Scientific Research Publishing

Open Journal of Psychiatry, 2026, 16(2), 189-199
https://www.scirp.org/journal/ojpsych
ISSN Online: 2161-7333
ISSN Print: 2161-7325

Hospitalization of Minors in Adult Psychiatric Units and Its Impact on the Quality of Their Care, at the Public Mental Health Establishment of Marne (France)

Serigne Souaibou Ba[1], Bachir Mansour Diallo[2], Malick Ngom[3], Karim Pouabizan[1], Edouard Sene[1], Papa Souleymane Seck[4], Abdou Khadre Dieng[4], Thuy Nguyen[1], El Hadji Makhtar Ba[5]

[1]Department of Psychiatry, Marne Public Mental Health Institution, Reims, France
[2]Department of Internal Medicine, Mame Abdou Aziz Hospital Center, Tivaouane, Senegal
[3]Department of Public Health, Faculty of Health Sciences, University of Thiès, Thiès, Senegal
[4]Department of Psychiatry, Meulan Intercommunal Hospital Center, Mureaux, France
[5]Department of Neuropsychology, Albert Royer National Children's Hospital of Fann, Dakar, Senegal
Email: bamarabout1@gmail.com

How to cite this paper: Ba, S.S., Diallo, B.M., Ngom, M., Pouabizan, K., Sene, E., Seck, P.S., Dieng, A.K., Nguyen, T. and Ba, E.H.M. (2026) Hospitalization of Minors in Adult Psychiatric Units and Its Impact on the Quality of Their Care, at the Public Mental Health Establishment of Marne (France). *Open Journal of Psychiatry*, **16**, 189-199.
https://doi.org/10.4236/ojpsych.2026.162014

Received: December 24, 2025
Accepted: April 13, 2026
Published: April 16, 2026

Copyright © 2026 by author(s) and Scientific Research Publishing Inc.
This work is licensed under the Creative Commons Attribution International License (CC BY 4.0).
http://creativecommons.org/licenses/by/4.0/

Open Access

Abstract

Introduction: Adolescent mental health is a public health issue. The prevalence of mental disorders was estimated at 13% among French children and adolescents. These individuals are often hospitalized in adult psychiatric wards, despite documented inadequacies. The lack of specialized units exposes this population to poorly adapted care, both clinically and institutionally. The objective of this study was to analyze the conditions of hospitalization of minors in adult wards and to assess the relevance of establishing a specific unit. **Methods:** This was a twelve-month cross-sectional study (May 2024-April 2025) conducted within the Marne Public Mental Health Institution. The sample consisted of healthcare professionals and the minors they treated in adult units. A novel, anonymous, and self-administered questionnaire collected clinical, organizational, and subjective data related to care modalities, the achievement of therapeutic goals, and professional experience. The analyses were descriptive and thematic, grouping recurring response categories. Data concerning the adolescents were therefore collected from the caregivers interviewed. **Results:** Our study population consisted of 8 adolescents and 25 caregivers. The minors were between 16 and 18 years old. There were 5 girls and 3 boys, with a female-to-male ratio of 1.67. 62.5% of them (n = 5) lived with their parents, while the others came from residential care facilities. Hospitalizations were exclusively involuntary. The main reasons for hospitalization were severe de-

pressive states (45.5%) and anxiety disorders with suicidal behavior (35.7%). The caregivers were psychiatrists (16%), registered nurses (80%), and nursing assistants (4%). The stays, often prolonged and sometimes repeated, were largely considered unbeneficial. Medication was perceived as largely ineffective (68%), with frequent use of isolation and restraint (according 75.2% of caregivers). Coordination with medical and social service partners was considered difficult, and adolescents showed little engagement in their care plan (84%). **Conclusion:** While the data clinical collection method may be debatable, the results highlight the structural and clinical limitations of hospitalizing minors in adult psychiatry. The inadequacy of the institutional framework and the lack of therapeutic approaches adapted to adolescence contribute to treatment failures and staff distress. The data support the need to develop specific units offering a supportive, transitional environment that respects the developing autonomy of adolescents.

Keywords

Minors, Mental Health, Hospitalization, Inadequacy

1. Introduction

The mental health of children and adolescents is a major public health issue. In the countries of the Organisation for Economic Co-operation and Development (OECD), the prevalence of mental health disorders in children and adolescents is approximately 13%. In France, no recent epidemiological study has been able to precisely measure their incidence. According to an older study, the frequency of mental disorders was estimated at 12.5% among French children and adolescents [1] [2].

In 2020, there was no unit specifically for young people under 25 years of age in half of the metropolitan regions. Several reports and studies highlight the value of this type of service, which provides care tailored to this age group [3].

However, we are witnessing a resurgence in the hospitalization of minors in adult psychiatric wards. Although widely criticized, this practice remains common in France. Several reports, notably those of the General Controller of Places of Deprivation of Liberty (CGLPL), have demonstrated the detrimental effects of such situations [4].

The inadequacy and lack of specificity of the resources provided reinforce the minor's sense of insecurity. Staff have difficulty receiving and containing them, exacerbating their intense anxiety or feelings of abandonment [5].

We conducted a study within the Marne Public Mental Health Establishment (EPSMM) to consider the implementation of an inpatient unit to meet the specific needs of minors.

The objective is to analyze the conditions of the adolescents' stay and to assess the experiences of the caregivers, in order to demonstrate the relevance and acceptability of the project to build this specific unit, considering all the factors involved.

2. Materials and Methods

2.1. Type, Framework and Period of the Study

This was a cross-sectional study conducted within the EPSMM. It is the reference hospital establishment in the department and the Marne region for psychiatric and addiction care. The Marne is a French department, which owes its name to the river that waters it. It is part of the Grand Est region of France. Marne public mental health institution. The study took place over a 12-month period (May 1, 2024-April 30, 2025).

2.2. Presentation of the Study Sample

Our sample consisted of all caregivers in the service. We included the healthcare professionals and the minors they had to care for in an acute hospitalization unit for adults. The healthcare professionals consent to participate in the study.

2.3. Data Collection

A novel questionnaire, designed specifically for this research, was developed. It was self-administered on paper and took an average of 15 minutes to complete, ensuring anonymity and confidentiality. The guide included several sections exploring: personal and professional information (age, sex, position, years of experience), experience with hospitalizing minors in adult wards, the number of minors followed over a one-year period, their ages and sex, their places of residence, the most frequent clinical indications, admission methods, average length of stay, perceived benefit and achievement of care objectives, coordination with partners (child welfare services, special education or therapeutic, educational and pedagogical institutes), use of other therapeutic approaches, perceived effectiveness of medication, use of therapeutic seclusion, and finally, motivation to work in a unit dedicated to adolescents. Data concerning the adolescents were therefore collected from the caregivers interviewed.

2.4. Data Processing

Closed-ended responses (yes/no/"don't know," multiple choice, duration scales) were coded and analyzed in terms of frequencies, percentages, and averages.

Open-ended responses (e.g., types of complementary therapeutic methods used) were subjected to thematic analysis to identify and group recurring response categories.

3. Results

Our study population consisted of 8 adolescents and 25 caregivers.

3.1. About the Adolescents

They were between 16 and 18 years old. There were 5 girls and 3 boys, with a female-to-male ratio of 1.67.

The hospitalization method was involuntary psychiatric admission at the request of a state representative.

The adolescents lived with their parents in 62.5% of cases (n = 5), and the others came from residential care facilities.

The reasons for the adolescents' hospitalization were varied. The frequencies are based on adolescents' symptomatic episodes reported by the staff. The results are shown in Table 1.

Table 1. Distribution of patients according to reasons for hospitalization.

Symptoms	Frequency (n)	Percentage (%)
Severe depressive state	13	45.4
Anxiety disorder with suicidal ideation	10	35.7
Personality disorder	3	10.9
Behavioral disorder induced by psychoactive substances	1	5.2
Hospitalization integrated into a long-term plan (temporary respite admission)	1	2.8

Some adolescents were hospitalized multiple times: 4 were hospitalized 3 times during the study period, 2 were readmitted once again, and the rest had a single stay.

Of the 6 who were readmitted, 3 came from residential care facilities, and the others lived with their parents.

The length of these stays varied between 30 and 90 days, punctuated by weekend leaves. These leaves were granted in the context of good clinical progress and preparation for returning home or to the residential care facility.

3.2. Regarding the Healthcare Staff

These consisted of 4 psychiatrists (16%), 20 registered nurses (80%), and 1 nursing assistant (4%), as illustrated in Figure 1.

Among them, 5 (21.7%) had previously worked in a psychiatric admissions unit for minors.

Regarding treatment, medication was ineffective, according to 17 caregivers (68% of the sample). They used therapeutic modalities (other than medication) such as: therapeutic isolation (for all minors, at least overnight), or therapeutic restraint (according 75.2% of caregivers) during suicidal crises and episodes of aggression towards others, and play therapy or other forms of therapy (24.8%). The denominator is staff-reported experience across multiple admissions.

Coordination with child welfare services was difficult, according to 21 caregivers (84%).

The hospitalized minors did not have their own treatment plans, according to 21 colleagues (84%). In addition, 22 healthcare professionals (88%) reported not having met their objectives during hospitalization and found the stays unbeneficial for the adolescents.

Finally, 17 healthcare professionals (68%) did not plan to work in a specialized adolescent inpatient unit.

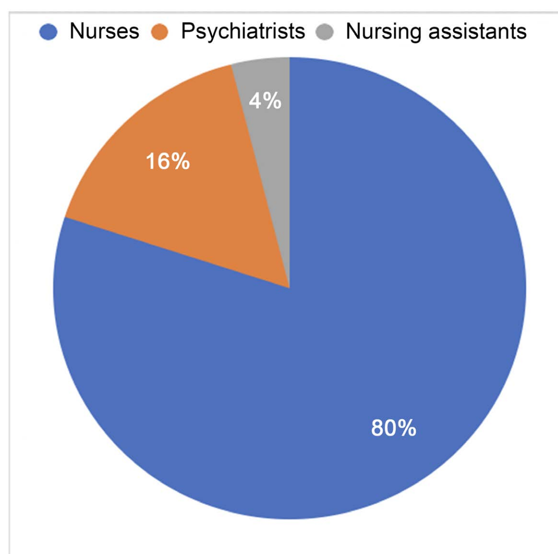

Figure 1. Distribution of healthcare workers surveyed.

4. Discussion

4.1. Regarding Adolescents

Girls are more represented in our study. These results contrast with those of Richard *et al.*, where the sex ratio was 0.8 with a majority of boys. This could be explained by the fact that the psychological distress expressed by girls is often more easily identified as requiring psychiatric care, increasing the likelihood of referral to protective care facilities [6] [7].

In our facility, minors are admitted exclusively from the age of 16. Generally, they are often hospitalized in pediatrics. We found younger ages (14.7 ± 1.7 years) in Benarous [8] and (12 - 20 years) in Wouters [9].

The hospitalization method was involuntary psychiatric care at the request of a state representative. This result is explained by an internal policy of the establishment consisting of systematically placing all minors in care without consent because they are placed in therapeutic isolation at night to protect them from adults who are in the same department with them. However, this therapeutic measure cannot be applied if they are not in involuntary psychiatric care. Indeed, the hospitalization of minors in psychiatric care is ambiguous, raising questions about how their rights and those of their parents interact with the hospital. In France, no provision specifically addresses the consent of minors in psychiatric care; the law uses vague concepts. Thus, the question of the legal framework remains complex. Adolescents are always brought in by others, and the notion of consent to treatment arises [4].

The most frequent reasons for hospitalization were severe depressive states (45.4%) and severe anxiety disorders with suicide attempts (35.7%). We find sim-

ilar results in Benarous, where the most frequently made diagnoses were: anxiety disorder (47%), persistent depressive disorder (36%), disruptive behavior disorder (30%), and stress and trauma-related disorder (29%) [8].

In Wouters' work, the psychopathological manifestations leading to hospitalization were varied: anxiety disorders, depressive disorders, psychotic symptoms, relational or family difficulties, and post-traumatic symptoms [9].

Some minors were hospitalized several times during the study period: four returned twice, and two were readmitted again. We found no studies allowing us to compare these results. However, this could be explained by the adolescent's need to engage in a therapeutic framework, often requiring hospitalization to stimulate their capacity to internalize the treatment model. The absence of this internalization would lead to repeated hospitalizations, which should not be considered "relapses" but rather "resumptions of subjectivation". Indeed, child welfare services would be overwhelmed by the reduced number of caregivers in residential care facilities. With limited resources and few support networks, adolescent clashes are often difficult to manage because educators' responses are not adequately suited to their behavioral problems.

Hospitalization aims, among other things, to offer the minor a "psychological security". The lack of containment in some family profiles could explain the threats of family breakdown. In this context, it would be up to the therapist to temporarily convey the adolescent's needs. It seems important to remember that the pleasure of interaction and shared action gradually replaces the pressure to act. But this takes time; it is neither constant nor linear, and the adult (caregiver) establishes requirements that provide structure for the adolescent and reassure them through the external constraints of the hospital setting [10].

The length of stay for these adolescents in hospital varied between 30 and 90 days. We find roughly the same figures in the work of Benarous, where the average length of hospitalization was 96 days [8]. However, in Ayoun's study, lengths of stay varied: a few days to a few weeks for a depressive episode; three to six months for severe anorexia. This could extend up to a year in chronic and severe psychotic disorders [11].

4.2. Regarding Healthcare Professionals

With respect to care, medication was largely ineffective according to most healthcare professionals. Indeed, adolescents admitted to this service often had excessively long prescriptions. This reflects a focus on symptomatic management rather than comprehensive care. This therapeutic failure, despite the over-prescription of medication, is thought to be linked to the lack of structured relational and therapeutic alternatives [12].

The exclusive creation of child and adolescent psychiatry beds for minors has had positive consequences on their care. Adolescents treated in child and adolescent psychiatry receive less medication (23.8% compared to 39.7% in adult psychiatry) and benefit more frequently from therapy (28.6% compared to 13%) than

those treated in adult psychiatry [13].

It would therefore be necessary to invest in specific inpatient units for minors. Adapted systems exist in some countries, such as England, where Hayes *et al*. demonstrated the effectiveness of Child and Adolescent Mental Health Services (CAMHS) in preventing readmissions [14].

In Australia, Headspace services promote early access and the collaborative development of care [15]. In Sweden, Ambresin *et al*. emphasized a school-care-family integration model to provide tailored care for young people [16].

The aforementioned models stress the need for a suitable environment that guarantees a holistic approach, conceived as transitional spaces to offer young people respite in their trajectory while avoiding abrupt disruptions. Faced with this failure, care teams resorted to therapeutic alternatives such as therapeutic isolation or restraint during suicidal crises or hetero-aggression (75.2%). The unanimous observation is that the "adults" (caregivers) looking after these adolescents were constantly being solicited and tested. Ideally, they should know how to respond to and manage conflicts firmly without provoking unnecessary confrontations. Responses are often inappropriate, insufficient, or too harsh, leading to self-harm and aggression towards others, which in turn results in isolation or restraint measures [11].

The limitations of such a care arrangement sometimes lead to "endangerment" for these minors (close proximity to adult patients admitted for a wide variety of conditions). Thus, caregivers were faced with the imperative of ensuring their safety. This fear became too important compared to the imperative of providing care, resulting in restrictions on their freedoms (prohibition of going out alone in the hospital grounds, mandatory isolation protocol from 8 p.m. to 8 a.m. without any clinical indication). The aim was to shield them from the persistent advances or inappropriate behavior of adult patients. This constitutes a violation of fundamental rights, since the restrictions on the minor's freedom are not based on a therapeutic indication and are not the subject of a medical decision related to their health, but rather an institutional one [4].

As a reminder, the HAS emphasized the principle of minimal restriction, positioning isolation as an indication of last resort, concerning only patients receiving involuntary psychiatric care, implemented for therapeutic purposes and in no case to resolve an administrative, institutional, or organizational problem, nor to address the scarcity of staff or professionals [5].

A specialized unit, as envisioned at the public mental health establishment of Marne, would ensure a degree of consistency in care. It would offer a transitional space that takes into account internal conflict, ambivalence towards care, and the need for a framework that is both supportive and flexible, as suggested by Winnicott [17]. The time frame would be designed to allow for gradual psychological restructuring, supported by therapeutic interventions.

Coordination with other partners was often difficult, according to 84% of colleagues. Indeed, it is in emergency or crisis situations that minors are hospitalized.

This crisis corresponds to a phase where all partners are overwhelmed, even exhausted. A return home or foster care becomes unlikely due to a lack of support from these partners, who fear a relapse and cling to the illusion of a "miracle cure." As Bastianelli stated, separation from the natural environment is only beneficial if it aims to rebuild connections, without relieving parents and socio-educational partners of their roles and responsibilities [18]. It would be therefore necessary to work with them on their perceptions of the illness and care, but also, and above all, on their perceptions of the minor described as "difficult" or "unmanageable." The team should be open to parents and external partners (the importance of controlling information sharing). In this way, addressing the acknowledged suffering would prevent the labeling of a diagnosis that would negatively impact the minor's future plans.

At the end of hospitalization, treatment goals were rarely met. A significant number of caregivers (84% of the sample) maintained that hospitalized minors were not actively involved in their treatment plans. The unsuitable atmosphere contributed to creating a discouraging image of psychiatric hospitalization for minors and explained their lack of engagement in the treatment setting. In fact, the demands placed upon them created a conflictual relationship that was often neither accepted nor tolerated by the adolescent, making the treatment "brutal." In our study, these conflicts, poorly tolerated by the caregivers themselves, were a source of negative countertransference, leading to rejection by colleagues [19].

Furthermore, the failures in treatment could be explained by the fact that in adult psychiatric services, institutional therapy is not designed to address the specific developmental characteristics described during adolescence [20].

Finally, in its report, the CGPL said: "*In all cases, children or adolescents should not be hospitalized in psychiatry with adults and their follow-up should be carried out under the close control of a doctor and a team specifically trained in pediatrics and child psychiatry*" [4].

4.3. Implications for Practice

To overcome this problem and in order to improve the care pathway for adolescents in crisis, we propose the establishment of a hospitalization unit for adolescents in Châlons, with a capacity of 08 beds in total.

The primary role of this unit will be to provide appropriate reception which will be underpinned by team operating methods which are specific to adolescence.

This specific approach requires a particular environment and an organization of the service and teams taking into account the minor in his developmental and relational particularity (centered on the body, preponderance of action over thought, emergence of behavioral disorders, risky experiences but sometimes necessary for the acquisition of autonomy).

The service must be part of a healthcare network by promoting trans-disciplinary and inter-institutional connections; the presence of a somatician is essential. Professional multidisciplinarity allows the implementation of individualized and group activities as well as support work with families.

Psycho-education, one of the strong points, will greatly contribute to early detection but also to the reduction of risky behavior, with the aim of positive medium-term development for these young people.

The participation of the minor as an actor in his health journey will remain a priority. This will allow better adherence to the care offered.

The objectives will be as follows:

- Allow full hospitalizations for minors in a structure more adapted to their ages and their problems.

- Offer maximum protection preventing the adolescent from putting themselves in danger.

- Allow the restoration of balance and internal security, the resumption of relational links, activities, at a pace adapted to its possibilities.

- Avoid hospitalizations of adolescents in Adult Psychiatry and Pediatrics.

- Allow early and intensive treatment of psychiatric disorders emerging countries enabling favorable developments in the medium term.

- Detect as early as possible and reduce risky behavior, consumption of psychoactive substances and possible psychiatric co-morbidities through psycho-education work.

- Readapt a psychotropic treatment, by modulating medication intake, by monitoring the tolerance/effectiveness of the medication.

- Define with the medical-psychological center a post-hospitalization monitoring protocol, which is one of the keys to preventing re-hospitalization and "disharmonious" care pathways.

4.4. Study Limitations

However, caution is advised when interpreting these results, as the small sample size may introduce bias, preventing generalization. The data clinical collection method may also be problematic: the minors were not directly questioned and some variables are confounded (e.g., several adolescents may have been treated by the same healthcare provider), while others were difficult to explore or were not assessed (e.g., healthcare providers' experiences).

5. Conclusion

These observations, without being exhaustive, reveal that the situation in child and adolescent psychiatry is particularly fragile, even if the issues of care for minors suffering from serious mental disorders are crucial to ensure a quality mental health policy. Public authorities should ensure that any child whose condition requires care can be admitted to an appropriate facility. In addition, implementing prevention and early care policies among young people in order to prevent serious mental illnesses in adulthood makes it possible to limit the economic costs relating to the latter.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Houzel, D. (2023) Cour des comptes, La pédopsychiatrie. Un accès et une offre de soins à réorganiser, mars 2023, rapport accessible sur le site internet de la Cour des comptes: Www.ccomptes.fr. *Journal de la psychanalyse de l'enfant*, **13**, 550-557. https://doi.org/10.3917/jpe.026.0550

[2] Etiemble, J. (2003) Troubles mentaux déspistage et prévention chez l'enfant et l'adolescent. *Sauvegarde de l'Enfance*, **58**, 107-111. https://doi.org/10.1016/s0036-5041(03)90009-5

[3] Brunner, J. (2020) Psychiatric Care of Young Adults in the French Public Sector: Focus on Specific Hospitalization Units. Medical Doctorate Thesis, Henry Warembourg Faculty of Medicine, 102.

[4] Contrôleur général des lieux de la privation de liberté (CGLPL) (2021) Droits fondamentaux des mineurs enfermés. DALLOZ, 120-125. https://www.cglpl.fr/app/uploads/2024/10/cglpl_rapport-droits-fondamentaux-des-mineurs-enfermes_web.pdf

[5] Guidi, J., Sigaud, J.P. and Guiot, F. (2018) Retrospective Study Concerning Minors Hospitalized in Adult Psychiatry. *L'information Psychiatrique*, **94**, 183-188.

[6] Richard, Y., Saint-André, S., Porchel, G. and Lazartigues, A. (2010) Hospitalisation en pédopsychiatrie: description et évolution d'une unité. *Archives of Pediatrics*, **17**, 446-451. https://doi.org/10.1016/j.arcped.2009.12.001

[7] Jaquin, P. (2002) La différence des sexes dans la demande de soins à l'adolescence. *Gynécologie Obstétrique & Fertilité*, **30**, 596-602. https://doi.org/10.1016/S1297-9589(02)00381-8

[8] Benarous, X., Cravero, C., Jakubowicz, B., Morales, P., Iancu, C., Pellerin, H., *et al.* (2020) Durée d'hospitalisation en pédopsychiatrie: étude rétrospective des facteurs prédictifs sur deux ans en unité d'adolescents. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, **68**, 377-383. https://doi.org/10.1016/j.neurenf.2020.03.004

[9] Beine, A. and Wouters, V. (2023) Sortir de l'hôpital psychiatrique pour (re)trouver sa place en famille: difficultés adolescentaires du réaccordement. *Thérapie Familiale*, **45**, 70-85. https://doi.org/10.3917/tf.243.0070

[10] Jeammet, P. (2002) Spécificités de la psychothérapie psychanalytique à l'adolescence. *Psychothérapies*, **22**, 77-87. https://doi.org/10.3917/psys.022.0077

[11] Ayoun, P. (2008) L'hospitalisation à temps complet des adolescents et ses indications en psychiatrie. *L'information Psychiatrique*, **84**, 701-707. https://doi.org/10.1684/ipe.2008.0352

[12] Verdoux, H., Pambrun, É., Tournier, M. and Begaud, B. (2016) Use and Misuse of Antipsychotic Drugs: Are Antipsychotic Drugs the New Panacea for Psychiatric Disorders? *Bulletin de l'Académie Nationale de Médecine*, **200**, 1155-1166. https://doi.org/10.1016/s0001-4079(19)30636-3

[13] Sabbah Lim, I., Garnier, B., Dauriac-Le Masson, V., Fortias, M. and Contejean, Y. (2013) Characteristics of an Adolescent Population under Care According to Its Place of Consultation: Comparison between an Adult Psychiatric Department and a Department of Child Psychiatry. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, **61**, 1-7. https://doi.org/10.1016/j.neurenf.2012.10.005

[14] Hayes, D., Fleming, I. and Wolpert, M. (2015) Developing Safe Care in Mental Health for Children and Young People: Drawing on UK Experience for Solutions to an Under-Recognised Problem. *Current Treatment Options in Pediatrics*, **1**, 309-319. https://doi.org/10.1007/s40746-015-0037-1

[15] Rickwood, D., Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowan, J., *et al*. (2018) Australia's Innovation in Youth Mental Health Care: The Headspace Centre Model. *Early Intervention in Psychiatry*, **13**, 159-166. https://doi.org/10.1111/eip.12740

[16] Ambresin, A., Michaud, P. and Haller, D.M. (2014) Youth Friendly Health Services: How to Promote Quality Health Care for Adolescents. *Revue Médicale Suisse*, **10**, 1278-1281. (In French) https://doi.org/10.53738/revmed.2014.10.434.1278

[17] Boukobza, C. (2003) La clinique du holding Illustration de D.W. Winnicott. *Le Coqhéron*, **173**, 64-71. https://doi.org/10.3917/cohe.173.0064

[18] Bastianelli, M. (2002) Adolescents en psychiatrie: un travail sur les limites. *La lettre de l'enfance et de l'adolescence*, **48**, 83-89. https://doi.org/10.3917/lett.048.0083

[19] Marcelli, D., Braconnier, A. and Tandonnet, L. (2018) Adolescence and Psychopathology. 9th Edition, Elsevier, 926 p.

[20] Botbol, M. and Balkan, T. (2006) Borderline States in Institutions: Psychotherapy through "The Environment". *Psychothérapies*, **26**, 15-20. (In French) https://doi.org/10.3917/psys.061.0015