Family domains: a conceptual framework with practical application for adolescent inpatient services

Received: 15 May 2023 | Accepted: 3 September 2023

DOI: 10.1111/1467-6427.12440

RESEARCH ARTICLE

Family domains: A conceptual framework with practical application for adolescent inpatient services

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Abstract

According to the Family Domains Framework (FDF), family life consists of a movement of parents and children across four domains: exploratory, attachment, discipline/expectation and safety. Each has its own typical behaviours, ways of speaking and pacing, and each serves distinct and equally important functions for the growing child. On admission to an adolescent psychiatric unit, staff become temporary custodians of some of the domains' processes, while also working in partnership with parents. Here we outline the Family Domains Framework and describe its application in a Family-Domains-informed systemic therapy, attending to the roles of unit staff, the family therapist, parent and young person. We outline how the FDF can be used to review everyday challenges involving staff, parents and young people to generate hypotheses and ideas for alternative staff strategies. We also describe how the framework can be used to clarify the roles of unit staff and parents.

KEYWORDS

adolescence, family domains, in-patients, parent–young person interactions, staff–parent communication

Practitioner points

1. The FDF can be used by all staff to generate hypotheses on the basis of the detail of observed or reported family interactions.
2. The FDF provides a basis for clarifying and agreeing on the roles of unit staff and parents.
3. Events on the unit can be reviewed in family therapy using the FDF, and in turn be linked back to life on the unit.
4. The FDF can be offered as a tool which is handed over to families, or as a set of principles used by unit staff and family therapist.

INTRODUCTION

According to the social domains hypothesis, all human social interactions depend on shared rules and assumptions among the participants about the range of behaviours and emotions that each will show, and how these will be interpreted (Box 1; Hill et al., 2010). The Family Domains Framework (FDF) uses this perspective to understand, and to solve challenges in, parent–child relationships, and can also be applied to the relationships between the adolescent, family and the adolescent unit staff.

Some domains have an explicit identity, such as through a work contract, but still require clarification day by day. Others, such as social interactions at a party, are identified by social context and from participants' signals. Some social domains can be identified on the basis of who is participating, but in families the domains, summarised in Box 2, are transacted between the same participants (Hill et al., 2003, 2014; Riley et al., 2019; Weinstein et al., 2023). Three of the four domains – exploratory, attachment and discipline/expectation – are informed by an extensive developmental literature, and in particular by features of parent–child interactions revealed by direct observation (Ainsworth, 1969; Deater-Deckard & Petrill, 2004; McElwain & Booth-LaForce, 2006). The fourth, safety, does not have a similar well-researched background but is important throughout childhood, and often acquires particular salience for families where a young person has a serious mental disorder.

Each domain is an important resource to children, provided they are confident they know which one is operating, and provided the domain is matched to their needs at that moment. As we describe in Box 1 many of the Family Domains (FD) ideas have their origins in systemic family therapy, and in particular Bateson's writings. Consequently the core principle of FDF is understanding and clarifying social communication within families, which is necessarily context dependent. It aims to create a basis for identifying where communications between family members are not clear, and where parents and young people do not have shared aims in their communications. Key to this is observing, and talking about, the details of communications, to create a platform for greater clarity and sharing. However, unlike many current family therapy traditions it is not committed to a particular method of implementation. As we describe in this paper, it has a complementary fit with established family therapy practices, but equally it can be used to create a framework for parents to make choices in other arenas such as implementing new parenting skills (Webster-Stratton, 2000), and as an adjunct to Dialectical Behaviour Therapy (Linehan, 2020). It is therefore suited to therapy which aims to find a fit between therapeutic approach and family preferences. In some instances it provides a tool which is handed to families

BOX 1 Background and theory.

The Family Domains Framework (FDF) has its origins in the idea that, as with individuals, whole families might be assigned an attachment classification. To explore this, we interviewed families using an adaptation of the Adult Attachment Interview, referring to current interactions among family members. This revealed what we should have known from the start, which was that attachment processes belong to a wider 'ecology' of family processes (Bateson, 2000; Hill et al., 2003). Drawing on our observations, and the developmental research literature, we proposed that this ecology comprises, in addition to attachment, exploratory/sharing activities, discipline/expectation, and safety. We refer to these as the four domains of family life, following Bugental's characterisation of domains as the 'algorithms of social life' (Bugental, 2000). The idea of family domains is part of a wider social domains framework based on conceptual and philosophical ideas (Bolton & Hill, 2004), and empirical work into personality functioning (Hill et al., 2008, 2023). The idea here is that humans are capable of generating such a wide diversity of interpersonal behaviours and meanings that, without a way of reducing the possibilities to be considered moment by moment, social life would be frozen in a timeless indecision among alternative possibilities. Social domains in general, and family domains in particular, provide a way for participants to narrow the possible interpretations of each other's behaviours, and hence arrive at rapid shared understandings, and provision of social, educational and health resources. Much of this is achieved in day-to-day life within close relationships, notably in families, but has to be made explicit in interactions between strangers, a key point for adolescent unit staff aiming to create rapidly shared understandings and provision of resources to families at times of crisis.

Even where the rules of domains are made explicit, such as in schools and workplaces, there are still moment by moment interpretations to be made regarding which domain is in operation. In an imaging study designed to test this, an area of the brain was identified which appears to be part of the early warning system for violations of domains expectations (Bland et al., 2021). In families, the identity of the domain is signalled in the detail of what a parent says, how they say it, and their nonverbal signals. If the parent is aiming to respond to an adolescent attachment need, such as worry or anxiety, they signal the domain through a gentle warm voice, being alongside without being intrusive, and offer of gestures of support, which could be a hug but also making a hot drink or favourite meal. By contrast discipline/expectation is signalled by clarity of instruction, reference to the reasons for the instruction (for example, related to regard for others) and firmness of voice. More generally the domains are signalled by a range of verbal and non-verbal meta-communications (Bateson, 2000). Where the domains are not signalled clearly, the participants remain in doubt as to the algorithm for proceeding. For example, when a parent says to a young person who has self-harmed, 'So what has been going on then?', depending on their tone, facial expression and body posture, this could signal any of the four domains, leaving the young person confused, and parent and young person talking past each other, or worse on a collision course. These processes are two way. The young person who, after self-harming answers, 'Nothing, I already told you', also provides signals for any of the four domains, creating a challenge for the parent to find a way to a clear domains response.

BOX 2 What are the Family Domains?

Safety The key principle of the safety domain in family life is that the parent takes direct action to reduce risk to the child or young person, based on their judgement, and even where the young person is not in agreement. With younger children, safety is often enacted without the child being aware of it, through the parent watching out for sources of risk such as sharp objects or hot fires, and ensuring the child is not close to them. Monitoring who comes into the house and who takes care of the child is crucial to ensure that they are not exposed to maltreatment. Predictable routines such as for providing clean clothes and meals, ensuring vaccinations are administered and making appointments for the doctor or dentist all belong in the domain.

In safety the parent either takes direct action or speaks emphatically, firmly and quite slowly, but without hesitation, making eye contact, but not waiting for the child's reaction to what they are saying. In other words the pacing belongs to the parent.

Exploratory These are often playful, conversational, enquiring interactions. They can also be serious-minded attempts by parents and young people to understand each other's point of view. This requires listening from all participants! While the safety domain can proceed without the participation of the child or young person, the exploratory domain cannot. It requires reciprocity. However the parent can signal a readiness for the exploratory domain through showing interest, enquiring about something (such as the child's day at school) or commenting about a book, or the news, or a footballer. Then exploratory domain only proceeds if the child responds. Equally the child may start the exploratory domain by talking about their day, bringing a picture they have made at school or talking about their friends or a movie, video game or football. In the exploratory domain, the parent goes at the young person's pace, making eye contact to monitor their responses. Their voice is light, gentle, enquiring and often hesitant and without applying pressure to speak.

Attachment Attachment processes entail a young person showing fears, worries, sadness or distress to a parent in a way which conveys a wish to be comforted and the parent responding soothingly and warmly. As with the exploratory domain, attachment sequences are at the young person's pace, with the parent monitoring what the child says and does, how they look and what emotions they are conveying. Stated in this way, what could be more straightforward? In practice it is often more complicated. For example, the smooth attachment sequence relies on the young person being able to convey their worry or anxiety, and signal a wish to be comforted. However, they may come home from school after a worrying experience, and appear angry and oppositional, leading to a disciplinary response, whereas what they need is understanding and comfort. As in the exploratory domain the parent goes at the young person's pace, making eye contact to monitor their responses. The parent's gestures and what they say aims to show recognition of, and empathy for, the young person's emotional state, and a readiness to do what they can to help them feel better. Their voice is tender and often hesitant, and without pressure.

Discipline/expectation As with safety this is a parent-led domain, but with a focus on acceptable behaviours. Importantly, this is the domain in which the parent aims to equip

the young person for the wider world of acceptable and kind behaviours with peers, in the families of friends, in work and as a future citizen. The domain is made clear through house rules, and predictable rewards for acceptable behaviours, and consequences for unacceptable behaviours. It is also clarified through what is said and how it is spoken. Generally, the parent uses expressions such as 'After you have cleared the table, you can go on your game', and not questions, or more tentatively worded requests. Their tone of voice is firm and emphatic, perhaps slowed down for emphasis. They make eye contact but do not wait for the child's response, nor do they say anything such as 'Is that OK?' Once the instruction is delivered, the parent does not engage further with a child's objections.

so they can find their own way with it, and in other instances it guides the therapist's thinking as they explore family processes, without the framework being made explicit to the family. Or, as in the example described in this paper, the family therapist finds a middle way between those two polarities.

We have drawn on the experience of the authors working in a range of National Health Service (NHS) child and adolescent mental health services to propose four broad areas in which the Family Domains Framework can be used to inform what happens when a young person is admitted to a psychiatric in-patient unit. First, it creates a context for linking the work of unit staff and family therapy. This is described in Section "Linking the work of unit staff and family therapy", illustrating the processes with reference to FDF-informed family therapy conducted on an adolescent unit. Second, it provides a framework for linking the work of unit staff and the family outside of family therapy. In Section "Linking the work of unit staff and the family outside of family therapy" we outline how this may be done drawing on discussions held in an FD consultation group. Third, it has the potential to clarify the relative roles of parents, other caregivers, and unit staff, for example at admission or when decisions need to be made. This is described in Section "The application of the FDF to the system of the in-patient unit, the young person's family and the wider system". Finally, it provides a method for review of staff–young person interactions, moment by moment, for hypothesis testing and planning. We will discuss this in a future paper.

LINKING THE WORK OF UNIT STAFF AND FAMILY THERAPY

Family Domains are identified by the specific features of what the participants say, how they say it and by their non-verbal communications (Box 1). The family therapist who is using the FDF therefore listens very carefully to the way family members describe interactions, and where needed, asks them to describe a specific incident, 'blow by blow'. Similarly, when they meet with a family, they attend to the details of the way family members speak to each other and, to do this more systematically, may ask the family to talk together about a topic for a short time, without the therapist getting involved. The Social Domains framework encompasses all social interactions, and thus provides a basis for connecting unit staff interactions with parents and young people. We therefore use the framework to connect multiple narratives – those on the unit pre-session, the in-session discussion and the subsequent developing stories on the ward.

Tracy, a sixteen-year-old young person on the unit with an eating disorder had a potassium level which was low enough to be a cause of concern and so she was not allowed home.[1] Her mother had agreed that she would take them for a walk locally and would ensure that they did not go home. They went home! The young person's link-worker, a senior nurse, knocked on the door of the family therapist soon after they had left the unit, and informed the therapist that the young person and her mother had indeed gone home despite the agreed plans. The link-worker had spoken with Tracy and her mother, while they were at home, and had reiterated the underpinning rationale re physical concerns for Tracy. He had also re-asserted limits previously set by stating that Tracy would need to return to the ward promptly. The nurse wondered what was happening in the interactions between the young person and their mother that had resulted in plans being changed – and asked the family therapist to think about this in the next family therapy session. Tracy had called later that afternoon to let the staff team know she had indeed gone home when on leave and did not want to come back to the ward.

The details of this sequence provide the context for the meeting of the family therapist with the mother and young person. The young person's health is threatened by their low potassium, accentuating the safety role of staff. The link-worker had sought to establish that this responsibility could be shared with the parent. How then should the family therapist take this up in the session? From an FD perspective, exploratory and safety processes are seen as potentially complementary. Exploration can enhance participants' understanding of how each sees a problem through attentive listening; however, it is typically slow, and does not have a close link to action (Weinstein et al., 2023). *Safety processes entail the responsible adults taking action, in this case to ensure the young person does not develop a dangerously low potassium level. Understanding acquired during exploratory conversations can enhance the quality of the safety action.*

In this spirit, in the next session the therapist said that they had heard from the link-worker how things went during leave earlier this week, and said, 'It sounded like it didn't quite go as planned. I am interested in what happened, and I am wondering if we could explore it a bit to see if anything useful comes out of it that could help us. Are you up for that?' The mother immediately – in a 'mea culpa'-style admission with her hands up – said 'It's me, it's me, I know, I just can't stick to boundaries!' The therapist suggested that they think further, and perhaps there might be something that happens between her and Tracy that could help them and the team manage similar moments differently in the future.

From a FDF perspective the therapist provides an exploratory opportunity, regarding the safety issue, thus seeking to understand it better rather than to emphasise the safety element. The mother's reply is complex and a rich source of questions which can be explored further. On the one hand, is she saying something similar to, 'I need to think about this some more so I can be clearer about boundaries with Tracy' or, on the other, something more similar to, 'I should have done better applying the rules set by the unit'? If it is the first, it would seem she believes the safety rules are right and the question is how to apply them. If it is the second, there are several possibilities including that she values the rules set by the unit in support of her parenting, or that, while she is prepared to apply the unit rules, she does not agree with them. In fact, she may have different ideas about the most appropriate safety rules for her daughter, which the therapist may seek to understand better. This understanding might in turn inform the unit rules.

The mother said that she had every intention of following the plan, but on leaving the ward Tracy became upset, and she had capitulated and had taken Tracy back with her.

One of the priorities for an FD understanding of what mother says is to try to tease out what 'upset' consisted of, whether it is 'upset-angry' which is more likely to be cue for discipline/expectation or safety, or 'upset-distressed', which may be a cue for attachment. If it is upset-angry, the safety

task for the parent may be to talk over with the young person what needs to be done for their health, bringing out that they need to do this even if the young person does not want it. If it is upset-distressed, the parent is more likely to seek to find a way to respond to their attachment needs. When this was explored in a subsequent session, Tracy talked about feeling angry and distressed, and the mother described her facial expressions and the way she spoke conveying both emotions. The therapist therefore kept in mind the dilemma for the parent of how to follow through on safety in spite of angry protests, and how to respond to attachment signals.

At this point, the therapist has to decide how explicitly they wish to make the necessary choices for proceeding, and which framework to use to best advantage. An important principle for implementing the FDF is the stance of neutrality (Selvini et al., 1980), *which allows the family and adolescent the opportunity to explore, and understand the various domains. Being too prescriptive at this stage may shut down communication. Contemporary systemic practice encourages a spirit of transparency in the therapeutic process* (Bertrando & Arcelloni, 2006; Burnham, 2018), *and this also informed what the therapist said next.*

'I am aware of certain ideas about relationships and communication between parents and their adolescent children – would it be okay to use this idea to explore the exchange between you both?' In response, the mother was a little more enthusiastic than Tracy, but nonetheless there was agreement from both.

The therapist wondered with Tracy and Louise whether they had they ever felt a difficulty in working out how best to respond to each other at times, depending on the situation? They said they were not sure what the therapist meant, so they went on to explain 'Parents at times might need to take a directive lead, for example when a young person's safety is important or where expectations for certain family or life rules need to be upheld – in those moments the parent has to step in. At other times when a young person is distressed, parents might follow the young person's lead as to what care they need from their parent. Then there are the moments when there are "relaxed back and forth" exchanges between parent and young person, each exploring what the other thinks and feels.'

The therapist describes the four domains simply and clearly. Importantly, they refer not only to the focus of each domain but the parent's manner: 'take a directive lead', or 'follow the young person's lead', or 'relaxed back and forth'. By referring to being aware of an idea which the therapist offered to share, they imply a neutrality regarding their view of it, rather similar to describing for the parent and young person a landscape with contrasting features in which they may identify the features which were relevant to them. This landscape is in some respects external to them, and available to be scrutinised/observed. So they are able to make choices. The mother may feel that there are some features she is good at while others she 'struggles' with. So it is not that 'I', 'all of me' struggles, but some features of the landscape come more easily than others.

The mother responded, 'It's that one, setting the rules that I really struggle with, always have – it's that one.'

This sentence is rich with information which can be thought about using the FDF in relation to the therapy, and in relation to staff roles on the unit. The mother is not explicit about whose rules, and for what purpose, as would be the case in, 'I completely see the need for me to set rules, agreed with the unit, and keep to them for the sake of Tracy's recovery, but I struggle to apply them.' As we noted earlier, she may be referring to struggling to set the rules stated by the unit, which she may also experience as a demand on her, or that she is not confident that the rules are helpful and hence struggles with them. Within the therapy session, although mother is speaking to the therapist, her daughter hears what she says and may also interpret it as ambiguous regarding mother's commitment to applying the rules. This is a good example of a topic which may be taken further within family therapy session, in conversations between

nursing staff and mother, or both. Also to be considered is whether Tracy joins some conversations. Where staff are familiar with the FDF, they might explore with the mother her views, feelings or beliefs about the limits, and talk over the key features of the safety domain, such as calmly but firmly keeping to the plan for the sake of the young person's health.

The therapist asks, 'Could we think about the exchange between you a little more...so Tracy...' And Tracy says, 'I was just fed up, it felt great to be off the ward but I wanted to go home, to see my dog and just feel normal for a bit. I started shouting and swearing when mum said I couldn't. It pissed me off!'.

Tracy explains that her feelings were ones of longing to go home, and of anger. However, only the anger and perhaps appearance of disrespect were apparent to mother. So, from Tracy's perspective her mother's insistence on the rules would not be matched to her emotional state. From mother's point of view, perhaps she could not see the longing for the dog and the wish to feel normal, and just saw angry and disrespectful daughter. So, there was nothing mismatched. To tease out the Family Domains processes, we need to know the behaviours, and we need to know the thoughts and feelings. In this case the impressive thing is that Tracy explained the feelings to her mother. Another adolescent might not do that in a session, but might tell a trusted member of the nursing staff after the session. This creates the opportunity for a cycle linking young person–staff conversations with the family therapy.

The therapists asks the mother, 'How did that land with you?', and she replied, 'I just caved in, I gave in. I know I shouldn't have, but I did.' In turn the therapist asks, 'What was it about what Tracy said that made you "cave in" – was it the level of shouting and swearing?' 'No, no – it wasn't that... it's the distress. When I see her get all upset and tearful...and tell me how desperate she is just to be at home... I find it so hard to then stick to what was agreed. I know I should for her own safety, but it's hard.'

The therapists detailed questions bring out that mother could see the distress, and we can begin to see the 'caving in' as the outcome of competition between the pull of two domains, safety and attachment. The pull of the attachment domain even in adolescence may be powerful and similar to that of that seen in mothers' responses to infant cries, which activate multiple brain regions linked to caregiving (Kim et al., 2011). *Thus, the 'caving in' is also a reflection of mother's sensitivity to her daughter's feelings*.

The therapist responds, 'Aah, okay – you can see the distress amongst what was being said ...and how it was said. And what about you Tracy, what other feeling is strongest when you are getting angry at not going home?' 'I feel sad, upset – I've been here so long...I just want ...some normal time at home you know, away from this place.'

So, now the pulls are clarified and the dilemma and challenge for mother are clear. The therapist says, 'So, maybe we are in the area...maybe of expressing upset and that's what you respond to as a mum – and working out the safety issues that might need an expectation set as a parent...that's hard in these moments?'

The therapist and mother and Tracy went on to think about the clues that the mother used to make her decision as to what was needed from her as a parent in these moments – they joked that Tracy had a very expressive face, and that Louise could often read Tracy through facial expressions as much as the words that were said.

Although a small moment in a therapy session, the home leave and not following through with plans could be understood from the perspective of a mother and daughter trying hard to clarify issues of safety, expectation, attachment and exploration – the cornerstones of the Family Domains framework. By mother and daughter venturing into safe uncertainty with an increased curiosity in their relationship and each other (Mason, 2019), *a context is created for keeping the domains*

distinct, so that safety and discipline are clearly parent-led, and exploratory and attachment are attuned to the young person's emotions and thoughts. In turn, clarifying domains for Tracy and her mother, and supporting them recalibrating their communication, would likely make some of the broader treatment plans on the ward progress more smoothly.

LINKING THE WORK OF UNIT STAFF AND THE FAMILY OUTSIDE OF FAMILY THERAPY

The FDF is well suited to observing and analysing very brief, often apparently inconsequential interactions between parents and young people, to which unit staff may have to find a rapid response. We have used the FDF in staff consultation groups, both face-to-face, involving up to twenty staff comprising whoever is on duty that day, and during coronavirus disease (COVID), online with a relatively constant group of around five staff. Only a brief outline of the FDF is needed as a basis for a detailed 'blow by blow' analysis of who said what and how. In this example the FDF consultation group discussed a brief but painful incident on the unit.

Parents arrived to visit their young person on the unit, and after a few minutes they told the unit staff that they were going home because 'she is in a bad mood'. Discussion of this in the group started with the question of what the parents might have meant by 'bad mood'. What emotions might this refer to – angry, fed up, uncommunicative, worried or sad? What aspect of the daughter's behaviour might have led them to that interpretation? What had she said? What were her facial expression? Her tone of voice? Even though it sounded as though the young person's domains signals were not clear, was there evidence that they were clearer that we might suppose? In discussion it turned out that she later had told staff that she had said to her parents, 'You just visit because you have to. You are not really bothered about me'. So even though the tone did not signal receptiveness to attachment responses, the content suggested an attachment focus to her 'bad mood'.

Discussion also considered whether understanding of the situation would be increased by knowing how the parents had greeted their young person. What did they say and how? What domain(s) did they signal and was that clear or unclear? Then, after the young person behaved in a way that conveyed 'bad mood' to the parents, how did they respond? What were their behaviours, tone, facial expression and pacing?

This illustrates how, even where the information is sparse, we can clarify what more we need to know to start building the FD picture. Often, as in this case, speculating about what might have been the case leads someone to recall something which is illuminating. This can lead to initial hypotheses and very specific further enquiry.

The discussion led to specific questions which staff might use to follow up on the initial ideas, asking a parent something similar to, 'How could you tell she was in a bad mood? What was it something she said? Or the way she said it? Or how she was behaving?' Even the answer to that question can provide initial information about the young persons' signals and the parents' interpretations of them. Our experience is that questions such as this lead to a wide variety of responses ranging from something similar to, 'Nothing specific, that's just how she was' to 'She looked like thunder and wouldn't speak to us', to 'Oh, I didn't think about it at the time but I suppose it was that she looked cross and wasn't saying much, but maybe now you are asking, she also seemed worried'. These variations are informative in three respects. First, they add information about the young person's signalling of the domain; second, they tell us how comfortable the parents are with making detailed observations and talking about them; and third, they convey the extent to which the questions of themselves prompt reflection.

Another focus for the discussion was who would talk with the parents and when? Should it be a staff member who knows them well, or one who can provide continuity, or one with a designated link role, and how important is seniority or experience? Crucially, what would be the purpose of this enquiry? It could be with the circumscribed, but potentially very important, aim of improving the chances of a more successful visit next time, in which case unit staff might talk with parents and with the young person about whether this would be something helpful to aim for. They would then hold parallel conversations with parents and with the young person, with a view to agreeing how to make the signalling clearer, and for each to consider how to clarify if in doubt. For example, staff and parents might plan that, if the parents think the young person is in a 'bad mood', they would say something such as 'You know the other day we thought you were in a bad mood and didn't want to talk, but we are not sure whether we got that right. How are you feeling at the moment?' Or staff may talk with the young person about what they were trying to convey, and how parents could helpfully respond when it looks as though they are cross. Often, discussion of this kind leads to the question of whether some of these reflections among family members might best be taken into family therapy, perhaps observed by key staff, and then brought back into the daily life of the unit.

THE APPLICATION OF THE FDF TO THE SYSTEM OF THE IN-PATIENT UNIT, THE YOUNG PERSON'S FAMILY AND THE WIDER SYSTEM

The system which is established when a young person is admitted to an in-patient unit is complex! Commonly, the elements not only comprise the family and the unit staff but also refer to mental health or paediatric teams, and social services and educational teams. The FDF has the potential to be used to think about the way the unit orients to each of the elements domain by domain, and hence clarify and inform conversations between them. Here we give some illustrative examples working systematically through the domains.

Safety domain and the unit

In most paediatric medical contexts, parents hand over much of the responsibility for safety, in this case the child's health, to the professionals (Delaney, 2017). For example, parents expect an oncology team to establish a treatment protocol for the child's cancer based on the best available evidence. Team members will aim to give the parents and child as much information as they would like, including on the balancing of benefits and risks of the treatments, leaving some scope for responding to their wishes. However, there is very little overlap between the safety issues for which the parents take responsibility and those taken by the professionals. By contrast, there is often substantial overlap when it comes to the problems of the young person admitted to an in-patient unit, such as suicide attempts, self-harm and self-starvation. Parents will often have been struggling to reduce risk immediately prior to admission, which may be precipitated by concerns that the risk can only be managed through admission. The FDF can be used to clarify questions regarding roles and conversations at these times. For example, has the unit taken over the safety domain, at least temporarily? If so, how is that talked about with parents? To what extent will the unit be guided by parents' views of their child, or by established principles? Are the parents' feelings mainly of failure or relief? How does the initial arrangement regarding safety relate to

plans for phone calls, and the role of parents during phone calls, and similarly for weekend leave? It may be that parents will be helped early on by a description of the ground rules for safety, whereby parents, and therefore also unit staff, need to take action for the health of the young person, even if they are not happy about it. In turn, this can help with clarifying roles of unit staff and parents. For example, a senior member of the unit may explain to parents that, on the basis of clinical experience and research, they may need to take steps which not only the young person is not happy with but also the parents. In that case the unit will also explain that they will make sure that parents have an opportunity to express their views before it happens.

Exploratory domain and the unit

The admission can be seen as serving two kinds of functions for the young person in relation to exploratory processes. For the young person with their parents, where the unit takes a lot of the responsibility for safety, it can create the space for parents to relinquish their safety role, at least temporarily and focus on exploratory (and where appropriate attachment) processes, a focus that may well ameliorate some of the relationship disconnect that young people feel on admission (Haynes et al., 2011; Reavey et al., 2017). This can be made explicit so that times together on the unit, outings or weekend leave can be planned together with the aim of expanding shared activities. Apart from being a source of pleasure, this can also help separate what parents and young people do to help them recover, and what they do for its own value. Second, many activities on the unit seek to make use of exploratory processes to increase a young person's understanding of their problems, review cognitions, and promote accurate mentalising. These can be important both because of the content of the conversations and through expanding the young person's capacity to participate in the to and fro of exploratory processes. Staff participate in these processes mindful that the therapeutic task often includes taking these new capabilities into relationships outside of the unit, for example, with parents or with friends. It can be helpful and important to talk over with unit staff which topics, including intimate/personal fears, thoughts and perceptions stay within the clinical conversations and which are shared with parents.

Attachment domain and the unit

Clinical experience suggests that young people admitted to units have often struggle to provide clear attachment signals for worry or distress to parents, or they have been so fleeting that parents have missed them. Equally, for a variety of reasons including that they have lost confidence in parents as an attachment resource, they may talk more readily about fears, worries, sadness or distress with staff. Being able to identify these emotional states may be important to making progress, but equally, staff do not have a long-term personal commitment to the young person, and so are not attachment figures in the usual meaning of the term. Thus, staff can find themselves on the horns of a dilemma: how to respond sensitively to emotions which the young person may not have shared with parents, while keeping in mind the limits of their role without appearing insensitive. The FDF can be used by staff first to identify where conversations and emotional expression with the young person have features of the attachment domain. Once identified, they can be talked about in handovers, or reviews of therapeutic and clinical progress. Importantly, given the deep personal meaning of talking about fears, worries or sadness, young people will often have talked about them only with one or very few staff, leading to differing, and at times

sharply different, staff perspectives on the young person. In effect different, staff may have experienced different domains signals, on the one hand for attachment and exploratory and on the other hand for discipline/expectation and safety. Just as the task for a parent can be to create a boundary between the young-person-led and parent-led domains, so there may be an analogous task for staff. But in this case the young person may need to have the experience of staff with different perspectives on them working together to bring the domains into a complementary fit. This can entail working out in some detail what needs to be said, along the lines of, 'We can see that the things you have been talking about with ... are (e.g. scary, painful, worrying) and we want to do what we can to understand and support you with them, and at the same time when you (e.g. self-harm, don't eat enough) it is our job to take every step we can to keep you safe. When we are doing one thing it can look as though we are neglecting the other, and perhaps sometimes it is hard to work out which we are doing?'

The link with parents regarding attachment-like processes with staff often needs a lot of thought. During admission, parents can vary in their awareness their young person's attachment signals, and in their ability to provide opportunities for them to express their fears (Sherbersky, 2018). We cannot assume that, if a young person has, or acquires during treatment, the ability to show how they feel to a staff member, this will transfer to parents, nor that if it does, the parent will respond sensitively. This is a topic in need of constant review during an admission, and may be an important focus of separate conversations between young people and staff, and staff and parents. This may be an important focus of a family-domains-informed family therapy.

Discipline/expectation domain and the unit

This domain resembles safety in that it is parent led, but unlike safety, for which the unit takes most of the responsibility during admission, discipline/expectation is in some respects delegated by parents, and in other respects taken on by the unit. This can be made explicit and discussed on admission. Asking parents about their values and standards can both be informative for staff, and also convey the unit's respect for the parents and their views of what is best for their child. Equally, the unit will have rules which are there for the sake of the community, bearing in mind that the community includes vulnerable young people. Staff can explain this to parents, and ask for their support in upholding the standards, talking over where a parent may feel there is a conflict.

In some ways discipline/expectation can be the forgotten therapeutic domain. While making changes in relation to the other domains can be demanding, changing behaviour in relation to discipline/expectation can be straightforward. For example, making the bed, clearing the dining table and asking others if they would be OK watching something else (scope for the unit to expand on this) are not demanding, and give a young person immediate control over their behaviour. This may be something which can be agreed with parents, presented to the young person jointly by staff and parents, and implemented jointly once the young person is going home. This is also the natural domain to link the young person's consideration for other young people on the unit with consideration of siblings, friends, romantic partners and their children of the next generation.

CONCLUSION

The FDF lends itself to informing the treatment of a young person on an in-patient psychiatric unit, tailored to the priorities and ethos of the unit and the needs of the young people

admitted there. It may be adopted as a comprehensive framework informing procedures such as admission, home leave and phone calls with parent, while at the same time creating a cohesive link between the work of unit staff and family therapy. Crucially, it is well suited to complementing the work of unit psychotherapists, occupational therapists and teachers. Equally, it may be used to address a particular need or area requiring development, while other activities are informed by other frameworks. In this paper we have described our experience of applying the framework in linking processes in family therapy to the work of nursing staff, and of using it in discussion with unit staff. We have also outlined its potential to inform crucial moments in the encounter between the family and the unit, such as at the point of admission. Our aim is to provide a framework within which adolescent in-patient teams may develop procedures and modes of understanding, when establishing a therapeutic alliance between the unit and the family. Our hope is that the framework is sufficiently specific that it could be used to write a training manual to be used in systematic evaluations of this mode of working.

ACKNOWLEDGEMENTS

The authors have no conflicts of interest.

FUNDING INFORMATION

No funding was received for the work described in the paper.

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ENDNOTE

[1] The names of the family members have been changed. All family members have provided written approval of the description of the conversations described in the paper.

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How to cite this article: Hill, J., Cornwell, S., James, A., Lee, H., Riley, S., Tranter, P. et al. (2023) Family domains: A conceptual framework with practical application for adolescent inpatient services. *Journal of Family Therapy*, 45, 414–427. Available from: https://doi.org/10.1111/1467-6427.12440