Questions about alcohol and other drugs follow naturally after questions about coffee and cigarettes. “How much alcohol do you drink?” or “Tell me about your use of alcohol” are good opening questions that avoid the easy yes or no response. Learning about alcohol consumption is always relevant to complaints of abdominal pain. Asking about alcohol use may not be very helpful in detecting an alcohol problem. For this purpose, try two additional questions: “Have you ever had a drinking problem?” and “When was your last drink?” An affirmative answer to the first question, along with a drink within 24 hours, has been shown in at least one study to suggest a drinking problem. (Cyr MG, Wartman SA: The effectiveness of routine screening questions in the detection of alcoholism. JAMA 259:51–54, 1988)

Four other questions, known as the CAGE questions, are also helpful in detecting alcoholism. Their name comes from their themes of Cutting down, Annoyance by criticism, Guilty feelings, and Eye-openers.

**The CAGE Questionnaire**

<table>
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<th>Question</th>
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<tr>
<td>Have you ever felt the need to Cut down on drinking?</td>
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<tr>
<td>Have you ever felt Annoyed by criticism of drinking?</td>
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<tr>
<td>Have you ever had Guilty feelings about drinking?</td>
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<tr>
<td>Have you ever taken a drink first thing in the morning (Eye-opener) to steady your nerves or get rid of a hangover?</td>
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Two or more affirmative answers suggest alcoholism. They also suggest further lines of inquiry. If indicated, ask about blackouts (loss of memory for events during drinking), seizures, accidents or injuries while drinking, and job losses, marital problems, or arrests. Mixing alcohol use and driving or operating machinery should be addressed specifically.

Questions about drugs take a similar pattern. “How much marijuana do you use? cocaine? heroin? other illegal drugs? How about prescription drugs such as sleeping pills? diet pills? pain-killers?” And further:

- How do you feel when you take it?
- Have you had any bad reactions? What happened?
- Any drug-related accidents, injuries, or arrest? Job or family problems?
- Have you ever tried to quit?

Addressing this area with adolescents can be even more challenging. It may be helpful to ask first about the use of such substances by friends or family members. “A lot of young people are using drugs these days. How about at your school? your friends?” After patients have found your response nonjudgmental and concerned, they may feel more comfortable telling you about their own patterns of use.

Remember that alcohol and drug use can start at young ages. These topics should be introduced, along with tobacco use, in front of the parent.
at age 6 or 7. Also, remember that drug use, in particular IV drug use, relates to the risk for a variety of other diseases, including HIV disease and hepatitis.

The Sexual History. Asking questions about sexual function and practices serves at least four purposes. (1) Sexual practices determine the risk of unwanted pregnancy and sexually transmitted diseases, including AIDS. Discussion may lead to preventing disease. (2) Sexual practices may be directly related to specific symptoms, and they need to be understood for diagnostic, therapeutic, and preventive reasons. (3) Many patients have questions or problems about sexuality that they would like to discuss with a professional if given the opportunity. Even if they choose not to discuss these questions on the first visit, they may feel free to do so at a later time if you have introduced the topic. (4) Sexual dysfunction is sometimes the consequence of medication which, if recognized, may be readily addressed.

Questions about sexual functions or practices may be relevant at multiple points in a patient's history. Sexual practices may be part of the lifestyle issues covered in the Personal and Social History, or for women may be covered in the Obstetric/Gynecologic history. If a patient's chief complaint involves genitourinary symptoms, a sexual history is included in the Present Illness section. Questions about sexuality can be an expansion of asking about the important relationships in the person's life, or specifically introduced as part of the Health Maintenance questions similar to those about drug use, diet, and exercise. Whenever a person has a chronic illness or serious symptoms such as pain or shortness of breath, sexual function may be affected. Asking about it in the context of other effects on the patient's life is a natural sequence of inquiry.

An orienting sentence or two is often helpful. "Now, to figure out why you have this discharge and what we should do about it, I need to ask you some questions about your sexual activity." If there have been no apparent sex-related complaints, a different introduction is indicated. "I'd like to ask you some questions about your sexual health and practices."

Questions about the patient's specific sexual behaviors and satisfaction with sexual function can both be addressed. Specific questions that should be addressed include:

1. "When was the last time you had intimate physical contact with anyone?" "Did that contact include sexual intercourse?" Using the term "sexually active" can be ambiguous. Patients have been known to reply, "No, I just lie there."
2. "Do you have sex with men, women, or both?" The health implications of heterosexual, homosexual, or bisexual relationships are significant.
3. "How many sexual partners have you had in the last 6 months?" Again, this question assumes that the patient may have had more than one partner. It is not meant to insult patients but to provide them with the easy opportunity to acknowledge multiple partners.
4. If the patient is engaged in heterosexual activity, it is important to ask both men and women about the use of birth control, and specifically the use of condoms. “What birth control are you currently using?” If the patient responds that he or she is not using any birth control, follow up with “Are you currently trying to become a parent?”

5. “Are you satisfied with your sexual function?”

6. “Are you concerned about HIV disease or AIDS?” This question, then, gives you an opportunity to ask about the specific behaviors that put a patient at risk for HIV disease, and to review those behaviors.

Note that these questions make no assumptions about marital status, sexual preference, or attitudes toward pregnancy or contraception. Listen to each of the patient’s responses, and ask additional questions as indicated.

Remember that sexual behavior, too, can start at a young age. Introducing sexuality and encouraging parents to talk to their children about sexual behaviors at an early age are appropriate. It is often easier to discuss these normal physiologic functions with children before they have been heavily socialized outside the home. Because sexual behaviors of adolescents are often kept secret from parents, clinicians must be sensitive to the need for patient confidentiality, as discussed in the section about talking with adolescents (see p. 26).

Domestic and Physical Violence. Because of the high incidence of physical, sexual, and emotional abuse in our society, routine screening of all female patients for domestic violence is currently recommended. While not all victims of physical and sexual abuse are female, women are at a much greater risk. Initiating this part of the interview by indicating that the problem is common creates a context to normalize the questions. “Because violence is common in many women’s lives, I’ve begun to ask about it routinely.” “Are there times in your relationships that you feel unsafe or afraid?” “Many women tell me that someone at home is abusing or hurting them. Is this true for you?” “Are you currently in a relationship in which you have been physically hurt or threatened?”

Physical abuse—often not mentioned by the victim or the perpetrator—should be considered (1) when injuries are unexplained, seem inconsistent with the patient’s story, are concealed by the patient, or cause embarrassment; (2) when the patient has delayed getting treatment for trauma; (3) when there is a past history of repeated injuries or “accidents”; and (4) when the patient or person close to the patient has a history of alcohol or drug abuse. At times, the behavior of the abuser raises suspicion: he (she) tries to dominate the interview, will not leave the room, or seems unusually anxious or solicitous. It is important in such situations to spend part of the interview alone with the patient.

Child abuse is also common in our culture. Asking parents about their approach to discipline is a normal part of well-child care. Another approach to consider is talking about how parents cope with the normal

Mental Illness. About men and women about the illness. This is often a difficult issue. Many clinicians hesitate to ask about mental illness, feeling that patients might be offended by such questions. Yet, you ever considered the patient’s wishes. Have you ever seen a patient in your practice who was suffering from a mental health problem?

Many patients with mental illness are withdrawn, not telling you of their problems. It is important to be aware of these patients, as they may benefit from being referred for a psychiatric evaluation. While depression is often a part of the treatment of many patients who experience it, it is important to realize that it is important to ask about such problems. You should always ask patients about their feelings and behaviors.

Two open-ended questions that have been overheard by many patients, and have been thought to be helpful in evaluating their situations, are:

Death and dying. Asking patients about their attitudes to death is often a situation.
experience of babies who won’t stop crying or children who have been misbehaving. “Most parents get very upset when their baby cries (or their child has been naughty). How do you feel when your baby cries?” “What do you do when your baby won’t stop crying?” “Do you have any fears that you might hurt your child?” You should also inquire about other caretakers or people the child spends time with to explore possibilities of both physical and sexual abuse.

Mental Illness. Our society and many cultures have ingrained beliefs about mental illness that separate it and treat it differently than physical illness. Think about how easily people talk about diabetes and taking insulin compared to discussions of schizophrenia and the use of chlorpromazine. Asking specific questions about a history of mental illness in the individual patient and the family should include both open-ended questions—“Have you ever had any problem with emotional or mental illnesses?”—and specific questions about treatments—“Have you ever visited a counselor or psychotherapist?” “Have you or anyone in your family ever been hospitalized for an emotional or mental health problem?”

Many patients with schizophrenia or other psychotic disorders are able to function in the community. Such patients are frequently capable of telling you freely about their diagnoses, their symptoms, their hospitalizations, and their current medications. You should feel comfortable inquiring about these without embarrassment or circumlocution. You should always assess the degree to which symptoms are causing distress.

While depression is known to be a common problem with effective treatments, it is still underdiagnosed and undertreated, even among patients who are receiving health care. Some clinicians advocate screening all patients for depression. While this had not been accepted universally, it is important to be alert to the possibility of depression. Mood change might not be the presenting symptom; you should always ask about the specific symptoms of depression in patients who have fatigue, vague symptoms, weight loss, insomnia, or other clues to poor functioning. Two open-ended questions to use are, “How have your mood or spirits been over the past month?” and “What about your level of interest or pleasure in each day’s activities?” To diagnose depression you must actively consider it as a possibility, identify it by knowing the typical symptoms, and explore its manifestations. Be sure you know how severe the depression is by asking for thoughts of suicide. “Have you ever thought about hurting yourself or ending your life?” Just as you would evaluate the severity of chest pain, you must evaluate the severity of depression. Both are potentially lethal.

Death and the Dying Patient. In communicating with fatally ill or dying patients, clinicians are at risk of avoiding the subject of death because of their own discomforts and anxieties. With the help of reading and discussion, you will need to work through your own feelings. As in any clinical situation, it is helpful to know what reactions the patient is likely to have.
Kübler-Ross has described five stages in a patient’s response to impending death: denial and isolation, anger, bargaining, depression or preparatory grief, and acceptance. These stages may come sequentially or in different times and combinations. At each stage, your approach is basically the same. Be alert to the feelings of such patients and to cues that they want to talk about their feelings. Help them to bring out their concerns with nondirective techniques. Make openings for them to ask questions: “I wonder if you have any concerns about the operation? . . . your illness? . . . how it will be when you go home?” Explore these concerns and provide whatever information the patients request. Be wary of inappropriate reassurance. If you can explore and accept the patients’ feelings, if you can answer the patients’ questions, if you can assure and demonstrate your ability to stay with the patients throughout the illness, reassurance will grow where it really matters—within the patients themselves.

Fatally ill or dying patients rarely want to talk about their illnesses all the time, nor do they wish to confide in everyone they meet. Give such patients opportunities to talk, and listen receptively, but if the patient prefers to keep the conversation on a lighter plane you need not feel like a failure. Remember that illness—even a terminal one—is only one small part of personhood. A smile, a touch, an inquiry after a family member, a comment on the day’s ball game, or even some gentle humor all recognize and reinforce other parts of the patient’s individuality and help sustain the living person. To communicate appropriately, you have to get to know the patient; that is part of the helping process.

Understanding how a patient wishes to be treated at the end of life is an important part of a clinician’s role. In general, however, our society avoids death and, in health care, it is usually seen as a failure. These factors, in addition to your own discomfort, may make it difficult for you, but this should not prevent you from asking specific questions. The health of the patient and the context of care will partially determine what needs to be discussed. With an ill patient in an acute hospital setting, the need to find out what a patient wants done in the event of a cardiac or respiratory arrest is usually mandatory. Asking about “DNR status” (Do Not Resuscitate) is often made more difficult by the lack of an established relationship with the patient and little knowledge of the patient’s personal values or life experience. Patients may also have unrealistic beliefs about the effectiveness of resuscitation based on programming in the media. Find out about the patient’s frame of reference. “What experiences have you had with the death of a close friend or relative?” “What do you know about cardiopulmonary resuscitation?” Educate patients about the likely success of cardiopulmonary resuscitation, especially in chronically ill or older patients. Assure them that attending to physical needs such as pain will be a priority.

In general, encouraging any adult, but more specifically the elderly or those with chronic illness, to complete health proxies or living wills is an important task. You can do this as part of a values history. A values history is a part of the interview aimed at finding out what is important to patients, what they would no longer want to do, how they would like to spend their time. It is also a way to look forward to any statement the patient might make about his or her family. What else do you do to find out about the patient’s religious or spiritual beliefs? Why are these important in understanding the patient’s concerns and in deciding appropriate decisions?

Sexuality in Clinical Practice

Clinicians of both genders must remember that their patients—men, women, and children—consider sexual concerns to be valid and important. Often the patient relationship becomes a source of support for you as you become a more sensitive observer of your patients’ responses, and that increases your confidence in expressing your behavior and in understanding the patient. Inappropriate attitudes toward sexuality are inappropriate attitudes toward patients is entirely inappropriate within professional practice.

Occasionally, your patients may attempt to make sexual advances or to interfere with your relationships. View your interactions with your patients as personal and expressed your feelings. Has your colleague spoken to you about this?

Ethical Consulations

The area of medical ethics is a broad one. In the context of our discussion it is important to remember that ethical questions are raised not only in the hospital and the clinic or office, but also at home. There is now a more realization that the clinician has an obligation to determine the needs of the patient and that the clinician needs to ask the patient what he or she needs. This principle should guide the clinician in determining whether a patient is competent to make decisions about his or her care.
patients, what makes their life worth living, and at what point their life would no longer be worth living. Asking questions about how they spend their time on a daily basis, what brings them joy, and what they look forward to are useful. Make sure to clarify the specific meaning of any statements. “You said that you don’t want to be a burden to your family. What exactly do you mean by that?” In addition, exploring any religious or spiritual framework the patient may believe in or practice is important in understanding how you and the patient can make the most appropriate decisions about health care.

Sexuality in the Clinician–Patient Relationship

Clinicians of both sexes will occasionally find themselves attracted to their patients. The emotional and physical intimacy of the clinician–patient relationship may make sexual feelings more likely to occur. If you become aware of such feelings, accept them as normal human responses, and think about them consciously to prevent them from affecting your behavior. If you deny these feelings, you are more likely to act inappropriately. Any sexual contact or romantic relationship with patients is entirely unethical; keep your relationship with the patient within professional bounds.

Occasionally, clinicians may meet patients who are frankly seductive or make sexual advances. Calmly but firmly, you should make clear that your relationship is professional, not personal. You may also wish to review your image. Have you been overly warm with the patient? Expressed your affection physically? Sought his or her emotional support? Has your clothing or demeanor been unconsciously seductive? It is your responsibility to avoid these problems.

Ethical Considerations

The area of medical ethics is broad, complex, and usually considered in the context of treatment decisions and research. But if you remember the importance of the clinician–patient relationship as a therapeutic alliance and the central role of the patient interview in creating that alliance, you will more readily understand the need to be guided by three fundamental principles: Nonmaleficence, Beneficence, and Autonomy.

Nonmaleficence or primum non nocere is commonly stated as “First, do no harm.” In the context of an interview, harm can be done by giving information that is incorrect or not really related to the patient’s problem. Harm can also be done by avoiding relevant topics or creating barriers to open communication. The degree to which a patient can communicate most fully his or her experiences, thoughts, and feelings helps to determine the accuracy of your assessment. Beneficence is the dictum that the clinician needs to “do good” for the patient. As clinicians, our actions need to be motivated by what is in the patient’s best interest. This principle must be linked to autonomy, which is the patients’ right to determine what is best for themselves.
As you can readily see, these principles can create challenges when deciding on the best course of action. A patient's ability to understand the medical thinking about a given situation and the ability of a clinician to understand the patient's perspective are integrally related.

**Patients at Different Ages**

As people develop, have families, and age, they provide you with special opportunities and require certain adaptations in your interviewing style.

**Caring for Children**

Unlike adults who frequently receive health care as individuals, children usually appear with a parent or caregiver. Even if adolescents come in alone, they are often seeking health care at the request of their parents—indeed, the parent is often sitting in the waiting room. This aspect of caring for children calls for some specific clinician approaches. You need to consider the needs and perspectives of both the child and the caregivers. In addition, because so much of the care of children is in the context of "well child care," the clinician may also have a set agenda such as immunizations, anticipatory guidance, or developmental assessment. The specific approaches related to caring for children expand on themes covered earlier in this chapter.

**Establishing Rapport.** With children, as with adults, begin the interview by greeting and establishing rapport with each person present. Refer to the infant or child by name rather than by "him," "her," or "the baby." Clarify the role or relationship of all of the adults and children. "Now, are you Jimmy's grandmother?" When the family structure is not immediately clear, you may avoid embarrassment by asking directly about other members. "Who else lives in the home?" "Who is Jimmy's father?" "Do you live together?" Address the parents as "Mr. Smith" and "Ms. Smith" rather than by their first names or "Mom" or "Dad." First names may be used with permission when you have established a reasonably long-standing relationship.

Establishing rapport with a 2-year-old is obviously different from establishing rapport with a 25-year-old. The key here is to meet children on their level. Use your personal experiences with interacting with children in other settings as a guide for how to engage children in the health-care context. Eye contact on their level (for example, sit on the floor if needed), playful engagement, and talking about what interests them are always helpful guides. Ask children about their clothes, a toy they have, what book or TV show they like, or their adult companion in an enthusiastic but gentle style. Spending time at the beginning of the interview to calm down and connect with an anxious child or crying infant can put both the child and the caregiver at ease.

**Working With Families.** One of the biggest challenges in working with more than one person is being conscious of where you direct your ques-
tions. While eventually you need to get information from both the child and the parent(s), it is useful to start with the child, if he or she is verbal. Even at the age of 3, some children can tell you the specific problem. Asking simple, open-ended questions—"Are you sick?... Tell me about it"—followed by more specific questions can often give you much of the history of the present illness. The parents can then verify the information, tell you additional details that give you the larger context, and identify other specific issues you need to address. Sometimes children are embarrassed to begin, but once the parent has started the conversation you can direct the questions back to the child.

Your mother tells me that you get a lot of stomach aches. Tell me about them.
Show me where you get the pain. What does it feel like?
Is it a pin prick, or does it ache?
Does it stay in the same spot, or does it move around?
Anything else about feeling sick?
What helps make it go away?
What do you think causes it?
How about missing school a lot?

In addition to the specific communication between clinician, patient, and family, the presence of multiple family members provides a rich opportunity to observe the interactions. While you talk with the parent, see how a young child relates to a new environment. It is normal for a toddler to open drawers, pull at paper, and wander around the room. An older child may be able to sit still or may get restless and start fidgeting. You may see specific examples of how the parents set limits on the child's actions or fail to when they should.

Multiple Agendas. As discussed earlier, each individual in the room, including the clinician, may have a different idea of the nature of the problem and what needs to be done about it. It is your job to discover as many of these perspectives and agendas as possible. In addition, family members who are not present (the absent parent or grandparent) may also have concerns. It is a good idea to ask specifically about those concerns. "If Suzie's father were here today, what questions or concerns would he have?" "Have you, Mrs. Jones, discussed this with your mother or anyone else?" "What does she think?" Mrs. Jones brings Suzie in for abdominal pain because she is worried that Suzie may have an ulcer. She is also worried about Suzie's eating habits. Suzie is not worried about the belly pain. It rarely interferes with what she wants to do. She is, however, worried about the changes in her body, especially her belief that she is getting fat. Mr. Jones thinks that Suzie's school work is not getting enough attention. You, as the clinician, need to balance these concerns with what you see as a healthy, 12-year-old girl in early puberty with some mild functional abdominal pain. Your goals need to include your agenda of helping the family to develop a realistic attitude toward the range of normal. You also need, however, to specifically address the concerns of Mr. and Mrs. Jones and Suzie.
The Family as Resource. Much of the information you obtain about a child will come from the family. In addition, most of the care provided to the child, both explicitly health related and in general, is provided by the family. They are your major allies in caring for this child. Recognizing the range of what is normal in parenting behavior will help you establish this alliance. Raising a child is not a medically defined task. It is determined by cultural, socioeconomic, and family practices. As clinicians, we know some specific approaches that enhance a child's healthy growth and development, and some specific approaches that are harmful. Beyond that, there is huge variation. Your ability to develop an alliance with the parents or caretakers will be most successful if you respect those limits. In addition, taking the stance that the parents are the experts in the care of their child and that you are there as a consultant will minimize the potential for parents to discount or ignore advice that they are given. There is a lot at stake for most parents as they try to cope with the problems of their children, so health practitioners who are supportive rather than judgmental are needed. Comments like, “Why didn't you bring him in sooner?” or “What did you do that for!” will not improve your rapport with a parent. Statements acknowledging the hard work of parenting and praising successes are always appreciated.

Hidden Agendas. Finally, as with adults, the chief complaint may not relate to the real reason the parent has brought the child to see you. The complaint may serve as a “ticket to care” or bridge to concerns that may not seem legitimate reasons for seeking care. Try to create an open and trusting atmosphere that allows parents to express all their concerns. If necessary, ask questions that will facilitate the process.

Are there any other concerns with Johnny that you would like to tell me about?
What did you hope I would be able to do for you today?
Was there anything else that you wanted to tell/ask me today?

Talking with Adolescents
Adolescents, like most other people, will usually respond positively to anyone who demonstrates a genuine interest in them. It is important to show interest early and then sustain the connection if communication is to be effective. Adolescents are more likely to open up when the focus of the interview is on themselves and not on their problems. In contrast to most interviews, start with specific direct questions to build trust and rapport and get the flow of conversation going. You may have to do more talking than usual. A good way to begin the interview with adolescents is to chat informally about their friends, school, hobbies, and family. Using silence in an attempt to get adolescents to talk or asking about feelings directly is usually not a good idea. It is particularly important to use orienting (see p. 19) and transitional statements (see p. 13) and explain what you are going to do during the physical exam. The physical can be an opportunity to get the young person talking. Once rapport has been established, return to more open-ended questions. Make sure at that point to ask what concerns or questions the adolescent may have.

26 Chapter 1 ♦ Interviewing and the Health History
Remember also that adolescents’ behavior is related to their developmental stage, not necessarily chronologic age or physical development. Their age and appearance may fool you into, assuming that they are functioning on a more future-oriented and realistic level. The reverse can also be true, especially in teens with delayed puberty or chronic illness.

Issues of confidentiality become important as children enter adolescence. Explain to both parents and adolescents that the best health care allows adolescents some degree of independence and confidentiality. It helps if the clinician starts asking the parent to leave the room for part of the interview when the child is 10 or 11. This prepares both caregivers and young people for future visits when the patient spends time alone with the clinician.

Speaking alone with an adolescent or a child should be done only after you have taken certain steps. Before the parent leaves the room, get relevant medical history from the parent (the patient may not know certain elements of past history) and clarify the parent’s agenda for the visit. Also discuss confidentiality. You should explain to both parents and children that confidentiality is to improve health care, not to keep secrets. Adolescents need to know that what they discuss with you will be held in confidence. However, never offer unlimited confidentiality. Always be explicit that you may need to act on information that makes you concerned about the safety of the adolescent. “I will not tell your parents what we talk about, unless you give me permission or I am concerned about your safety—for example, if you talk to me about killing yourself and I think that there is a risk that you would actually try it.”

Your goal as clinician is to help adolescents bring their concerns or questions to their parents whenever that is safe and realistic. Encourage adolescents to discuss sensitive issues with their parents, and offer to be present or help. While young people may believe that their parents would “kill them if they only knew,” you may be able to promote more open dialogue. This takes a careful assessment of the parents’ perspective and the full and explicit consent of the young person.

Aging Patients
At the other end of life’s cycle, aging patients also have special needs and concerns. Their hearing and vision may be impaired, their responses may be slow, and they often have chronic illnesses with associated disabilities. For several reasons, elderly people may not report their symptoms. Some may be afraid or embarrassed to do so. Others may be trying to avoid the medical expenses or the discomforts of diagnosis and treatment. They may think their symptoms are merely a form of the aging process, or may simply have forgotten about them. Aging patients also may tell their histories more slowly than younger patients.

Give an elderly person extra time to respond to your questions if needed. Speak slowly and clearly but do not shout or raise your voice. A comfortable room, free of distractions and noise, is helpful. Ask to
turn off the radio or television. Remember that visual cues may be more important, so make sure that your face is well lit. Do not try to accomplish everything in one visit. Multiple visits may be less fatiguing and more productive.

From middle age on, people become increasingly aware of their personal aging and may begin to measure their lives in terms of the years left rather than the years lived. It is normal for older people to reminisce about the past and to reflect upon previous experience, including joys, regrets, and conflicts. Listening to this process of life review can give you important insights and provide opportunities for you to support patients in working through painful feelings or recapturing experiences of joy or accomplishment.

While generalizations about elderly people are useful, you must recognize and avoid stereotypes that can block your understanding and enjoyment of each individual patient. Work to determine the unique priorities and goals of each patient. Learn how patients have handled problems in the past. Because they may pursue similar adaptive patterns in the present situation, this knowledge will help you plan with them. Find out how they perceive themselves and their situation. “Can you tell me how you feel about getting older? What kinds of things do you find most satisfying? What kinds of things worry you? What would you change if you could?”

Learning how elderly people (and others with chronic illness) function in their daily lives is essential to your understanding of and care for them. Establishing their level of function also provides a baseline for future comparisons. There are two standard categories of assessment, physical activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

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Can the patients perform the activities of daily living independently, do they need some help, or are they entirely dependent? Instead of asking about each area separately, have the patient go through a typical day, in detail. Start with an open-ended request—“Tell me about your day yesterday”—and then guide the story to a greater level of detail. “You got up at 8? How is it getting out of bed?” “What did you do next?” Ask how things have changed, who is available for help, and who actually

does what. In this way, you can help the patient develop a new, more productive role for himself. And, if you continue to do so, you can help to create a sense of hope and encouragement.

Silence

Silence, don’t be afraid to it. It is not a signal that you are not interested or that you need not talk. If you ask a question, remember that the answer may be that the patient has no idea, or that the answer is too complex to express in words. This is particularly true with elderly patients. Petriella may be waiting to answer your questions or to tell you the answers to the questions you have already asked. If they do not, you need to ask them again. Too often, we mention to the patient what is going on, but they need help to regain their sense of control over their lives. Do not be afraid to speak to the patient, but do not be afraid to listen, and then ask the question again, if you must.
does what to help. Keep safety as an important priority. Remember that increasing dependence on others is difficult for most people to accept.

Situations That Call for Specific Responses

Regardless of patient age, certain behaviors and special situations may particularly vex or perplex the practitioner. Your skills in handling these problems will evolve over a lifetime. *Always remember the importance of listening to the patient and clarifying the patient's agenda.*

Silence. Novice interviewers may grow uncomfortable during periods of silence, feeling somehow obligated to keep the conversation going. They need not feel so. Silences have many meanings and many uses. When recounting a present illness a patient frequently falls silent for short periods to collect thoughts, remember details, or decide whether or not to trust you enough to report something. An attentive posture on the interviewer's part is usually the best response here, sometimes followed by brief encouragement to continue. During periods of silence, be particularly alert to nonverbal cues, such as evidence that the patient is having difficulty controlling emotions. Depressed patients or those with dementia may have lost their usual spontaneity of expression, give short answers to questions, and fall silent quickly after each one. If you sense one of these problems, shift your inquiry to asking about the symptoms of depression or begin an exploratory mental status examination (see Ch. 3).

At times, a patient's silence results from interviewer error or insensitivity. Are you asking too many direct questions in rapid sequence? The patient may simply have yielded the initiative to you and taken the passive role you seem to expect. Have you offended the patient in any way?—for example, by signs of disapproval or criticism? Have you failed to recognize an overwhelming symptom such as pain, nausea, or dyspnea? If so, you may need to ask the patient directly, "You seem very quiet. Is there something I have done to upset you?"

Patients Who Like to Talk. The garrulous, rambling patient may be just as difficult as the silent one, possibly more so. Faced with limited time and a perceived need to "get the whole story," the interviewer may grow impatient, even exasperated. Although there are no perfect solutions for this problem, several techniques are helpful. First, you may need to shift your agenda and accept less than a comprehensive history. Second, give the patient free rein for the first 5 or 10 minutes of the interview. You will then have the chance to observe the patient's pattern of speech. Perhaps the patient has simply lacked a good listener for a long time and is expressing pent-up concerns. Maybe the patient's style is to tell detailed stories. Does the patient seem obsessively detailed or unduly anxious? Is there a flight of ideas or a disorganization of thought processes that suggests a psychotic disorder? Could it be confabulation? Third, try to focus the discussion on what seems to be most important to the patient. Show interest and ask questions in those areas. Interrupt if you must, but courteously. It is acceptable to be directive. A brief sum-
mary may help you change the topic while letting the patient know that you have both heard and understood. “As I understand it, your chest pains come frequently, last a long time, and do not necessarily stay in any one place. Now tell me about your breathing.” Finally, do not let your impatience show. If you have used up the allotted time or, more likely, gone over it, explain that to the patient and arrange for a second meeting. Setting a time limit for the next appointment may be helpful. “I know we have much more to talk about. Can you come again next week? We will have a full hour then.”

Patients with Multiple Symptoms. Some patients seem to have every symptom that you mention. They have an “essentially positive review of systems.” Although it is conceivable that such a patient has multiple organic illnesses, a somatization disorder is much more likely. In such cases it will profit little to explore each symptom in detail. Focus on the meaning or function of the symptom and guide the interview into a psychosocial assessment.

Anxious Patients. Anxiety is a frequent and normal reaction to sickness, to treatment, and to the health-care system itself. For some patients anxiety is a filter for all their perceptions and reactions, and for others it may be part of their illness. Be sensitive to nonverbal and verbal clues. For example, anxious patients may sit tensely, fidgeting with their fingers or clothes. They may sigh frequently, lick their dry lips, sweat more than average, or actually tremble. Carotid pulsations may betray a rapid heart rate. Some anxious patients fall silent, unable to speak freely or confide. Others try to cover their feelings with words, busily avoiding their own basic problems. When you sense an underlying anxiety, encourage such patients to talk about their feelings.

Anger and Hostility. Patients have reasons to be angry: they are ill, they have suffered a loss, they lack their accustomed control over their own lives, they feel relatively powerless in the health-care system. They may direct this anger toward you. It is possible that you have justly earned their hostility. Were you late for your appointment, inconsiderate, insensitive, or angry yourself? If so, recognize the fact and try to make amends. More often, however, some of the response is a displacement of the patients’ anger onto the clinician as a symbol of their pain.

Allow patients to get angry feelings off their chests. Accept their feelings without getting angry in return. Beware of joining such patients in their hostility toward another part of the clinic or hospital, even when you privately harbor similar feelings. You can validate patients’ feelings without agreeing with their reasons. After a patient has calmed down, you may be able to help him or her to identify specific steps that will be useful in the future. Rational solutions to emotional problems are not always possible, however, and people need time to express their angry feelings and have them validated.

The Obstreperous Intoxicate. Few patients can disrupt the clinic or emergency room more quickly than an acutely intoxicated person who is angry, because you will have a right to throw him out and appear as you wish. Mount the questioning and note the patients lower their voices, and the persons fall into an open conversation.

Crying. One major issue to consider during an interview is expression of feelings. Is the patient’s pain expression of true existential distress? Does the crying seem out of proportion to the actual distress the patient may feel at the moment? How will you allow this crying to occur? Offer a tissue. In the presence of the patient, offer appropriate remarks. Most patients are able to control the tears. In some cases the patient’s crying may be an expression of anger; you will see it then.

Confusing the patient. The patient may be confused, frazzled, frustrated, or depressed. Personal history is a great tool to use in order to figure out what to do next. Your question needs to be as clear as possible, patient’s name, and the patient’s age. It is important to ask in a way that is not inappropriate, such as “What did you mean by ‘My fingers are too big’?”

With the patient’s cooperation, information gathering is crucial. It is important to determine what the patient is thinking, feeling, and perceiving. It is not uncommon to find that the patient is hearing voices, seeing things, or feeling things that are not real. It is crucial to have patients complete the interview and assess their mental status, memory, and intellectual functioning. It is important to keep patients informed throughout the interview.
angry, belligerent, and uncontrolled. Before interviewing such a patient, it is wise to alert the security force of the hospital. As a clinician you have a right to feel and be safe. It is especially important to stay calm and appear accepting, not challenging. To do this, approach the patient as you would normally, but keep your posture relaxed and nonthreatening and your hands loosely open. Do not try to make inebriated patients lower their voices or stop cursing you or the staff, but listen carefully and try to understand what they are saying. Since some such persons feel trapped in small rooms, it is usually best to talk with them in an open area. You too are likely to feel more comfortable there.

**Crying.** Crying is an important clue to emotions. While it is often an expression of sadness, it can be due to anger or frustration. If the patient seems on the verge of tears, gentle probing or an empathic response may allow the patient to cry. It is usually therapeutic for the patient to allow this expression of feeling. Quiet acceptance is then appropriate. Offer a tissue, wait for recovery, perhaps make a facilitating or supportive remark: “It’s good to get it out.” In that kind of accepting context, most patients will soon compose themselves and will feel better and capable of continuing the discussion. Many people in our culture find that crying makes them uncomfortable. If that is true for you, as a clinician you will need to work to support patients in this important expression.

**Confusing Behaviors or Histories.** At times you may find yourself baffled, frustrated, and confused in your interaction with the patient. The history is vague and difficult to understand, ideas are poorly related to one another, and language is hard to follow. Even though you word your questions carefully, you seem unable to get clear answers. The patient’s manner of relating to you may also seem peculiar: distant, aloof, inappropriate, or bizarre. Symptoms may be described in bizarre terms: “My fingernails feel too heavy” or “My stomach knots up like a snake.” With the usual nondirective techniques, you may be able to get more information about the unusual qualities of the symptoms. These characteristics should alert you to possible alterations in mental status, such as psychosis or delirium that may be due to mental illnesses such as schizophrenia or some other cognitive dysfunction (see Ch. 3). Be particularly alert for delirium when dealing with an acutely ill or intoxicated patient, and for dementia when dealing with an elderly patient.

Patients with these problems may be unable to give clear histories. They may be vague and inconsistent about symptoms or events and unable to report when and how things happened. They may be inattentive to your questions and hesitant in their answers. Occasionally such patients may confabulate to fill in the gaps in their memories. When you suspect a cognitive disorder, such as dementia, do not spend too much time trying to get a detailed history. You will only tire and frustrate the patient as well as yourself. Shift your inquiry instead to an evaluation of mental status, checking particularly on level of consciousness, orientation, and memory (see Ch. 3). You can work the initial questions smoothly into the interview. “When was your last appointment at the clinic? Let’s
see, then, that was about how long ago?” “Your address now is?... and your phone number?” Responses can all be checked against the chart (presuming, of course, the chart is accurate).

Patients with Limited Intelligence. Patients of moderately limited intelligence can usually give adequate histories. You may, in fact, overlook their limitations and thereby make mistakes, such as omitting their dysfunction from a disability evaluation or giving instructions they cannot understand. If you suspect such problems, pay special attention to the patient’s schooling and independent function. How far did they go in school? If they didn’t finish, why not? What kinds of courses are (were) they taking? How did they do in those courses? Did they have any testing done? Are they living alone? Do they get help with any activities (e.g., transportation, shopping)? If you are unsure, you can make a smooth transition into a mental status examination, including simple calculations, vocabulary, information, and tests of abstract thinking (see Ch. 3). The sexual history is equally important and often overlooked in the care of these patients. When patients suffer from severe mental retardation, you will have to obtain their history from family or friends. Always first show interest in the patients themselves. Establish rapport and eye contact and engage in simple conversation. As with children, avoid “talking down” to mentally retarded patients and using affectations of speech or condescending behaviors. The patient, family members, caretakers, or friends will notice and appreciate respectful behavior.

Limited or No Ability to Read. Before giving written instructions, it may be advisable to assess a patient’s reading ability. Literacy levels vary significantly, and marginal reading skills are more prevalent than commonly believed. People cannot read for many reasons: language barriers, learning disorders, poor vision, or lack of education. Illiterate people may try to hide their inability to read. Asking about educational level may be helpful, but can be misleading. Respond sensitively, and remember that illiteracy and lack of intelligence are not synonymous. When you give written instructions, check to see if the patient can read what you have written.

Language Barriers. Nothing will more surely convince you that a history is essential than having to do without one. When you cannot communicate with your patient because you speak different languages, take every possible step to find an interpreter. A few broken words and gestures are no substitute. The ideal interpreter is a neutral, objective person who is familiar with both languages. When family members or friends try to help, they are more likely to distort meanings and may also present confidentiality conflicts for both the patient and the interviewer. Many interpreters try to speed the process by telescoping a long communication into a few words. Try to make clear at the beginning that you need the interpreter to explain everything, not to interpret or summarize. Make your questions clear and short. You can also help the interpreter by outlining the goals for each segment of your history.
When available, written bilingual questionnaires are invaluable, especially for the review of systems. Before using one, however, be sure patients can read in their own language or can get help with the questionnaire. Some clinical settings have access to speaker-phone translators; use them if there are no better options.

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**Guidelines for Working With an Interpreter**

1. Choose a trained interpreter when possible, in preference to a volunteer or family member.
2. Orient the interpreter to how you want the interview to proceed. Include reminders to translate 2 literal meanings and avoid interpretations or advice to the patient.
3. Arrange the room so that you and the patient have eye contact and you can read nonverbal cues. Seating the interpreter next to you works well.
4. Allow the interpreter and patient to establish rapport.
5. Address the patient directly (“How long have you been sick?” rather than “How long has he been sick?”). Use your body position to reinforce your rapport with the patient.
6. Keep statements short and simple. Think about the most important concepts to communicate.
7. Use the interpreter as a resource for cultural information.
8. Verify mutual understanding by asking the patient to report back what has been communicated.
9. Be patient. The interview will take more time and may provide less information.

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**Deaf and Hard-of-Hearing Patients.** Communicating with people who are deaf presents many of the same problems as communicating with patients who speak a different language. Deaf people may preferentially use sign language, which is a unique language with its own syntax. In addition, the deaf often identify themselves as being part of a separate cultural group. Thus, this is often a truly cross-cultural communication. Find out the patient’s preferred form of communication. If the patient knows sign language, make every effort to find an interpreter, using the principles identified above. Although very time consuming, handwritten questions and answers may be the only solution. When patients have partial hearing impairment or can read lips, face them directly, in good light. Speak slowly and in a relatively low-pitched voice. Do not let your voice trail off at the ends of sentences, avoid covering your mouth, and use gestures to reinforce your words. If the patient has unilateral hearing loss, arrange the seating for access to the hearing side. A person who has a hearing aid should, of course, wear it, and you should check to be sure that it is working. Patients who use glasses should use them, too; visual cues may help them to understand you better. Supplement any oral instructions with written ones. Written questionnaires are a great help.

**Blind Patients.** When meeting with a blind patient, shake the person’s hand to establish contact and explain who you are and why you are there. If the room is unfamiliar, orient the patient to it and explain what is there and whether anyone else is present. Remember to respond vo-
cally to such patients when they speak, since facilitative postures and gestures will not work. At the same time, guard against raising your voice unnecessarily.

**Talking With Families or Friends.** Some patients are totally unable to give their own histories due to age, dementia, or other limitations. Others may be unable to describe parts of the history, such as their behavior during a convulsion. Under these circumstances, you must try to find a third person from whom you can get the story. At times, although you may think you have a reasonably comprehensive knowledge of the patient, other sources may offer surprising and important information. A spouse, for example, may report significant family strains, depressive symptoms, or drinking habits that the person has denied.

The basic principles of interviewing apply to your conversations with relatives or friends. Find a private place to talk. Introduce yourself; state your purpose, inquire how they are feeling under the circumstances, and recognize and acknowledge their concerns. As you listen to their versions of the history, be alert for clues to the quality of their relationships with the patient. These may color their credibility or give you helpful ideas in planning the patient’s care. It is also important to find out the basis for their knowledge. For example, when a child is brought in for health care, the adult may not be the primary or even frequent caregiver, just the most available ride. Always try to find the best informed source.

When seeking data from a third person, it is necessary to have the patient’s approval. Assure such patients that you will keep confidential what they have already told you, or get their permission to share certain information. Data from other persons must also be held in confidence. Occasionally a relative or friend insists on accompanying the patient during the history or even the physical examination. If you can, ascertain his or her reasons as well as the patient’s wishes. When patients can communicate at all, even just by facial expressions or gestures, it is important that they be given the chance to do so with complete confidentiality. It is usually possible to divide the interview into two parts—one with the patient alone and the other with both the patient and the second person. Each part has its own value.

**Responding to Patients’ Questions.** Patients’ questions may seek simple factual information. More often, however, they express feelings or concerns. Try to elicit these feelings or delve further, lest you offer a misguided answer.

- **Patient:** What are the effects of this blood pressure medicine?
- **Response:** There are several effects. Why do you ask?
- **Patient:** (Pause) Well, I was reading up on it in a friend’s book. I read it could make me impotent.

Similar caution is indicated when patients seek advice for personal problems. Should the patient quit a stressful job, for example, or move...