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Journal of Family Therapy (2000) **22**: 211–224
0163–4445

The Darlington Family Assessment System: clinical guidelines for practitioners

Ian Wilkinson[a]

The Darlington Family Assessment System (DFAS) consists of a framework of widely accepted concepts, a semi-structured family interview and rating scale, and a detailed account of how to use the system in clinical practice. The model views health issues within a family life-cycle (developmental) framework. It assesses problems at four systemic levels: the child perspective, the parental perspective, the parent–child perspective, and the whole family perspective. The semi-structured interview is designed to see how family members perceive problems and to map out other possible problems, and is a useful basic training tool. Empirical work suggests that the framework of key concepts and the rating scale offer a powerful method for describing and differentiating families. There is evidence that the model is useful as a training method for health professionals undergoing basic training. Detailed clinical guidelines have also been developed, to show how the model can be applied in practice. The advantage of the model is that it can be used with a variety of therapeutic approaches, and to inform choices about which interventions are likely to be successful or not.

Overview

The Darlington Family Assessment System (DFAS) consists of:

1 A framework of widely accepted concepts in child and family work.
2 A semi-structured family interview and rating scale using this conceptual framework, which can be used to teach family interviewing to trainees in the helping professions, and combined with other assessment methods in a flexible way.
3 A detailed account of how to use the system in clinical practice (Wilkinson, 1998) which can be summarized as a short set of clinical guidelines for child and family assessment.

[a] Consultant Clinical Psychologist, The Roseberry Centre (YPD), St Lukes Hospital, Marton Road, Middlesbrough, Cleveland TS4 3AF, UK.

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The model was developed and applied in a child mental health context by Ian Wilkinson and colleagues at the Marion Family Centre in Darlington between 1983 and 1993 (Wilkinson, 1987; Wilkinson and Stratton 1991; Wilkinson *et al.*, 1988). From the beginning, the aim was not to invent a new theory but to combine and integrate what were thought to be the best ideas and practices of others. The model is best considered as a way of defining the most important factors for child and family assessment in a health context, using principles of psychotherapy integration applied to assessment technology. The issue of how to apply the model has been considered in detail and developed into clinical guidelines for practitioners about the process of assessment. The guidelines help to inform choices about which therapeutic methods are likely to succeed or not. The model has been described as 'user friendly for the child, the family and the practitioner' (Bailey, 1999).

Initially, the system was modelled around the concept of multi-system multi-method assessment (Cromwell and Peterson, 1983). This involved the use of a deliberately pluralistic assessment model (using ideas from various theories) in conjunction with a package of assessment methods, which examine the problem from several perspectives using different methods. The aims were to develop an assessment which was efficient and pragmatic but nevertheless could help to make sense of the complexity of family life, and also be capable of use for both clinical and training purposes.

Four key perspectives upon the family (or 'systemic levels') were used to construct a framework. These were the child perspective, the parental perspective, the parent–child perspective and the whole family. The characteristics of the children, the parents, the parenting style and the family group as a whole are examined in turn. The logic for this is simple but important – just as the child should be understood in the context of the family, so the family is best understood with some knowledge of the individuals within the family. For each perspective, a set of problem dimensions were chosen which would:

- provide clear and meaningful distinctions between different types of problems on each systemic level;
- enable a clear understanding of complex problems through the use of descriptors of key aspects of the family system;
- be based upon widely accepted and validated concepts, with minimal jargon;

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TABLE 1 *Conceptual framework for the Darlington Family Assessment System*

CHILD-CENTRED PROBLEMS
CHILD HEALTH (PHYSICAL) especially chronic illness and disabilities
CHILD DEVELOPMENT including self-care, communication, independence
EMOTIONAL DISTURBANCE – mood disturbances and their effects
RELATIONSHIPS within and outside family
CONDUCT – behaviour towards others
NEGATIVE LIFE EVENTS* – bereavements, separations or other trauma
PARENT-CENTRED PROBLEMS
PARENTAL HEALTH (PHYSICAL) especially illness and disability
PARENTAL HEALTH (PSYCHOLOGICAL) particularly psychiatric illness
MARITAL PARTNERSHIP and its effect upon family and parenting
PARENTING HISTORY – the parents' experiences of being parented
PARENTS SOCIAL – the support available
PARENT–CHILD INTERACTION
CARE (including over-involvement as well as neglect)
CONTROL (from lack of control to over-control)
WHOLE FAMILY FUNCTIONING
CLOSENESS AND DISTANCE – attachment patterns in the family
POWER HIERARCHIES – responsibilities and dominance
EMOTIONAL ATMOSPHERE + RULES – patterns of emotional expression
CONTEXTUAL STRESSES* living conditions, poverty, stigma
SUMMARY OF FAMILY DEVELOPMENT (problems viewed in the context of the life-cycle)

Note: *These problem dimensions are additions to the original framework.

- provide a brief but reasonably comprehensive set of descriptors for each perspective.

This resulted in the conceptual framework shown in Table 1.

Walsh (1982) distinguished between different types of family models. In her terms this is a model which primarily relies on health concepts but uses the family life-cycle concept as a fundamental integrating theme. This is therefore a model that views health issues within a general developmental framework. The family development

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concept also provides a useful way of assessing the severity of the problem, by comparing the actual difficulties in the family to those expected in families at this stage of the family life-cycle.

The dimensional framework provides a useful means of describing families in a way that helps to generate hypotheses. The use of various perspectives enables causal links (both linear and circular) to be perceived more readily between problems in different parts of the family system, and links made between individual and relationship phenomena within a hypothesis.

Another point about the model is that it utilizes concepts from several therapeutic traditions, including both individual and systemic therapy. As such it suits practitioners using an eclectic or integrated therapeutic approach. Norcross and Goldfried (1992) provided a thorough review of the topic of therapy integration, making important distinctions between types of integration:

- technical eclecticism, or the use of various techniques without being too concerned about the theoretical ideas that go with them;
- theoretical integration, in which two or more theories are blended in the hope that the result will be more powerful than any of the original theories alone (e.g. cognitive analytic therapy);
- common factors approaches, which look for core ingredients that all effective therapies share.

As a model, the DFAS framework is an example of theoretical integration applied to the assessment process, while the interview and the clinical guidelines use principles which could be viewed as 'common factors'. The system also contains an integration of both the realist and social constructionist traditions. (The emphasis upon clear assessment and overt consideration of health issues is realist. The emphasis within the methods upon understanding the client's views, and working with them, is constructionist.)

Recent work considers how the ideas and methods can be applied in normal clinical practice. During this process the model has been significantly influenced by ethical considerations with an emphasis upon practice which is open, contractual, and which empowers clients. Most families wish to understand the difficulties they are experiencing, in order to go on and manage the difficulties for themselves. In this context, clear assessments are not only ethically desirable but also acts of empowerment for clients. The

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model has therefore evolved into a set of clinical guidelines for the process of assessment.

Description of the assessment methods

Certain principles underlie the methods that have been developed:

- Using both client views and observer views within the assessment process, and carefully comparing these views (so that both perspectives are taken into account).
- Matching the choice of assessment method to the situation, so that methods are appropriate for the purpose, acceptable to the clients, efficient and effective.
- Being aware that there are likely to be several different client views within the family, and the process of comparing them is also important.
- Understanding that different viewpoints can illuminate different beliefs and attitudes in the family (which in turn relate to motivation and therapeutic contracts).
- Adopting an open and contractual approach to assessment wherever possible, which includes giving the results of the assessment back to the family in a professional (verbal and written) manner.

A matching semi-structured clinical interview schedule and interviewer rating scale were constructed covering the topics in the conceptual framework, known as the Darlington Family Interview Schedule (DFIS) and the Darlington Family Rating Scale (DFRS) respectively.

Darlington Family Interview Schedule

The interview has several significant features:

- There is an emphasis on seeking permission to make enquiries as part of the process of the interview.
- It is carefully structured in its sequence so that it moves in an easy and natural progression from simple aspects of problems to more complicated ones and from less threatening to more threatening topic areas.
- The interview systematically covers the problem areas listed in Table 1.
- For each problem area the script includes a carefully worded

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'normalizing statement'. These statements set the agenda for a topic and provide a conversational opening. More importantly, they 'normalize' problems (in ways that provide rationales for asking a question) and refer to common links between problems. The result is usually a significant reduction in defensive responding from the family. How questions are asked is a crucial skill in interviewing. The systematic use of normalizing statements is a distinctive feature of the interview. For example, 'I don't believe there is a right or wrong way to bring up children. Lots of ways can work, but people often have different ideas about it. Do the two of you ever disagree about how to handle the children?'

These features of the interview format make it a valuable training tool. The script for the interview is included in the book about the system (Wilkinson, 1998) and also in the *Child Psychology Portfolio* (Sclare, 1997). In practice, the DFIS takes about one to one-and-a-half-hours to complete, depending on the efficiency of the interaction between the interviewer and the family.

The major goal of the interview is *to map out possible problems and see how they are perceived or constructed by family members.* The process of doing so then helps with dialogue about, and formulation of, a therapeutic contract with the family.

Darlington Family Rating Scale

The rating scale is a purpose-designed record form which accompanies the structured interview. Its main function is to provide a means for summing up the main features of a case and includes a front sheet designed to summarize a formulation. It can be used independently of the interview although it is recommended that initially it should be used in conjunction with it. The rating scale consists of eighteen subscales, one for each of the problem dimensions listed in Table 1. Seventeen of these sub-scales are five-point ordinal scales and one is a three-point scale. The DFRS is fairly brief (particularly when the format is familiar), and takes between five and fifteen minutes to complete.

Using the system with a client-centred initial interview

In clinical practice an initial client-centred interview can be used to understand the family members' views before proceeding to a

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comprehensive interview based on the DFIS. The broader perspective provided by the DFIS is important with some families because the level of public awareness about children's mental health problems is low (leading to a high rate of unrecognized problems) and in health contexts there is an implicit professional duty to screen for potential health problems.

Client position and motivation

Family members often have different views about their involvement with the presenting problem and their willingness to engage in therapy. The DFAS uses some very specific and clear methods with which to understand and work with clients' views and motivations. These are drawn from the work of the MRI group (Fisch *et al.*, 1982). According to the MRI group, clients' views of their involvement in the presenting problem and their motivation for ongoing therapy may be addressed by enquiring about the following:

- whether a particular person is defined as part of 'the problem';
- if so, whether they accept this role willingly or reject it;
- if not, the degree of sympathy with which they view the person who is labelled as the problem (e.g. as sick (sympathetic) or bad (unsympathetic));
- whether they are a 'customer', i.e. whether any changes are desired, how strong this desire is, and the exact nature of the changes desired;
- whether the person is optimistic or pessimistic about the possibility of change;
- key self-concepts with which the person tends to identify themselves (e.g. 'caring mother', 'working man' or 'honest and straightforward').

Views that clients express about these issues are particularly useful for deriving therapeutic or assessment contracts, as the offer of help can be framed in terms of the client's own concepts and language. For example, if one person is a customer and the others are ambivalent: 'I understand that X is sure there is a problem and everyone else is not so sure. I would suggest that we organize two more appointments with the purpose of clarifying whether there really is a problem, and if so, what it is. How does that sound?' A second example, where one person is optimistic and the other pessimistic about change, would be 'I can see that X thinks this is a

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small problem that can be easily solved, whereas Y is not so sure and thinks it may be very difficult. At this point I am not sure but I think it would be helpful to try to keep an open mind.' Where views differ radically within a family group, it may be important to offer different contracts to different members of the family.

Summary of the research

It can be argued that the use of established constructs from the literature gives the DFAS system face validity. The psychometric support for the DFAS was summarized in Wilkinson and Stratton (1991), and consists of evidence from a training study and from a comparison of clinical and volunteer families.

The training study

In a carefully designed study in which eighty-one trainees participated, an eighteen-hour training course (which focused upon the conceptual aspects of the DFAS) produced improvements in trainees' ability to assess family problems.

In a quantitative evaluation of this training programme, the DFAS training was compared both to a no-training control group and also to a comparison group having a work placement experience (an unstructured learning experience) in a child mental health context. This was therefore a fairly stringent test of the training since the placement experiences (between twenty-six and a hundred working days) were of much longer duration than the DFAS course (two-and-a-half days). The design of this research is summarized in Table 2.

There were eighty-one participants (twenty in three groups and twenty-one in the fourth) from mixed professional groups (psychiatrists, clinical psychologists, social workers, probation officers and

TABLE 2 *Design of the training study*

Group A	Baseline exam	Training (DFAS course)	Exam 2
Group B	Baseline exam	No training	Exam 2
Group C	Baseline exam	DFAS + placement experience	Exam 2
Group D	Baseline exam	Placement experience only	Exam 2

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nurses) undergoing their basic professional training courses. The exam procedure used standard materials (two videotapes of family interviews). After viewing each tape the trainee was given an examination paper about the family to be completed in forty minutes. Three separate expert external examiners (who did not know the origin of each script, or the content or purpose of the training, and who developed their own criteria of quality after viewing the videotapes independently) marked all the papers.

The quantitative evaluation demonstrated a positive and a significant effect of the training course, equivalent to a mean improvement for each participant of 8% of the exam total. This was a very significant and powerful effect (a stronger effect than that of a placement experience). This suggested that our training course, which focused upon the DFAS, was effective in the short term, in teaching perceptual and conceptual family assessment skills at an early stage of professional development. The result can be interpreted as evidence that the DFAS has good construct validity.

The training course was also evaluated qualitatively. The trainees' subjective views about the course were obtained from a feedback questionnaire, which asked for ratings about the value of the course and gave a space for free comments. The participants gave generally positive feedback reflected in a high level of satisfaction with the value of the course for learning concepts and skills, and for creating some change in working practice. The free response section produced approximately two positive comments per person, most of which concerned four topics: theoretical concepts such as the family life-cycle, applied concepts such as patient position, the teaching methods, and 'gaining skills' and 'gaining confidence'.

The clinical study

Fifteen clinical families and fifteen non-clinical volunteer families from the local community participated in this study (Wilkinson and Stratton, 1991). The two groups of families were assessed with a comprehensive package of measures including the DFRS rated from the DFIS before the clinical families began treatment. The clinical families were reassessed at discharge and follow-up. There were five important findings:

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1 The majority of the problem dimension measures discriminated significantly between the clinical and healthy families, although there was a wide variation in the level of discrimination.
2 The research version of the DFAS included a number of additional psychometric measures so that it could be considered as an example of 'multisystem-multimethod assessment' (Cromwell and Peterson, 1983). In this form, the DFAS detected complex idiosyncratic patterns of change in those families which received treatment.
3 The family dimensions of the DFRS were predictive of poor outcome, suggesting that high levels of family dysfunction are likely to predict poor outcomes for child mental health problems, even with intervention.
4 Strong associations occurred between DFRS subscales and a range of other similar constructs, especially where there were clear external criteria to compare with the DFRS subscale (e.g. for child development) or closely related measures with good psychometric properties (e.g. the General Health Questionnaire as an index of parental health).
5 Moderate levels of inter-rater reliability were found for the DFRS. Thirteen video-recorded DFIS interviews were shown to a mean of eight raters (of varying experience and background) from which a matrix of ratings for each scale was constructed. The alpha coefficients (average correlation between raters) varied from 0.46 to 0.72 with one exception: the child health scale, which was 0.27. All were significant beyond the 0.01 level. In practice, reliability will drop when interviews are unstructured or when different interviewers are used. The implication of this level of reliability is that the rating scale is best considered as a way of organizing information rather than as a precise psychometric measurement.

It seems reasonable to conclude that the dimensional scheme as a totality offers a powerful method for describing and differentiating families. The use of core constructs from the literature gives the system robustness, and although the empirical data supporting the system is on a small scale it is positive. The problem dimension scheme passed several tests of validity and the inter-rater reliability scores of the rating scales were adequate. A carefully designed study of training showed that the system was effective as a method of training basic concepts about the family.

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Clinical implications

Applications of the DFAS

The DFAS may be used as a training device in child mental health work for novices and non-specialists. Specifically the DFAS helps clinicians who are unfamiliar with family work to acquire a broader understanding of family problems; develop interviewing and formulation skills; and clarify choices for intervention. For experienced clinicians the DFAS may serve as a set of clinical guidelines and as a general framework for the assessment of children and their families. In specialist services and research projects, the DFAS may be used as the basis for a comprehensive family assessment package.

Ethical concerns: empowerment and choice

The current legal and ethical frameworks for professional practice emphasize the need to offer a range of services for children with special emotional needs, to help parents make informed choices, and to work in partnership with them (Herbert, 1993). Clinicians working in non-specialized roles need to have a working knowledge of a range of approaches so that they can be creative and flexible in their assistance to children and their families; offering help which suits the particular problem and family context, and empowering service users to make informed choices.

There are complex ethical issues (as well as theoretical ones) involved in the decisions about who to work with in families. It is also part of the trend towards children's rights that child-centred work should be available as one of the choices that families can be empowered to make for themselves. However, it can also be argued that a broad systemic understanding of the problem gives an overview which enables rational and informed choices about which therapeutic approaches are likely to be successful and which are not. The DFAS framework provides this broad overview which assists a more rational choice of therapeutic strategy (for more details see Wilkinson, 1998, ch. 9).

Use with other assessment procedures

In clinical practice, a constructive and economical approach is to select and use only those assessment instruments that are clearly

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relevant for specific situations. The flexible use of other measures (carefully selected to suit the problem) is relatively easy alongside the DFAS because it is based on a framework of established concepts.

More specific assessment methods can help to:

- investigate particular problems
- assess whether problems are global or specific
- clarify particular viewpoints, especially that of the child
- allow comparisons to normative scores
- evaluate change and the attainment of specific treatment goals.

In routine clinical practice, other measures are selected according to the nature of the problem and the helpfulness or otherwise of using other types of assessment instruments for one or more of the reasons listed above.

Outcome can be routinely evaluated by repeating measures used initially and comparing pre-treatment and post-treatment scores. Given the pressures for audit and outcome evaluation in public services, the use of the DFAS provides a framework that can integrate clinical assessment and quality assurance in service provision.

Novice practitioners may find using the DFIS on a few occasions helpful as a training device. More experienced practitioners may find the principles of the interview and the conceptual framework given in Figure 1 useful for organizing clinical observations and inferences. The DFRS may appeal to some practitioners as a device for summarizing clinical observations and treatment planning.

Clinical guidelines

Clinical guidelines are intended to summarize the literature in relation to good practice and good professional ethics, to be based upon evidence about effective procedures, to be applicable by multiple professions, and to encourage more standardized practices where these are known to be effective. Clinical guidelines can be considered as a bridge between science and practice. The strength of the DFAS is that it provides such clinical guidelines which cover four main areas:

- using a comprehensive assessment framework
- obtaining family members' views of the problem using this framework

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- problem formulation
- communication of problem formulations.

The general approach to the first two areas has already been summarized above. The main recommendations for the second two areas will be outlined in the following two sections.

Formulation of the problem

Once assessment information has been gathered, a clear formulation of the problem should be made. Formulations should identify and connect problems which occur at different systemic levels including the individual, dyadic and family levels. Formulations based on the DFAS should be grounded in a developmental framework and state the role of specific factors in problem development and maintenance. Such formulations may involve reference to both linear and circular causation. A good formulation must be communicable to clients and others involved with offering clinical services to clients.

For clinicians learning to use the DFAS, where cases are very complex and formulation is difficult, or where risks for the well-being of family members are causing grave concern, then further advice should be sought from more experienced or specialized professionals. It is important to balance the need for other professional frameworks or skills against the danger of passing on difficult problems as a form of avoidance. Good supervision is essential, and should aim to enhance the conceptual skills of relating theory to practice; the technical skills of family interviewing; and be sensitive to the personal life experiences of novice therapists insofar as this affects their clinical work. Good supervision should help novice clinicians from whatever profession consider possible psychiatric diagnoses (such as ADHD, or psychotic conditions) and the need for additional specialist advice or multi-professional work in complex cases.

Communication of the formulation

A clear statement of the formulation should be given back to clients in an empowering manner and preferably in writing. The formulation of the family's problems based on the assessment should make clear the choices that are available to the family in terms of further work, intervention, or referral to other professionals or agencies.

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The need to pass on this information to others involved should be considered in relation to the wishes of the patient and family regarding confidentiality. It is particularly important to communicate the results of the assessment and formulation to the child or young person in developmentally appropriate terms. In child protection cases, where there is a risk of child abuse within the family, due regard must be paid to managing the process of feedback so that child protection is prioritized as a central concern.

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