

Title

A phenomenological investigation of reflexologists' attitudes, beliefs and experiences concerning the use of reflexology for people seeking treatment for crack cocaine abuse.

Aim of the investigation

The purpose of this study is to gain an understanding from a group of expert reflexologists in how they justify using reflexology as an adjunct to orthodox treatment of crack cocaine users. This small-scale research project will be undertaken as part of an MSc (Health) and is being funded by an Enterprise Award granted by the Department of Health. The study will be supervised by Dr Barbara Steward (Honorary senior lecturer, University of East Anglia).

Background and introduction

Crack cocaine is produced in the UK from imported cocaine and is associated with intense psychological dependence (Platt, 1997). It disrupts the metabolism and distribution of neurotransmitters such as adrenaline, dopamine and serotonin which gives the user a feeling of intense euphoria, reduced fatigue and creates a sense of mental acuity (Stahl, 2000). Taken in high doses, it can produce undesirable effects such as anxiety, paranoia and hallucinations as well as cardiac and respiratory symptoms (Robson, 1994). Evidence that the use of crack cocaine is growing is demonstrated by the Regional Drug Misuse Database for the northwest of England, showing a nine-fold increase in cocaine use since 1990 and more than half being used in the form of 'crack' (Sievwright et al, 2000). The Home Office (2000) have also reported an upsurge in recent seizures of 'crack', which although not reaching the proportions predicted based on cocaine use in the USA (Donmall et al, 1995), is causing problems in the UK (Bean, 1993), associated with property and violent crimes, breakdown and deterioration in social relationships, social crises and homelessness (National Treatment Agency for Substance Misuse, 2002).

Despite these effects there is a lack of specific treatment for 'crack' users, with the majority of services geared towards treating opiate addicts and users also reporting that services are unsuitable for their needs (Sievwright et al, 2000). Providing care is problematic because many users only seek help when they are in crisis and they commonly use a variety of other substances such as alcohol and heroin to reduce withdrawal symptoms (Platt, 1997). A recent longitudinal study recruited a cohort of one hundred 'crack' users from a specialist drug centre during an eighteen-month period. Semi-structured interviews were used in order to identify effective forms of treatment and gain an understanding of patterns of crack cocaine use. Findings indicated that treatment services do not address the needs of the user and therefore development of mechanisms to encourage users to complete treatment programmes is important (Harocopos et al 2003).

Evidence suggests that psychological therapies in the treatment of crack cocaine dependence are more effective than pharmaceutical therapies (Platt, 1997). For example, research from the USA (Simpson et al, 1999) show that cognitive behavioural therapy approaches with sympathetic counsellors, combined with low waiting times and ongoing aftercare can be effective. Although various medications have been used to improve symptoms associated with 'crack' abuse, such as antidepressants, there is currently no compelling evidence to support their use (Witton

& Ashton, 2002). Treatment needs to address two primary goals; initiation of abstinence and prevention of relapse and no single treatment package has been demonstrated to achieve this (National Treatment Agency for Substance Misuse, 2002). The Government has recognised this dilemma and is currently funding research into assessing the most effective forms of treatment for this group. This is being led by the National Treatment Agency for Substance Misuse, which is a special health authority set up in 2001 in order to increase the availability, capacity and effectiveness of treatment for drug misuse in England.

Complementary and alternative medicine

Complementary and Alternative Medicine (CAM) includes various therapies, such as acupuncture and shiatsu, which embrace a holistic approach to treatment (Endacott, 1993). The term complementary relates to the use of these therapies being given as an adjunct to orthodox medicine and alternative relates to the use of those, which are used in place of orthodox medicine, but they are often used synchronously (Kassab & Stevensen, 1996; Milton, 1998). A brief explanation of reflexology and the possible theories relating to its use will now be discussed.

Reflexology

Although a uniform definition of reflexology does not appear to exist (Ernst, 1997), it is based on the principle that the whole body is represented in the foot and by applying specific pressure to the feet (less commonly to the hands), it stimulates reflexes causing a reaction in the corresponding part of the body (Crane, 1997). Despite its popularity the mechanism of reflexology remains unclear (Mackereth & Tiran, 2002). Various theories have been postulated and these appear to be based on either eastern or western approaches to health or a combination of both. For instance eastern philosophy assumes that the body contains energy channels called meridians through which subtle energy flows. An example of a western approach includes the hypotheses that reflexology releases endorphins and enkephalins, which are the body's natural painkillers and mood enhancers (Mackereth & Tiran, 2002). However, these and other theories stated in the literature (Crane, 1997; Mackereth & Tiran, 2002) are unproven and consequently there is no scientific rationale for reflexology (Ernst, 1997). It has been suggested though, that the therapeutic relationship and the nurturing physical contact play a significant role in the healing process (Mackereth & Tiran, 2002).

Reflexology is used to treat a diversity of conditions, particularly those that are chronic in nature such as back pain, arthritis pain, gastrointestinal symptoms, menstrual problems and migraine (Botting, 1997) and it is widely used in palliative care (Mackereth & Tiran 2002). Reflexology is also becoming more popular as a therapeutic intervention for those experiencing mental health problems such as stress, anxiety and depression (Mackereth & Tiran, 2002). Although anecdotal evidence supports its use, there is a paucity of good quality published research (Botting, 1997).

Research has been undertaken to validate the use of reflexology to treat emotional problems. Trousdell's (1996) study recruited a sample of fifteen mentally ill women who were offered eight weekly sessions of reflexology. Semi-structured interviews and focus groups were used to establish whether or not reflexology helped to increase feelings of well-being and reduce stress. A noticeable reaction was experienced by 80% of participants between the first and fifth session, which included both emotional

and physical responses. The majority of patients felt relaxed, energised and an improvement in self-esteem was experienced. These positive results are less impressive than they appear, as there are several flaws in the study including researcher bias and uncertain data collection and analysis methods. Similar results were obtained with a larger group of psychiatric patients attending a day centre, when a mixed methodology was also used to establish the physical, mental, emotional and spiritual effects of reflexology (Trousdel & Uphoff-Chmielnik, 1997). Again, the study lacks rigour.

One pilot study (Boyd et al, 2001) explored the feasibility of providing and evaluating the effects of reflexology on clients with severe and enduring mental health problems. Six clients were randomly selected and offered a course of six reflexology treatments. Data were collected from semi-structured interviews and two validated psycho-social ratings scales completed at the start and end of the reflexology course. Only two participants completed the full course of treatment. Two core themes emerged, which included identification of the difficulties in researching this client group and that touch was found to be very beneficial.

Despite the lack of evidence of effectiveness the use of CAM has grown significantly during recent years in the management of many medical conditions (Botting, 1997; Lewith et al, 2002) including drug addiction. The Standing Conference on Drug Abuse (1997) found 40% of residential services were providing CAM. A recent postal/email survey found that of those who responded, 55.5% of substance misuse agencies in England used CAM (Thomas, 2004). The most common therapy used was auricular (relating to the ear) acupuncture (56%) with reflexology being used by 18%.

The National Treatment Agency for Substance Misuse (2002) however, declared that the evidence base for the use of CAM in the treatment of drug addiction remains inconclusive or contradictory and it is difficult to isolate its impact from other interventions. Effectiveness may be due more to the care and attention, which may attract drug users into treatment services (Task Force to Review Services for Drug Misusers, 1996). Much of the evidence focuses on the use of auricular acupuncture (National Treatment Agency for Substance Misuse, 2002).

The use of auricular acupuncture for the treatment of addiction has grown substantially during the last decade in both the USA and UK and is being used with many crack cocaine users (Killeen et al, 2002). A recent study by Margolin et al, (2002) using a sample of six-hundred and twenty in a single blind randomised trial, tested the efficacy of using auricular acupuncture as an aid to reduce cocaine use. Patients were randomly assigned to receive auricular acupuncture, sham auricular acupuncture (pretence of acupuncture), or a relaxation control condition. Treatments were given five times per week for eight weeks with concurrent drug counselling. Results showed an overall reduction in cocaine use, but with no differences between each condition.

The empirical evidence to support the use of reflexology in the treatment of drug addiction is negligible. In 1996 a small quantitative study was performed in China, involving the application of hand and foot reflexology in conjunction with acupressure, to treat thirteen patients addicted to opium derived substances (Chongguo, 1996). The authors claimed 100% effectiveness; three of the patient's

withdrawal symptoms being eliminated after one treatment while the remaining ten required further courses, some with additional therapies, including tranquillisers. The quality of this study is poor, furthermore the findings are likely to have been distorted during translation from Chinese into English. Gardiner (1997) suggests that both reflexology and auricular acupuncture had a calming effect and reduced the withdrawal symptoms of his clients who were treated at a chemical dependency unit in Canada.

Despite the paucity of evidence, users themselves have indicated that they value CAM and it appears to enhance client retention and improve treatment compliance (Burns, 1999; Russell et al, 2000; Gurevich et al, 1996). This is especially important for 'crack' users who usually present for treatment in crisis and require an urgent response (National Treatment Agency for Substance Misuse, 2002). So while the evidence generally lacks rigour and depth, there is a wealth of anecdotal evidence to suggest that reflexology is an effective form of CAM (Griffiths, 1996). However, there appears to be a lack of understanding of how reflexology achieves its effectiveness and the benefits it can offer.

Personal motivation for undertaking this study

My own experience in treating patients with reflexology suggests it is beneficial. I was involved in giving reflexology to a group of twelve prison inmates on a voluntary basis over a three-month period four years ago, with the intention of helping them to relax. Some of these had been imprisoned due to drug related offences and at least half of these had been using heroin or cocaine. It was difficult to establish whether they were accessing drugs while in prison. Treatments consisted of a short initial interview followed by a thirty minutes of reflexology. A total of twenty-three treatments were given overall, with a maximum of three sessions per individual. Their feedback was positive with many inmates expressing a feeling of well being during and following their treatment. This prompted me to examine the use of reflexology in community drug treatment centres where it appeared to be both popular and beneficial, particularly with crack cocaine users (Thomas, 2003). However, there was no evidence to show its effectiveness.

One charity-based, specialist crisis centre in London offers reflexology as an adjunct therapy for crack cocaine users. Having used CAM on an ad hoc basis previously, in 2002 they became the first centre in the country to run accredited courses for reflexology. After reading an article about this (Thomas, 2003), I made contact with the author and was invited to attend this centre. During a meeting with the management, it was agreed that my proposed study (outlined below) could take place there pending ethical approval. I had considered interviewing crack cocaine users to find out their experiences of receiving reflexology, but because this group are difficult to access I decided to interview the reflexologists that treat them. The gatekeeper agreed to provide the names of at least six reflexologists who had trained there, who would be willing to take part in this study and would be likely to be able to provide data in order to answer the following research question.

Research Question

This enquiry aims to gain an understanding of the theory and practice of reflexologists who give (or have given) reflexology to crack cocaine users in relation to:

- How they describe their practice and define its effectiveness.

- What specific beliefs or evidence they offer for the effectiveness of reflexology in the treatment of crack cocaine users.

It aims to answer the question, "How do reflexologists describe and evaluate the palliative and curative effects of reflexology with crack cocaine users?"

Design

This study is a qualitative, inductive enquiry using a phenomenological approach, appropriate for the exploration of unknown values, attitudes and beliefs. A Hermeneutic approach to phenomenology was chosen as it seeks to explore and obtain a deeper understanding of people's experiences of their lived worlds using an organic flexible, data driven, process (Denzin & Lincoln, 1998). This requires the researcher to be reflective, insightful, sensitive to language and continually open to experience (Mason, 2002). It is directed towards revealing the meaning of a phenomenon as the person experiences it and is based on the philosophy that there is no single reality, as individuals have their own unique experience (Laverty, 2003). It uses in-depth interviews that allow participants to communicate openly (Morse, 1994) and generally uses small, purposefully selected participant numbers (Patton, 1990). This approach is congruent with the aim of this study, which is to provide a collective overview of the perceptions of six reflexologists who treat (or have treated) crack cocaine users.

As is usual in phenomenological enquiry, personal presuppositions are made explicit before the study commences in order to clarify potential bias. In this case the researcher as a reflexologist with personal experience in this field is likely to identify with the reflexologists' experiences, which will have implications for this research. Although this may be viewed negatively in positivist research, it is considered a valued, accepted method in this form of naturalistic enquiry (Morse, 1994). In fact the biases and assumptions of the researcher are embedded and are essential to the interpretive process (Laverty, 2003). The use of a field diary and reflexive journal will be used to record observations, personal feelings and thoughts which will add trustworthiness and bring deeper meaning to the study (DePoy & Gitlin, 1993).

Participants

Six reflexologists will be selected from the list provided by 'The training centre.' This amount is appropriate due to the time restraints of this study and will provide a richness of data by in-depth interviewing, which relies on quality rather than volume (Bowling, 2000). A nominated person from 'The training centre' has agreed to maintain communication with the researcher via telephone and email for the duration of this research project. Some reflexologists may not be working with 'crack' users when the research is performed but because their experiences of working at 'The training centre' will be recent, they are likely to relate easily to these. Further names will be obtained from the gatekeeper should any reflexologist decline to take part to ensure that the target number of six will be interviewed.

Inclusion/exclusion criteria

The inclusion criteria are that all reflexologists have undertaken specialist training at 'The training centre' since 2002, having used reflexology to treat crack cocaine users. There are no exclusion criteria, apart from excluding those that decline to take part in the study.

Ethical consideration

'The training centre' is a charity outside the NHS, therefore ethical approval will be sought from the University of East Anglia as agreed by the management board of the centre. The participants need to know that the information they give will be handled in a sensitive and constructive manner (Bowling, 2000). Therefore interviews will be held in private and all data collected will be kept in a locked cabinet at the researchers home. Data will be made anonymous by using codes so only the researcher knows the identity of the participants and this information will be kept separately from the main data. It may not be possible for complete anonymity to be guaranteed. This is due to the small number of participants having trained in a small organisation and the possibility that certain imparted information will be recognised by the team. Even if participants cannot be identified individually, they can be identified as a group. Furthermore, even if 'The training centre' is not named in any publication, it could easily be identifiable. Therefore the participants and the management of 'The training centre' will be made aware of this at the outset of the project. At this stage it has not been established whether to name 'The training centre' in any publication, although the management have agreed to be named, provided they have the opportunity to veto material before it is published. Participants will be made aware that they may leave the study at any time without prejudice. An information sheet (see appendix 2) outlining all aspects of the study with the consent form (see appendix 3) will be sent to six reflexologists once ethical approval has been granted. If they agree to take part, they will be required to sign and date the consent form and return it in the pre-paid envelope. Should anyone decline to take part, this process will be repeated until six participants have been established. All data relating to subjects will be destroyed at the end of the research project and the Protection Act 1984 will be adhered to.

Procedure

Once participant consent has been granted the reflexologists will be contacted and appointments will be made for them to attend an interview. This will take place at 'The training centre.' In the unlikely event that a participant lives outside London, the interview will be performed in a mutually agreed venue. Before the interview commences each participant will have a chance to ask further questions about the procedure, then they will re-sign and date the consent form as will the researcher. Each interview will take approximately one hour and will be taped. Initially, to direct the focus of the interview and to facilitate a rapport, participants will be asked to narrate how they became involved in using reflexology with 'crack users', followed by a semi-structured interview.

Three main topics will be explored, although other themes may become apparent during the interview.

- How participants see reflexology being practiced with this client group.
- How they perceive the user's response to receiving reflexology.
- Their beliefs around the effectiveness of using reflexology with crack cocaine users.

These topics are likely to incorporate the physical, emotional, psychological and spiritual aspects of this treatment.

Full verbatim transcriptions will be made as soon as possible following each interview, after which preliminary analysis will take place. A summary of the emerging themes from their own interview will be posted to each participant within a

month of the interview. A week or two later the researcher will telephone each participant to discuss these findings for participant validation and to comment on the interpretation, allowing them to become collaborators in the research project (DePoy & Gitlin, 1993). If preferred a written response of the summary can be returned using the reply paid envelope. Their responses will be recorded in note form and used to update the data, so further coding may be necessary.

Plan of analysis

The transcripts will be read along with the researcher field notes and data will be organised by topic and coded. Themes will be identified as they emerge, grounded in what was said by the participant (Bowling, 2000). Data analysis will be performed manually. The findings will be reported in such a way as to preserve the essence of the lived experiences of the reflexologists' and these will be explored and debated. Particular points made about a lived experience will be reported from the information given by the participants in the form of direct quotes (DePoy & Gitlin, 1993). A written report will be offered to all participants and to the management of 'The training centre.'

Bowling (2000) discusses the importance of rigour in qualitative research, which include the concepts of reliability and validity. In essence reliability refers to the extent in which data are replicable or consistent (Bowling, 2000) and validity relates to the extent to which measures such as codes, themes and categories are truly represented in a way that they are supposed to be represented (Mason, 2002).

Therefore the researcher will employ the following procedures:

- Personal views will be made explicit at the start and throughout the study, which will be conducted in a systematic way.
- A field diary will be used to describe and interpret personal experiences as a researcher, which will offer material for reflection throughout the study.
- Participants will be asked to comment on the researchers interpretation of emerging themes following data collection.

The employment of a reflexology colleague to read the transcripts for confirmation of coding and themes was considered. However, this idea was rejected due to limited resources.

Timetable

The research project will be undertaken in a year in line with usual dissertation guidelines. An outline of the anticipated timetable has been set out below.

Date	Action
April 2004	Literature review & critical appraisal. Send research proposal to ethics committee.
May 2004	Await ethical approval. Continue literature review and critical appraisal.
June 2004	Contact potential participants to arrange interviews. Send letters outlining the study and obtain written consent. Arrange venue for interviews.
July/August/September 2004	Perform data collection, transcriptions. Send summary of emerging themes to participants for comments on interpretation. Continue coding and analysis.
October/November/December 2004	Continue coding and analysis.
January/February/March 2005	Write dissertation and edit as required. Submit dissertation by date required.

Financial aspects

The research will be performed for the purpose of a dissertation for an MSc (Health) at the University of East Anglia. An Enterprise Award of £2,918 from the Department of Health has been granted to fund the study. No payment will be given to the participants but travelling expenses will be reimbursed.

Summaries of the anticipated costs are given in the table below.

Item	Cost
MSc Module Fees	£980
Travel costs to UEA and parking	£560
Train tickets	£208
Participant travel costs	£100
Accommodation costs	£180
Academic supervision	£500
Telephone/postage	£100
Tape recorder/batteries	£70
Photocopying/printing/stationery	£100
Books/library/journals	£120
Total cost	£2,918

Discussion

Difficulties may arise during any process of this research project (DePoy & Gitlin, 1993). I anticipate that my main problems will be in arranging suitable times for data collection. I will therefore need to be flexible with appointment times and undertake the interviews as soon as possible once the project gets underway (This may involve staying overnight depending on appointment times). As with all methodologies, limitations exist (Portney & Watkins, 2000). The main restriction of this study is that all participants have been selected from only one training centre, which is likely to have adopted a specific approach to treating 'crack' users with reflexology and therefore inference about the findings will be limited. However, it is envisaged that the findings of this under researched area will have implications for my own practice as a reflexologist and for other reflexologists working in this field. It is likely that the participants of this study will also benefit. It is hoped the findings will enlighten reflexology practitioners, inform practice and encourage further research in this area. A further study could involve interviewing 'crack' users to establish their interpretation of the effectiveness of reflexology and to compare this with the reflexologists' experiences.

The researcher will attempt to publish the results of the study in reflexology and CAM journals and also present the findings at both CAM and drug conferences. The researcher has already been approached to publish this research proposal on the newly formed Association for Complementary Healthcare Practice with Substance Misusers website (<http://achpsm.org.uk>) whose main aim is to promote the development of complementary healthcare in the UK substance misuse field. It is therefore also likely that the results of this study will be published on this website.

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APPENDIX 1

CORE QUESTIONS FOR SEMI STRUCTURED INTERVIEW

To find out what are the perceptions, experiences and expectations of reflexologists in relation to their treatment of crack cocaine users.

- How do they describe their practice and define its effectiveness?
- What specific beliefs do they offer for the effectiveness of reflexology in the treatment of crack cocaine users?

Can you tell me (briefly) about how you became involved in treating crack cocaine users with reflexology?

Can you explain what you do during a typical reflexology treatment of a crack cocaine user?

Can you tell me what you believe is happening to the client when you give a reflexology treatment?

How do the clients respond to having reflexology?

APPENDIX 2

REFLEXOLOGISTS' INFORMATION SHEET

Research Question

This enquiry aims to gain an understanding of the theory and practice of reflexologists who give (or have given) reflexology to crack cocaine users in relation to:

- How they describe their practice and define its effectiveness.
- What specific beliefs or evidence they offer for the effectiveness of reflexology in the treatment of crack cocaine users.

It aims to answer the question, "How do reflexologists describe and evaluate the palliative and curative effects of reflexology with crack cocaine users?"

Invitation: You are invited to take part in the above research project. Before you make a decision, it is important that you take time to read this information sheet so you understand fully what is expected of you. Please feel free to discuss this with anyone if you wish. Make sure you ask the researcher about anything which is not clear to you. [For a leaflet entitled 'Medical Research and You' which may answer your questions and offers further information, contact Consumers for Ethics in Research (CERES), PO Box 1365, London, N16 0BW. Also available online: www.ceres.org.uk].

What is the purpose of this study? Evidence that the use of crack cocaine is growing is demonstrated by the Regional Drug Misuse Database for the northwest of England, showing a nine-fold increase in cocaine use since 1990 and more than half being used in the form of 'crack'. The Home Office have also reported an upsurge in recent seizures of 'crack', which although not reaching the proportions predicted based on cocaine use in the USA, is causing problems in the UK, associated with property and violent crimes, breakdown and deterioration in social relationships, social crises and homelessness. Despite this problem there is a lack of treatment available for crack cocaine abusers with the majority of drug treatment services geared mainly towards heroin users.

Surveys and censuses have indicated that Complementary and Alternative Medicine (CAM) is increasingly being used in the treatment of drug addiction. Many drug treatment centres are now offering complementary therapies to their amphetamine and crack cocaine users. However, The National Treatment Agency for Substance Misuse declares that the evidence base for the use of CAM remains inconclusive or contradictory. Despite this lack of evidence, the clients themselves have indicated that they value these forms of treatment. It has been shown to enhance client retention and improve treatment compliance. This is especially important for 'crack' users who tend to present in acute crisis and require an almost immediate response if they are to be kept in treatment.

With the current crack cocaine problem and the perceived lack of available treatment for abusers it is apparent that treatment programmes should be improved. Evidence suggests that CAM and reflexology are widely used by substance misuse agencies and are also popular amongst users. This has been demonstrated to encourage users into

treatment programmes of which they are more likely to complete. Although the use of reflexology is not supported scientifically in this area, anecdotally it has been demonstrated to be effective. It is hoped the findings of this study will enlighten practitioners, inform practice and encourage further research in this area.

Why have you been chosen? You have been chosen to take part in this research because you have been trained to work with drug abusers (including crack cocaine) using reflexology at “██████████”. You are therefore likely to have views, experiences and perceptions about treating these individuals.

Do you have to take part? No, taking part is voluntary. If you would like to take part, you will be asked to read this information sheet and will need to sign the attached consent form. Even if you take part and then decide you no longer wish to remain in the study, you will be able to withdraw at any time without giving a reason.

What will happen to you if you take part? If you agree to take part in this research project, you will be considered for a place as a research participant. Six participants from a list provided by “██████████” will be invited to attend for an interview with the researcher. This will take place in private in a room at “██████████” or if you live outside London, this will be performed in a mutually agreed venue.

What will you have to do? You will attend an interview with the researcher when you will be asked to describe your practice of reflexology in relation to treating crack cocaine users. You will also be asked to talk about your beliefs and experiences with regards to its effectiveness. This interview will be taped and later transcribed by the researcher. A written summary of the transcript will be sent to you within a month. This will be followed a week or two later, by a telephone call from the researcher to obtain your comments regarding this. If this is at an inconvenient time, a telephone appointment can be made to discuss this. Alternatively, you may send a written response of the summary using the reply paid envelope. Your response will enable the researcher to update this information and this will be incorporated with information from your fellow participants to draw up a collective general analysis of your views.

What are the possible disadvantages and risks of taking part? You may feel uncomfortable talking openly about your views during the interview and may fear being individually identified as a source of information. Please be reassured that all information will be handled with sensitivity.

What are the possible benefits of taking part? By taking part in the project, you will be helping the researcher and it is hoped the findings will enlighten reflexology practitioners, inform practice and encourage further research in this area.

Will you taking part in this study be kept confidential? All information collected during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed, so that you cannot be identified from it. Some of what you say may be written as direct quotes, but this will not be linked to your name. Confidentiality will be attempted, but it is not possible to guarantee this completely. This is due to the small number of reflexologists being

interviewed, and therefore it may be possible for individual's comments to be identified from fellow participants and the staff at "[REDACTED]". Furthermore, whether "[REDACTED]" is made anonymous or named in any publication, there is also a possibility that you may be identifiable.

What happens to the information I give out during the interview? The interviews will be taped and this information will be used for this research project. The researcher will also make hand written notes during the interview to support what is said. This data will later be analysed and written up as part of an MSc (Health) dissertation. It is also envisaged that the findings will be published (see next paragraph).

What will happen to the results of the research study? The findings of the study will be written up in an academic way, so that other researchers can interpret the study. It will reflect a clear understanding of the experiences and views reported. It is envisaged that an attempt to publish the findings will be made, for example, in reflexology and drug addiction journals, with the possibility of other journals if appropriate. It is also likely that the findings may be presented at conferences relating to this subject and may also appear on relevant websites.

All participants will be offered a summary of the findings and a copy will be given to the management of "[REDACTED]" and to the organisation that funded this research. The main reason for the researcher undertaking this study is as part of an MSc and it will therefore be read by the tutors of this course and by the researcher's academic supervisor.

Who is organising and funding the research? Funding is through an Enterprise Award. This has been paid to the researcher from the Department of Health to undertake this small-scale study as part of an MSc (Health).

Who has reviewed the study? The University of East Anglia Ethics Committee has reviewed this study. They have given permission for the study to go ahead as the research proposal is ethically sound [Subject to approval].

About the researcher: Anne Perkins is a trained nurse and reflexologist and has experience of giving reflexology in the prison setting. She is presently undertaking an MSc (Health) at the University of East Anglia and this research project will form the basis of a dissertation undertaken in the final year of her course. Her academic supervisor, Dr Barbara Steward (Honorary senior lecturer, University of East Anglia) will be giving her guidance and support throughout the study.

Contact for further information: For further information and answers to any questions you may have, please write to the researcher, Anne Perkins via the University:

Post Graduate Training Programme Office, Queens Building, University of East Anglia, Norwich, NR4 7TJ.

What do I do now? Thank you for taking time to read this information sheet. If you decide to take part in this study please sign and date the consent form as indicated and return it in the stamped addressed envelope. If the researcher does not hear from you within two weeks, she will contact you by telephone or email to see if you still want to take part in the study, but please feel free to decline if you wish and you do not need to give an explanation for doing so. If you wish to proceed, you will be contacted by telephone or email and invited to attend an interview. This will take place at “██████████” if you live in the London area, or at a mutually agreed venue if you live elsewhere. (Your travelling expenses will be reimbursed). A mutually convenient appointment time will be arranged for the interview. Before this takes place, you will have a chance to ask further questions then you will be asked to re-sign and date the consent form with the researcher. You will need to keep a copy of this in a safe place, and preferably with the ‘Patient information sheet’.

If you would like to discuss this further, please telephone or email Anne who will be pleased to talk to you.

