# Overcoming Professionals’ Challenging Experiences to Promote a Trustful Therapeutic Alliance in Addiction Treatment: a Qualitative Study

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### Abstract

**Background and aims**

A good therapeutic alliance plays a major role in the healing process. Professionals working in addiction treatment report high levels of psychological distress related to work and this may challenge the establishment of a trustful therapeutic alliance, and lead to a loss of care quality provided to service users. The purpose of this study was to investigate the experience of specialized professionals, its effects on trust and the therapeutic alliance, and the means to restore them.

**Design**

We conducted a qualitative study using a semi-structured questionnaire and a narrative tool. Discourse was extracted from focus groups and individual interviews and analyzed following the Interpretative Phenomenological Analysis method.

**Participants**

Twenty-six professionals from three addiction treatment centers in the Paris area were interviewed.

**Findings**

The difficulties weighing on the care alliance were described by the participants in terms of their nature, their effects and means to overcome them. Emotional drain leads to a climate of relational distrust and the temptation to desert or over-control patients. Teambuilding, specific training and self-care are viewed as means to restore a therapeutic alliance based on an appropriate type of trust.

**Conclusions**

Distrust deriving from professionals’ challenging experiences may lead to worrying consequences. Promoting democratic organization of care structures, specific training, and also responsible self-care on the part of professionals could help to restore a type of trust that helps to establish a therapeutic alliance suited to service user individualities. This could ultimately be beneficial for user care, professional wellbeing and team functioning.

**Keywords:** Substance Related Disorders; Professional-Patient Relations; Qualitative Research; Compassion Fatigue; Delivery of Health Care; Personnel Management

### Introduction

The therapeutic alliance is a process of interpersonal bonding between a care provider and a patient, which implies emotional labor from both parties as well as mutual trust (Horvath et al., 2011; Larson and Yao, 2005). It plays a major role in the healing process along with other care characteristics (Hoffmann et al., 2014), and a good therapeutic relationship is a predictor of commitment and retention of substance users in treatment, and of treatment outcomes (McKay, 2009; Meier et al., 2005). It is thus important to understand the factors influencing a quality alliance. In the scientific literature, providing addiction treatment is described as a challenging experience (Livingston et al., 2012; Oser et al., 2013). Professionals who have chosen to become involved express high levels of job satisfaction, legitimacy and interest in the patients (Iqbal et al., 2015), and also report high levels of psychological distress related to work (Oyefeso et al., 2008) and this may hinder the therapeutic alliance (Garman et al., 2002; Lacoursiere, 2001).

Studies on professional burnout syndrome currently provide the main body of information on the difficulties faced by providers. Burnout is an individual response to prolonged exposure to emotional stressors. It is classically defined by three dimensions: emotional exhaustion (EE), depersonalization (DP) and professional accomplishment (PA) (Maslach et al., 2001). Different studies assessing burnout among health professionals in the field of addiction have highlighted high levels of EE and DP (Oyefeso et al., 2008; Tartakovsky and Kovardinsky, 2013). Factors influencing levels of burnout are characteristics of the professionals, of the service users and of the work environment. Being a young professional is a risk factor (Knudsen et al., 2006; Oyefeso et al., 2008) while being older (Vilardaga et al., 2011) with a high level of education is protective (Knudsen et al., 2006; Shoptaw et al., 2000; Vilardaga et al., 2011). Professionals working with a population characterized by high case complexity (Shoptaw et al., 2000), high relapse rate (Vilardaga et al., 2011) and psychiatric comorbidity (McGovern et al., 2006) experience higher levels of burnout. Finally, treatment structures providing low job support (Shoptaw et al., 2000), heavy workload (Broome et al., 2009) and low salaries (Ogborne et al., 1998) expose professionals to burnout, while co-worker social support (Vilardaga et al., 2011) and fair management (Knudsen et al., 2006) reduce burnout scores.

It has been suggested that burnout risk factors have an impact on professionals’ experiences of care and thereby challenge the establishment of an effective care relationship (Lacoursiere, 2001). Besides consequences on professional wellbeing (health issues, poor job satisfaction, intention to leave (Knudsen et al., 2008)) and healthcare organization (quality of care (Knight et al., 2012) and staff turnover (Eby et al., 2010)), a poor therapeutic alliance deriving from burnout could be associated with poor client outcomes (low satisfaction and participation (Garman et al., 2002; Landrum et al., 2012) and low retention rates (Knudsen et al., 2006; McKay, 2009)).

In a previous conceptual article, we presented trust as a grounding for the therapeutic alliance. We analyzed the effects of mistrust on the care process and its dangers for patients (Reyre et al., 2014). Considering the preeminent responsibility of the professional in restoring a climate of trust, we presented different ideas to promote a shift in the positions and attitudes of professionals and the development of democratic care organizations. The expected strengthening of the patient-provider relationship was intended to guarantee the possibility for the service user to choose what he wants to invest in the relationship without having to fear the negative reactions of professionals who feel disappointed. These concerns are shared by other authors, who present trust as a key-element of the provider-patient relationship (Jauffret-Roustide et al., 2012; Thom et al., 2011).

We set out to work on the hypothesis that the numerous difficulties experienced by providers lead successively to poor professional wellbeing, lack of trust in the patient and in trust itself, a poor therapeutic alliance and finally poor patient outcomes. This opens up a wide research question, which we chose to address through a qualitative study, given the lack of systematic knowledge on the subject. The purpose of this study was to reach a satisfactory understanding of the experience of professionals in different addiction treatment facilities in France, its effects on trust and on the therapeutic alliance, and the means they perceive to restore trust.

### Method

#### 2.1 Approach, characteristics and reflexivity of the researchers

A research group was created one year before the scheduled beginning of the study. It gathered health professionals working in addiction treatment (physicians, psychiatrists, psychologists, nurses and social workers) and was led by a PhD student (AR) mentored by an experienced qualitative researcher (OT). All the interviews were conducted or supervised by AR and two psychiatrists trained in qualitative methods (RJ and ML). Considering the closeness of the researchers with their research question, reflexivity was sought by several means. Researchers were asked to write down their preconceptions about the issue in hand and the results they expected, prior to the first interview. They also recorded their preconceptions as a group. These documents were put aside and stored to help validate and discuss the results as recommended by Malterud (Malterud, 2001). A summary of the preconceptions of the research group and the coding researchers brought to light in these documents is provided in table I. Reflexivity was also sought using dedicated questionnaires for researchers, research meetings and group supervision conducted by an academic psychologist expert in research reflexivity.

#### 2.2 Context and sampling strategy

In France, the institutional care offer for substance users comprises three different and complementary components: CAARUD (community care), CSAPA (primary and secondary care) and hospital wards - CHU (tertiary care). This system coordinates with family doctors and the other sectors of medical and social aid. It is essentially of a public or associative nature. Very few private or confessional structures are involved. As different philosophies of assistance and treatment still influence practice in the three components of the system, there are significant differences in staff composition, and in the choice of tools and treatment objectives. However, for more than a decade now, intense efforts have been made to better integrate and coordinate the offer to service users across the different system components.

We chose three addiction treatment centers for their typical representation of the three components of the French health system. This choice was intended to diversify professional viewpoints and enable the observation of any differences in experiences. Staff members were recruited for the study with no other requirements than that they should have reached the age of 18 and be involved in addiction treatment. It was also important that the researchers should have no previous professional or personal relationships with the team leaders and staff members from these centers.

The sociodemographic characteristics of the 26 participants are detailed in Table II. The sample comprised 15 women and 11 men. Occupations were, as could be expected, quite different from one center to the other, with a majority of social workers in the CAARUD facility, psychologists in the CSAPA facility and hospital personnel in the CHU. In the CAARUD and the CHU facility, there was considerable variation in age and experience among the professionals and in time of presence on the unit staff, but the three centers all had properly trained and skilled professionals.

#### 2.3 Interview procedure

Information meetings were conducted in the centers to present the aims and terms of the study. Ten days later, participants were asked to sign a consent form and were assigned an anonymous identification code. They were also asked to complete a short questionnaire regarding sociodemographic characteristics before proceeding to the interviews.

The interviews were supported by two questionnaires. A semi-structured “difficulties” questionnaire was designed by the members of the research group using a participative process, based on the results of the literature review and several exploratory interviews. It was tested in both group and individual settings and then adjusted. The questionnaire was made up of open questions exploring (1) professionals’ attitudes toward service users, (2) professionals’ experiences of the care relationship and (3) opinions on means to support the therapeutic alliance. The other questionnaire was administered after participants had listened to a piece of a fiction. We read aloud a short extract from Joseph Conrad’s novel “Lord Jim” summarizing the enigmatic wandering of the main character. Participants were then asked to imagine what could come before and after the extract, to give their opinion about the different protagonists and to say if the story reminded them of their patients. This narrative approach is related to qualitative research strategies aiming to produce more in-depth, emotional and personal insight among participants about sensitive topics (Knowles and Cole, 2008).

We used two different research settings. In each center, two professionals were interviewed individually, and the other participants met in focus groups. The individual interviews were conducted by a single researcher using both the “Lord Jim” and the “difficulties” questionnaires. The focus groups were headed by two researchers. One of the three main researchers (AR, RJ, MJ) facilitated the discussion supported by the “difficulties” questionnaire while the second collected elements of informal and implicit communication in the group and between participants and researchers.

In each center, the team leader was interviewed separately from the other professionals. The interviews were supported by a grid exploring the history, constitution, organization, and practices of their staff. These data were used only to contextualize the discourse of staff members and not included in the discourse analysis.

The study protocol was approved by the relevant IRBs (CNIL, CCTIRS and CEERB – notice n°11-075).

#### 2.4 Conduct of the Study

Two of the first three centers approached declined to take part for organizational reasons. They were replaced by two other centers with similar characteristics. The professionals attending the information meetings expressed great interest in the research question and protocol, and we did not have any difficulty enrolling participants. The interviews took place between April 2011 and January 2012. Three focus groups gathered 20 participants (6 to 7 per center) and were held once in each center. They lasted between 1 and 2.5 hours. Six participants were met in individual settings (2 per center). Individual interviews lasted between 20 minutes and 2 hours. All the interviews were audio-recorded and immediately transcribed in order to enable an early start for the analyses. After the first focus group and 2 individual interviews, we had a research meeting to discuss the first results and adjust the protocol. We modified the “difficulties” questionnaire without altering its overall structure, by downgrading several questions into subsidiary questions. We initially considered enrolling other centers, but did not because our analysis reached a satisfactory level of saturation.

#### 2.5 Data analysis

Transcripts were imported and managed using QSR NVivo®10 software. We used Interpretative Phenomenological Analysis (IPA) which enables the researcher to produce results integrating participants’ overt discourse and interpretations of implicit content and indirect communications. In discourse, we identified recurrent ideas, which became sub-themes. These sub-themes were progressively gathered into themes and meta-themes. In these successive stages, the overt content of discourse was linked to interpretative elements derived from the observation of individual and group dynamics during the interviews and throughout the study process.

The three main researchers independently analyzed each transcript. Theme trees were compared and discussed when divergent. Discrepancies were not systematically reconciled but rather used to enrich the emerging theory. The process was supervised by a fourth researcher who had no detailed knowledge of the verbatim (OT) and who helped the coding researchers to compare and discuss their analyses and progressively structure the general theory. Five meetings with the four researchers were necessary to reach a satisfactory level of consistency and comprehensiveness for the theory.

Transcripts were written and analyzed in the original French. The quotes used in this article were translated by a professional native English-speaking translator aiming to render the underlying meaning of the discourse and as far as possible its tone and idiom.

#### 2.6 Validity assessment

From the study design phase, the researchers’ reflexivity, the triangulation of observations, and participants’ feed-back were major concerns. The researchers had previously been trained to take account of their subjectivity at the different stages of the study. Triangulation consists in the diversification of sources and methods of observation and analysis. In our study, this was provided by the diversity of center profiles, of the health professionals’ occupations, and of the modes and tools for data collection, as well as by the final analysis by three different researchers. Both triangulation and reflexivity were also enhanced by four sessions of research group supervision (see 2.1 above). Participant’s feedback was sought from the beginning of the study through informal discussions, and in the final stages via communication of the preliminary results.

### Results

The general theory resulting from the analysis is divided into three parts: (1) the nature of the difficulties, (2) their effects and (3) the means to overcome them.

#### 3.1 The nature of the difficulties

Participants reported a complex experience of the difficulties they have to face in their relations with service users (see figure 1). Four main sources of difficulty can be identified: the users, the addictive substance, the professionals themselves, and the environment.

*3.1.1 The service users*

The professionals expressed anxiety for service users who often present serious health conditions, psychological suffering and have distressing personal histories to tell.

“On the ward, in a way, consciously or unconsciously, you're coming up against the issue of death – things that are really hard to cope with.” CHFG-B

“Sometimes people have life histories that are so... sometimes you're dealing with things that are so sordid...” CSI-2

They also find it difficult to help service users who do not really commit themselves to the relationship, and even sometimes go against it.

“It's not easy to generalize, but maybe there are difficulties specific to people with an addiction... in the way they question the therapeutic alliance, or question, upset or demolish the boundaries that are set: not coming to appointments, being late, coming drunk or stoned, all sorts of things like that.” CSFG-A

*3.1.2 The addictive substances*

The different substances can drastically change the service users' personalities, making them highly aggressive, but they may also help them to survive.

“When people are under the influence of alcohol or other substances, you see acting out that is unbelievably violent... they are warriors at heart.” CAI-2

“There are even some who say "if I hadn't got hold of the stuff, I would have killed myself".” CHFG-F

The addictive substances are therefore of great importance to service users, and are perceived as rivals by professionals.

“Relations are necessarily a bit skewed. It's not a relationship of one person to another. It's a relationship of one person to another who has an addiction. I think it's something he always carries around in his head, like baggage, and it somehow gets in the way of any real relationship.” CHI-1

*3.1.3 The professionals*

The professionals often consider their training insufficient or inadequate for coping with the strong emotions they feel in their relations with service users.

“That what I personally find hard to manage at times... Finding a sort of right distance, not too impermeable, nor totally in it with them.... always having to judge the right distance from the violence of the life histories we hear.” CHFG-C

Concerning themselves or their close colleagues, they sometimes wonder if the users are the real beneficiaries of the care. Several participants told stories about their own past or present addictive behaviors or about those of close family or friends.

“Even so, it’s obviously one of the failings of social workers, that they have to deal with their own problems with people who are not doing as well as them – it's not very constructive.” CAI-1

“You know why we all work here – it's because we all have links with addiction problems.” CHFG-C

*3.1.4 The care environment*

The environment comprises several successive "envelopes" surrounding service users and/or professionals: friends and families, teams and institutions, the health care system and society. The families and friends of both users and professionals can have attitudes and adopt a discourse toward care that compromise their mutual involvement in the relationship. But the interactions among professionals in a given team are also critical, and the participants regretted the inflation of administrative and organizational tasks, which reduces the time the team can spend together.

“Generally we tend to deal more with issues involving the organization of the facility – so not much discussion about essentials, in fact.” CSI-2

Within the health care system, the participants reported experiencing a lack of recognition and support from the other professionals and sometimes felt isolated in their efforts to help service users.

“It's complicated, because there is often a lot of reluctance by others to take on these patients, sometimes providing that sort of care is too demanding.” CHFG-F

More generally, the social sphere is perceived as hostile toward substance users and not supportive of the professionals and the help they provide. The political stances and the resulting legal framework are likewise not considered helpful.

“All too often, outside, I hear things such as "paying for rehab, and post-rehab – no wonder the health insurance can't make ends meet!".” CHFG-D

“We come under public health legislations that organize what we do, and we have no leeway to get further funding. It's not easy to design projects, and they rarely last – never in fact.” CAI-1

#### 3.2 The effects on the relationship

Effects on professionals, service users and the relationship are presented in figure 2.

Confronted with these numerous difficulties, professionals can experience emotional drain, feelings of uselessness and an urge to withdraw from the relationship.

“I feel I'm asking a lot of myself. Sometimes I get the feeling I've had enough, I'd like to drop it all.” CSI-2

The professionals can be tempted to exercise control over the service users through practical measures such as demanding contracts, or taking regular blood and urine samples, even if they feel ill at ease with them.

“We're policing them a bit, really.” CHFG-C

“It's a sort of policing that I really don't like.” CSI-2

In this situation, the professionals cannot rely on trust. Trust is seen as too binding, making the user a captive while exposing the professional to a high risk of bitter disappointment.

“I don't trust users. Every time I've lost out, I had said to myself, this one seems nice enough, so now I don't trust any of them. In fact I'm particularly wary of those who seem a bit too "nice".” CAFG-A

Distrust that seeps into the relationship can also be observed in the frequent use of security devices such as CCTV, remote-controlled doors or one-way mirrors.

#### 3.3 The means to restore the alliance

In the face of this deterioration in the relationship, professionals still have numerous ideas and means to restore it (see figure 3).

Overall, the restoration of mutual trust between service users and themselves is the main aim of their efforts. Despite their initial reluctance to rely on trust and the scale of institutional distrust, they feel that no patient improvement can be hoped for without taking the risk of personal involvement and reinvestment in trust.

“You have to give... get involved. You have to get involved in this sort of pathology. CHFG-A

Generally speaking, I couldn't do my job if I couldn't trust. Anyway, patients would never trust me if I didn't trust them.” CSI-1

To reach this desirable state of the relationship, the participants propose different courses of action.

They note the need of further training and better consideration for their personal wellbeing. Being aware of one’s personal difficulties and cultivating balance and happiness in life is also important.

“It seems to me that it's essential in this sort of facility to do some work on yourself [...] To be efficient and available [to users] in this job, you really need to have a life that is dense and fulfilling outside work, where you can return to your fundamentals.” CAI-1

“You have to evacuate [the stress]. If the staff are suffering, the patients will necessarily suffer.” CHFG-A

A supportive working environment, which is provided by teamwork, is also an important aspect. This kind of environment enhances professional creativity.

“It's a collective thing, relationships, strong relationships. That's something that supports you, contains you.” CSI-2

For several participants, opening up the structure to professionals from other addiction treatment centers, and from fields such as psychiatry or sociology, or to clinical supervisors not directly involved in local teamwork, is viewed as a powerful way to enhance personal reflexivity and feelings of legitimacy in their work.

“We have a supervisor who allows us scope for reviewing our practices, and our feelings... Times like that help to understand, or at least to have fewer doubts.” CAFG-C

### Discussion

Our results show the richness and complexity of specialized professionals’ experiences of the care relationship with the service users. This relationship should not be regarded as solely painful and exhausting. However our findings do contribute to the understanding of the various difficulties that the professionals have to face when trying to promote a therapeutic alliance with service users. The analysis of discourse demonstrates high levels of emotional intensity deriving from four main sources: the professional’s vulnerability, the attraction of the substance of abuse, the service user's vulnerability and the lack of support from the care environment. It also suggests that these challenges lead to a climate of distrust which generates behaviors of withdrawal and control over service users. In their attempt to restore an alliance, professionals see trust as an important element alongside the need to find the right amount of commitment to establish an effective therapeutic alliance. In their views, the climate of trust can be restored through improved team management and specific training, and also through a type of self-care that enables stronger personal and professional commitment.

The qualitative design of the study is in line with our aim to report on the complexity of professionals’ experiences, but it also has inherent limitations. In our research process we integrated several devices aiming to raise the level of reflexivity and triangulation in the analysis, and have reported the conduct of the study in detail. This enables us to claim good validity for our results, and to anticipate their transferability. However, complementary qualitative and quantitative studies are needed to support the generalization of our results. The confrontation of the results with our recorded preconceptions suggests that we probably favored the emergence of rather negative discourse. This is a limitation, and we now consider that we could have designed a more open questionnaire on professional experiences. This observation does however strengthen the weight of any emergent “positive” sub-themes, such as commitment, motivation or pleasure at work.

It can also be noted that we chose three typical representative addiction treatment centers in urban areas. The diversity of the professionals working in these centers, and of the substance users attending them, ensured the relevance of our results on the professionals' widely shared emotional experiences, but we did not reach the satisfactory level of saturation in the individual teams that could have enabled us to report the differences in relational experiences of staff across the three groups.

Our results are partially in line with previously published data. In a qualitative study, Oser (Oser et al., 2013) described experiences of work with substance users among counsellors in the USA. She focused on the feeling of burnout, and how participants thought it was affecting treatment outcomes. She found three meta-themes: (1) causes (Challenging clients, Large caseload, Paperwork, Office politics, Low prestige), (2) consequences (Poor client care, Reversing roles, Clients try choosing counselor, Changing jobs) and (3) prevention of burnout (Co-worker support, Clinical supervision, Self-care). From our analyses we derived the same structure in three meta-themes. We found quite similar themes and sub-themes concerning service users and the work environment as potential sources of emotional drain. Similar results have also been found in several studies on burnout (Broome et al., 2009; McGovern et al., 2006; Ogborne et al., 1998; Shoptaw et al., 2000; Vilardaga et al., 2011). Poor support from the environment is a major theme in our results, but interestingly, themes like low salaries and heavy caseload were not found in our study. This could result from the structure of care provision planning in France. There are salary scales, and the numbers of professionals and centers match the needs of service users, at least in urban areas.

Preeminent themes in our study like the power of the substances and particularly the vulnerability of the professionals are more original. These themes are highly emotional and there may be settings where professionals are not inclined to speak out. It is possible that we were able to collect this intimate information because we spent several hours over a period of several weeks with the teams in the centers and developed a relationship with them. The fact that the focus group participants were interviewed as teams, and all participants were in their workplace, may also have enhanced their feelings of security. But it could also suggest the usefulness of a broader angle for questioning professionals about their experiences, not strictly focused on burnout, and the interest of using of a non-clinical fiction to support individual interviews.

Poor quality client care, underlined by Oser as a consequence of professional burnout, is also reported in our results. The respondents suggest that poor quality care is associated with a climate of distrust surrounding the care relationship, damaging the therapeutic alliance and leading to both professional and service user relational withdrawal and excessive control. Professional relational withdrawal is a very important component of burnout and service user withdrawal has already been described as an effect of burnout in addiction treatment. However, excessive control is an original and unusual result. It is an important sub-theme of our analysis and is supported by the observation of practical security devices, sometimes embarrassing for the professionals themselves. In another article (Reyre et al., 2014), we underlined the possibility of the development of mutual control to reach a problematic level, and of care institutions to run non-democratically. We think that the recognition of the presence of excessive control and its negative effects on the therapeutic alliance is an important clinical and ethical issue which still needs to be explored.

Another interesting result of our study is the role of restoring trust in order to enhance the therapeutic alliance. These findings are in line with other recent research highlighting the crucial role of professionals’ trust toward patients in building a sound and fair therapeutic alliance (Miller, 2007; Reyre et al., 2014; Thom et al., 2011). The participants in our study stressed the importance of trusting patients as a means to lead them to experience an unfamiliar, comforting feeling, and secondarily to gain their trust. In their views, this requires a change in their own positions and attitudes toward service users, allowing more freedom for the users, mutual creativity, and advocacy and the sharing of a cause.

Most of the participants in our study encounter the numerous difficulties which they identify as challenges rather than obstacles. They seek solutions through team management, advanced training and self-care. Along with Ogborne (Ogborne et al., 1998) and Joe (Joe et al., 2007) our results show the importance of promoting fair management and peer support, but the participants also stressed the need for less institutional control of service users, such as regular urine sampling or video monitoring. This supports our conceptualization of the need to ensure the democratic functioning of our structures (Reyre et al., 2014). In line with this, the call for more team supervision should be understood in the French setting from the psychoanalytical viewpoint as a means to enhance team coordination, wellness and efficiency as well as to promote a user-oriented ethical approach to care organization.

Training is another important theme in our results. Iqbal (Iqbal et al., 2015) showed that training and specialism favor more positive attitudes and support the therapeutic alliance. In line with this, professionals in our study would like advanced training to help them modify their attitudes toward service users in order to better cope with their own vulnerability, but above all to give users more freedom in the relationship. When the participants expressed demands for further training, they usually envisaged it in their own conceptual and practical frameworks, which differ across the three centers. In order to support the therapeutic alliance, they all rely predominantly on specific techniques leading to similarly specific evolutions in their attitudes toward users. The staff of the hospital ward (CHU) use motivational interviewing, which has shown sound evidence of its efficacy in enhancing the therapeutic alliance in addiction treatment (Cheng, 2007; Miller and Rollnick, 2012). In psychotherapy, the training and experience of therapists have a similar effect (Tschuschke et al., 2015). Some particular approaches seem suited to supporting the therapeutic alliance, for instance multidimensional family therapy (Shelef et al., 2005) used by the psychologists in the CSAPA. The professionals in the CARRUD for their part use empowering techniques facilitating a genuine equal-to-equal alliance. This could explain why the three centers share the concern for trust and respect for the other’s individuality, and for the need for at least some commitment on the part of the service user. Several professionals in these centers have qualifications indicating extensive training in these different alliance-supporting strategies, but we do not know from our study if the knowledge and skills acquired are adequately used in daily practice, nor to what extent they disseminate within the teams. The call for more training could therefore be the result of unmet needs in the area of training. In this case, the team leaders could enhance the quality of the services provided to users by implementing state-of-the-art-based training programs in their centers.

The call for more training could also be understood, in the particular setting of our study, as a sign of the lack of something that may not be easily achievable via training when the issue is to restore the therapeutic alliance. In the participants’ views, self-care also seems to be a powerful ingredient, complementing team organization and individual training. Oser also identified this important theme. In her understanding, self-care includes several methods for enhancing professional wellbeing, such as meditation, time off, debriefing with co-workers or involvement in other tasks outside clinical work. We found the same results, with a particular emphasis on the importance of having a happy, rich, private life and being able to seek personal therapy when necessary. This pleads for more room in team organization for professional self-care, not just for their own benefit but above all for the benefit of service users (Reyre et al., 2014). This is in line with a broader concern over health professionals’ ability and desire to take care of themselves (Wallace et al., 2009), and supports the call for a better acknowledgment of this issue.

### Conclusions

By collecting emotional intimate discourse we have contributed to the description and understanding of the complex experiences of care provision among specialized professionals. The challenges faced can foster a climate of distrust in care relationships with service users in addiction treatment, and can lead to worrying consequences. On the basis of these professional insights, promoting fair management and functioning of care structures, adequate advanced training, and also responsible self-care on the part of professionals could help to restore the type of trust that can favor the establishment of a therapeutic alliance that respects the service user's individuality. These results encourage the design and assessment of complex multifaceted interventions aiming to simultaneously improve service user care, professional wellbeing and team functioning in the field of addiction treatment.

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