

20 interview questions that work

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The contents of this article are typical of the information we are trying to share with the professional participants of "Children's Emotional Health Link. In addition, the author, Dr. Morris Green, is actually its "godfather." Dr. Green was the Perry W. Lesh Professor of Pediatrics at Indiana University Medical Center, Indianapolis.

At the 2001 annual meeting of the Pediatric Academic societies, the first Bright Futures Medallion was awarded to Dr. Green. He was recognized for his leadership and insight in developing the Bright Futures Guidelines.

In 1990, the Health Resources and Service Administration's Maternal and Child Health Bureau, with support from HCFA, launched the Bright Futures for Infants, Children, and Adolescents initiative. The Bright Futures guidelines represented a shift from a strict medical focus to one with a more expansive view of health – one that addresses children's growth, healthy development, and important psychosocial factors that influence health and development. Dr. Morris Green, a recognized leader in ambulatory and contextual pediatrics, was engaged as chairperson of that effort.

It is unlikely without Dr. Green's leadership, that either this website or the training project, "Children's Emotional Health Link," would have come into being. We owe him a great debt of gratitude for being an inspiration and a mentor to all of us for bringing this kind of innovative care to the attention of pediatricians as well as to members of the general community.

By Morris Green, MD

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questions. This set of 20 questions will help you elicit clinically useful information for some of the most difficult problems that come your way.

When considering a behavioral, developmental, psychosocial, or family-related cause for a symptom, your interviews are most productive when the patient and parents feel able to talk freely about their concerns. Establishing a diagnosis depends on your ability to explore and clarify those concerns. This can be done in an efficient, non-intrusive manner through a combination of direct questions and open-ended requests for further elaboration. These queries are cued largely by what the parent or child is saying and by nonverbal clues that depend on your ability to hear, see, feel, empathize, and read the patient.¹ The 20 interview questions offered here not only elicit information needed to make a diagnosis, they also help forge an effective therapeutic alliance with the family. Some of the questions are best directed to the parent, some to the child or adolescent, and some to both.

1. "I'm interested in what you think may have caused this problem." A 15-year-old girl who complained of chronic fatigue had undergone numerous laboratory evaluations with no diagnosis to show for it. When her mother was asked what she thought might be causing the complaint, she promptly replied: "You know, no one else has bothered to ask me that question, so I'll give you my opinion. I wonder if it's related to school. When we moved to this community a few months ago, Kim had to transfer to a different high school in midterm. She tends to be sensitive and shy, and I know that she is very discouraged about fitting in and making friends. She really misses her old school and good friends and wishes that she were back there."

Children may respond to the same question with great candor. When a 10-year-old boy was asked what he thought might be causing his recurrent headaches and declining grades he promptly replied, "I think it's because I worry all the time that my parents are going to get a divorce." Whenever a child is seen for a persistent illness, it is important to establish what the parent or child believes may be the cause. If they initially say, "I don't know" or "I have no idea," you may respond, "I recognize that, but this problem has been present for some time, and it's only natural for a parent to think of some possible causes. You may have read something about this problem, or discussed it with your family or friends. It would really be helpful to have your thoughts."

When the parents share the possibilities they have considered, you can help clarify why some can be ruled out on the basis of the history and why others warrant further study. If the parent suggests a psychosocial cause ("I wonder if her abdominal pain could be caused by her nerves"), you can respond: "I guess that's a possibility. Could you explain why you think that may be the cause?"

Parents are more accepting of a psychosocial etiology when they suggest it themselves. After they offer an explanation, you can respond: "That seems to make sense. From what you've told me, that's a likely possibility." Later, you can involve parents in planning the intervention: "You've obviously been thinking about this for some time. What do you think might be helpful for John?" When asked this question one mother replied, "I think we need more conversation in our family. Our lives have become so hectic that we don't talk as a family as much as we really should. This is the push we need to change that!"

2. "I'm not quite sure what you consider to be your main concern. Could you clarify that for me?" A parent may not be forthcoming in answering question No. 1. Further follow-up and exploration may be necessary. A parent who is secretly worried that her child might have a fatal or life-threatening disease, for example, may be reluctant to mention the possibility. A helpful question may be: "We've talked about some possible causes, but I need to know what really worries you the most about Marie."

Travis, a 7-year-old, was brought to the pediatrician's office because of his mother's concerns about his "frequent colds, leg pains, and poor appetite." Although she had already consulted a number of physicians, she remained worried. When asked what her greatest worry was, she hesitated briefly before tearfully disclosing that she had been scared for some time that Travis had leukemia: "He has those dark circles under his eyes." She was greatly relieved to be told authoritatively that her son did not have leukemia.

Travis had obviously heard his mother talk repeatedly about the dark circles. In his earlier interview with the pediatrician, when asked to draw a picture of his family, the boy had drawn dark, heavy, circles around his own eyes. Although the pediatrician did not know how to interpret the drawing at the time, it became evident that Travis had incorporated his mother's concern into his body image.

Sometimes it is difficult to determine the chief reason for the visit. It may have been at the behest or insistence of someone else—the school, the mother-in-law, or because a parent's anxiety or depression magnified a particular worry. At other times, the parent may be unable to describe the problem comfortably or adequately because of doubts about what it is. You can help determine the underlying reason for the visit by encouraging the parent to elaborate on the chief complaint: "Mrs. Smith, you've mentioned your concern about Jason's poor grades and his lack of motivation. What would be your third concern?" Another approach is to say, "I am still a bit puzzled by what you see as the chief problem. Could you clarify that for me, or give me an example?"

3. "How's everything in your family?" (to the parent) If you sense that the symptoms reported in the infant or child may be related

to family tensions, this simple, friendly question may be very revealing. A too-quick response of "Fine!" may mean just the opposite. The most important material may not be disclosed until later in the interview. Stay tuned.

4. "How's everything in your family?" (to the child) You can also phrase this question in a more open-ended fashion: "Tell me about your family." Such a general question may produce a very specific response from the child. Bobby, at age 8, seemed listless, would come in from play to lie down, and complained of recurrent abdominal pain. When asked to talk about his family, he sadly replied: "Well, my grandpa died this summer." Bobby had been very close to his grandfather, who lived nearby and spent considerable time with him, taking him to ball games, fishing, and making model cars. The child thought about him frequently and missed him greatly. His parents had not realized the extent of his grief because he did not talk about it.²

A 7-year-old boy presented with a combination of "hyperactivity," inattentiveness at school, and recurrent abdominal pain. When interviewed alone, he responded to the doctor's request to "tell me about your family" by dejectedly reporting that his parents had been divorced that summer and that he no longer saw his father regularly. He expressed the hope that his parents would reunite, and he wondered whether his father would have left home if he had been "better behaved."³ When his mother was asked later how she thought her son had adapted to the divorce, she was surprised by the question: "He's adjusted very well. He never asks questions or talks to me about it." The reason he did not ask questions, of course, was that he sensed they were unwelcome and would upset his mother.

5. "Have any major changes occurred in your family recently--illness, hospitalization, death, separation, divorce, a move, loss of job?" If the open-ended approach in questions 3 and 4 does not yield useful information, this more pointed question may produce information about family stresses and their possible effect on the child. It is obvious to the pediatrician, but may not be to the parents, that changes in the family or the community, especially in school, can strongly affect a child's behavior and development. Many parents do not think contextually; they don't see the child, the parents, the family, and the community as a system in which what happens to one inevitably affects the others.

Parents understandably don't have enough knowledge about the causes of biomedical disease to report spontaneously all the relevant historical facts you need to know to arrive at a diagnosis. They have to be asked to elaborate. Similarly, they are unaware of the historical data required to understand and manage psychosocial problems. They may be totally unaware of what may seem clear and self-evident to the physician. Accordingly, many parents do not make the connection between the child's symptoms and such stressful family events as maternal depression, divorce, parental alcoholism, a disruptive move, or other major discontinuities. Preoccupied with their own adaptation to a major change, many parents experience a "moratorium on parenting" during which

they seem unaware of the feelings and problems their children are experiencing. When parents remarry, for instance, they may be caught up in their new romantic relationship and often do not recognize the significant impact such a change has on their children.⁴ Parents tend to under-report their own personal difficulties to physicians.

It is important to know about any significant parental illnesses. They are generally not reported spontaneously because the parents do not recognize their relevance to the child's complaint.

6. "How much school has Elizabeth missed because of this illness?" In some instances, a persistent symptom such as "low-grade" fever, headache, fatigue, dizziness, nausea, or recurrent abdominal pain may mask the problem of school refusal.⁵ By asking how many school days the patient has missed, you may be able to understand why the symptom persists and address the underlying problem.

7. "Was Mark ever seriously ill?" This is a helpful question when the vulnerable child syndrome is a possible diagnosis.⁶⁻⁷ A combination of factors may lead you toward the diagnosis:

- The reason for a sickness visit is unclear.
- A parent's worries about the child seem greater than warranted.
- The parent may not have been reassured when told by other physicians that the child is healthy.
- The parent and child may have trouble separating.
- A persistent sleep problem is reported because the parent unwittingly awakens the baby to make sure he is breathing and all right.
- The parent seems unable to set age-appropriate limits.
- The child is disobedient and uncooperative.
- The parent appears to be overly vigilant.
- The child has been taken frequently to physicians or emergency rooms with such complaints as "paleness," "easy fatigability," "circles under his eyes," "poor resistance," or "breathing too fast."

When the child has had a serious illness during which one or both parents feared the child might die, the parent will vividly recall the anxiety that engulfed the family during that stressful time. Parents are usually relieved when informed that they are not alone in experiencing those feelings. A good opening line is, "Some mothers who have endured an experience like yours tell me that they continue to worry secretly that they still might lose him, even though he has fully recovered. I'd

guess that you may also have felt that way."

8. "How Is your health, W Mrs. Smith?" In order to understand the factors that may be contributing to the child's problem, it is important to know about any significant parental illnesses. These are generally not reported spontaneously because the parents do not recognize their relevance to the child's complaint. They also may not wish to disclose family secrets such as parental alcoholism.

A 13-year-old girl had undergone an extensive work-up, including an MRI, for severe, recurrent headaches. In an effort to identify possible stressors in her life, the pediatrician asked the parents about their personal health, although they appeared to be healthy. When the mother replied that she was fine, her husband and daughter looked at her incredulously. The physician turned to the mother and said, "Your husband and daughter don't seem to agree with you."

It turned out that the mother had had a mastectomy for breast cancer two years previously. A few weeks before this visit, she had felt what she thought were nodes in her axilla. She feared that they were metastases, but she adamantly refused her husband's and daughter's pleas to see her surgeon for a checkup. When informed that her daughter's worry about possibly losing her mother was the likely cause of the headaches, the mother reluctantly promised to make an appointment for herself. No evidence of metastases or recurrence was found, and the daughter's headaches soon ceased.

It is also helpful to find out if other members of the family have been ill. One parent seemed inordinately concerned about a mild viral bronchitis in her 18-month-old. When questioned, she revealed that she had been very upset over a grandfather's recent complications from black lung disease.

9. "How were things for you when you were growing up?" To understand the reason for problems in the parent-child relationship, you may wonder about the quality of the parents' relationships with their own parents. This question usually provides considerable information about the strengths and weaknesses the parents perceived in their own families, the role models their mother and father provided, and the presence of parental alcoholism or violence. It may also tell you whether the parent felt valued as a child. Similar information may be forthcoming in a prenatal interview in response to questions such as: "Do you intend to raise this baby pretty much as you were reared, or somewhat differently?" The question "Who are you expecting to help after the baby comes?" provides information on the supports potentially available to the mother, including the father and other family members.

10. "Our children sometimes remind us of someone we know, perhaps in our own family. Who does Billy remind you of?" This is a revealing question to ask when a parent's complaints that the child "never minds," "fights," and is "obstinate" seem overstated based on your own observations of the child alone. A divorced mother, for example, may report a resemblance to the child's father -- "He's just like his no-good father!" The child may also be compared to a grandparent with whom the parent had a difficult relationship, or occasionally to a sibling of the parent or other relative who has serious problems. Less frequently, a mother or father may say of their child, "He's actually a lot like me."

The parent often does not seem to recognize that such family comparisons may have contributed to negative expectations. If asked about the future, a parent may express fears that the child will fare poorly in life. Although managing the situation requires much more than merely recognizing this association, the discussion does permit you to point out that the child is really his or her own person and not genetically destined to be like the person with whom he has been gratuitously compared.

By taking a positive approach to a child who is used to hearing only about "what is wrong" with him, you help to initiate a therapeutic alliance that enlists his active participation in the solution of the problem.

11. "How does your baby spend his day?" An infant who presents with failure to thrive, irritability, or poor feeding may suggest a problem in the quantity and quality of mother-infant interaction. Asking the mother to describe how the baby spends his day may reflect her understanding of the infant's developmental needs, her ability to read and respond to the baby's cues, her coping skills, the extent of the father's participation, and the social supports available.

Mothers who are positively engaged with their babies customarily respond in an animated way to this question. They offer details about what their baby does, her emerging abilities and skills, her rewarding responsiveness, and other evidence of a warm parent-infant interaction. For others, however, parenting abilities are constrained by depression, multiple stressors, drug use, a lack of understanding of infant development, or underdeveloped parenting skills. These parents characteristically give a sterile, impersonal report of the baby's day. They don't have the data to answer the question and may not even understand why it is being asked. Such parents may give a sketchy recital confined largely to the mechanical aspects of infant care-time in the crib, the playpen, the swing, or the high chair, an account that is devoid of comments about the baby's personality or references to the interaction between parent and child.

The mother of a 5-month-old infant with failure to thrive reported

that her baby spent most of the day in a jump seat watching television. She seemed unaware that this arrangement was developmentally inappropriate. When asked what she did while the baby was so occupied, she said, "Well, I like to watch TV too."

12. "You've shared some of Jim's behaviors that displease you. What are some of the things he does that you like, that you're proud of?" After reciting all the child's faults, a parent may respond to this question with a prolonged, befuddled pause, followed by a somewhat embarrassed admission that "At the moment, I can't think of any good points." The resolution of such alienation is not simply accomplished, but the question may help initiate the process by making the parent aware of the bias: "Gee, that doesn't sound very fair of me, does it?" A positive response to the question, on the other hand, enables you to catalogue family strengths, which is every bit as important as documenting the problems.⁸ It also gives you information you can put to good use in your interactions with the child.

13. "Tell me some of the things you're really good at." When you see a child or adolescent for the first time because of a suspected behavioral, developmental, psychosocial, or school-related problem, it is a good idea to start the interview by asking the youngster to tell you about his greatest strengths. A child who comes to the doctor expecting to be questioned about his problems and failures will be relieved when the interview opens with a statement like: "I don't know you very well yet, Adam, so I'd like you to tell me what you're especially good at, things you're particularly proud of." This positive approach to a child who has grown accustomed to hearing repeatedly about "what is wrong" with him helps initiate a therapeutic alliance that enlists his active participation in the solution of the problem. Most patients, especially boys, reply that they are good in football or another sport. Others are happy to report that they have talent in art, music, computers, or academic subjects. On the other hand, an occasional child will shrug his shoulders and say that he can't think of anything. You can then reply: "Well, I think you're just being modest. I'll bet you're good at being someone's friend."

14. "You know, I just have the feeling that things aren't going so well for you. . . ." This leading remark can be helpful when, on the basis of the history or a clinical impression, you believe that an older child or adolescent may be depressed. If the presumption is correct, the patient may nod or turn his head toward you as if to say, "I'm glad someone noticed." You can then respond: "Tell me about it."

Relieved that someone has finally sensed that things are not going well, the patient will share his feelings quietly. Based on the degree of depression present, you can decide whether the patient needs to be referred to a psychiatrist or psychologist.⁹ This approach seems to be more productive than confronting the patient with the direct question "Are you depressed?" The answer triggered by such an abrupt, unanticipated question is likely to be "No!" The patient may not understand what "depressed" really means or may ascribe his symptoms to some other cause.

15. "Is there anyone you can talk to about your problems or worries?" When interviewing older children or adolescents, it sometimes becomes evident that they have not previously shared their problems and worries with anyone else. They do not have a confidant. Some lonely children may even confide that they talk at times to their dog, who listens attentively, with unconditionally positive regard, and seems intuitively to understand. There is often poor communication within the family, especially when both parents are employed, a single parent work outside the home, or one of the parents is an alcoholic or other substance abuser. When alerted to the problem, most parents seek to find individual time for their children and to become more accessible. This is especially important when a parent is fatigued, lacks personal support, and is preoccupied with his or her own problems. Many children also need to be encouraged to be less reticent about bringing up their concerns, questions, and the day's events with their parents. Social skills training may be recommended for children who do not have a close friend. Such training, designed to make the child more socially competent and comfortable, may be available in some schools or through consultation with selected psychologists and social workers.

16 "Many girls your age tell me they worry (about their parents' health, about not developing as rapidly as other girls, about becoming pregnant). I would guess that you do also." Although many or most of the concerns that children have are shared by their peers, they are usually unaware of the universality of such feelings, and relieved to learn that others worry about the same things. Their personal doctor's remarks about the normality of such feelings is highly reassuring.

17. "It's natural for everyone to become angry at times. What makes you really angry, and how do you show it?" Children above the age of 9 or 10 may have difficulty managing their anger in a developmentally appropriate fashion. Some display acting out behavior, while others develop encopresis or muscle contraction headaches. More frequently, the child withdraws, unable to express anger in an effective fashion.

Identifying the causes of a child's anger may help to ameliorate them. You can suggest actions or responses the child can use when someone or something makes him angry, rather than simply withdrawing or sulking. Parents who are made aware of the avoidable precipitants of the child's anger can then help the child master this developmental challenge. Some parents, however, may have a problem expressing anger themselves.

18. "How would you change your life If you could? Your relationship with your mother? Father? Friends? School?" Mindy, 13, was a very bright girl who did well in school and was gifted in music. She had no problems outside the home. At home, however, she had started to unleash angry outbursts at her mother. When asked how she'd change

her life, she promptly replied: "I'd like for us to do more as a family, to go out to dinner together or something like that. My father works all the time and doesn't spend much time with us. He also has a bad temper and gets really mad at us. I wish he wouldn't do that." With Mindy's permission, the problem was discussed in a family interview. The father, heavily involved in his professional career, admitted that his life had evolved into a pattern that he increasingly realized was not good for Mindy, his family, or himself. The family interview, he said, was the stimulus he needed to make some changes. The parents made specific plans to do things together with their children on a regular basis, and Mindy's angry outbursts gradually ceased.

19. "What changes would you like to see in your child? Your spouse? Yourself? Your family? Your job?" Most parents are vaguely or intermittently aware of ways in which they could improve the quality of their lives. Your personal interest in and reinforcement of healthy life-style choices can be a powerful influence—one that should not be underestimated—in initiating such practices as smoking cessation, regular physical activity, improved family communication, and increased participation of the father in family activities. The pediatrician can point out that such choices are beneficial to the parent as well as the child.

20. "Did this visit meet your expectations? Did you have other concerns or questions you wanted to bring up?" Parents and patients usually have certain expectations for their visit to the pediatrician, and they leave dissatisfied when these expectations are not met. At the end of the visit, if you sense that something was left unsaid, or that the parent's agenda has not been fully expressed or addressed, it may be worthwhile to comment: "I'm not sure that we covered all that you expected we would today. Some things are difficult to bring up. If that's the case, let me know, and we'll be sure to talk about it at your next visit. I'll make a note in the chart as a reminder."

Open the door to an effective relationship

Interviews are important in pediatric practice, not only to obtain the data necessary to make a diagnosis but also to establish a solid therapeutic alliance with the family. Expertise in interviewing is the key to the pediatrician's psychotherapeutic effectiveness. The 20 questions presented here are intended to enhance that effectiveness within the realities of level I and level II ambulatory pediatric practice. Skill in interviewing involves more than asking the right questions; it also requires an ability to empathize, to observe, and to listen carefully.

Previous articles in this continuing series include "When fever won't go away" (March 1992), "Pollakiuria: Frequency in the child, urgency in the parent" (May), "An itch that won't go away" (July), and "The child with 'delayed speech'" (September), as well as the

introductory article from our January issue, "Persistent symptoms: How to end the frustration." For a copy of any of those articles, please give us a call at 1-201-358-7242.

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Questions for the child or adolescent

Question

Significance

I'm interested in what you think may have caused this problem.

Children and adolescents may have things on their mind that they haven't been able or willing to share with their parents.

How's everything in your family?

Children may reveal recent upsetting events (death in the family, divorce, conflict).

Tell me some of the things you're really good at.

A child who expects to be asked about "what's wrong" with her will be pleased to talk about what's right.

You know, I just have the feeling that things aren't going so well for you. . .

This can draw out a youngster whom you believe to be depressed.

Is there anyone you can talk to about your problems or worries?

Parents can be alerted to the fact that the child needs to be able to share feelings.

Many girls your age tell me they worry (about their parents' health, about not developing as rapidly as other girls, about becoming pregnant, etc.). I would guess that you do also.

Young people are often not aware that their concerns are shared by many others the same age and are perfectly normal.

It's natural for everyone to become angry at times. What makes you really angry, and how do you show it?

Identifying sources of anger may help to ameliorate them and improve the child's ability to deal with them.

How would you change your life if you could? Your relationship with your mother? Father? Friends? School?

Can help to identify family stresses that are responsible for certain behaviors and symptoms and serve to promote healthy changes in life-styles for patients and parents alike.

Did this visit meet your expectations? Did you have other concerns or questions you wanted to bring up with me?

Enables the patient to mention concerns that can be addressed at the next visit.

Helpful questions to ask parents

Question

Significance

I'm interested in what you think may have caused this problem.

Helps to rule out certain parent concerns and to discover others that deserve further study.

I'm not quite sure what you consider to be your main concern. Could you clarify that for me?

Asking the parent to elaborate on the chief complaint can help determine the underlying reason for the visit and assures that parental expectations will be met.

How's everything in your family?

A knee-jerk response of "Fine!" may mean just the opposite.

Have any major changes occurred in your family recently-illness, hospitalization, death, separation, divorce, a move, loss of job?

Parents often don't make the connection between family stresses and a child's symptoms.

How much school has Elizabeth missed because of this illness?

A persistent symptom may mask the problem of school phobia.

Was Mark ever seriously ill?

Helps to determine if the vulnerable child syndrome is at work.

How is your health, Mrs. Smith?

Parental illness, which may have significant impact on the child, may not be spontaneously reported.

How were things for you when you were growing up?

Problems the parent had as a child may shape the current parent-child relationship.

Our children sometimes remind us of someone we know, perhaps in our own family. Who does Billy remind you of?

Family comparisons can contribute to negative expectations for the child.

How does your baby spend his day?

Reveals whether or not parents are positively engaged in the baby's growth and development.

What are some of the things your son does that you like, that you're proud of?

Negative answers may reveal deep-seated problems; positive answers help to catalogue family strengths.

What changes would you like to see in your child? Your spouse? Yourself?
Your family? Your job?

Parents may be receptive to health-promoting suggestions (smoking cessation, regular exercise, better family communication) made by their respected, trusted pediatrician.

Did this visit meet your expectations? Did you have other concerns or questions you wanted to bring up with me?

Enables the parent to mention concerns that can be addressed at the next visit, and promotes parental satisfaction. .