Partnership Envelope: a Therapeutic Dimension Relevant in Situations of Abuse

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Keywords

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Abstract

Objectives

Our societies still struggle to recognize that the family is often the place where a child is most at risk of psychological, physical, or sexual violence. Child maltreatment fundamentally challenges the foundations of connection, relationships, and personal boundaries.

These are complex phenomena with multiple facets, including physical and psychological abuse, neglect, sexual abuse, exposure to spousal violence, highly conflictual parental separation, and institutional abuse. These forms of violence typically occur within a specific relational context, usually the family. The para- or intra-family framework, which should provide a safe environment for the child's development, is instead compromised. This presents a fundamental paradox: the very setting meant to protect and nurture the child becomes a source of trauma.

Methods

We revisit some considerations on the concept of psychic trauma, including the impact of certain events that cause "injuries" to the psyche. A "traumatic" event is one that brutally confronts an individual with death, the threat of death, serious injury, or violent circumstances.

Rather than proposing a specific framework for addressing trauma related to child abuse, we are developing a therapeutic approach that could serve as a meaningful avenue of support and care for the affected child and their surrounding environment.

Results

While not exhaustive, we propose three interrelated guiding principles aimed at supporting practitioners in navigating the challenges that arise in these complex situations.

The first principle emphasizes the need for a well-defined framework for intervention. The therapeutic framework, a fundamental element of any practice in the humanities, is particularly strained in cases of domestic abuse. Families with abusive dynamics often challenge and disrupt the very structure that, in theory, should provide a safe and trust-based environment for intervention.

The second principle focuses on the establishment of an intermediate space and a partnership framework. These concepts form the foundation of an approach that helps mitigate risks of dysfunction. Every therapeutic encounter, regardless of its format, serves as an intermediate space where knowledge, representations, and emotions can be processed and worked through.

The third principle highlights the importance of network-based practice. In the humanities, the concept of a network is closely linked to that of a system, incorporating the dimensions of relationships. From this perspective, every individual must be understood not only in terms of their intrapsychic experiences but also as part of a broader, more or less structured and expansive social system.

Conclusions

Multi-stakeholder collaboration thus forms the foundation of the "partnership envelope." Professionals involved create a dynamic group, shaped by emotions and personal reactions. This necessitates dedicated time to analyze the interplay between relational dynamics within the multi-professional team and those present in the family system.

Through multidisciplinary team meetings, this collective process is established, put into practice , and refined. Such a multi-stakeholder approach emphasizes consultation and aims to prevent fragmentation in the care of families, particularly those experiencing abusive dynamics.

Introduction

In the face of increasingly complex cases of child abuse—partly due to the diverse family structures in today's society—professionals must demonstrate both creativity and perseverance (1-3). These situations, which generate a range of traumatic consequences, inevitably raise critical questions in clinical practice, theoretical frameworks, and ethics (4).

Ideological stances can sometimes influence professionals toward two extremes: either prioritizing "bonding with and within the family" at all costs or enforcing a strict "zero tolerance" protective policy, which may lead to the rapid placement of children into care.

Rather than advocating a fixed framework for addressing trauma related to child abuse, we are developing a therapeutic approach that serves as a meaningful avenue of support for the affected child and their surrounding environment. This approach

involves creating a collaborative framework that unites various stakeholders, fostering a partnership that moves beyond the divisions and rivalries often seen in current networking policies.

Child abuse

Child maltreatment fundamentally challenges the foundations of connection, relationships, and personal boundaries. It encompasses a range of complex phenomena, including physical and psychological abuse, neglect, sexual abuse, exposure to spousal violence, highly conflictual parental separation, and institutional abuse.

These forms of violence occur within a specific relational context, most often within the family. The para- or intra-family framework, which should provide a safe environment for the child's development, is instead compromised. This presents a fundamental paradox: the very setting meant to protect and nurture the child becomes a source of trauma.

Moreover, the perpetrator is often closely linked to the child, and despite the abuse, this connection remains significant for the young person's sense of identity (5-7).

This paradox has several characteristics:

- Abusive relationship dynamics occur within a system, most often a family system, which must be seen as a whole to prevent the recurrence or displacement of abuse.
- The child often maintains a sense of loyalty to the perpetrator, whether it is a parent, sibling, family friend, or other close figure.
- Abuse exists on a continuum—any kind of violence against a child stems from these dysfunctional relationships. Without intervention, the severity of abuse typically escalates, making early intervention crucial.
- Abuse occurs within a broader societal context and evolves over time as social norms and values change. Consequently, approaches to addressing abuse must be regularly reassessed and adapted.
- The primary focus of intervention should be on protecting and caring for the child, parallel to punitive measures.

Abuse often originates within a complex family system. Therefore, it is useful to examine each situation of abuse from social, psychological, medical, and legal perspectives. These different aspects are helpful in identifying violent relational dynamics and offering appropriate help. The clinic of abuse is, in most cases, closely linked to the clinic of trauma (8-10). While some children and adolescents appear to go through abuse events without apparent trauma (though possibly latent), many do manifest obvious discomfort.

Psychological trauma and complex trauma

Psychological trauma can originate when certain events lead to "injuries" of the psyche. A "traumatogenic" event is one that confronts an individual with death, the threat of death, serious injury, or violent contexts. Knowing someone who has been injured or killed in such an event, or, as a professional, being repeatedly exposed to stress, is now viewed as potentially traumatic (11, 12).

In practice and literature, several types of trauma are distinguished. Type I refers to single, time-limited exposure to an isolated, unexpected event. Type II reflects repeated or long-term exposure, most often interpersonal, including resignation (no surprise). Type III incorporates multiple, pervasive, and violent early-onset and long-lasting events, such as child maltreatment.

Another concept is Developmental Trauma Disorder (DTD), which can account for the difficulties experienced by a traumatized person. DTD is based on five criteria: childhood exposure to multiple and prolonged traumas, difficulties in physiological and emotional regulation, difficulties in regulating attention and behavior, difficulties in regulating social relations, identity problems, and traumatic symptoms similar to those observed in post-traumatic stress disorder (PTSD).

Furthermore, the concept of "complex trauma" refers to the dual reality of prolonged exposure to particularly pervasive traumatic situations. Domestic abuse and the multiplicity of negative impacts of this exposure as well as its lasting effect on the dynamics and functioning of the victim is one example. Two intrinsic characteristics of trauma explain severe and lasting impacts: the interpersonal nature of the traumatic events or situations specific to complex trauma and the fact that these traumas occur at key periods in the individual's development.

There is no doubt about the connection between child abuse and trauma, as highlighted by various studies (13-16). Abused children often experience a prolonged "chain of trauma" throughout their development. In our clinical work, we encounter many adults with post-traumatic symptoms stemming from childhood abuse. The psychological and physiological effects of trauma can persist throughout a person's lifespan. Bapolisi and colleagues demonstrated a link between trauma and high blood pressure in a population of adult men in Congo (17). Additionally, several studies have explored the potential correlation between child abuse and psychosomatic symptoms in both children and adults (18-20). Thus, abuse correlates with changes in the functioning of the immune system, brain, and DNA, accelerating the process of cellular aging. Stress induced by trauma can lead to deregulation of the hypothalamic-pituitary-adrenal axis and result in epigenetic effects.

Moreover, abused children are often diagnosed with multiple mental disorders, sometimes receiving several diagnoses, which complicates the assessment of trauma and the provision of effective help. Various authors, such as Blavier and Delhalle, have shown that a large number of abused children receive a variety of mental disorder diagnoses (21). Consequently, they may accumulate two, three, or even four separate diagnoses over their lifetime, sometimes even simultaneously. As Van der Kolk points out, it is not uncommon for "oppositional defiant disorder", depression, ADHD or separation anxiety to mask a traumatic situation related to a context of abuse (22). This complicates also the work of assessment and therapeutic intervention. There is a risk of a fragmented intervention strategy, which may overlook the traumatic trajectory in the development of young people.

The axes of intervention

While not exhaustive, we propose three axes of reference. The purpose is to support the professionals and help them overcome the challenges posed by these difficult situations (23).

The first axis emphasizes the need for a defined framework for intervention, tailored to the patient's complaint. We believe that a clear framework helps to avoid misunderstandings. It is important to remember that some psychopathological profiles specifically address the relationship to the framework, to the alterity and to the law (24). On the other hand, it is important to recognize and articulate the limits of our jurisdiction. It makes sense to determine one's area of knowledge and skills in the patient's best interest. Following this initial assessment, the objectives of the therapeutic intervention should be defined by exploring the explicit and implicit expectations of the person seeking help. The more precise we are in clarifying the details of the approach, the more we can avoid pitfalls that may lead to potential failure (25).

The therapeutic framework, a fundamental element of any intervention in the humanities, is challenged in situations of domestic abuse. Families with abusive dynamics are more likely to

challenge and confront the framework that, ideally, should protect the therapeutic relationship based on trust. However, violence inflicted on children can quickly contradict the prospect of providing caring support for family members. It jeopardizes the basic conditions for therapeutic bonding, which include an effective meeting, a project based on a clear plan, and a framework that encompasses both elements. For most professionals, the framework essentially includes a dimension of a paternal function. The latter refers to authority, which encompasses aspects such as sanctions (both negative and positive), limits, and organization. In the field of medical-psycho-social assistance, the notion of framework is closely tied to authority. It is both invoked and feared, as it serves to limit chaos and impose order, albeit at the risk of reducing freedom. Following Lebrun, we can consider that in our contemporary society, marked by the weakening of collective representation structures, the framework faces two main pitfalls (26). First, there is a loss of meaning due to a lack of benchmarks and rules, driven by the need for immediate gratification and impulsive actions. Second, the application of the framework can be either too rigid or overly adapted, leading to its ineffectiveness in fulfilling its functions. The child often finds themselves ensnared in a pre-existing system, established long before their conception, within a fantastical realm. Consequently, the second axis involves creating an intermediate space and a partnership envelope. Regardless, the child or adolescent inevitably exists within a network, a specific relational context. Among the theoretical-clinical benchmarks supporting the management of maltreating systems, the concepts of space-intermediary and partnership envelope form the foundation of work that mitigates the risks of malfunctioning. Any encounter, regardless of its format, serves as an intermediate space where knowledge, representations, and emotions are developed. This process is a co-construction, achieved through mutual listening, aimed at recognizing, understanding, analyzing, and developing to support resilience and modify inappropriate behaviors. This co-construction is facilitated by teamwork, as collaboration among various aid and healthcare actors, centered around the patient and their socio-family environment, ensures coherence in therapeutic approaches, preventing dissonance from contradictory interventions. In this intermediate space, professionals and/or teams create a 'partnership envelope.' This concept is inspired by Anzieu's observation that a group forms an envelope that holds individuals together (27).

Until that envelope is built, there may be a human aggregate, but not a cohesive cluster. The concept of the 'envelope of the group' in relation to the 'containment function' allows us to consider the weaving of attention necessary to contain the child's symptoms and the possible psycho-affective movements of the adult, whether depressive, aggressive, or otherwise. Welcoming someone necessitates creating an envelope system that allows for the expression of emotions, whatever they may be. For both individuals and groups, it can be essential to build an envelope that contains, delimits, and protects us while simultaneously facilitating exchange with the outside. Anzieu developed the concept of 'Moi-Peau' (28). In children, psycho-affective and cognitive development is intimately connected to sensorimotor experiences, which are primarily felt through the skin. What the toddler experiences physically during their initial experiments is reintroduced and contributes to the construction of their psychic apparatus. Similarly, the skin forms a boundary with others, its permeability filtering out tensions and emotions. The group is conceived as a living envelope with a double-sided membrane. One side is oriented towards the external, physical, and social reality, particularly towards other individuals or groups. This side of the group envelope constructs a protective barrier against external influences and, if necessary, functions as a filter for incoming information. The other side faces the inner reality of the group members, formed from the projections of their experiences and fantasies by professionals. Through this inner face, the group envelope facilitates the establishment of a 'trans-individual' psychological state, which Anzieu termed the 'self of the group.' In the context of a medical-psycho-social and educational team, this can be referred to as the 'self of the team,' where members share a group psychic reality and develop a sense of belonging to the system. This 'team self' acts as a protective container, allowing perceptions and emotions to flow between individuals. The concept of the 'partnership envelope' is also based on the work of Parret and Iguenane, highlighting functions such as building a container, protecting impulse movements ('arousal barrier'), and establishing a boundary between the inside and outside to ensure consistency of reality (29). The professionals' task is to create a psychic team envelope that can perform these functions to evaluate and treat the multiple impacts of abuse.

Metaphorically, the partnership envelope is the second skin that can help adults and minors whose self-image and self-esteem are affected by individual and/or systemic dysfunctions. This envelope, like the skin, benefits from being flexible, permeable, and continuous. It acknowledges the mobility and flexibility of the professionals who comprise it. Improvisation is embraced, and trial and error enriches everyone personally and collectively, fostering a stance of 'not knowing everything' about each other. With the protective wrap provided by the professionals, parents and children agree to dialogue, benefiting from the mirror effect offered by team members. The goal is to raise awareness of inappropriate behaviors and ways of being through the feedback that the support aims to provide. This general attitude is based on the creation of an envelope that includes all the partners involved and concerned by a specific situation, taking into account the logics and rules specific to each. This collective work helps to overcome judgments and stereotypes against patients, colleagues, partner services, and institutions. This constant and unifying process in family care seeks to avoid undermining the effectiveness of multiple interventions. It supports the development of solidarity links between professionals, enabling coordinated activities by accepting the complementarity of the constituent disciplines. By acknowledging the differences between stakeholders, we can welcome those of the families concerned and accompany them in understanding themselves and their environment. The aim of the partnership envelope is to provide institutional care for all professionals involved with a family. By organizing useful contact points and consultation meetings with and without family members, the envelope is built, each time singular and unique.

The third principle emphasizes the importance of working with the existing networks. Several categories of networks are defined based on the quality, function, and mandate of the professionals and/or structures that comprise them. Networks can be very tight or loose, more or less open or closed. Elkaim has developed applications of network practice, depending on the cultures involved and the type of work to be carried out, such as crisis situations or the presence of psychopathology in adults (30, 31). Responses are then introduced that are flexible, adaptive, and suited to the resources identified in the environment of a subject or a system in arrears. Families in socio-economic difficulties see around them the multiplication of assistance and protection interventions with the inherent risk of disqualification. Measures such as expertise, evaluation, specialized replacement care, and placement of children that follow one another over time contribute to this phenomenon. The larger and denser the network, the greater the risk of institutional abuse arising from configuration failures.

In general, network practice aims to stimulate the complex process of 're-functionalization' of a dispersed social field, which is fragmented or rendered impotent. Professional networks often need to be mobilized in situations of anomie, a state that generates exclusion and 'ghettoization.' Human systems labeled as 'problematic' typically induce and maintain ambiguous relationships with professionals who intervene in isolation, leading to exhaustion and dysfunction among the professionals themselves. Effective network practice avoids a reductionist approach by not considering the problem solely at an individual or family level. Instead, it aims

to create a context that integrates multiple components, enabling the generation of new hypotheses through shifts in perspective and elevation of understanding. This approach fosters collective intelligence, yielding original and unexpected insights. Network therapy is sometimes mentioned in this context. However, controversies within networks are not uncommon, as professionals working in their specific fields with defined mandates often find themselves in positions of mutual ignorance or rivalry, which can be very destructive to working relationships. These damaging positions result from macro-societal structural dysfunctions, due to the lack of social consensus and power challenges stemming from political, historical, and short-term reasons (32, 33). Moreover, the presence of conscious manipulations by patients or those involved in the field often reinforces the observation of system paralysis. Situations of abuse frequently generate frustration, exhaustion, a sense of helplessness, or even worthlessness. Our intention is to overcome this state by creating a dynamic of exchange based on respect for individuals, structures, and their missions. The tool for achieving this ambitious objective is consultation, which should be distinguished from negotiation and mediation. Consultation involves exchanges between multiple parties to agree on a common project, embracing confrontation, argument exchange, and clarification of viewpoints. Multidisciplinary should not be seen as merely the juxtaposition of competencies specific to each discipline, which could be perceived as 'constrained multidisciplinary.' This approach may necessitate reconciling or arbitrating different viewpoints inherent in the interests of each profession. We support the research and construction of business models based on consensual planning. Ideally, all interventions should be part of the human action, requiring a memory and a form of alliance around which professionals can come together to help and heal. Ideally, all interventions should be part of human action, requiring a sense of history and a form of alliance around which professionals can unite to help and heal. This consideration of history and the alliance established guarantee real concertation, providing coherence to the project of care and the resulting decisions (34).

Conclusion

Professionals involved in childhood and adolescence care often feel uncomfortable when they witness inappropriate parental behavior towards young people in need of identity and positive identification (35) (35). In the complexity of child abuse situations, professionals can improve their working comfort(environment) and efficiency by having clear benchmarks that define the scope of their intervention, allowing them to avoid dynamic duels(conflicts?) with family members. Ideally, in many situations, they will choose to work based on a multi-stakeholder model, supported by multidisciplinary team reflection and the possibility of referring to supervision sessions in any form.

Multi-stakeholder work forms the foundation of the 'partnership envelope.' Professionals constitute a living group with feelings and resentments, necessitating time to analyze the relationship between the relational dynamics within the multi-professional group and those within the family. Through multidisciplinary team meetings, this collective development is realized, experienced, and evolved. This multi-stakeholder practice emphasizes consultation and aims to prevent fragmentation in the care of families, particularly those with abusive interactions.

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