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Opiate Dependents' Experiences of the Therapeutic Relationship in Methadone Centers; A Qualitative Study

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Abstract

Background: Methadone maintenance therapy is a treatment of choice for opiate addiction. Understanding opiate dependents' experiences of patients' treatment is a key to continue the treatment and can provide help to revise the standards of methadone centers and improve the quality of treatment. This study aimed to describe the essence and structure of opiate dependents' experiences with methadone maintenance therapy.

Methods: It was a qualitative phenomenological study, in which participants were selected from opiate dependents referred to methadone centers in Kerman city in 2007. Sampling was purposive and continued until data saturation, which was achieved at 32 participants. Data were collected by in-depth interviews. Colaizzi's method was applied for data analysis. The rigor of the present study was assessed based on the criteria of confirmability and credibility.

Findings: A total of 26 themes were extracted and categorized into three main themes including positive therapeutic alliance, negative therapeutic alliance and therapeutic alliance requests.

Conclusion: Client–centered therapy in methadone clinics creates a positive therapeutic alliance, and persuades patients to continue their treatment. Establishing a good relationship with patients during their treatment procedure is an effective way to meet the goals. Individual and group counseling sessions and advices on family and career related issues during the treatment should be considered as well.

Key words: **Methadone, Experiences, Professional Patient Relationships, Qualitative research, Opiate dependence**

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Introduction

Methadone maintenance therapy (MMT) is a treatment of choice for opiate addiction. Although there is an ongoing research for finding other forms of treatment, methadone maintenance therapy is still the most common treatment used.[1] This treatment started in Iran some year ago. At first there was a pilot experiment and it is currently performed as a national project with a great deal of investment throughout the country. Special centers have been established in prisons, State Welfare centers, detoxification clinics, etc. to distribute methadone among addicts; and a great number of staff are employed in this project.[2] It seems that, in spite of this national project, just a small percentage of addicts are under methadone maintenance therapy and a group of them have frequently tried the therapy and left it in the middle, believing that a long term treatment with MMT is not suitable for them.

Assessing the clients' satisfaction and their opinion about the therapy is a necessary step in evaluating the quality of MMT project. The clients' feedback can provide a ground for evaluation of services and shack the presumption that put all the faults on the client.

The specialists' advices can be helpful in improving the quality of services, and the clients' ideas can be as beneficial, too.[3]

United Nations Office on Drugs and Crime (UNDCP), World Health Organization (WHO), and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) have jointly published an international guide to assess treatment system used for the addicts. This guide direction introduces an assessment system including need assessment, process evaluation, outcomes evaluation, customer satisfaction assessment and economic assessment. Group analysis of the clients and qualitative studies are the major methods advised for need assessment. Also, deep individual and group interviews are mentioned as major methods for process evaluation.[4]

Qualitative studies have been used in social sciences for a long time, but they are new in health sciences and particularly studies on addiction. There are many studies on assessing various detoxification treatments for addicts, but a few of them are qualitative studies and less than that are studies on high risk groups.[5,6]

Methadone maintenance therapy strongly emphasizes on the clients needs and identification and consideration of these needs would significantly encourage the accomplishment of treatment process. In case the visitors can not afford to follow through on the treatment there will be a slight chance for the potential benefits of the When clients are not able to continue the treatment, there will be little chance for therapy accomplishment. The duration of treatment has a direct relationship with positive outcomes[7] and has an impact on reducing usage of other narcotics as well as criminal acts.[8] A good relationship between clients and clinics that distribute methadone during the treatment process is an effective factor in accomplishment of therapy, while if such relationship doesn't work well, the therapy would fails.[1] Therefore, it is important to understand the clients' experiences during the treatment process to improve services and outcomes and also to revise the standards of methadone centers and improve the quality of treatment. This study aimed to describe the essence and structure of opiate dependents' experiences with methadone maintenance therapy.

Methods

The research method is phenomenology, in which the researcher studies life experiences through interviewing those who live in the experience.[9] In other words, phenomenology is "exploring and developing insight into the world as it is experienced"[10]. Phenomenology is a qualitative method that tried to systematically and interactively determine the essential properties and structures of life experiences.[11,12] Qualitative research is used to understand human behavior and emotions which is not possible to do by quantitative methods.[13]

The study population included clients referred to selected methadone clinics. Sampling was purposive and the subjects were selected from those who had experienced MMT, were willing to participate in the study and could remember and explain their daily life experiences. The sample size was determined by data saturation[14], which was achieved at 32 participants. Data were collected by in-depth non-structured interviews. The subjects were selected based on the entry criteria and received necessary instructions. After receiving their permission for the study, we arranged the time and place of the interview with them. Before the interview, once again their permission was taken and they were

assured about the data secrecy. Each interview lasted 30 to 45 minutes and the maximum time was 90 minutes. All the interviews were recorded by a tape recorder and nonverbal expressions such as crying, tone of voice or reactions of others presented in the interview as well as observations of the relationships was noted and recorded at the end of interviews after the interviewee had left.

The study was carried out from October 2007 to March 2008. Participants included 32 clients (30 males and 2 females). Demographic data are presented in table 1 and treatment conditions are presented in table 2.

The interviews started with a wide and general question, asking the participants to explain their treatment relationship with the methadone distribution center and the rest of the questions were designed based on the answers and their explanations of the experiences during the treatment. Further questions were asked when there was an ambiguity.

In this study, Colaizzi's method was the guide for data analysis. According to the first stage, at the end of each interview and notes, the recordings were listened and transcribed word by word. Then, the written interviews were reviewed several times to discover the participants' experiences. According to the second stage, after studying the explanations of the participants and understanding their feelings, significant sentences were underlined. In the third stage, the important statements of each interview were identified and a theme that explains the notion and major believe of the interviewee was extracted from each statement. Once all the themes were extracted, they were checked again to see if they were related to the significant sentences primarily identified and the validity of the themes were assured. In the fourth stage, the themes were organized and categorized based on subjects and in the fifth stage, the results were joined together to make a more general description of the phenomenon. In the sixth stage, from the exhaustive description of the phenomenon, as unequivocal a statement of its fundamental structure as possible was described and in the seventh step the standardization was done by referring to each interviewee and asking them about the findings up to this stage.[11]

The rigor of the present study was assessed based on the criteria of confirmability and credibility. For this purpose, the extracted codes were referred to the participants and their approval made the data credible. Also, the findings were referred to a specialist in qualitative study to check the validity. Besides, the research process was explained in details to all researchers to help them understand the data process.

Results

After transcribing and reading the interviews over and over according to the first stage of Colaizzi's method, the important sentences were highlighted in the second stage. For example participant number 1 who was a 44-year-olddivorced woman and was under treatment for six months, said: 'at the beginning I thought that they grounded something other than the pill (methadone) to pour in the glass they gave us, because I was in pain and I thought they were fooling us.' Participant number 6, who was a 32-year-old married male and under treatment for four years, said:' I was at the point of suicide and

Table 1. Demographic features of the participants

Characteristics	Age			Marital status			Education			Career			Addiction	
	<20	20-40	>40	Married	Single	Divorced/ widowed	< High School	High School	> High School	Unemployed	Employed	Laborer	Opium	Heroin, etc.
Male	1	8	21	11	10	9	14	11	5	10	5	10	4	26
Female	0	1	1	0	0	2	1	1	0	2	0	2	1	1

Table 2. Treatment condition of the participants

Treatment characteristics	Number of pills			Length of treatment (year)	
	< 10	10-20	> 20	< 1	> 1
Male	9	17	5	11	19
Female	1	0	1	2	0

Table 3. The list of extracted codes in this study

Rows	Significant sentences	categories		Main theme
1	Less nervousness and temptation due to referring to the centers vs. nervousness and temptation for self-medication with methadone.	Positive therapeutic relationship		Clients' therapeutic relationship with the centers
2	Treating clients as patients			
3	Respecting clients			
4	Counseling with doctors			
5	Clients' lack of authority and not involving in decision making	Limited authority	Negative therapeutic relationship	
6	Doctors' refrain from prescribing medicine	Mistreating		
7	Ignoring clients by psychologists and neurologists of the centers			
8	Drug use in reaction to being mistreating by doctors			
9	Quitting treatment after arguing with personnel			
10	Argument between some clients and centers' authorities which led to throwing clients out.			
11	Discriminating among clients			
12	Centers' authorities lack of understanding and lack of acquaintance between clients and authorities	Communication problems		
13	Difficulty in explaining sexual problems with female doctors and referring to others as a result.			
14	Encouraging the clients to quit because of free services of the centers	Mistrust		
15	Death of some clients and authorities responsibility for not providing medication			
16	In the first few days, the pills are like children's aspirin, not real medication because of the pain			
17	The medication feels to be fake in the first few days of the treatment			
18	Clients' belief that the centers don't give them enough syrup.			
19	Psychologists' help in fighting temptations	Need for counseling		
20	The need for counseling and talking to a counselor in the centers			
21	Usefulness of reviewing memories and causes of addiction in order to prevent going back to drugs			
22	The efficiency of psychologist in the centers			
23	From the suicidal point to having lots of hopes for life.			
24	Individual psychological sessions to solve psychological problems			
25	Request for social workers' help and giving job and family related counseling services to clients' parents.			

the psychologist of the (methadone) center led me to a point that I wanted the best for myself.' Participant number 11, a 23-year-old divorced woman who was under treatment for 10 months with 20 pills, said: 'the doctor of the (methadone) center treated me really bad.'

Next, the significant statements were extracted. For example from participant number one's sentence that 'I thought they were fooling us,' the concept of distrust was extracted. Or from the description by participant number 6, the concept of positive therapeutic relationship and from the description by participant number 11, the concepts of inappropriate behavior were extracted. The result of this stage was 25 codes. It should be mentioned that after each interview, first the codes were extracted and then, the next interview was performed. The list of codes developed in this stage is presented in table 3.

Once the codes were extracted, the concepts were categorized into themes, according to the fourth stage of Colaizzi's method. Positive therapeutic relationship, limited option, mistreating clients, communication problem, and mistrust were categories describing codes 1-4, 5, 6-11, 12-13, and 14-18, respectively. Codes 19-20 were categorized as need for counseling. Next, the categories with close concepts were classified in more general categories. For example, limited options, mistreating clients, communication problem and mistrust were categorized as negative therapeutic relationship; and negative and positive therapeutic relationships were categorized in the bigger category of therapeutic relationship with the centers during treatment.

In this study, a number of the participants described positive therapeutic relationships while some others described negative therapeutic relationships with the centers. Besides, the need for counseling, psychotherapy and social services was mentioned as well. Finally, the more general concept of therapeutic relationship with centers was extracted.

Discussion

Positive therapeutic relationship from the viewpoint of the participants (codes 1-4) included treating as patients, respecting, being treated by and consulting with doctors, all of which show the importance of client-centered approach in this therapeutic program. Guichard's study showed that assessment by a doctor could improve the treatment and prevent the gap between clients and the centers, which could led to drug abuse[15]. Some qualitative studies conducted on the methadone maintenance therapy centers in Russia reported nonjudgmental attitude toward clients as one of the reasons for clients' positive view toward the MMT.[16] Using Winicotte's theory, Potik introduced psychodynamic model for maintenance therapy. He believes that methadone maintenance therapy is associated with some changes in patients' lifestyle and behavior, which is equivalent of transitional state in Winicotte's theory and that methadone, counseling and centers' services are similar to transitional objects. He concludes that maintenance therapy influences various aspects of addicts' lives and some therapists of the centers, who are chosen by clients, play a significant role in the treatment outcomes.[17]

The negative therapeutic relationship (codes 5-18) described by the participants included clients' limited authority, mistreating of the centers' personnel, problems in communicating with the personnel and distrust towards personnel.

One of the advantages of the program mentioned by the participants was physicians' supervision, but some clients complained about frequent visits to doctors and their lack of authority and requested less frequent visits and more stabilized dosage of medicine. It seems that the patient-doctor relationship is not mutual, and the physicians change the dosage of medications frequently regardless of patients' requests.

Some relationship challenges reported included physicians' and psychologists' lack of concern, personnels' mistreating and discriminating behavior towards clients, and arguments between clients and the centers' authorities, the last two of which are among the most destructive therapeutic relationships. These conditions not only had the clients leave the treatment, but played a role in dangerous complications such as being poisoned due to adhesive usage of narcotics. In a qualitative study in Russia, judgmental attitude towards the patients was reported as one of the major issues in negative therapeutic relationships.[16]

Another issue in negative therapeutic relationship was difficulty in communicating with the centers' personnel. For example one of the male participants faced premature ejaculation and uncontrolled emissions at the beginning of his treatment, and could not share his problem with the female physician in the center. Based on his friends' advices, he started using drugs again to solve his problem.

In a study on 28 clients referred to methadone centers in France, the following four patterns

were found for the patient-doctor communication: 1. discussing only the dosage of prescribed methadone, 2. communicating just about methadone medication, 3. mutual communication between physician and patient leading to a joint decision, 4. a communication in which the clients, according to their view, could acquire a legal free medicine for uremia. In all these forms of communication, the clients had difficulty reporting other drug use or injection within this relationship because of their fear of the outcomes of drug dependency.[15]

Personnel's' mistreating clients in centers had also a role in rumors and distrusts. At the beginning of the treatment and due to the hardships or at the time of shifting from pills to syrup, a number of participants were suspicious of medicines being fake or the dosage being inadequate. Therefore, giving the factual information to the clients especially at the beginning of their treatment and when there is a shift in the process can increase most of distrusts.

Another experience during MMT in methadone centers was the client's needs. Most participants mentioned their need for counseling and psychotherapy and emphasized on the roles of the psychologists or counselors of the centers especially in overcoming their stress and preventing mistakes. They also found counseling useful in improving their quality of life. In an ethnographic study on 17 patients in methadone centers in the USA, the patients who followed advanced organized programs with cognitive-behavioral approaches, showed a significant decrease in returning to drug use. Besides, they were emotionally and psychologically healed.[18]

In Joe et al study conducted on people with opiate dependency during the first 6 months of methadone maintenance therapy, there was a "positive effect of pretreatment motivation on greater engagement and a reciprocal positive relationship between components of engagement and their effects on lowering drug use throughout treatment.[19]

As it is mentioned in Guichard et al study [15], "the lack of clarity about the treatment objectives and the time frame of the consultation limit the users' ability to integrate the treatment into their lives and to commit themselves to it. The heterogeneity and fragility of the users' situations, and the treatment objectives require regular assessment during contact with the physician" and therapeutic and counseling sessions should be planned for the clients during their treatments in methadone centers.

The participants of this study preferred individual psychotherapies to group ones and the reason might be their sense of privacy and low tendency to appear in public.

Some of the clients wanted their families to be involved in psychotherapy session. They suffered from high emotional expression and stress in family. Some others asked for a social worker. They were mostly unemployed. A study conducted in Massachusetts on patients under methadone maintenance therapy reported "the need for MMT providers to work collaboratively with other service organizations to improve clients' employment, housing, and family stability to help improve MMT retention rates[20]. In his study, Dickinson found that apart from prescribed dosage of methadone, supervising and rehabilitation are critical factors for MMT retention rates.[21]

Opiate dependents need a wide range of services and support in addition to prescription and distribution of methadone to reduce drug use and improve their quality of life. Therefore therapeutic programs should include social support services and family and job related counseling and provide their clients with any of such services they need.

In general, client-centered approach of MMT was its most significant strength and those centers which paid attention to this approach, their clients remained in the treatment program. Disrespecting clients and not giving them the right of choice in their treatment program were the most vivid negative therapeutic relationship. These findings suggest that involving clients in treatment related decisions and developing a good relationship between the center and them can significantly improve the treatment outcomes. The clients should receive proper counseling during the treatment and individual, group counseling sessions and family and job related counseling as well as educational therapy should be included along with MMT in methadone centers.

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