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**HEARING THERAPISTS' AND AUDIOLOGISTS' KNOWLEDGE
OF AND ATTITUDES TOWARDS OLDER ADULTS**

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ABSTRACT

The predicted increase in adults over 65 will challenge health and social service providers. Productive ageing, where healthy older adults are encouraged to remain in the workforce for longer, may be a solution. One barrier to this solution may be the negative attitudes many people have towards older adults. Fishbein & Ajzen's, (1975) theory of reasoned action postulates that attitudes are based on beliefs or knowledge and can have an affect on how people behave. Attitudes may also be influenced by such factors as age, gender, experience and, most importantly, the attitudes and beliefs of significant others (subjective norms) (Fishbein & Ajzen, 1975. Hearing impairment is the third most limiting chronic condition for older adults (Chen, 1994). In the present study, 15 Hearing therapists and 30 private audiologists in New Zealand completed Palmore's (1998) Facts on Aging Quiz (FAQ), Kogan's (1961) Attitudes towards Old People Scale, a vignette measuring treatment intentions and subjective norms, and gave biographical data. It was hypothesized that audiologists would have higher knowledge levels (FAQ) and more positive attitudes (ATOP) than hearing therapists. Despite the differences in education, there were no significant differences between the two groups in FAQ scores. However, hearing therapists did have more positive attitudes towards older adults. Further analyses suggested that this was a function of gender and possibly education, with less-educated females having more positive attitudes. When considering the two professional groups together, those 40 years old and over had more positive attitudes than those less than 40 years old. It was also hypothesised that, based on the theory of reasoned action, positive attitudes will result in positive treatment (as measured by the vignette) and this relationship will be moderated by subjective norms. Subjective norms were not measurable using the vignette and were not investigated further. While all participants had positive attitudes these did not always result in the most appropriate treatment. It was concluded that a lack of specific gerontological knowledge resulted in less appropriate treatment rather than negative attitudes towards older adults.

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OVERVIEW

The number of adults over 65 is projected to increase to over twenty-five percent of the total population of New Zealand by 2051 (Statistics New Zealand, 1998). As the population of the world, and New Zealand, ages, it presents new challenges to governments, health services and researchers alike. Issues such as chronic health problems and superannuation become more important as the proportion of older adults compared to younger adults changes. An increasing amount of the money available for general health care may have to be used to deal with the chronic illnesses associated with ageing. Also, there will be a far lower ratio of workers compared to superannuitants available to fund pension plans (Organisation for Economic Cooperation and Development, (OECD), 1988). One potential theory about how to deal with these problems is productive ageing. If older adults are healthy and able to work longer, then perhaps they should be encouraged to do so. This may lessen the financial pressure on both health care and pension plans. However, there are certain barriers to be overcome if productive ageing is to be realised. Perhaps the most crucial barrier is that of the attitude many people, such as policy makers and health professionals, have towards older adults.

There is much empirical and anecdotal evidence to suggest that the attitude of western society in general is negative towards older adults. Ageing is seen as a time of both physical and cognitive decline leading to death, even though there is a great deal of evidence to suggest that such decline does not occur evenly across all functions or at the same rate and that every individual is different (Salthouse, 1991; Schaie, 1994). Additionally, many conditions, while possibly age-related, are not inevitable and there are many other conditions that respond well to treatment when given appropriately. Unfortunately, if knowledge of ageing is inaccurate and if negative attitudes towards ageing and older adults exist, appropriate treatment may not occur. There may also be assumptions made regarding what is and what is not normal ageing.

Attitudes are important because they have an effect on how people behave (Ajzen, 1988; Eagly & Chaiken, 1993; Fishbein & Ajzen, 1975). Attitudes of the general public and health professionals are often based on inaccurate beliefs or knowledge

regarding older adults (Palmore, 1998). For example, a psychologist may believe that depression is normal in old age and therefore not worth treating. Other health care specialists may think that older adults are unable to learn new knowledge so it is pointless trying to train them in new tasks. Thus appropriate treatment may not be forthcoming. In addition, positive attitudes towards older adults that result in an overestimation of abilities are also likely to be detrimental to older adults, such as assumptions about how quickly they can learn or how good their memory is.

As well as being affected by knowledge, attitudes and behaviour are also influenced by such factors as personality, age, prior experience, gender and, importantly, the knowledge and attitudes of significant others (Fishbein & Ajzen, 1975). These may have a direct effect on either the attitude or the behaviour – a person may have positive attitudes towards a target but behave negatively because that is what is expected by significant others. Thus the relationship between knowledge, attitudes and behaviour is complex (Eagly & Chaiken, 1993).

In order to examine the above relationship, the present study focuses on a certain section of health professionals who have an important role in helping older adults deal with a very common chronic condition, that is, age-related hearing loss or presbycusis. This is a progressive and incurable condition that can have a large effect on the psychological well being of the sufferer (Hétu, 1996; Hull, 1997; Stephens, 1996) and it is usually treated with the fitting of hearing aids. Both audiologists and hearing therapists have important roles in aural rehabilitation that sometimes overlap. While only audiologists dispense hearing aids (chosen based on both audiological information and the needs of their clients), both groups work with older adults post-hearing aid fitting to help give the best possible result. In addition, hearing therapists run speech-reading and hearing-aid management classes as well as advise on and sell assistive listening devices such as vibrating alarm clocks and television headphones.

Hearing loss imposes limitations on those who suffer from it (Hétu, 1996; Stephens & Hétu, 1991). While hearing aids cannot totally replace the loss of hearing, they do allow a far higher level of functioning for older adults than would be achieved without hearing aids. Unfortunately, many people who overcome barriers such as finance,

attitudes to hearing loss and aids, and accessibility to health professionals and are actually fitted with hearing aids do not use them (Jerram & Purdey, 1996; Kochkin, 2000; Satherley, 1992). There are a number of explanations why this occurs, one key reason may be the knowledge or attitude of hearing professionals towards older adults and the influence this may have on treatment. The aim of this study is to examine the knowledge and attitudes hearing professionals have towards older adults and investigate whether these affect the treatments that are potentially offered to older adults.