

Administering questionnaires to older people: Rigid adherence to protocol may deny and disacknowledge emotional expression

Abstract

This paper draws on data from a larger study conducted in care home facilities in: Seattle, USA; West Sussex and Surrey in the UK; and in the lower North Island in New Zealand. Two extracts from interactions between the researchers and an older person during the administration of The Philadelphia Geriatric Morale Scale in a care home facility in New Zealand were analysed following Houtkoop-Steenstra and using a Conversation Analysis (CA) approach. In the first extract the audio-recorded transcript was examined for events of institutional talk and rephrasing of questionnaire questions. We also examined the transcript for missed cues and the impact of closed questions when administering questionnaires to older people living in care home facilities. We then present an extract where the researcher uses a conversational approach during the administration of the same questionnaire. We conclude that rigid adherence to interview protocols when administering questionnaires to older people who cannot complete these themselves disables the interviewer from interacting and engaging in a meaningful conversation or responding to cues that indicate distress or expressions of grief. The effect of this approach may deny and disacknowledge older persons' emotional experiences and for the older person the interview may not be a therapeutic encounter. Based on our analysis and experiences of conducting this research we support recommendations that a collaborative approach, allowing an interactional exchange between interviewer and respondent, be used when administering questionnaires to older people in care home facilities.

Key Words:

administering questionnaires; conversation analysis (CA); aged care; institutional talk; rephrasing questionnaire questions; missed cues; closed questions; disacknowledging emotional experiences

Introduction/Background

Interviewing Older People and Standardized Questionnaires.

Questionnaires are frequently used in research undertaken in aged care facilities. They are popular as methods of collecting large amounts of data quickly and efficiently.

Standardisation is emphasised in questionnaire data collection as a means of increasing the reliability and validity of the results by controlling and reducing interviewers' contributions to error (Fowler & Mangione 1990; Schaeffer 1991; Schaeffer & Maynard 2002). Interaction in survey interviews is supposed to be standardised, predictable, and unvaried (Fowler &

1 Mangione 1990; Schober & Conrad, 1997; Conrad & Schober, 2000; van „t Hof, 2006) and
2 the goal of standardisation is to control and reduce interviewers“ contributions to bias and
3 systematic influences of interviewers on respondents (Fowler & Mangione 1990; Schober &
4 Conrad, 1997; Schaeffer & Maynard 2002).

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11 Generally during the administration of questionnaires interviewers are expected to maintain
12 the neutrality of the questionnaire by sticking to the rules of standardised interviewing. Strict
13 standardisation protocols require the interviewer to: read the question exactly as worded; if
14 the respondent“s answer is incomplete or inadequate then probe for clarification or
15 elaboration in a non-directive way; record the answers without interviewer“s discretion; and
16 do not provide any positive or negative feedback regarding the specific content of responder“
17 answers (Houtkoop-Steenstra, 2000:9). It is expected that interviewers remain
18 interpersonally neutral and not give feedback that is evaluative; that conveys approval or
19 disapproval to the response (Schaeffer & Maynard 1996). When it is necessary to probe an
20 answer, the interviewers must not ask leading questions (Fowler & Mangione, 1990). It is
21 argued however, that although this may be the theory of standardised interviewing, in reality
22 this is often not the case (Suchman & Jordan, 1990; Houtkoop-Steenstra & Antaki, 1997;
23 Schober & Conrad, 1997; Houtkoop-Steenstra, 2000; Conrad & Schober, 2000; Schaeffer &
24 Maynard, 2002; Viterna & Maynard, 2002; van „t Hof, 2006;).

25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 **Rephrasing Questions and “Institutional Talk”**

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51 Rephrasing of questionnaire questions is the most common intervention, referred to as an
52 „interactional device“. These are used by interviewers to generate an adequate or recordable
53 answer if the answer given by the respondent does not follow the question (Houtkoop-
54 Steenstra, 1996). The interviewer may rephrase the question to encourage positive, face-
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1 protective responses, particularly in environments that are marked by „interactional troubles“
2 (Houtkoop-Steenstra & Antaki, 1997). Interactional troubles refers to responses that occur
3 when asking supposedly neutral questions from an interview schedule where the aim is to
4 deliver them in a way that worries can be anticipated and reduced and to encourage positive
5 responses, also referred to as „institutional talk“ (Houtkoop-Steenstra & Antaki, 1997).
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7 Interviewers have been shown to use reformulation and delivery of standard and neutral
8 questions in such a way as to pre-empt or minimise troubles in the interviewees“ responses or
9 to encourage positive and optimistic responses, referred to as „high-grade assessments“
10 (Houtkoop-Steenstra & Antaki, 1997; Antaki, Houtkoop-Steenstra, & Rapley, 2000). High-
11 grade assessments e.g. “brilliant,” “terrific,” work differently from markers closing off a
12 question using “neutral or conventionally “positive” topic-transition tokens like “right,”
13 “ok” or “right/ok then” (Antaki et al., 2000:236). Antaki et al. (2000:236) suggest that high-
14 grade assessment sequences “claim a closure on the previous material as having been, in the
15 circumstances, successfully completed as a section in a segmented whole”.

36 **Closed Questions vs Conversation**

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38 It has also been noted that there is an “unresolved tension between the survey interview as an
39 interactional event and as a neutral measurement instrument” (Suchman & Jordan, 1990:
40 232). Turning the interview into an instrument disallows interaction between the interviewer
41 and respondent (Suchman & Jordan, 1990; Schober & Conrad, 1997; Conrad & Schober,
42 2000). However, few researchers have critically examined the use of questionnaires to
43 collect data from older people. Isaksson et. al. (2007) carried out a small study to explicate
44 the support given to very old people in the process of completing a research questionnaire.
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46 Twelve community dwelling people aged 90 years or older in northern Sweden completed a
47 Resilience Scale questionnaire in a supportive face-to-face manner with the researcher. The
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1 researchers analysed the transcripts of audio-recorded administration of the questionnaire
2 using content analysis. Their findings support the positions of Suchman and Jordan (1990),
3 Schober and Conrad (1997) and Conrad and Schober (2000) in that the conversational
4 approach to administration of the questionnaires, that is, engaging in an encouraging,
5 explanatory, or pensive dialogue with the participants, did not detract from collecting valid
6 and appropriate data.
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17 **Missed cues**

18 A cue is perceived by the way the brain processes auditory, tactile and visual senses then
19 interprets the signals and allows action (Ernst & Bühlhoff, 2004). There are different types of
20 cues which could be verbal or nonverbal, consequently, each individual will respond and act
21 differently to different cues and signals. By missing cues people don't engage with each
22 other. The patient's perspective is often expressed to the provider through emotion cues (Del
23 Piccolo, Goss, & Bergvik, 2006) and verbal or nonverbal cues which suggest an underlying
24 unpleasant emotion would need clarification by a health professional (Zimmermann, Del
25 Piccolo, & Finset, 2007; Zimmermann et al., 2011; Del Piccolo, Mazzi, Goss, Rimondini, &
26 Zimmermann, 2012). Patients seldom express their concerns and emotions directly and
27 spontaneously, but instead give indirect cues that something is worrying them (Zimmermann
28 et al., 2007; 2011; Del Piccolo et al., 2012). Furthermore, closed questions themselves
29 automatically block behaviours by the expectation that when a question is asked a response
30 will be forthcoming, rather than free flow of communication.
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51 In this paper we use a conversational analysis (CA) approach to examine the interactions
52 between interviewers and older people during administration of the Philadelphia Geriatric
53 Morale Scale (PGMS). We address five conversation events: institutional talk; rephrasing of
54 questionnaire questions; missed cues; and the impact of closed questions in blocking rapport
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3 between the interviewer and responder and relate this to interactive engagement with older
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7 **Methods**

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10 The parent study, from which this paper is drawn, explored resident outcome measures that
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12 could help evaluate how living in care home facilities affects residents' quality of life (QoL).
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14 Three questionnaires were used; the World Health Organisation Quality of Life (WHOQOL-
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16 BREF) (US and UK versions) instrument measuring the physical, psychological, social, and
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18 environmental domains; the WHOQOL Spirituality, Religiousness and Personal Beliefs
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20 (SRPB) instrument measured on an importance scale, which augments the assessment of the
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22 spirituality and personal beliefs domain; and the Philadelphia Geriatric Centre Morale Scale
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24 (PGCMS) measuring dimensions of attitudes towards ageing, agitation and lonely
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26 dissatisfaction. The parent study has been conducted with residents in care home facilities in
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28 Seattle, USA, (n=49) West Sussex and Surrey in the UK (n=39) and in the lower North
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30 Island, New Zealand (NZ) (n=37). Almost all residents requested assistance in completing
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32 the questionnaires. This was mainly due to physical limitations such as arthritis, Parkinson's
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34 disease, physical effects of stroke, hearing or vision loss, or simply resident preference. It is
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36 common for old people to request researchers to administer questionnaires because of frailty
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38 in writing, unfamiliarity with written questionnaires, general physical and mental frailty and
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40 respondent fatigue, or using the situation to give them the opportunity to engage with others
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42 (Coast, Peters, Richards, & Gunnell, 1998; Isaksson, Santamäki-Fischer, Nygren, Lundman,
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44 & Åström, 2007).

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47 Trained interviewers conducted interviews with residents in their care home room. While
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49 following the structured questionnaires as the interview guide, all interviewers noted
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1 considerable amounts of „story telling“ or elaboration in resident responses. We began to pay
2 particular attention to the conversations that occurred during administration of the
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4 questionnaires in care facilities in West Sussex, UK and notes taken revealed insights into
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6 events and experiences that impact on the QoL of the residents that were not being captured
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8 in the questionnaire data or in the accompanying field notes. Consequently we decided to
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10 audio-record the administration of the questionnaires. The addition of the audio recordings of
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12 the UK (n=8) and NZ (n=36) allowed us to make comparisons between transcribed
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14 conversation and responses recorded on the questionnaires. This paper focuses transcripts of
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16 The Philadelphia Geriatric Centre Morale Scale in a care home facility in NZ to explore two
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18 selected interactions between interviewer and the resident using a CA approach. Ethical
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20 approval for the questionnaire survey research was attained from the University of
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22 Washington IRB in the USA and the University of Surrey Ethical Review Board in the UK
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24 and Central Ethics for Health and Disability in NZ. Supplementary ethical approval was
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26 gained to include audio-recorded conversations during administration of the questionnaires in
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28 Surrey, UK and in NZ.
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39 Inclusion criteria for participation in the study were: the resident was judged by staff
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41 (normally the manager of the care home facility) as capable of participation; English
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43 speaking; and must have been resident in the home for at least one year. Care home facility
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45 managers initially approached residents and provided them with the information letter about
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47 the research. The resident (on some occasions in consultation with families or significant
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49 others) made the decision to participate in the study. Prior to administering the questionnaires
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51 the resident signed a consent form, including consent to have the administration of the
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53 questionnaire audio-recorded. The questionnaires were anonymized, and any information
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55 about each participant in relation to the care home facility, address or any identifying code
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1 removed so that they could not be recognised. Quantitative data were analysed using SPSS
2 software to explore the reliability of the scales and to explore comparisons between Seattle,
3 USA, UK and NZ care facility populations (Results of the parent study have been reported
4 elsewhere or are available from the authors and publication forthcoming).
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10 11 **Conversational Analysis**

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14 Conversational analysis (CA) is an alternative methodology to be considered to augment the
15 standardised questionnaire. CA approaches language as a form of social action in the sense
16 that it is integral to social interaction where the organisation of taking turns to talk is
17 fundamental to conversation or other speech exchange systems (Sacks et al. 1974, 1978).
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24 When using CA particular emphasis is placed on pattern and context for the understanding of
25 communicative exchanges during conversation (Sacks et al. 1974, 1978). In CA audio-
26 recorded transcriptions are analysed for a broad range of speech exchange systems, or spoken
27 interaction, collectively known as „talk-in-interaction“ (Sacks et al. 1974, 1978; Markee,
28 2007). Houtkoop-Steenstra (2000) has long been considered an authority on using this
29 methodology in the analysis of questionnaire data, with a specific interest in the interactions
30 between interviewer and interviewee during the administration of survey questionnaires and
31 in particular, interview conversations that occurred within institutions.
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46 Following the CA methodology, this paper primarily focuses on a section of one transcription
47 of the PGCMS questionnaire and discusses the impact on the interaction with the older
48 person during the process of closely following a questionnaire protocol. The questionnaire
49 session under discussion was administered by one of our team early in her involvement with
50 the research. The interviewer was a very experienced nurse but was a relatively novice
51 researcher and was determined that the questionnaires were administered in keeping with a
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1 standardised approach to ensure collection of valid and reliable data. The second extract was
2 conducted by an experienced researcher/interviewer and provides points of comparison for
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4 our discussion.
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9 **Findings and discussion**

10 In initial analysis of the Philadelphia Geriatric Center Morale Scale (PGCMS) questionnaire,
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12 where we compared the audio-recorded responses with the questionnaire results, we found
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14 that the response to the question; “*I have a lot to be sad about*”, was often the first
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16 opportunity offered to residents to express or reflect on bereavement experiences. Both of
17
18 the respondents from which these extracts have been taken scored low on the PGCMS
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20 questionnaire (4 and 6 respectively; Mean for NZ=11.8; SD=3.4) indicating that these
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22 residents may have some degree of depressed mood or low morale.
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32 CA notation meanings are provided in Box 1.

33 **Box 1: CA Symbols**

34 ?	35 appeal (final)
36 ?	37 appeal (continuing)
38 (h)	39 laughter in speech
40 <u>underlining</u>	41 indicates emphasis
42 ↑	43 marked rise in voice pitch
44 £	45 indicates speaker was smiling while speaking
46 °	47 quiet soft speech
48 °°	49 whisper
50 (0.4)	51 pause timed (4 tenths of a second)
52 (.)	53 micropause, hearable but too short to measure

54 Extract #1

- 55 1. I: As you get older you are less useful.
 - 56 2. R: Awh (h-ironic) yes (h-ironic)
 - 57 3. I: I sometimes worry so much that I can't sleep.
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4. R: No
 5. I: Well that's **good** ↑ £ as I get older things are better or worse than I thought they
 6. would be.
 7. R: ° Worse °
 8. I: I sometimes feel that life isn't worth living.
 9. R: ° Yes °
 10. I: I am as happy now as when I was younger.
 11. R: (.) ° ° No ° °
 12. I: I have a lot to be sad about. (0.4) I have a lot to be sad about. Yes or no? Do you
 13. have much to be sad about?
 14. R: ° He's dead ° [YES MARKED ON QUESTIONNAIRE]
 15. I: ° Yes ° [INTERVIEWER TO SELF] (0.2) I am afraid of a lot of things.
 16. R: ° ° No ° °
 17. I: I get mad more than I used to.
 18. R: (h-ironic) What's the use
 19. I: So is that a no?
 20. R: Awh I suppose so [NO MARKED ON QUESTIONNAIRE]

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In this extract the interviewer responded to a perceived positive response using a high-grade assessment, an enthusiastic, “*Well that's good*” (line 5). In this case the interviewer was not using a pivotal particle marker like “ok” as a means of closing off each question on receiving the answer to the previous one (Anaki et al., 2000). The response to the question on sleep explicitly signalled the previous material as “*having been successfully, indeed praiseworthy, completed*” (Anaki et al., 2000:246) and signals a closure that allowed the interviewer to move immediately to the next question. There is no hesitation or pause at this point, however ironic laughter from the resident in response to “*As you get older you are less useful*” (line 1) could be deemed non-closure of the line of inquiry by the resident, as irony implies a deliberate contrast between apparent and intended meaning of her “yes” response to the question. At this point, if this had been an open-ended interview or conversation, the researcher would have explored the response.

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The next question introduces a particularly sensitive line of enquiry “*I sometimes feel that life isn't worth living*” (line 8) to which the resident responds “yes” (line 9). The response and tone of the resident should have signalled concerns about her emotional and possibly her mental state, however these were left unacknowledged and unexplored to the extent that her

1 response to the next question *“I am as happy now as when I was younger”* is a whispered
2 *“no”* (lines 10, 11). This reflects concerns that have been raised that the questionnaire could
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4 be termed as not fit for the situation and type of respondents for which it was being used
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6 (Houtkoop-Steenstra & Antaki, 1997, Houtkoop-Steenstra, 2000) as they offer the
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8 opportunity for the resident to reflect on their happiness (or not) which is left unexplored and
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10 unsupported.
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17 Both the interviewer and resident had not paused in responding to each other until the
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19 question asked (lines 12, 13). At this question the resident pauses for the first time. *“I have a*
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21 *lot to be sad about. Yes or no?”* (pause). The interviewer does not allow the pause to
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23 continue for long. She rephrases the question with *“Do you have much to be sad about?”*
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25 This is an example of revising and repairing questionnaire items (Houtkoop-Steenstra &
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27 Antaki, 1997; Houtkoop-Steenstra, 2000). However the question again raises concerns about
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29 the appropriateness of initiating a conversation with older people who may be experiencing
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31 bereavement and loss. Using questionnaires may shut down any potential for meaningful
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33 engagement and emotional expression and in the extract we present the bereavement
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35 experiences of the older person was denied and disacknowledged. In this case the
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37 interviewer recorded YES on the questionnaire in response to the resident saying *“He’s*
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39 *dead”* to the question *“Do you have much to be sad about?”* However the YES recorded,
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41 based on the resident’s response, would appear to be an accurate recording despite the lack of
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43 investigation by the interviewer to the response. This same section of data (lines 12-14) we
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45 believe also demonstrated an example of a „missed cue“.
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Missing cues

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2 We posit that focusing on the administration of the questionnaire and a desire to get „valid“
3 data caused the interviewer to be detached from the emotions and feelings of the older
4 person. On line 14 the response to the question, “*Do you have much to be sad about?*” after
5 a pause, is simply “*He’s dead*”. The interviewer had no recollection of the resident making
6 this statement. What occurs in the interaction is that the interviewer does not „listen“ to the
7 responses and when cues are missed the likelihood of information (and emotion) not being
8 expressed, captured or qualified increases (Maguire, Faulkner, Booth, Elliott, & Hillier, 1996;
9 Maguire & Pitceathly, 2002). When examining the transcripts she was horrified at the
10 enormity of missing a cue that indicated a possible depth of sadness that the resident may
11 have been experiencing about the death of the husband. The despondency of the resident
12 becomes even more evident as the interview continued. We propose that this occurred due to
13 the non-engagement of the interviewer who was focused on completing the questionnaire and
14 was not „listening“ to the responses. The interviewer marks YES on the questionnaire,
15 murmuring “yes” to herself and with minimal pause asks the next question, “*I am afraid of a*
16 *lot of things*” (line 15) the response of the resident is barely audible and on line 18 she
17 expresses her feelings quite explicitly “*What’s the use*” with ironic laughter. This response
18 appears to have as much to do with her responses to the interactions occurring within the
19 „conversation“ as to do with her experience of loss regarding her husband.
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49 In this extract the interviewer, although a healthcare professional, did not attempt to clarify or
50 investigate a potentially significant emotional situation at the time. We further conclude that
51 it was possible that the sadness of the response was overwhelming and not able to be
52 addressed by the interviewer, even though she had no recollection of the response by the
53 resident. The focus of research on responding to patient cues has been predominantly
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1 conducted in the field of communication with cancer or palliative care patients. In these
2 fields it has been found that patients seldom express their concerns and emotions directly and
3 spontaneously, but instead give indirect cues that something is worrying them. Research has
4 demonstrated that both doctors and nurses have difficulty both eliciting and responding to
5 cues that may heighten their own emotional responses, or to emotions displayed by their
6 patients, and use blocking behaviours, primarily to protect themselves (Uitterhoeve et al.,
7 2008; Uitterhoeve et al., 2009; Mjaaland, Finset, Jensen, & Gulbrandsen, 2011).
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19 **Impact of closed questions and blocking behaviours**

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21 During the study, on initial meeting, residents were generally animated and keen to talk. In a
22 number of cases however the resident became more and more despondent and less interested
23 in the questions or the encounter as the questioning progressed that required YES or NO
24 answers, or responses to a Likert Scale. One of the reasons for this despondency could be
25 attributed to the nature of the questioning style i.e. use of closed questions. The question
26 format on the questionnaire discussed in this paper was that of closed questions which are
27 typically used in questionnaires and are limited to a predetermined set of responses
28 (Houtkoop-Steenstra, 2000). As seen in the closed question example cited earlier (lines 12-
29 20) elicited a YES/NO response with little else. It was noted that the impact of asking closed
30 questions was to „shut down“ the older person quite quickly blocking interaction,
31 consequently very little communication spoken or otherwise takes place.
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51 Extract #2 is presented here as a comparison piece.
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- 55 **1. I: Things keep getting worse as I get older? (.04) It's just a yes or no answer.**
 - 56 **2. R: (.4) I'd have to say yes wouldn't I? [WORSE MARKED ON QUESTIONNAIRE].**
 - 57 **3. I: (.2) Because it isn't what you expected to happen is it? [REFERRING TO ILLNESS]**
 - 58 **4. R: (.2) No.**
 - 59 **5. I: (.) No**
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7. **R:** (.2) You could enter that but that's not that they want (.) um
 8. **I:** Well you don't have to (.) it can be yes or no or somewhere in the middle because
 9. **R:** Yes, oh well just put yes.
 10. **I:** (.2) It's something you don't think about.
 11. **R:** Oh no ↑ I've thought about it, I never thought that I would be old and get sick.
 12. **I:** No.
 13. **R:** A friend came yesterday you know. Joe
 14. **I:** Yeah
 15. **R:** And he said he never, you know, that he'd see me like this, you know
 16. **I:** Mm
 17. **R:** because I'm usually full of beans running around
 18. **I:** Yeah
 19. **R:** and I won't be doing that again no matter what unless they come up with some magical
 20. **R:** cure
 21. **I:** Yeah
 22. **R:** but that ain't going to happen
 23. **I:** No probably not (.) not in the short term (.) no.
 24. **R:** but then again (.2)
 25. **I:** Yeah
 26. **R:** They said one thing you can be sure of it will get worse.
 27. **I:** (.) Yeah
 28. **R:** (.) Yeah
 29. **I:** (.) Yeah. At least they've talked about it really well with you haven't they.
 30. **R:** Yes.
 31. **I:** About the illness and how it will progress and [OVERLAPPING]
 32. **R:** and how they could help
 33. **I:** Yeah

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This extract presents a similar question from the PGCMS to illustrate the researcher/resident interaction. In the extract the interviewer uses a more conversational approach (Suchman & Jordan, 1990; Schober & Conrad, 1997; Conrad & Schober, 2000; Isaksson et. al., 2007)) when interacting with the resident. The interviewer also draws on information gained earlier in the meeting about a recent diagnosis of an illness the resident was experiencing (line 3), as the response to the question, “*Things keep getting worse as I get older?*” was clearly related to this. Lines 4 to 10 demonstrate the interviewer allowing time for the resident to contemplate and reflect on the reference to this illness. The interviewer also offers a potential „middle ground“ as a response. This example of revising and repairing questionnaire items (Houtkoop-Steenstra & Antaki, 1997; Houtkoop-Steenstra, 2000) would potentially lead to an invalid or incomplete questionnaire as the responses required were YES or NO. Based on the conversational approach to administering the questionnaire the interviewer was

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acknowledging that yes or no may not adequately express the position of the resident about getting older. This offer is not taken up by the resident, who settles on “*oh well just put yes*”, which is however not a firm affirmative.

At line 10 the interviewer makes a statement suggesting that the resident has not reflected on the impact of her illness. This is immediately met with a response that indicates that the illness was very close to mind and there are no contemplative pauses between lines 11 to 22 where the resident reveals that she understands the impact of her illness and that there is no cure. On line 23 the interviewer acknowledges that there is no cure “*in the short term*” which allows the resident to contemplatively express hope “*but then again*”, (line 24) and the interaction continues with a contemplative exchange of yeah, pause yeah pause. This interaction allows the interviewer to again refer to the resident’s illness offering the resident the opportunity to continue the discussion and to extend this to include further exploration of what engagements the resident may have had with the medical team regarding her future.

Suchman and Jordan (1990) argue that the standardised procedures used when conducting a survey interview suppresses crucial elements of ordinary conversation, and, in the first extract presented here, emotional expression. Their seminal paper is widely cited in debates on the validity of survey data where standardisation is understood to be that which identifies the interview process as a scientific procedure. However they show that the survey interview is “*fundamentally an interactional event*” (241) and propose taking a collaborative approach to the problem that; “*would allow the kinds of interactional exchanges between interviewer and respondent necessary to ensure standardized interpretations, without introducing interviewer bias*” (232) which is demonstrated in extract 2. In taking this approach the interviewer would be allowed to discuss the meaning of questions, offer clarification and elaboration, and to

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engage in a “*limited form*” of discussion and interpretation. Thus they would also be empowered to respond to emotional expressions that may arise, particularly when administering questionnaires to the respondent group under discussion in this paper. Whilst the first extract is an extreme example our data demonstrates multiple occasions of rephrasing questions, missed cues, and evidence of closed questions shutting down residents.

Conclusion

QoL and other questionnaires are frequently used in research undertaken in aged care. There has been little study in this field that considers the impact of using questionnaires in research with older people. Using a CA approach we have shown how institutional talk, missing cues, and the use of closed questions and blocking behaviours are inhibitors and barriers to communication with older people. Rigid adherence to questionnaire protocol may deny and disacknowledge emotional expression and consequently be detrimental to the older person’s psychological health. The approach disables the interviewer from interacting and engaging in a meaningful conversation and creating a therapeutic encounter. Furthermore, the validity of the data obtained by this method is potentially undermined by the constraint this places on interaction between the interviewer and respondent. Conrad and Schober (2000) have shown that conversational (to collect survey data) take three times as long to conduct as standardised interviews. However, in regard to the population under discussion and based on our analysis and experiences of conducting this research we support the recommendations that both a collaborative (Suchman & Jordan, 1990) and supportive (Isaksson et. al., 2007) approach, allowing an interactional exchange between interviewer and respondent, be used when administering questionnaires to older people in care home facilities. This approach rejects the “*strategy that mistakes sameness of words for stability of meanings*” (Suchman & Jordan, 1990:233). We agree with Suchman and Jordan that stability of meaning in administering

1 questionnaires to older people depends on an engaged conversational interaction. This allows
2 collecting systematic quantitative data, enhances the accuracy of the data collected by
3 focusing on the meaning of the questions, and concurrently results in a meaningful
4 conversation that could possibly include a referral for further attention if such a need was
5 identified.
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