“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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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 (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 (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 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. François Tosquelles (Tosquelles, 1967), Felix Guattari (Guattari and Deleuze, 2003) or Paul-Claude Racamier (Racamier, 1993) in the 1950s and 1960s, or Didier Anzieu (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 (Author 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 (Author 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 (Author et al., 2011). This group performed a first qualitative, multi-centre study on the experience of professionals in addiction treatment (Author 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 (Author) between March 1st and June 30th 2014. On the basis of best-practice recommendations (Cresswell 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 consent was required of service users for participation in the study, for the

recording of the interviews and for the use of their photographs for research publication. The study received CEERB Paris Nord (IRB) approval (N-13-016, 2013).

2.3-Tools

The participants' socio-demographic data (age, gender, profession, occupational status, educational level, substance use motivating the care provision, ongoing opioid substitution treatment, time in treatment) were collected using a dedicated questionnaire. Participants in research, and more particularly individuals questioned on their experiences in care can have difficulty in putting their emotions into words and in spontaneously giving their opinions in the setting of a face-to-face interview. Various strategies, such as narrative, art-based or visual approaches have been conceived, partly to circumvent this difficulty (Denzin and Lincoln, 2017). For instance, in an exploration of the role of the room where psychotherapies occur, Fenner (Fenner, 2011) conducted art-based interviews of participants to ensure rich data collection. We chose a comparable participatory approach based on a visual mediation method to facilitate the interviews. Visual mediation methods differ from visual methods in that they focus on discourse facilitated by images and not on images themselves. These methods are designed to produce verbal data rather than visual data and the images serve as illustrations helping to understand the context of the discourse rather than forming the material to be analysed. Photo-elicitation, a method that was developed in the social and anthropological sciences (Collier and Collier, 1986; Rose, 2013), consists in introducing photographs into research interviews (Harper, 2002). "It is a tool and methodology to engage patients, improve communication under difficult circumstances, and achieve person-centered care. [Furthermore] it allows patients to bring their expertise into the clinical setting and teach clinicians" (Lorenz and Chilingerian, 2011). In practice, photographs are provided by the researcher and/or the participant, or produced by the participant. They are used during an interview to facilitate discourse, the researcher encouraging the participant to alternate between descriptive comments on the images and more personal accounts of the meaning the participant draws from the images. The interest of this visual mediation in qualitative research is well documented today (Clark-Ibánez, 2004; Guillemin and Drew, 2010). Some members of the research group (Author, Author) had previous experience of the method, since it was used in two earlier studies on adolescent psychopathologies (Author et al., 2012a, 2012b). The choice of this method made it possible for us to: 1) collect verbatim arising within a relationship between participant and researcher, 2) help the participant put his/her experiences and intense affects into words, and 3) valorise and make use of the participants' relational styles, giving them empowerment in the

research interview. A digital camera and a portable computer were used to take the photographs and to view them immediately afterwards.

2.4-Conduct of the Study

On the occasion of encounters with the CSAPA team, information sheets explaining the research were made available to service users at the entrance desk in the centre. A researcher (Author) was then posted in the waiting room so as to enter into contact with service users and ask them to participate in the study. Once formal consent and socio-demographic data was collected from participants, the interviews took place in a quiet room generally used for consultations, without any predefined duration, but remaining compatible with the opening hours of the centre and the availability of the participant. No compensation was offered to the participants.

First of all, the participant was asked to "take photos of the different places here" with a digital camera that was lent to him/her. Participants were told that the photographs could concern "a room or a particular significant detail" for him/her from personal experience of care delivery. The researcher did not interfere with the taking of the photographs but remained at the participant's disposal to help him/her to use the camera and access the different areas. These moments, and the preliminary discussions in the waiting room turned out to be privileged opportunities to build a trustful relationship with the participants before beginning the interviews. The time devoted to taking the photos was not limited and lasted 10 to 25 minutes. The interview started with the viewing of all the photos. The participant was then asked to choose two of them, which were used for the rest of the interview. For each photo, the following were explored: 1) the choice of the place photographed, 2) the choice of any particular view (composition, framing, colours etc), 3) the emotions felt when viewing it, and 4) any other places associated with the photo or with the emotions felt. Finally, the participant was asked to give a title or to add a legend to each of the photos, and the two chosen photos were confronted. During the interview the researcher endeavoured to follow up the themes raised by the participant, avoiding being over-directive. The interviews were entirely recorded and the verbatim transcribed by a researcher (Author), and all the photos were rendered anonymous at the end of the interview, using image-editing software so as to ensure no individual was identifiable. For the purpose of the present publication, key quotes have been translated by a professional native English-speaking translator aiming to render the meaning, tone and idioms of the discourse as faithfully as possible.

2.5-Data analysis and validity assessment

The transcribed verbatim was analysed using Interpretative Phenomenological Analysis (Smith, 2007, 2004, 2011). This method of discourse analysis was designed to provide an in-depth exploration of the experience of the participant. It combines phenomenological and hermeneutical approaches of discourse in order to achieve the dual purpose of the analysis: reflecting the efforts of "the participants […] trying to make sense of their world; [and of] the researcher […] trying to make sense of the participants trying to make sense of their world" (Smith, 2007). The theory emerging from the analysis is thus the result of a dual reading of the verbatim: a phenomenological reading faithfully extracting the meaningful content of the overt discourse, and an interpretative reading restoring the meaning of the discourse in its context by answering questions such as: "Is something leaking out here that wasn't intended? Do I have a sense of something going on here that maybe the participants themselves are less aware of?" (Smith, 2007). The choice of a method that is both phenomenological and interpretative seemed to us consistent with our aim to explore the complex relationships between service users, place and the therapeutic alliance. In our study, the transcriptions were analysed independently by three researchers (Author, Author, Author). They were perused several times and annotated to enable the investigators to take in the content and identify units of meaning. In a given interview, and then across interviews, the recurrent themes were identified and grouped in coherent, organised manner into meta-themes reflecting common experiences among participants. Following Smith's recommendations (Smith, 2011), themes were validated when five participants provided discourse related to them (or at least three participants when their contributions to the themes were particularly meaningful). Isolated or divergent discourse was also pinpointed, extracted and analysed. The fact that the analysis was performed by the three researchers was intended to improve the consistency and coherence of the analysis, to ensure that the themes identified were a faithful reflection of the data, and that the analysis was not reduced to a single viewpoint. The results were then discussed in research group meetings. The members of this group also attended the analytic supervision sessions to elaborate the transferance/countertransferance issues for the group, intra and inter-institutions, in the setting of this research activity.

3-Results

3.1-Participants and materials

Ten service users took part in the study. The analysis of the first three interviews yielded the first two meta-themes reported below, which reached saturation after the seventh interview.

Three more interviews were necessary to enrich the data related to the third meta-theme. The socio-demographic characteristics of the participants are given in Table 1. In all, thirty-nine photographs were taken and nineteen were discussed in the interviews. The second photograph by Participant E was not recorded by the camera, and the participant did not wish to repeat it or discuss it without the image. Fifteen photos were taken inside the centre and four outside but within the hospital grounds. Among the indoor photographs, five show an office room and three include professionals. The ten interviews lasted from 30 minutes to 1 hour and 20 minutes.

Tab.1: Sociodemographic characteristics of the participants

Participant	Gender	Age	Profession	Occupational status	Educational level	Substance originally used	OST	Time in treatment (y)
A	M	39	Head waiter	Permanent contract	2 yrs higher education	C	N	17
B	M	53	NS	Unemployed	Baccalauréat	H	Y	7
C	F	52	Secretary	Unemployed	Vocational training	A	N	3
D	M	50	Sound technician	Permanent disability	2 yrs higher education	H; CC	N	15
E	M	34	NS	Permanent disability	Baccalauréat	H; C; A	N	4
F	M	37	Lawyer	Sick leave	6 yrs higher education	A; C	N	0.5
G	F	55	Sales agent	Unemployed	2 yrs higher education	H	Y	0.7
H	F	62	Secretary	Unemployed	Lower secondary diploma	H	Y	30
I	M	44	Engineer	Unemployed	5 yrs higher education	H; C	Y	3.5
J	F	57	Project officer	Permanent contract	5 yrs higher education	H; C	Y	29

NS: not specified; H: heroin; C: cocaine; CC: crack cocaine; A: alcohol; OST: opioid substitution treatment

3.2-Thematic analysis

The general theory organises the themes for which data saturation is reached at the end of the analysis. As a result, the themes related to how participants saw the use of photographs in the study process were not included in the theory. It is thus composed of three meta-themes: (1) a place of refuge and remembrance strengthening the therapeutic alliance, (2) a place of control and confinement that weakens the therapeutic alliance and (3) A place mediating anxiety and damaged images of self. The participants' contributions to the themes are detailed in Table 2.

Tab 2.: Summary of the participants' contributions to the themes

		Participants' contributions									
Meta-themes	**Themes**	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
A place of refuge and remembrance strengthening the therapeutic alliance	A shelter	X	X	X	X	X		X	X	X	X
	A sacred place	X	X			X		XX			XX
	Remembrance	X			XX				XX		
A place of control and confinement that weakens the therapeutic alliance	Confinement	XX			X		XX		X		
	Law enforcement	X	X	X	X		X	X		XX	X
	Control			X	X		XX	X		X	X
A place mediating anxiety and damaged images of self	Disrepair	X				X	XX		X	XX	
	Anxiety	X		X	X	XX	X		X		XX

X: contribution to the theme; XX: particularly meaningful contribution to the theme

3.2.1. A place of refuge and remembrance strengthening the therapeutic alliance

Fig.1: "Appeasement" (G1) SINGLE-COLUMN FITTING IMAGE

Fig.2: “Remembering” (A1) SINGLE-COLUMN FITTING IMAGE

The place in which care is delivered is frequently seen as a welcoming place, and also very strongly as a protective and “sacred” place, in the manner of a sanctuary or a maternal womb.

One participant compared the entrance desk area to the desk of a hotel reception:

> *“It’s as if you were in a hotel... there are hotels that have the same layout at the entrance, like it is here” (B1).*

Another participant used the metaphor of the womb when referring to the entrance space:

> *“As I am one of the first 52 patients, it’s as if – well, I’ve become a chronic fixture... Yes... [name of the centre] was a big womb” (J1).*

This metaphor of the womb can also be suggested in the description of the warm atmosphere of the toilets by a female participant:

> *“Yes, it was a lamp in a room, a light, a ceiling light that was red [...] that lights the toilets and gives a sort of gentle, cosy light [...] But afterwards, I found out (laughs) that the red colour, cosy and not very bright, had a particular purpose, which was to stop people from injecting... inside the toilets, but I thought it was really nice and relaxing and cosy – it’s true – I really like it” (G1; Fig.1: “Appeasement”).*

One participant used the metaphor of a sanctuary when talking about the entrance area shown in the photograph entitled “Glimpsed moment at the entrance of [name of the centre]”, a sanctified place that needs to be protected:

> Participant: *“It’s a photo taken in a place where you are really about to... on the edge of the ultra-sanctuary area”.*
>
> Researcher: *“Sanctuary?”*
>
> Participant: *“Yes, hospitals, they’re sanctuaries, they aren’t not just any old place you can be in. [...] A sanctuary, it’s a place where violence is forbidden, where all violence*

is forbidden [...] It's like the first snow, it's virgin, it's a place where you don't want... well when I am faced with a stretch of snow, I don't want to walk across it, I don't want to make marks on it, I don't want to put my mark, I don't want to... I wouldn't go and tag it" (E1).

The consultation rooms were the rooms most often photographed. The "sanctuary" dimension of place is also found in the image of the confessional, characterising both the place itself and the type of relationship deployed there:

"Even so, it's like a confessional... I mean you are inside 4 walls and you tell things... your whole life, really, even the most private things and all that, so really, the walls… if they could talk, hold secrets [...]. You confess every week to a priest, and it's the same sort of thing with the psychologist, in fact – forgive me father because I have sinned – and then you tell about your life, all the wrong things you've done... it's the same really" (A2).

The place of care also appears as a place of memory or remembrance, apparently especially for participants who have long been users of the place. One female participant chose to photograph a painting on the wall, because *"it's a painting painted by a patient" (H1),* an object that remains, even after the service users are no longer there. She also photographed the statue in the courtyard, which she called *"We remember you" (H2).*

Memory is an object of the relationship that is deployed within the place. This memory or remembrance appears to be traded between service users and professionals, and in the intermediate spaces between outside reality and the space of care. Thus, one participant told how he would go to the hospital cafeteria after his appointment in the CSAPA for moment of remembering and writing. He explained how this time prepared him for a return to everyday life after his psychotherapy appointment, enabling him to *"exorcise"* his demons and rumination, and thus "lightening" the psychotherapy session:

"Often what I do after the consultation, I go to the cafeteria for a coffee, to read the paper and write... about myself... to remember later on, putting it down on paper, any old how [...] your problems... negative thoughts or dark ideas... while in the consultation, I won't necessarily bring up only negative things" (D1).

Another participant, commenting on his photograph named "Remembering", explained that for him the hospital grounds had a memory function: the memory of ordeals in his life and the efforts made to break the dependence. He explained that he felt the need, at critical moments in

his later life, to return to the place associated with his experiences of hospitalisation in the hope of halting his addictive course:

> *"And then I started over again, I started on the same bad course and I needed to come back here... I think you need to always come back to the same place to remember where you've come from, it's a sort of reminder... I needed to come back to remember more, so that what I'd lived through before would help me get better... and to think about it – 'take care, if you continue you can still come back here'" (A1; Fig.2: "Remembering").*

3.2.2. A place of control and confinement that weakens the therapeutic alliance

Fig.3: "*Parloir*" (prison visiting room) (F2) SINGLE-COLUMN FITTING IMAGE

Fig.4: "Doorless toilets" (G2) SINGLE-COLUMN FITTING IMAGE

References to a form of restriction of freedom and to an austere, prison or police environment were present in nine interviews. The centre was compared to a police station, a prison and a cage. Sometimes it was material elements in the place that recalled these places of confinement:

> *"That's the entrance door – grim and dismal, so there it is... and the posters aren't well done, they're not properly fixed, the door is damaged [...] in prisons you get the same sort of administrative notices, not properly posted on the doors" (F1).*
>
> *"It seems to me that even in the most sordid prosecution courts I've not seen a room like this... so, well, it's an odd sort of office... yes, you have this sort of desk – I'm telling you it's true – if you go there (I don't advise it, though), but if you do some day – well, if you go to Fresnes, the Fresnes prison, you have visiting rooms that look like that, the same colour, the same design of chair, the same type of table... it's no fun, in prison, it's not nice (...) now I just find it ugly... well, yes, it's still grim, it's a grim place" (F2; Fig.3: "Parloir").*

One female participant chose to photograph "Doorless toilets" (the title she gave) also recalling the prison setting:

> *"So that's the toilets in the care dispensary, which have no door... generally, when people go for a urine test, the staff wait outside in the corridor, they leave you... so the fact it has no door, what's the point? It's all wrong!" (G2; Fig.4: "Doorless toilets").*

Other participants stressed the pokiness of the small, rather cramped premises and the inhospitable atmosphere of the different places:

> *"It's true that for someone coming here for the first time, in this poky little cage... well... it's not easy" (A2).*
>
> *"Well, it's more like a police station for me – the layout, the chair, the computer, it's a bit cramped" (B2).*
>
> *"Even the window doesn't do away with the closed-in aspect of the room. It looks a bit lost, or not in its place... It's the room, its general atmosphere... so it could just as well open onto a blank wall" (F2).*

On other occasions, the characteristics of the place pervade the images that the participants give of their relationships with the professionals:

> *"It's like a parloir* (prison visiting room), *really. it'll do, even if it's not very welcoming [...] it does favour the spoken word [...] 'parloir', yes, that's the word, because talking*

is the only thing you do there... but even though I've been coming here for a long time, I have a... it's still a place apart, where you uncover your whole life" (A2).

"That's the place where the interviews are held, the consultations. You can hardly imagine anything more neutral! A table, two chairs a bit of light from the ceiling... you could be in an interrogation room, with the police" (I2).

On the subject of this same photograph ("The interview room"), the participant pursued the comparison with the police interrogation setting by associating it with his negative experiences in the delivery of opiate substitute treatments:

"At the start of the treatment they tell you to come in every day, it's very demanding, like having to report to the police [...] you could say it's like that, in fact, a police thing, nearly the same, a bit bigger, and with more people waiting!" (I2).

On the same theme, a female participant photographed the statue in the courtyard near the entrance to the CSAPA and entitled it "The one I love". She explained:

"For example, when you start in substitution treatment they tell you you have to come back... you have to come back often, and, well a lot of people are put out by that... It didn't bother me... I even said 'even if I had to come on my knees and kiss the feet of a statue every day, I would do it, because I have no choice'... It's nothing compared to getting the dope every day... and the statue, this one is nice and square, too, which is why it symbolises substitution treatment [...] it sets boundaries, boundaries that I need, rigid enough and flexible enough for me to manage to stay alive" (J1).

The constraints of the issue of substitution treatment via the centre appeared for the first of these two participants as something to be mistrusted, an obligation that was set within a game of power and control. For the second, it appeared more acceptable, a continuity from the addictive logic. The symbolisation by the statue shifts from the image of an idol or dictatorial framework to that of a structuring framework, supporting and helping to survive.

3.2.3. A place mediating anxiety and damaged images of self

Fig.5: “The one I love” (J1) SINGLE-COLUMN FITTING IMAGE

Fig.6: “Conversation between two fire extinguishers” (D2) SINGLE-COLUMN FITTING IMAGE

Through the discourse of the participants, it is possible to see the supporting role of place for their self-image and their anxieties. In her comments, one participant identified with the statue she photographed:

> *“There’s shade around [the statue], because there’s always shadow around me – so I act a bit like a squid, I blow ink... the shadow is there because I come with my anxieties... I’m burdened, I have my back-pack with me” (J1; Fig.5: “The one I love”).*

Other participants project images of disorder, dirt, ugliness, poverty and incandescence on the places, seemingly representing their interior life:

"We get into a room in my flat – it's a bit of a mess, but there is no-one to criticise, no judgement – 'hey, what a mess! It's a real mess in your head!' [...] you need at least to vacuum a bit and let a bit of air in... supposing there is a window..." (E1).

"It's small and cramped, it doesn't make you feel easy. You don't feel right. In fact, it's a photo that could look like the state of your thoughts... the walls are yellow, a bit dirty, the table is shoddy, the chairs are hideous [...] there was something in Zola like that, which was really good because there's a heroine who doesn't want the light on because she says – it's a pretty phrase – that she doesn't want to see the colour of her ideas... That sentence says everything, it's so true, so very true, so it's like that, to borrow the phrase, it's like the colour of your ideas, or it is for me at any rate" (F2).

"It's a dialogue between two fire extinguishers... It represents what we do here, we come here to put out the fires inside us... to relieve our anxieties" (D2; Fig.6: "Conversation between two fire extinguishers").

The participants often mentioned their anxieties, and a shared feeling of deterioration and dilapidation:

"Even so, there are people here who are damaged" (I1).

"You have to admit there were people roughed up by life [...] I've met people older than me, with twenty or thirty years of abuse behind them, who were really spent" (A2).

"They are people who are completely destroyed and damaged [...] you come because you're broken [...] we're stoned" (E2).

These representations of anxiety and damage emerged regularly in the interviews, in relation to the photographs of the different places, and in particular the indoor consultation spaces.

4-Discussion

These results show an intense emotional and symbolic investment on the part of service users in their place of care. This investment appears to be polarised at two extremes, the place of care being perceived alternately as a sacred and protective refuge and as a fearsome place of control and reclusion. Place also seems to carry various representations of the users' suffering and of the therapeutic relationship between them and the professionals, sometimes cherished, sometimes disquieting.

The present work contributes to the nascent body of literature dedicated to the role of place in the establishment of a good-quality therapeutic alliance. To our knowledge it is the first to explore this role in the field of addiction treatment. We think that the choice of a relational

theoretical framework and the use of a qualitative method using visual mediation has enabled us to collect rich and diverse data reflecting the complexity of the research question. The focus on our research process, the triangulation and the researchers' reflexivity, and the thorough reporting of the study procedure as well as the satisfactory level of saturation in our results, warrants the claim of good internal validity for our results. However, some limitations should be acknowledged. The study was conducted in a single centre and the discourse collected is necessarily related to the particular characteristics of this specific place. Although this can restrict the transferability of our results, the choice of a long-established typical treatment centre suggests they could be valid for other urban outpatient addiction treatment facilities. Further observation of various types of addiction treatment facilities in other national contexts is needed to enrich our findings. Furthermore, to strengthen internal and external validity of our results, we intended to collect feedback from the participants on our results, but we failed to do so for organisational reasons. We then sought to correct this shortcoming by discussing the results with clinicians in addiction treatment and representatives of service users in academic and informal settings. This led us to further describe the themes related to the place of care as a place of memory, without modifying the overall structure of the theory.

In the present discussion, our results are put in perspective with philosophical and sociological research, and also with psychological conceptualisations. This is in line with the conceptual framework we designed for our research project (Author et al., 2014), and enables us to concomitantly deploy our analysis on the actor-network level, the interpersonal level and the intra-subjective level. The coexistence of strong opposite representations of the place of care, as a refuge and a place of reclusion, is a striking result. It could be expected that the place would be seen as benevolent and protective, in line with the results reported in Fenner's article, according to which places where psychotherapy occurs are filled with objects mediating support, holding capacity and relational attachment (Fenner, 2011). This is so when participants in our study talk about sacred places such as the sanctuary or the maternal womb. But they also give disquieting images of the place as a prison or a cage which can by no means be perceived as a propitious environment for the therapeutic alliance and recovery processes. In a previous study, we suggested that controlling mechanisms and attitudes could hinder the establishment of mutual trust between patients and professionals and therefore weaken the therapeutic alliance (Author et al., 2017). In the participants' discourse, we can see the impressions left by symbolic or practical artefacts, such as the red light in the toilets understood as a means to prevent IV injections, the toilets without a door to secure urine testing for drugs or the closed door covered with rules and instructions. These practices, perceived as controlling by the participants, are

probably not the direct source of their representation of the CSAPA as a place of control, which could stem from their past experiences of confrontation with law enforcement or from their own feelings of alienation. But it seems that these practices can revive these painful experiences. Furthermore, some pieces of furniture (identical to those in police stations or courts because there are common official suppliers for public services) and the bare walls materialise the controlling dimensions of the place in participant discourse. This evokes the disciplinary power brought to light by Michel Foucault (Foucault, 2016 (1980)) and reminds us that the places where care is delivered contribute to the social and moral "normalisation" of service users, even unbeknownst to the care providers. This has been thoroughly studied and reported by sociologists such as Bourgois (Bourgois, 2000) and Szot (Szot, 2015).

The dual nature of place, seen as both risk-ridden and therapeutic in our results, has been described in previous research. In a study examining the role of the environment in the recovery process among alcohol-dependent persons, Shortt (Shortt et al., 2017) showed that the different places they were living in could be risk-prone or therapeutic. These characteristics of the places envisaged were often quite clearly distributed, the home being a refuge and the retail store a risk-prone place. According to the same authors, but in a different manner, natural landscapes could be alternately uplifting or depressing. In our study, both comforting and disquieting perceptions of the place of care apply to the same spaces or objects, as with the statue or the consultation room. The concept of "enabling places" was applied to drug treatment services and harm reduction programs by Duff (Duff, 2010). This author stresses the fact that places are not found but created and recreated in a constant dynamic interaction between human actors and non-human components or "actants". In this relational perspective, places are shaped by the service users, the professionals and their interrelationships, and place shapes them in return. Depending on these interrelationships and the availability of different resources, the same place can thus be alternately protective or risk-prone. This characteristic of "enabling places" accounts very well for the discourse of our participants on their place of care.

Furthermore, Duff describes the resources available (or not) in enabling places as social, material and affective resources. The contribution of the place of care to the social capital of service users is central to the recovery process (Duff, 2010; Evans et al., 2015). On the basis of the results of interviews of individuals attending Managed Alcohol Programs in Canada, Evans highlighted that the feeling of belonging and perceived social support were the central social resources, giving the participants "a reason to care" (Evans et al., 2015). In contrast, in our results the availability of social resources is not patent. Surprisingly, few people appear in the photographs, and there were relatively few mentions of professionals, peers or family members

in the discourse. This could be the consequence of the research design, seeking individual discourse rather than collective discourse, but another hypothesis is that the location of the CSAPA inside the walls of a general hospital tends to isolate the service users from their social environment and limits the development of bonds amongst them. Material and affective resources seem to be easier to mobilise than social resources in this CSAPA. The participants in the study found material enabling resources in information, substitution therapy and medical treatment. Duff underlines that other material resources are less visible but nonetheless meaningful. One example of such resources is the use of the cafeteria by a participant going to sit there after visiting the CSAPA to write down his ideas on paper. According to Duff, hope and trust are affective states/resources generating a desire to change and giving individuals a "willingness or capacity to act" to actually change. In a study on the successive uses of Rotoroa Island in New Zealand as an alcohol treatment facility and a place of collective remembrance, Kearns (Kearns et al., 2014) showed the performative role of hope for the patients/inmates in the first phase and then for visitors. In line with this, hope, in our study, is strongly present in the discourse related to the place of memory helping the person not to stray from his course and enabling a better future to be envisaged. The instability of the participants' perceptions of the place as well as of the various resources more or less available in and around the place aptly illustrates Duff's conceptual framework of a place being "fluid" and relationally modelled by its occupants.

This social and interactional approach to the role of place in healthcare can be prolonged by a more psychological reading of our results. In line with other psychoanalysts, Racamier (Racamier, 1993) argues that places are also recipients of the patients' hopes and anxiety and props and symbols of the therapeutic relationship. In this perspective, we can understand more fully how this relatively well-kept place is perceived by several participants as dirty and dilapidated. The place becomes a kind of interactive screen where the patients project their affects and introject them again, altered by the place. As participant J (J1) explicitly says, the shadows in the place can hide disquieting thoughts, and the raw light can also unleash them. The two fire extinguishers can become a powerful representation of an intense, supportive relationship between a service user and a psychologist. Another useful psychoanalytically originated concept here is the ambivalence of the cohabitation of two (or more) opposite representations and desires in a person's mind (Laplanche and Pontalis, 1974). This is a common rule of our everyday life, but it can become exhausting in certain situations or conditions. The role of ambivalence in the development of an addiction and as a barrier to recovery is well documented (Feldstein Ewing et al., 2016; Shaffer and Simoneau, 2001) and

interventions such as motivational interviewing are designed to address this. The ambivalence of the participants is clear when they talk simultaneously of the place as benevolent and intrusive (participants A, B, G), when the statue figures a protective ancestor and a tyrant (J1) or when substitution treatment is both lifesaving and enslaving. This reading of the results recalls Duff's understanding of place as a relational network linking human actors and non-human "actants". In the psychoanalytical "institutional care" conceptualisation, the therapeutic relationship creates bonds among patients, health-care professionals and the place in a dynamic, constantly moving manner. This can also be illustrated by the conclusion reached by Fenner in her study on the properties of psychotherapeutic settings: "The therapy encounter is active and multi-dimensional, as clients and therapists develop relationships not only with each other but also with material elements of the room for the purpose of support, and embrace place as constitutive in the event of therapy" (Fenner, 2011).

This dynamic of the different relational levels can be further analysed through the perspective of Guattari's philosophical concept of the "three ecologies", and of "vital materialism" according to Jane Bennett. Guattari posits that human and non-human agency is embedded in an environment composed of three ecologies: environmental, social and mental (Guattari, 2000 (1989)). In his views, "processes of subjectivation" are closely linked with the social space and the natural world: the way we think, our intra-subjective life, is dependent on the social network and the concrete natural and man-made world surrounding us. Thus, an alteration of the environment results in alterations in our social and mental experiences. As a philosopher, Guattari urged us to reconsider our ways of thinking/interacting with others and with the environment, in order to preserve our world. As a psychoanalyst, he stressed the importance of acting on the care environment and society at large to help the patients alter their own mental ecology. In the three interdependent ecologies of Guattari's theoretical framework, offering care to people who need it is an ethical and clinical endeavour as well as a political and ecological one. Following Guattari, one could argue that, in the present case, reshaping place through interactions between users, professionals and the resources of the place in order to reduce its potentially alienating effect on the user and the therapeutic alliance would be in line with a project of this nature. Earlier in his work, Guattari backed up Deleuze in theorising agency, relying in particular on the concept of what they called "assemblage" (Deleuze and Guattari, 1987 (1980)). Here, agency cannot be merely seen has the sovereign power of a human to act on an inert environment. It is rather the result of multiple actions produced by a myriad of concrete material singularities, both human and non-human. The philosopher Jane Bennett (Bennett, 2010) resorted to this concept to found her contribution to a "vital materialism"

through “the blasphemous idea that nonhumans […] are actants more than objects” (p115). Following Deleuze and Guattari, she argues that “Assemblages are not governed by any central head: no one materiality or type of material has sufficient competence to determine consistently the trajectory or impact of the group. The effects generated by an assemblage are, rather, emergent properties, emergent in that their ability to make something happen […] is distinct from the sum of the vital force of each material considered alone”. Bennett places humans in the humbling situation where they are actants among other “materials”, merely parts of a complex agency exceeding their will for control. In this perspective, if we view the therapeutic alliance as the result of a greater “assemblage”, we could then understand how it appears, in our results, to be more than the mere “sum of the vital force(s)” of a service user’s wish to seek and find help, and of a professional's willingness to provide help. The place, its urban surroundings and the various human and non-human materials it contains, could thus be seen as potent, equally important, actants altering the therapeutic alliance.

The interpretation of our results, calling on Duff’s theorisation of enabling places, the French psychoanalytically-rooted conceptualisation of institutional care and the therapeutic relationship, and the approach of thinkers in the “New materialism” school of thought takes us some way towards enhancing our understanding of the perceptions and symbolic use of place by service users and of the role of place in the establishment of a good quality relationship. The participants in the study show complex, ambivalent relationships with place, the service provided and the providers, and a seemingly fairly unstable quality of the therapeutic alliance. The efforts we made to ensure good internal and external validity of these results enable us to think that the results do not apply solely to this specific CSAPA, and that they could be transferable to other outpatient addiction treatment settings. However, the French healthcare offer for people who use psychoactive substances is characterised by the pre-eminence of public and semi-public structures and a still strong medical model. This calls for caution in generalising our findings to other national contexts.

5-Conclusion

The participants in the study told of ambivalent perceptions of their place of care and appeared sensitive to controlling mechanisms and practices. Attention should be paid to the characteristics of places dedicated to people who use drugs since they can be a potent mediator of their hopes and anxieties. In our results, the quality of the therapeutic alliance seemed to fluctuate with the users’ perceptions of the place. This supports the idea that the therapeutic

alliance is not to be seen as the weaving of fixed interpersonal bonds, but rather as a dynamic and fluid process intertwining the relationships between service users, healthcare professionals, the place and the broader context. In this view, thoughtfully shaping and modelling the working environment could be as meaningful as developing professionals' competencies and trustworthiness in supporting the therapeutic alliance in addiction care and treatment. Service managers wishing to promote a good quality therapeutic alliance could draw benefit from encouraging the creation of place and its constant modelling by service users and professionals. This could contribute to easing the service users' ambivalence and provide a broader range of social, material and affective resources leading to a more profitable therapeutic alliance and empowerment of the service user. This proposal is a first step toward the understanding of the role of place in outpatient addiction treatment. It needs further exploration, and future research could advantageously diversify the methods and research settings, one limitation of the present work being the absence of discourse from professionals. An observation of the overall network of relationships at work in these places and its evolution through time would be helpful to offer further guidance to policymakers, service managers and healthcare professionals.

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