Health and Place 54 (2018) 69–78

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

"If walls could talk": A photo-elicitation-based observation of service users' perceptions of the care setting and of its influence on the therapeutic alliance in addiction treatment

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ARTICLE INFO

Keywords:
Therapeutic alliance
substance use
addiction
photo-elicitation
place of care
care setting

ABSTRACT

A good quality therapeutic alliance is central to the support and treatment of people who use psychoactive substances. Although previous research has suggested that place has an important role in sustaining the therapeutic alliance, this issue has been insufficiently explored in the field of addiction treatment. We conducted a qualitative study using photo-elicitation and interviewing service users in an outpatient addiction treatment centre. They reported both strongly positive and negative perceptions of the place, alongside an unstable therapeutic alliance. Apprehending the place in which care is delivered as a dynamic relational network helps to understand the role of place in shaping the therapeutic alliance in addiction treatment. There is a need for careful design and layout, and thoughtful organisation of these places.

1. Introduction

A good therapeutic alliance is perceived as a key to the healing process. In the scientific literature, it is usually defined as mutual commitment in a care relationship on the part of both the patient and the professional (Bordin, 1979). These approaches to the therapeutic alliance derive from classic views of the interpersonal doctor-patient and psychotherapist-client relationship. They focus on the cognitions and emotions experienced on either side, and reciprocal perceptions of trustworthiness, competence or compliance (Ardito and Rabellino, 2011). During recent decades, the literature has reported considerable data on the positive role of a good therapeutic alliance in patient satisfaction, compliance and retention in treatment, and health outcomes (Martin et al., 2000). In particular, Meier et al. (2005) showed that an early therapeutic alliance is a consistent predictor of commitment and retention in addiction treatment. In this field, the therapeutic alliance is also known to be difficult to establish and to maintain over time (Livingston et al., 2012; Oser et al., 2013).

The effects of the quality of the interpersonal bonds on the quality of care are therefore well documented in addiction treatment, and some authors have shown that this empirical relationship can be moderated by other variables, such as style of management (Broome et al., 2009), working climate and the symbolic and financial recognition of professional functions (Joe et al., 2007), suggesting that environmental characteristics of the therapeutic alliance should also be considered when exploring its nature. The place in which care is provided is precisely where the care relationship emerges, within a network of environmental contingencies (Fenner, 2011). But to date, very little attention has been paid to the role of place in the establishment of a good therapeutic alliance.

The architectural design, the topography and the spatial organisation of the care setting appear to have a significant impact on the quality of services provided for patients, and they could have an important role in the establishment of a good-quality therapeutic alliance. Previous research on architecture and interior design applied to healthcare has shown that the health service premises, and the way they are integrated into the natural and urban environment, contribute to patient well-being (Beauchemin and Hays, 1998). Thus, the concept of a "therapeutic landscape" suggested by Gesler (1992) refers to natural or man-made locations that are associated with the experiences of recovery or well-being. This concept has proved useful to demonstrate the effects of the care environment on care quality and patient

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https://doi.org/10.1016/j.healthplace.2018.09.007
Received 10 May 2018; Received in revised form 14 August 2018; Accepted 10 September 2018

satisfaction, for example in reference to the GP's surgery (Tièche et al., 2016), hospital waiting rooms (Biddiss et al., 2014), or intensive care settings (Sundberg et al., 2017). It has also been applied to the analysis of the relationship entertained by healthcare professionals with their working environment (Andrews, 2004; Mroczek et al., 2005). Studies in sociology and anthropology have underlined the power relationships that can surface in the use and appropriation of space by patients and professionals (Ferreira and Fainzang, 2004; Goffman, 1968; Moon et al., 2006) and the deterioration in the therapeutic alliance that can result (Zhou and Grady, 2016). In contrast, the refurbishment of care premises in a manner that is suited to the contemporary needs of service users, families and professionals could significantly improve the therapeutic alliance (Kotzer et al., 2011; Rice et al., 2008).

As such, the concept of the "therapeutic landscape" refers to the effects of the environment on individual wellbeing, and more marginally on the quality of the therapeutic alliance. But in most cases, it apprehends the environment as an external influence on the interpersonal relationship. This concept has been discussed and criticised, and it has been argued that it puts too much emphasis on the distinction between the environment and the interpersonal relationship, and that the role of place in the interplay of bonds between social agents should be conceived in a more "relational" manner.

Duff's concept of "enabling places" (Duff, 2011) focuses on the process of "making" places through a network of interactions between human actors and non-human "actants". On the basis of the work by the philosopher Gilles Deleuze and the sociologist Bruno Latour, Duff describes the actor-network interrelation as originating places that can support renewed capacities and agencies. In this perspective, human actors do not discover places but rather create them through their mutual interactions and their interactions with non-human elements such as objects, instruments, plans, logics and procedures. Depending on the quality of the dynamics of these interactions, social, affective and material resources can emerge, giving places their "enabling" properties.

In the same school of thought, French psychiatrists belonging to the "Institutional care" movement have proposed that places are potent substrates of identification and symbolic projection, and that shaping and moulding them contributes considerably to the care of in-patients. Tosquelles (1967), Guattari and Deleuze, (2003) or Racamier (1993) in the 1950s and 1960s, or Anzieu (1990) more recently, have suggested that patient care relies on the constant interactions between place, patient, professionals and society. In several places of care these theorists have implemented specific symbolic and practical devices intended to have an impact on care delivery, patients, professionals and place without distinction. This clinical project has been criticised for its political and philosophical underpinnings, but it nevertheless had considerable influence on the design and functioning of places dedicated to the care of patients with mental problems in France, and this strongly supports the idea that place in itself is at the heart of the dynamic of the therapeutic alliance and the relationship.

In an earlier article (Reyre et al., 2014) we considered research in the areas of psychology and psychoanalysis, and also economics, sociology and philosophy to establish a conceptual framework capturing the complexity of the therapeutic alliance and the whole range of facilitating and limiting factors that seem to have an effect on it. We focused on 1) the ability of healthcare professionals to sustain the therapeutic alliance by acting on themselves, and 2) the role of the conception and design of the place in which care is delivered, and the way in which service users and professionals appropriate such places. We then conducted a qualitative study among professionals to try to describe the different ways in which the therapeutic alliance can be sustained in the area of addiction treatment, in particular by way of specific training and responsible self-care, alongside a democratic organisation of the healthcare premises (Reyre et al., 2017). In the course of the analysis, several themes relating to the appropriation of place by service users and professionals emerged, but the lack of saturation of the data for these themes made it impossible to integrate them into the theoretical model.

We thus decided to design and conduct a second study aiming to gain a better understanding of the role of place in the care of service users in addiction treatment. Considering the complexity of the research question and the scarcity of the available literature on the subject, we chose a qualitative methodology to observe the perceptions that service users have of their place of care, and to describe the enabling characteristics and the influence of the setting on the establishment of a good quality therapeutic alliance.

2. Methods

2.1. Approach, characteristics and reflexivity among researchers

This study was designed by a research group focusing on the exploration of the care relationship in the area of addiction and on the evaluation of interventions aiming to improve the quality of the therapeutic alliance (Larguèche et al., 2011). This group performed a first qualitative, multi-centre study on the experience of professionals in addiction treatment (Reyre et al., 2017). With training in mixed methods, the group favours triangulation in the design of its studies (Malterud, 2001). Thus, different viewpoints are sought, alongside a range of narrative mediation techniques (passive and active perusal of extracts from novels, viewing of film extracts, photo-elicitation etc) accompanied by analyses. In addition, since the group is made up of professionals in addiction care, particular emphasis is placed by the researchers on reflexivity, so as to avoid analysis biases linked to their proximity with the object under study. Thus, researchers involved in this part of the study were asked to note down their preconceptions on the object of study, and the results they would expect, before moving into the study proper. A field notebook also enabled them to note down their personal observations and impressions on the research interviews. Finally, the research group received supervision sessions with a psychologist specialised in qualitative research, whose role was to bring to light and discuss the effects of subjectivity on the part of researchers on the conduct of the study and the analysis of results.

2.2. Context and sampling

The field setting chosen for the research was a centre for outpatient care and prevention in the area of addiction (CSAPA) located in the Paris area. In the French public system for the accompaniment of individuals with problematic psychoactive substance use, the CSAPA centres are medico-psycho-social facilities offering social services and outpatient healthcare, and also taking on missions of harm reduction. The location for the study was chosen because it pioneered addiction treatment in France and served as a model for the design of the current outpatient healthcare system and was therefore characteristic of the French context. This facility is located within the walls of a small general hospital, close to an important railway station in a quite dense urban area. It has a dedicated entrance and is connected to a small garden where patients treated in the hospital can walk out, and to other services such as the cafeteria. Participants were recruited successively in the facility by a researcher (JB) between March 1st and June 30th, 2014. On the basis of best-practice recommendations (Creswell, 1998; Smith, 2011) and our previous experience, the required number of participants to reach a satisfactory level of data saturation (when new discourse collected does not provide any notable enrichment of the emerging set of results) was expected to be from 7 to 15. The inclusion criteria were: age 18 or over, current follow-up in the CSAPA, and the ability to undertake an interview in French. Non-inclusion criteria were: attendance at a first consultation, obvious signs of acute intoxication or withdrawal symptoms, and subjects waiting for emergency hospitalisation, since these situations would not have enabled the subjects to feel comfortable with the interview. Informed signed