setting firm boundaries and stopping treatments to relying on management. Minor incidents were often managed verbally, while serious or repeated violations could lead to formal discharge. Many patients self-discharged or stopped returning after boundaries were enforced.
- Incidents were documented, discussed with supervisors, or reported to authorities.
- Unclear regulations, managerial reluctance, and gaps in ethics training left some therapists feeling vulnerable.

Reporting the incident

Most respondents (83%) disclosed the assault, typically to a colleague (74%), clinic owner (63%), or spouse/partner (47%). While 75% felt supported after sharing, 25% did not.

Among those who did not report, common reasons included:

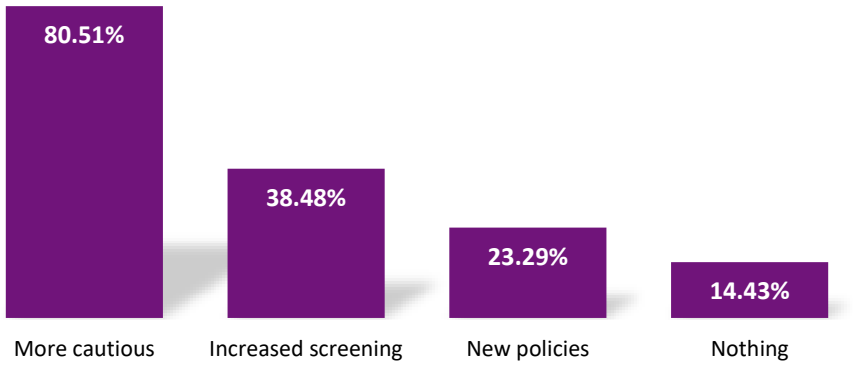
- Unsure how to respond while remaining in line with CMTO regulations (49%)
- Fear of retaliation from patient (44%)
- Fear of not being believed (42%).



- Respondents described a range of personal and institutional responses to inappropriate patient behaviour. Many took direct action, such as setting clear boundaries, stopping treatment, issuing verbal warnings, refusing future appointments, or leaving the clinic. Some relied on staff, school, or clinic management to handle the situation. Some patients were formally discharged or restricted from booking, others were allowed to continue attending, and in several cases, patients self-discharged.
- Decisions not to report the incident were influenced by factors such as ambiguity of behaviour, fear of retaliation, fear of CMTO repercussions, or uncertainty about how to discharge a patient.
- Some incidents were downplayed as minor or accidental, highlighting the difficulty therapists face in navigating subtle or ambiguous misconduct.

After the incident

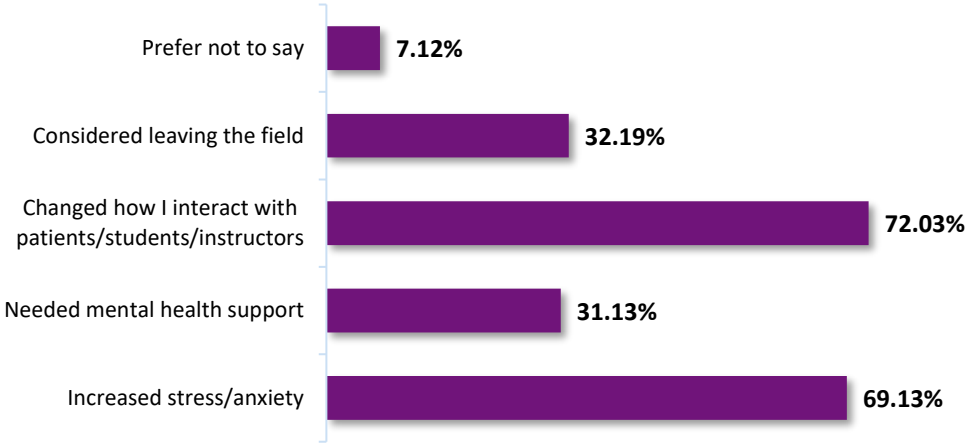
Following the assault, most respondents became more cautious (81%), with many increasing screening (38%) or implementing new policies (23%), while some took no action (14%).



- Respondents described a wide range of strategies to prevent or respond to inappropriate patient behaviour. Common actions included:
    - Adjusting intake policies
    - Changing treatment techniques or therapy types to maintain full clothing
    - Implementing clearer boundaries during sessions.
- Many relied on heightened vigilance, modifying how they interacted with patients, or working in environments with others present for safety.
- Some involved clinic owners filed reports or pursued legal action, while others sought therapy, attended boundary-setting seminars, or changed workplaces.
- Overall, responses reflect a combination of personal strategies, environmental adjustments, and professional precautions to reduce risk and maintain safety.

How sexual assault affected the RMT

The impact of sexual assault was significant, leading to changed interactions with patients/students/instructors (72%), increased stress/anxiety (69%), consideration of leaving the profession (32%), and the need for mental health support (31%).



- Respondents reported a wide range of impacts from inappropriate patient behaviour, from minimal or short-term effects to lasting changes in practice and career choices.
- Some felt anger, violation, or unease but gained confidence, vigilance, and stronger boundaries.
- Many accepted referrals only or adjusted their interactions to protect themselves.
- A few experienced emotional strain, burnout, or considered leaving the profession.
- Overall, responses reflect increased awareness, cautious practice, and a mix of resilience and ongoing concern for safety.

Supports and Resources

What support and changes do respondents think would help RMTs and massage therapy students deal with these issues?

- Respondents reported a range of impacts from harassment and assault, from short-term distress to lasting changes in practice and career decisions. Many described anger, violation, emotional strain, and burnout, with some adjusting interactions, limiting patients, or considering leaving the profession.
- Harassment was often normalized or minimized, and personal safety frequently falls on therapists rather than patients, employers, or regulators, contributing to fear, self-doubt, and underreporting.
- There was strong support for comprehensive education and training, including mandatory, trauma-informed instruction for students and post-graduate RMTs.
    - Key areas included:
        - Recognizing predatory behaviour
        - Asserting boundaries
        - De-escalation
        - Documentation
        - Post-incident support
- Scenario-based learning, role-playing, scripts, peer discussions, optional self-defence training, and public education were recommended to build confidence, practical skills, and professional legitimacy.
- Clear professional policies and clinic protocols were seen as essential. Respondents called for:
    - Enforceable zero-tolerance policies
    - Explicit consent language
    - Visible signage
    - The authority to stop treatment, refuse care, discharge patients, or involve police without fear of repercussions
- Systems to document and address repeat offenders were also supported.
- Many highlighted the fear of reporting incidents due to a lack of guidance, potential investigations, and retaliation. Recommendations included:
    - Transparent reporting pathways
    - Legal support
    - Hotlines
    - A regulatory culture that prioritizes therapist safety
- Peer support, mentorship, and institutional backing were emphasized to validate experiences and reduce self-blame.

- Finally, respondents called for systemic and cultural change to address broader societal issues, including gender dynamics and misconceptions about massage therapy. Public awareness campaigns, stricter enforcement against illicit practitioners, and consistent messaging to affirm the professional identity of RMTs were recommended.
- Overall, a profession-wide approach combining education, policies, practical safety measures, regulatory support, and public awareness was seen as essential to ensure therapists' safety, dignity, and respect.

Additional Resources

If you require support, please reach out to a trusted friend, family member, colleague, or one of the following services:

- Ontario Coalition of Rape Crisis Centres: **https://sexualassaultsupport.ca**
- ON Network of SA/Domestic Violence Treatment Centres: 416-323-7327 | **https://www.sadvtreatmentcentres.ca**
- Victim Support Line (Ontario): 1-888-579-2888
- Assaulted Women's Help Line: 1-866-863-0511 (Mobile: #SAFE)
- Male Survivors Support: 1-866-887-0015
- Trans Lifeline: 1-877-330-6366
- Possibility Seeds: **With CARE: Resources to Attend to and Address Sexual Harassment in Ontario Workplaces**