

How safe is the practice of Reflexology?

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This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key messages

There is a huge amount of empirical but very little scientific research on the practice of reflexology. There has been no systematic review carried out to assess the safety of reflexology.

- It is obvious that there is a need for more research in this area.
- A literature review carried out in 1997 did not document any side effects or adverse events from the use of reflexology
- Users and practitioners need to be aware of the healing crisis that may occur after reflexology treatment, in order to recognise and manage the symptoms
- It is important to remember that harm may not be in physical form alone but may be manifested as emotional harm or failure to seek more appropriate treatment.



Who requested this rapid response?

This document was prepared in response to a specific question from a policy maker in Uganda.

! This rapid response includes:

- Key findings from research
- Considerations about the relevance of this research for health system decisions in Uganda

X Not included:

- Policy or practice related recommendations
- Detailed descriptions

What is SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.

www.evipnet.org/sure

Glossary

of terms used in this report:

www.evipnet.org/sure/rr/glossary

Background

Reflexology is a therapeutic method of relieving pain by stimulating predefined pressure points on the feet and hands. This controlled pressure alleviates the source of the discomfort. In the absence of any particular ailment, reflexology is thought to promote good health and for prevent illness and relieve symptoms of stress and injury illness (Norman Laura and Thomas Cowan, 1989).

Reflexologists work from maps of predefined pressure points that are located on the hands and feet. These pressure points are reputed to connect directly through the nervous system and affect the bodily organs and glands. The reflexologist manipulates the pressure points according to specific techniques of reflexology therapy. By means of this touching therapy, any part of the body that is the source of pain, illness, or potential debility is said to be strengthened through the application of pressure at the respective foot or hand location.

The popularity of clinical reflexology has increased in the recent years in the countries that have always practised the intervention and those new to it, with up to 33% of individuals using it in some settings (E. Ernst, 2000). However the ethical, legal and safety issues have not been studied extensively. Several studies have been done to establish the prevalence, efficacy and effectiveness of reflexology but not much has been done to study its safety. This is probably because reflexology is non invasive and only considered relaxing and harmless (Peter A. Mackereth, 2002). However it is generally agreed that any therapy or treatment that has the potential to be of benefit also has the potential to be harmful if used inappropriately (Peter A. Mackereth, 2002). Reflexology like any other therapy is expected to be of benefit to the clients or should in the very least cause effect with no harm at all; this is what underlies the ethical principles of beneficence and non-maleficence respectively.

There is a huge amount of empirical but very little scientific research on the practice of reflexology. There has been no systematic review carried out to assess the safety of reflexology, however a literature review done in 1997 (Edzard Ernst and Kersin Koder, 1997) is one of the few studies that has attempted a comprehensive look at the facts

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

What the quality of evidence (GRADE) means

The quality of the evidence is a judgement about the extent to which we can be confident that the findings of the research are correct. These judgements are made using the GRADE framework, and are provided for each outcome. The judgements are based on the type of study design (randomised trials versus observational studies), the risk of bias, the consistency of the results across studies, and the precision of the overall findings across studies. For each outcome, the quality of the evidence is rated as high, moderate, low or very low using the definitions below.

⊕⊕⊕⊕

High: We are confident that the true effect lies close to what was found in the research.

⊕⊕⊕○

Moderate: The true effect is likely to be close to what was found, but there is a possibility that it is substantially different.

⊕⊕○○

Low: The true effect may be substantially different from what was found.

⊕○○○

Very low: We are very uncertain about the effect.

For more information about GRADE:

www.evipnet.org/sure

about reflexology including safety. Several single studies looking at reflexology have also been found but these laid more emphasis on effectiveness than safety (Mei-Yeh Wang et al., Bamigboye AA and Smyth RMD, 2010).

This paper will present the findings on safety from the literature review mentioned above. It is however, evident that there is need for further research in the area of safety of reflexology and especially in relation to the African population and setting.

What we found

An overview of reflexology. Edzard Ernst, Kerstin Köder							
Objectives: Main questions asked: <ul style="list-style-type: none"> • How prevalent is reflexology • Is it effective • Is it safe • Is it cost-effective • 							
Methods: <ul style="list-style-type: none"> • Medline and CISCOC computerized literature searches • All professional organizations in US, UK, Germany asked to contribute original articles • Experts in the field consulted 							
First author (year)	Condition	Design	Intervention	Primary outcome	Result of Primary outcome	Result of Secondary outcome (safety)*	Follow up period
Engquist (1977)	Patients after cholecystectomy	RCT	Conventional care + foot reflexology vs conventional care	Blood cortisol levels	No intergroup difference	No adverse effects reported	None
Thomas (1977)	Patients with signs of anxiety	NRCT	Daily foot reflexology vs daily reassurance vs no intervention	Self assessed anxiety level	Drop in anxiety in reflexology group	No adverse effects reported	None
Lafuente (1990)	Headache	RCT (single blinded)	Foot reflexology + oral placebo vs arm massage + daily oral Flunarizin	Intensity and duration of headache	No intergroup differences	No adverse effects reported	3 mths
Petersen (1992)	Asthma	RCT	Conventional care + foot reflexology vs conventional care alone	Symptoms recorded in patients diary, use of medication, objective parameters of pulmonary function	No intergroup differences	No adverse effects reported	6 mths
Eichelberger (1993)	Post-operative care	NRCT	Conventional care + foot reflexology vs conventional care alone	Medication for tonisation of bladder	Fewer drugs were given in the reflexology group but no statistical evaluation was done	No adverse effects reported	Not known
Oleson (1993)	PMS	RCT	Ear, hand and foot reflexology vs placebo reflexology	Score of 38 PMS symptoms recorded in patient's diary	Symptom decrease in intervention group significantly greater than in placebo group	No adverse effects reported	4 mths

Wang (1993)	Type II Diabetes	RCT	Daily foot reflexology vs no reflexology	Blood sugar levels and other variables	Blood sugar and other variables normalized in the experimental group only	No adverse effects reported	Not known
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*No adverse events means an attempt was made to look for these by the studies and none were noted during the study and follow up periods.

Following reflexology therapy it has been shown from several case studies and reports that patients may experience what is referred to as a healing crisis (Griffiths, 1996, Mackereth PA., 1999). This is an apparent sign of detoxification thought to be a result of the gentle pressure that leads to the breakdown and elimination of calcium and uric acid deposits on the nerve endings of the foot. These deposits are originally thought to be caused by malfunction of an organ. Healing is thought to happen after this healing crisis. Symptoms of the healing crisis include the following and in some cases these may be serious enough to warrant further management probably using formal or conventional medical methods:

- Flu-like symptoms
- Light headedness
- Feeling very cold 3-4 days post treatment
- Increase in excretory functions
- A fall in blood pressure
- Lethargy
- Enhanced or altered sleep pattern

It is important however, that practitioners are aware of these and are able to manage them or know when to refer to other health care practitioners.

Conclusion

The limited information available suggests that reflexology though beneficial is not without harm. When considering reflexology, it is important to realise that it might not necessarily be physical harm but it can also be emotional damage or anything that would prevent the users from seeking more appropriate treatment. This rapid response has identified a major gap in that the safety of reflexology has not been well researched yet.

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Conflicts of interest

None known.

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This Rapid Response should be cited as

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The Regional East African Community Health-Policy Initiative (REACH) links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States. www.eac.int/health



The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available. www.evipnet.org