REVIEW ARTICLE

Reflextherapy in Healthcare – Reflection on Audit Result and Employment of Therapy

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Abstract

An article was published in 2014[1] reporting on an audit of the Membership of the Association of Chartered Physiotherapists in Reflextherapy (ACPIRT). This article reflects on the outcome of the audit in the context of a treatment tool in physiotherapy and allied health professions in the United Kingdom and abroad.
Background: ACPIRT was established in 1992 by Christine Jones, physiotherapist, and associated colleagues to provide a clinical interest group for physiotherapists and allied health professionals practising reflextherapy (RT), a manual therapy applied to the feet (or hands) similar and akin to *reflexology*. The audit was carried out in 2009 to establish a professional profile of members and to document their clinical experiences in using RT in healthcare.
Methodology: 161 ACPIRT members were sent a postal questionnaire (including a stamped return envelope) regarding their experience using RT treating patients in the NHS and/or in private practice. One hundred (62%) members responded.
A pilot study was carried out prior to the main enquiry including 14 ACPIRT committee members. Their results were included in the final audit result.
Aims: i) To describe members' demographics, work environments and opinions of the value of RT in healthcare.
ii) To describe the historical background and development of RT to become an accepted therapeutic intervention by the Chartered Society of Physiotherapy.
Results: Sixty-eight respondents (68%) considered RT 'very good', 'good' and 'as good as' orthodox physiotherapy. Fifty-eight respondents (58%) thought RT had a 25% placebo effect. No one considered RT to have a 100% placebo effect. Overwhelmingly, 95 respondents (95%) reported '**relaxation**', '**reduced stress'** and '**reduced pain**' as main benefits of the treatment. A few respondents reported 'increased fertility', 'improved bowel function' and 'reduced appetite'. Comments were made on the future of RT and recommendation for a Foundation Course. The results showed a mature, highly experienced professional membership with a female gender bias.

Keywords: Reflextherapy, RT, ACPIRT, Audit, Physiotherapy, Allied Health Professionals

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Purpose

The purpose of this paper is to reflect on an unorthodox method of treatment, Reflextherapy (RT), which was introduced to allied health professionals by physiotherapist Christine Jones in the 1990s to facilitate and improve general healthcare. ACPIRT, the Association of Chartered Physiotherapists in Reflextherapy, was established and approved by the Chartered Society of Physiotherapy (CSP) in 1992 to act as a clinical interest group for physiotherapists and allied health professionals.

One hundred physiotherapists and allied health professionals responded to an invitation to participate in an audit carried out by the ACPIRT to investigate the application of RT in healthcare settings in the United Kingdom and abroad in 2009. This paper reflects on the results from the audit including opinions and experiences of its members in their employment of RT in clinical settings and its inherent value to patients.

Introduction

‘**Reflextherapy’** (**RT**) takes its origins from reflexology, which is a therapy used to enhance well-being in people by massaging and applying acupressure on the feet.[2] Hands, ears and head can be used as an alternative. Reflexology was introduced to the UK by Doreen Bayly (State Registered Nurse - SRN) in the 1960s. Simultaneously, Lis Andersen, physiotherapist, published *Zonterapi* in Denmark, and then Hanne Marquardt (SRN) established ‘Reflexotherapy’ for health professionals in Germany in the 1980s. Furthermore, Ann Lett (SRN) published *Reflex Zone Therapy for Health Professionals*[3] in 2000 in the UK. In 2001, the House of Lords Select Committee on Science and Technology reported on complementary and alternative medicine, stating that reflexology pertains to the second most often used group of therapies to complement conventional medicine.[4]

Christine Jones founded The Midland School of Reflextherapy, which commenced education of physiotherapists interested in this form of therapy. RT is based on the orthodox theory and practical application of reflexology but adapted with reasoning of treating all body systems (urinary tract, circulatory, nervous, musculo-skeletal, gastric systems) in a methodical sequence.

Jones, with her colleagues, proposed to use ‘*reflextherapy*’ as an umbrella term for all forms of foot treatments pertaining to reflexology in the context of physiotherapy and allied health professionals. They argued that RT defined and portrayed the intervention as a practical application (therapy) rather than just a theory, *‘-ology’*, of the subject. Historically, ‘reflexology’ is the description of a foot massage technique described in the 1930s in the United States by Eunice Ingham,[2] who in turn described the Fitzgerald/Bowers[5] duo to be the originators of ‘reflexology’. They experimented with pressure on the skin to relieve pain. Scant ancient documents suggest Egyptian and Chinese use of foot treatments to provide good health and to solve physical and mental ailments. Since its introduction in the 1930s, reflexology has been taught by a plethora of schools of reflexology with varying professional backgrounds such as Lis Anderson (Physiotherapist), Doreen Bayly (SRN), Harry Bressler (Doctor of Chiropractic, Naturopathic Doctor), John Cross (PhD), Inge Dougans, Suzanne Enzer (SRN), Ann Gillanders, MajLis Hagenmalm (SRN), Christine Jones (FCSP), Kevin and Barbara Kunz, Ann Lett (SRN), Peter Mackereth (SRN), Hanne Marquardt (SRN), Clive O’Hara (SRN), Nicco Pauli (physiotherapist), Tony Porter, Joe Riley (Dr), Jane Sheehan, Carol Samuel (PhD),

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Chris Stormer, Denise Tiran (SRN), Lynne Booth, Robert St Cross and many more. Each school has an individual approach to teaching the theory and practical elements of reflexology but with a communal acceptance of the original proposals made by Eunice Ingham.

Christine Jones established recognition of RT/reflexology as a valid therapeutic intervention by the CSP in 1992. While the main part of the ACPIRT membership were physiotherapists, the association was open to other allied health professionals and had over 200 members at its height.

The UK's CSP describes an audit as a tool to measure best available evidence to inform practice and to share effective physiotherapy practice (SEPP).[6] In addition, an audit may provide a baseline for knowledge to improve patient care. The audit of the ACPIRT describes the demographics and recognises the professional commitment of its members to healthcare delivery and identifies areas of future improvements and concerns.

Methodology: The postal questionnaire was designed by an audit team that included the ACPIRT committee members and Research Officer, two Clinical Audit & Research Governance Facilitators from Hampshire Primary Care Trust, and the Project Lead. The questionnaires were sent with stamped return envelopes to all (n=161) members of the ACPIRT in the United Kingdom and overseas. One hundred (62%) completed questionnaires were returned. The final report was compiled by the Project Lead.

Results

Age (n=100):

The majority of members were between 31 and 60 years old.

- 21–30 - 2 (2%)
- 31–50 - 33 (33%)
- 51–60 - 41 (41%)
- 61–70 – 18 (18%)
- Over 70 - 6 (6%)

Gender:

Female: 99

Male: 1

Professional qualifications

83 respondents were qualified physiotherapists.

There was a high proportion of academic and 'further education' qualifications within the membership. See Table 1.

Table 1: Academic qualifications among ACPIRT members

Academic qualifications among ACPIRT members	
GradDipPhys	56 (56%)
BSc / BA	12 (12%)
MSc	2 (2%)
PhD	1 (1%)
Other higher educational training	29 (29%)
Some members may have more than one academic qualification and that academic degree is not always within the medical faculty.	

As the ACPIRT was open to allied health professionals, there was in fact alternate professional representation among the responders. See Table 2.

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Table 2: Other allied health professionals

Other allied health professionals	
Qualified nurses	12 (12%)
Midwives	4 (4%)
Occupational therapist	2(2%)
Health visitor	1(1%)
Radiographer	1(1%)
Other (lecturer)	Not identified

Employment status

73 (73%) were employed physiotherapists
4 (4%) were retired physiotherapists
3 (3%) did not answer
20 (20%) were other allied health workers, employment status not recorded

The qualified physiotherapists had extensive professional experience working in the UK as far north as the Isle of Skye to Guernsey in the south. Some members responded from the United States, Australia, New Zealand and South Africa.

Twenty-seven members had been **practising physiotherapy** for more than 35 years.

Almost half had been qualified physiotherapists for more than 20 years.

Twelve of the employed physiotherapists had been qualified physiotherapists for less than 5 years.

A little more than half (55) of the physiotherapists worked in private practice and 29 were employed by the National Health Service in the UK. Sixty-four members had been **practising RT** for more than 11 years.

Physiotherapy specialism (n=100)

All aspects of medicine and healthcare were represented in the question of 'Physiotherapy specialism'. The respondents would have applied their RT skills in any of these areas demonstrating a global application of RT. One respondent may have applied RT in more than one specialism. See Table 3.

Table 3. Healthcare specialisms

Healthcare specialism	**Respondents n=100**
Musculo-skeletal	40
Sports injuries	15
Neurology	14
Mental health/Learning disability	13
Orthopaedics	12
Medicine for the elderly	12
Paediatrics	10
Women's health & maternity	6
Palliative care	5
Long-term care	5
Chronic pain	4
Respiratory care	2
Amputee rehab	2
Obesity & weight management	1
Other	9

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(There may be an overlap in respondents working in more than one specialist area)

Patient numbers

In one year, 87 working respondents treated approximately 28,000 patients, of which 8,855 (32%) patients received RT. Members also treated family and friends in addition to the patient ratio.

Treatment outcomes

The respondents used various outcome measures to assess patients' progress having received RT, such as:

Verbal questioning	81	respondents
Active joint movement	45	
Visual Analogue Scale	37	
(VAS)	34	
Functional testing	20	
Pain diary	19	
Quality of living questions	10	
Goniometer	4	
MYMOP*	4	
Questioning/feedback	3	
Own assessment tool	2	
None	1	
Elderly Mobility Chart	1	
Through GP		

*MYMOP – Measure Yourself Medical Outcomes

RT outcomes vs orthodox treatments

Members were asked to compare RT outcomes with outcomes from orthodox treatments, which seemed favourable in 68 respondents thinking RT was '*very good'*, '*good*', '*as good as'*. Twenty-six respondents (26%) did not answer this question but no one said it compared '*very poorly'*.

Treatment methodology

Frequency

For 46 respondents (46%), the average number of treatments for a complete course was 3–5 treatments. For 25 respondents (25%), the average number was 6–9 treatments. Ten respondents left this question unanswered.

Length of treatment session

Commonly, patients were offered a 45-minute appointment on a weekly basis. A quarter of respondents treated their patients for 1–2 sessions per month. Nearly one-third (31) of the respondents saw their patients on request. Only 4 respondents allotted a 10-minute appointment to see their patient. Eight respondents did not answer this question.

Benefits of RT

Overwhelmingly, the responding members reported enthusiasm from patients having received RT. They felt a sense of 'improved general health' and 'function ability'. See Table 4.

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Table 4: Benefits reported by patients to respondents

Benefits of RT reported by patients to **Respondents**	
Benefit	**Respondents**
Relaxation	**95 /100**
Less stress	**87** /100
Reduced pain	**86** /100
Better sleep	77 /100
Improved health	70 /100
Increased function	67 /100
Increased mobility	63 /100
Self-help/awareness	13/100
Increased fertility	6/100
Improved bowel function	2/100
Reduced appetite	1/100

Respondent opinion of RT as treatment modality

More than two-thirds (68) of respondents reported RT to be 'very good', 'good', 'as good as' an orthodox physiotherapy intervention. Members reported positive experiences using RT in their practice, with managers commenting:

"My own doctor says I save the NHS cash because he can stop or reduce medicines."

"This is how I became a reflexologist. I asked if we could have a reflexologist in to see if it worked and was told it was 'mumbo jumbo', so I qualified and went on to do an ethically approved pilot study to see if there were any indications of benefits to the patients. There were, so then I was able to use it at my discretion with patients. In any doubt about medical conditions, our consultant is very supportive."

This was in contrast to negative experiences by practitioners using RT:

"As a nurse I experienced this and have not been able to treat patients."

"One manager did not allow it on religious grounds (her belief)".

RT and the placebo effect

Members were asked to consider 'the placebo effect' as part of the outcome from RT treatment.

58 (58%) respondents thought RT had **25%** placebo effect.

21 (21%) respondents thought RT had **50%** placebo effect.

5 (5%) respondents thought RT had **75%** placebo effect.

0 (0%) respondents thought RT had **100%** placebo effect.

9 (9%) did not reply.

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Additional complementary therapies

The respondents had experience of a wide field of 'other complementary therapies' used in their practice such as Acupuncture, Aromatherapy, Homeopathy, Hypnotherapy, Reiki, Shiatsu, Tai Qi and others.

Named term

Reflextherapy **compared with** ***Reflexology***

Members were asked to compare the term *Reflextherapy* with *Reflexology*. This created much debate and comments from the respondents. Founders of ACPIRT had decided to call the foot treatment *reflextherapy* instead of *reflexology* to highlight the context in which the therapy was carried out, i.e. a professional therapist carries out a 'therapy', while '-ology' indicates a theory of that subject.

There was a 50:50 split in the opinion as to whether this was a correct approach or not. Some members still considered *reflexology* a better term for the treatment as:

"*It is a term understood by most of the public – variations can confuse*"

in contrast with:

"*Reflextherapy is reflexology practised by the medically qualified: this can also be a hindrance as well as an advantage"*

as well as

"*Anyone can be a reflexologist – we have an academic education and can integrate and apply appropriate interventions to meet the needs of the patient."*

Discussion

Reflextherapy has been an integrated therapy in physiotherapy treatments since 1992. It is also considered a complementary therapy.[7] 'Hands-on' therapies were the mainstay of physiotherapy practice for many years and *massage* was considered a beneficial therapeutic intervention.[8] Priorities in physiotherapy practices have taken a different direction requiring 'evidence-based practice' to maintain a professional profile that satisfies modern interventions. Meta-analysis and well-conducted research are recommended to ensure treatment effectiveness. Reflextherapy falls short of this requirement but well-conducted pilot studies and a plethora of multi-cohort case studies have nevertheless been published to support the use of RT by health professionals in healthcare.

Reflections on this audit certainly advocate the use of RT in healthcare by health professionals who have considerable experience in both clinical and academic work in equal measure. The audit highlights a wide range of cohorts of patients wherein physiotherapists consider RT to be 'very good', 'good' or 'as good as' orthodox physiotherapy interventions. Most respondents achieve good outcomes in terms of relaxation and stress reduction as well as reducing pain levels in their patients based on thousands of treatment episodes. These observations are valid and support RT in our healthcare system today. Palliative care is another crucial area where RT can play a comforting role as well as facilitating easing of symptoms.[9] Phantom limb pain has been studied by Brown & Lido[10] in a pilot study assessing phantom pain levels before and after treatment which, again, offers valuable innovative approaches (foot treatment) to enigmatic pain profiles. Musculo-skeletal chronic neck pain was investigated by Udy in a double-blind pilot study involving 10 volunteers.[11] While both groups experienced reduced pain levels, the treatment group gained more pain relief compared with the controls using an adapted form of RT named Adapted Reflextherapy (AdRx). Furthermore, RT can be effectively used in ICU wards where unconscious patients remain in a supine position for extended periods.[12]

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The present worldwide pandemic has focused our attention on the importance of 'touch' in recovery, reassurance and comfort of patients. Gentle touch performed on the feet, as carried out in RT, justifies its valuable intervention in times of crisis.

Questions were asked in the audit about future training requirements and aspirations. One of them was the proposal of a Foundation Course in RT for physiotherapists and Allied Health Professionals. Although the Foundation Course is suspended presently, 2 training courses were run successfully with high student satisfaction. This audit supports the use of an unorthodox physiotherapy treatment. Unfortunately, hesitant managers in clinics and departments are reluctant to support prospective candidates to train in reflextherapy resulting in a shortage of students for the Foundation Course.

The ACPIRT audit reflects a female bias. In case of female vs male medical students, findings from this audit supports the findings of Greenfield, Brown, et al., (2006)[13] that females have a higher interest in Complementary and Alternative Medicines (CAM) than do male students. The audit found a paucity of younger members which may reflect a dwindling interest in manual therapies at time of audit. Professional requests for 'evidence-based practice' inhibit young practitioners to adopt a training in alternative methods on both financial and ethical grounds. The audit highlights extensive professional and employment experience of existing members which may reflect an individual realisation of shortcomings in an existing knowledge base urging a therapeutic curiosity and learning. This realisation becomes perhaps more apparent with increased age. Basically, you want to learn more and be more qualified. As a young qualified allied health professional, you are content with existing knowledge. However, with increased experience a realisation occurs that further education is needed to fulfil patients' needs and your own curiosity. Aspects of complementary therapies may fill that knowledge gap.

This audit highlights and supports the breadth of RT application in the context of healthcare. For many health professionals, they consider RT to be an integrated therapy in their professional work.

The ACPIRT was discontinued in 2014 because the membership dropped below the viable numbers (100) required by the Chartered Society of Physiotherapy for existing clinical interest groups. Ex-members are still working using RT to complement therapeutic interventions.

Post-script:
"As from March 2021 the Chartered Society of Physiotherapy, CSP, no longer recognize Reflextherapy as part of physiotherapy practice."

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