FAMILY HISTORY ASSESSMENT MODULE (FHAM)
COGA PROJECT VERSION
INSTRUCTIONS FOR USE

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INSTRUMENT

Family History Assessment Module (FHAM) is semi-structured diagnostic instrument intended for clinicians and non-clinicians to assess major DSM-III-R psychiatric disorders among relatives of the informant. The following psychiatric disorders are ascertained: alcoholism, drug abuse/ dependence, depression, mania, schizophrenia, antisocial personality and unspecified psychiatric disorder.

FHAM consists of the following parts:

1. Face Sheet

Contains general information about the informant, as well as the list of names and relationships of the relatives screened for at least one positive diagnosis.

2. Screener

Contains a set of questions to screen for relatives likely to have a history of a psychiatric disorder. Labels in the left margin beside questions 1-6 indicate which diagnosis is screened by a particular screening question (ALC = alcoholism, DRUG = drug abuse/dependence, DEP = depression, MAN = mania, SCH = schizophrenia, ASP = antisocial personality). Screening question 7 is intended to check for an unspecified psychiatric disorder (UPD). Other psychiatric disorders, for which no specific diagnostic sections exist in the interview (e.g. anxiety disorders), should also be recorded here. Screening questions 8-11 are intended for additional psychiatric information, and are not used in Diagnostic Scores.

3. Individual Assessment Module (IAM)

IAM contains lists of symptoms for specific diagnoses. IAM should be used for relatives who are screened positive in the screening questions 1-6. Enough IAM copies should be provided before the interview to ensure recording of all relatives.

The following coding convention is applied throughout the interview:

1 = no (symptom is absent)
5 = yes (symptom is present)
9 = symptom presence uncertain/unknown

Right margin provides space for interviewer notes about specific symptoms.

4. Diagnostic Scores

Scoring instructions for specific diagnoses are given. The following coding convention applies for diagnoses:

1 = diagnosis absent
5 = diagnosis present
9 = diagnosis uncertain (possible)

5. Relatives' Contact and Address List

This elicits information about other relatives who are to be contacted and interviewed.

6. Card 1

Contains a list of most commonly used drugs, and should be given to the informant as a reminder, while asking specific section on drug abuse/ dependence.

ADMINISTRATION

Step 1: Record general information.

Enter general information in the spaces provided on the Face sheet.

Step 2: Draw pedigree.

Draw pedigree using a set of conventional signs for relatives and relationships. Start with the informant, marking him/her with an arrow. Make sure that all members of the family are included, marked and placed properly. For each relative record the following:

a) name (first, middle, last, maiden)
b) date of birth (if DK, record age)
c) if deceased: date of death (if DK, age at death) and cause of death

For married relatives, check whether "this was his/her only marriage". If not, include all marriages, and children from each of them. Also check if "s/he has had other children than those you mentioned" (e.g. out of wedlock, or given up for adoption). If so, include them in the pedigree with as much information as you could obtain.

Step 3: Screen to identify possibly affected relatives.

In the introductory sentence of the Screener, list relatives referring to the pedigree. First degree relatives are to be mentioned by name and relationship (e.g. "your brother John"), and second degree relatives by group (e.g. "your mother's brothers and sisters"). To more distant relatives refer collectively (e.g. "anyone else in the family"). Repeat this through the Screener, as necessary.

Read screening questions 1-11, and for each relative mentioned by the informant, record name and relationship. In question 7, record psychiatric problems as well.

If a relative is mentioned in questions 8-11 only, go back and repeat appropriate screening question(s) in 1-7, this time using relative's name.

Question 12 is the second-chance question for first degree relatives who have not been recorded in questions 1-11. First degree relatives are to be listed following the pattern outlined above. If any relative is mentioned here, go back to appropriate screening question and ask it again. Record relative's name and relationship if screened positive.

When the Screener is completed, boxed instruction leads you to use Individual Assessment Modules for all of the relatives recorded in the Screener. Note that IAMs will be used for only those relatives recorded in screening questions 1-6. If no relative recorded in the Screener, complete Relatives' Contact and Address List before ending the interview.

Step 4: Code Individual Assessment Modules.

Go through IAMs on relative by relative basis. Record relative's name and relationship to the informant at the top of the IAM and ask introductory questions. For each relative ask and code only those diagnoses for which s/he has screened positive.

After you have checked all specific diagnoses for one relative, go to the next relative. When IAMs are coded for all relatives recorded in the Screener, the interview is completed. Before ending the interview, make sure that number and names of relatives recorded in the screening questions 1-6 correspond to those in the individual assessment modules. Clear any uncertainty on the spot. If the informant changes his/her mind about a relative (e.g."I didn't get what you were after, she really didn't have that problem"), be sure that you cross the name in the Screener (with a note to the editor).

Step 5: Collect names and addresses of other relatives.

In the Relatives' Contact and Address List, record names and addresses of the informant's relatives to be contacted and interviewed in the future.

SCORING

After the interview has ended, score specific diagnoses for each screened relative using Diagnostic Scores. Instructions for scoring are self-explanatory.

After scoring, record names and relationships of the relatives and circle codes for specific diagnoses on the Face Sheet.