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Perceived Rights of and Social Distance to People with Alzheimer's Disease

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Abstract

The present study investigated how laypeople and professionals (N = 185) judge the rights of a person affected with Alzheimer's disease (AD) and whether social distance exists towards this person. Participants completed a questionnaire after reading a vignette describing a target person with an early stage of AD. Half of the participants responded to a female target, the other half responded to a male target. Results showed that rights and competencies of the persons are rated high and social distance is exhibited only to a lesser degree, although there was a significant difference between the male and female target. Furthermore, health professionals approved more rights than laypeople, which suggests that there is a need for more detailed information about this disease in the general population.

Perceived Rights of and Social Distance to People with Alzheimer's Disease

Perception of people with Alzheimer's disease (AD) is currently a crucial issue, as a substantial number of people worldwide suffer from this neurodegenerative disease. In 2008, there were approximately 30 million people with dementia in the world (Alzheimer's Disease International, 2008). More and more people succumb to the disease because of longer life expectancy (Ferri et al, 2005). With respect to the specificities of AD it is particularly difficult to ascertain for people in an early or intermediate stage of dementia if they can live independently and stay autonomous without endangering themselves or others. Furthermore, it is not clear in how far deficits or competencies, respectively, are limited to certain activities or domains of functioning (Marson, 2001). For instance, psychological tests may assess the general *cognitive* performance of a person, but this does not allow a judgment concerning the general level of competence in everyday life and changes in personality characteristics related to the dementia process (Moye, Karel, Azar, & Gurrera, 2004; Moye & Marson, 2007).

If competency levels are judged as low, relatives and/or care workers often make decisions *on behalf* of the concerned person (e.g., with respect to health care, leisure time activities, etc.) even if there is no "objective" information about the specific competencies of this person. Moreover, most formal and family caregivers do not seem to question if they have the legal right to make such a decision (Moye & Marson, 2007). Specific frameworks that regulate the taking over of legal responsibility by a third person exist in most European countries in order to avoid harm to the concerned person and his or her environment. Those legal directives mostly deal with the regulation of finances and legal capacity, but do not cover issues of lifestyle and autonomous living.

It remains an open question if caregivers have ideas about the rights that *should* be assigned to persons at different stages of dementia. This question will be addressed within the present study.

Competencies, Rights, and Stigmatization

Only a few studies exist which analyze the participation of persons with dementia in health decisions. These show that the majority of family caregivers involve persons with dementia in decisions regarding health issues (Hirschman, Joyce, James, Xie, & Karlawish, 2005; Hirschman, Xie, Feudtner, & Karlawish, 2004; Karlawish, Casarett, Klocinski, & Sankar, 2001). The probability of a patient to participate in decisions is higher if the illness is in an early stage, the caring person is female, or if caregiver and patient are married; the impact of these factors decreases though with disease progression (Hirschman, Joyce, James, Xie, Casarett, & Karlawish, 2005).

Werner (2006) instructed laypeople to judge five competencies of a person with mild or severe AD depicted in a vignette. The competencies comprised the following activities with differing impact for the personal security of his or her environment: “drive a car”, “make financial decisions”, “make health decisions”, “choosing one’s clothes”, and “prepare a cup of tea”. The author summed up the ratings resulting for both questionnaire versions, and she showed that the majority of participants indicated that the person would no longer be able to “drive a car”, “make financial decisions”, or “prepare a cup of tea”. Most respondents estimated, however, that the person was still able to make a decision regarding health and choosing his or her own clothing. Preparing a cup of tea is probably considered to be more dangerous than making medical decisions as there could be an immediate negative outcome linked to it (e.g., a fire). The findings indicate that competencies involving a threat to the security of the person and his or her environment were rated lower than activities that do not have a direct impact on security. The

author confirmed these results in a second study in which she interviewed general practitioners (Werner, 2007).

When analyzing judgments about the rights of persons with dementia, “stigmatization” is also involved. According to the World Psychiatric Association and World Health Association (Graham et al., 2003) elderly people with cognitive impairment bear a double risk to be stigmatized due to their age and their disease. Findings of a survey conducted by De Mendonça Lima, Levav, Jacobsson, and Rutz (2003) illustrate this: The authors report that stigmatization of individuals suffering from dementia exists both in health care and in the general public. Here, we will focus on *social distance* which represents one of the three components of stigmatization besides prejudice and stereotyping. The wish for social distance towards a certain person means that one does not want to interact with him or her (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003), and social distance thus represents a specific and often used indicator of discrimination (Angermeyer, Beck, & Matschinger, 2003; Angermeyer & Matschinger, 2005; Corrigan, Backs Edwards, Green, Lickey Diwan, & Penn, 2001; Corrigan et al., 2003; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Werner, 2005, 2006). Moreover, social distance differs depending on the perceived competence of the person affected with dementia (Werner, 2006); differing profiles of distancing may thus be expected for different stages of the disease if these are associated with differing evaluations of the person’s competence. Besides disease progression, gender and familiarity with AD, which are analyzed in this study, represent further variables that may exert an influence on perceived competency and social distancing as indicators of stigmatization.

Gender

The *double standard of aging* (Krings & Kluge, 2008) holds that women compared to men are perceived to age earlier; therefore, they should receive the negative evaluation associated

with age earlier as well. According to this, women affected with AD should bear a triple risk of stigmatization, due to their age, due to the disease, and due to gender. Furthermore, there are social stereotypes associated with differing competence profiles of men and women: While men are considered to have higher intellectual competency and autonomy (Canetto, Kaminski, & Felicio, 1995), and trigger more anger (Wadley & Haley, 2001), elderly women are attributed higher nurturance and warmth, but are rated lower in general competency than men (Canetto et al., 1995; Fiske, Cuddy, Glick, & Xu, 2002). As a last point, one may mention that the respondent's gender may also exert an influence on the perception of a person with AD. Werner and Davidson (2004), for instance, demonstrated that men express more feelings of rejection towards a person with AD than women; a finding that may reflect differing attitudes and thus differing evaluation criteria of men and women.

Familiarity with Mental Illness and AD

Regarding perceived competency of persons with AD, Werner (2007) demonstrated an impact of familiarity: General practitioners who had more professional experience with people having cognitive deficits judged the same person with AD as more competent than less experienced practitioners.

The impact of familiarity with the disease on social distance towards a person with AD has to our knowledge not yet been analyzed; studies situated within the context of mental disorders, however, showed that familiarity with mental disorders reduces discrimination and prejudices towards persons affected with one of these disorders (Angermeyer & Matschinger, 2005; Corrigan et al., 2003). This result could indicate as well that familiarity with AD may decrease social distancing towards a person with this disease.

Goals of the Present Study

Besides a descriptive analysis of perceived competency and social distancing towards persons with AD, the current study will investigate the correlation of gender and familiarity with these variables.

Analyses of gender effects

Based on prior findings, we expect that women affected with AD will receive lower ratings of competency than men. Concerning social distance, two different associations are possible. On one hand and due to gender stereotypes, elderly women with AD could be more stigmatized – in terms of distancing - than men with AD. On the other hand and referring to the findings of Wadley and Haley (2001) on men with AD triggering more negative feelings, one could also expect a bigger wish for distancing from this group. A third gender hypothesis holds that there is a difference in how women and men perceive persons with AD. Based upon previous findings it is expected that male respondents may show more negative feelings towards persons with AD, that is, assign fewer competencies and show a greater distancing than women (Werner & Davidson, 2004).

Analysis of familiarity effects

With respect to familiarity, we hypothesize that persons having specific familiarity will assign more rights and show less social distance towards people with AD compared to people who are not familiar with this group. In order to test this hypothesis, we will compare the judgments of health professionals working with people having AD and laypersons.

Design and Methods

Data Collection and Sample Description

Data were collected by a self-assessment questionnaire specifically designed for the purpose of the present study. A total of 240 questionnaires were distributed to health

professionals, who successfully completed a “Gerontology Master Program” and “laypeople”, that is, individuals without any professional contact to persons with AD. We contacted the laypeople personally and asked them to forward the questionnaires to family and friends. A total of nearly 50% of the laypersons in the sample stated that they never had personal contact with individuals having AD. Almost 39% of the laypeople reported that once in a while they would have personal contact with people with AD, while 11 % stated that they had contact on a regular basis. The questionnaire contained a vignette with the description of a person in an early stage of AD whose cue symptoms were derived from the clinical description provided by Stoppe (2006) as well as Förstl and Calabrese (2001). A person in an early stage of AD was chosen, because this is a delicate state, where it is difficult to make clear judgments about the competencies of the person. One version of the vignette describes a man and another version describes a woman (“Mr. M.” and “Mrs. M.”) of the same age (75 years) and the same demographic background affected by AD (see Appendix for complete vignette). Altogether 185 questionnaires were completed and returned; this corresponds to a response rate of 66% which is quite high compared to the average rates for this kind of research (see Rosnow & Rosenthal, 1997). Table 1 depicts the cross tabulation of participants according to (a) their professional relationship with persons with AD and (b) gender of the patient.

The sample comprised $n = 136$ females and $n = 49$ males. Age ranged from 18 to 61 ($M = 36.6$, $SD = 9.35$). The following distribution was found for school education: 1.2% primary school graduation, 3.7% compulsory education, 24.8% apprenticeship, 32.3% high school diploma, 37.9% college degree.

Questionnaires

Perceived rights of persons affected with AD. Three different charters have been studied to create items which concern the *rights of a person with AD*; these comprised (a) Charter of rights

of people in need of help and care (*Bundesministerium für Familie, Senioren, Frauen und Jugend*, 2006), (b) „*Charte des droits et libertés de la personne âgée dépendante*“ (Fondation Nationale de Gérontologie, 1997) and (c) „*Recommendations on how to improve the legal rights and protection of adults with incapacity due to dementia*“ (Alzheimer Europe, 2001). The final questionnaire contained $k = 25$ items concerning autonomy, privacy, information, health care, decision making, and daily activities. One half of this item pool was negatively formulated and the other half positively; items were put in a random order. The respondents were instructed to rate the items on a 5-point Likert scale, with a possible neutral answer, ranging from “absolutely wrong” to “absolutely true”.

Principal axis analysis showed that a factorial structure differing between five domains of perceived rights fitted the data best (Table 2). The five factors comprised “right of privacy and information”, “right of autonomous living”, “human and citizen rights”, “right of self-determination and self-responsibility”, and “decision making by significant others”. Internal consistencies of the scales proved to be low but still acceptable for the intended group comparisons (see Nunnally & Bernstein, 1994).

Social distance. The *Social Distance scale* comprised eight items partly based on the Bogardus-Scale (Bogardus, 1933). These items described the willingness to live near the person depicted in the vignette, to spend an evening socializing with him/her, to make friends with him/her, and to accept the marriage of one’s child to the person’s child. Two additional indicators of social distancing addressed the willingness to support the person (Weiner, Perry, & Magnusson, 1988) as well as the question of where one would ask the person for a favor. The respondents were instructed to rate the items on a verbal 5-point Likert-scale ranging from “definitely willing” to “definitely unwilling” with a possible neutral answer. The principal axis analysis showed that items belonged to one factor showing satisfactory reliability ($\alpha = .80$).

Data Analysis

A MANOVA with repeated measurement across the five factor-analytically derived “rights” was calculated to identify possible differences between the scales. Six (2 x 2) multivariate analyses of variance (MANOVAs) were conducted to analyze the “effects” of the independent variables *version of questionnaire* and *gender*, respectively, *version of questionnaire* and *relationship to people having AD* on perceived rights. Subsequently, a follow-up analysis with separate univariate ANOVAs was performed. Further two-way ANOVAs were conducted to analyze the effects of the independent variables on social distance.

Results

Perceived Rights of Persons with AD

Descriptive results at the item and score level. At the item-level, the item with the lowest score was “Mrs. /Mr. M. should not be allowed to drive a car”; a total of 80% were in favor (i.e., responding “true“ and “absolutely true“), only 1.6% of the respondents were against this item. The second lowest rating concerned the management of finances; 52.5% did not approve this right, while 40.5% indicated that Mrs. /Mr. M. should not be made culpable for their acts in court. Nearly all the respondents agreed with the following rights: Care workers should not read the mail of Mr. or Mrs. M. without her or his consent (93.5% agreed). Nearly the same number of people thought that everyone should knock on the door before entering Mrs. /Mr. M.’s room.

A MANOVA with repeated measurement across the five factor-analytically derived scales showed that the agreement to the specific rights did significantly differ, $F(4, 171) = 89.12, p = .00$. Post-hoc comparisons by dependent sample t-tests with Bonferroni adjustment to reduce Type I error showed that there were significant differences between each of the scales, with the exception of “human and citizen rights” and “decision making by significant others”. The scale

with the highest approval was “rights of privacy and information” ($M = 4.35$, $SD = .51$), followed by “rights of autonomous living” ($M = 4.02$, $SD = .76$) and “rights of self-determination and self-responsibility” ($M = 3.84$, $SD = .66$); “human and citizen rights” ($M = 3.56$, $SD = .61$) and “decision making by significant others” ($M = 3.42$, $SD = .94$) received the lowest approval (see Figure 1).

Test of gender effects. A MANOVA revealed that there were no significant effects of the target person’s gender, $F(5, 167) = 1.08$, $p > .05$, the respondent’s gender, $F(5, 167) = 2.21$, $p > .05$, and their interaction, $F(5, 167) = 1.24$, $p > .05$, on perceived rights. Thus, it made no difference if a male or a female respondent had to evaluate a woman or a man affected with AD.

Test of familiarity effects. The results of a further MANOVA showed that there were significant effects of familiarity on perceived rights, $F(5, 167) = 11.51$, $p = .00$. With the exception of “citizen rights”, professionals scored *higher* on all perceived rights than laypersons. Separate univariate ANOVAs using Bonferroni adjustment revealed a significant effect of familiarity on “right of privacy and information”, $F(1, 171) = 16.53$, $p = .00$, “right of autonomous living”, $F(1, 171) = 36.67$, $p = .00$ and “right of self-determination and self-responsibility”, $F(1, 171) = 10.62$, $p = .001$. The interaction between target person’s gender and familiarity on perceived rights did not reach statistical significance, $F(1, 167) = 1.51$, $p > .05$.

There was a significant interaction between familiarity and respondent’s gender on “right of self-determination and self-responsibility”, $F(1, 175) = 4.95$, $p = .027$. While female laypersons and professionals did not differ concerning this right, male laypersons showed significantly less agreement for this right than male professionals (see Figure 2).

Social Distance

Descriptive results. The means and standard deviations for the indicators of social distance are listed in Table 3, with higher values indicating higher distancing. “High distance”

includes “rather unwilling” and “definitely unwilling”, while “low distance” contains “rather willing” and “definitely willing”. Respondents indicated the lowest social distance regarding the willingness to accept the marriage of one’s child to the patient’s child. The highest response was found for the question of whether one would ask the patient for a favor. All other items ranged about the response categories “low distance” and “neutral”.

Test of gender effects. A two-way ANOVA revealed a significant effect of the variable “target person’s gender” on the scale “social distance”, $F(1, 178) = 5.37, p = 0.021$. Respondents showed lower distancing with respect to the woman ($M = 1.99, SD = .65$) compared to the man with AD ($M = 2.20, SD = .61$). Respondent’s gender had no effect on social distancing, $F(1, 178) = .401, p > .05$, the interaction between respondent’s and target person’s gender on social distancing did not reach statistical significance either, $F(1, 178) = .65, p > .05$.

Test of familiarity effects. The results of the second ANOVA showed that there was a significant effect of familiarity on social distancing, $F(1, 178) = 3.90, p = .05$. Respondents with professional background scored lower on social distancing ($M = 2.00, SD = .62$) than laypersons ($M = 2.21, SD = .66$). The interaction between (a) familiarity and target’s gender $F(1, 178) = .86, p > .05$ as well as (b) familiarity and person’s gender were not significant, $F(1, 178) = .37, p > .05$.

Discussion

The most outstanding finding of this study certainly is that respondents agreed to a comparatively high degree with the rights that should be attributed to persons in an early stage of AD. At the item level, respondents showed less agreement for those rights that involve a potential threat for the person and his or her environment. This relates to findings described by Werner (2006) who also reported in a similarly designed study (i.e., use of vignette technique) that rights

relating to security, for example, “driving a car”, were rated lower than rights which had no relation to security, for example, “choosing one’s clothes”.

If one holds that the attribution of rights also reflects an estimate of personal competencies necessary to conduct or exert these rights, the findings indicate as well that competence is rated comparatively high. When looking at the five factor-analytically derived scales, a differential profile emerged indicating that respondents significantly differed between the specific rights described here. The “right for privacy and information” about ongoing medical procedures was rated highest, followed by the “rights indicating an autonomous living”. Agreement to “rights concerning self-determination and responsibility” was high though less pronounced than the other already mentioned scales. This scale comprises the management of finances by the person, explanation of medical diagnoses and treatments including the discussion of possible risks and alternatives with the concerned person, as well as making the decision about parenteral nutrition. Interestingly, male laypersons showed less agreement here and differed from female respondents belonging to this group as well as female and male professionals. It may be that the specific contents such as managing finances and the discussion of alternative treatments could have induced this specific finding, and this should be validated in further studies.

Finally, “human and citizen rights” showed less agreement than the scales above though the scale mean still indicated general approval. The scale describing the “overtaking of decisions by significant others” found the least approval in the sample. Summing up, the majority of respondents agreed to the rights of privacy, autonomy, and self-determination as described by the first three scales. Human and citizen rights did not find such a high rate of approval although they were still higher than the overtaking of decisions as described in the last scale. Agreement to and thus attribution of rights was not affected by the target person’s or the respondent’s gender (with the one exception described above).

Familiarity, however, significantly correlated with all but one scale: Persons with a professional background accorded more rights to the person affected with dementia than laypersons. There was no difference between the two groups with respect to “human and citizen rights”. These findings fit into existing research, and they confirm that the availability of information about a given disease – covered here by professional experience - may result in more elaborate representations and attitudes and thus differing judgments. This is in line with the contact hypothesis already proposed by Allport (1954) who claimed that contact between groups can reduce stereotyping and prejudice under certain conditions. With respect to the perception of persons with AD, little information may be dangerous because this will go along with the stereotyped reduction of rights and underlying competencies. The consequence of such a finding is evident: The general population needs to become better informed about AD, as more and more people come into contact with people with AD (Bickel, 2008). Further, these findings support the call for community based living in small groups for people with long-term disabilities, including people with AD, as expressed in the UN Convention on the Rights of People with Disabilities (UN, 2006), assuring an increase in typical social contacts and interactions with the “general” population, and, thus, contributing to the familiarity related to persons with AD.

Social distancing was not very pronounced in this study as the descriptive analysis showed: The majority of respondents (78% < n < 87%) indicated that they would live near the person, that they would spend an evening socializing with her/him, and that they would not mind their child marrying the person’s child. Far more than half of the sample stated they would support the person (68%) or make friends with her/him (61.9%). Asking for a favor – interestingly – found less positive resonance s because only 34% would do this. One cannot exclude if and in how far social desirability has influenced the responses here because it may seem difficult to overtly state distance from a person who is not to blame for his or her condition

(see Weiner, Perry, & Magnusson, 1988). Discriminant validity of the social distance indicators is, however, described by group differences between laypersons and professionals with the latter showing less distancing. This also validates the group differences already described above for perceived rights. Professional contact and, associated with this, knowledge about the behavior of persons affected with AD in an early stage – as it has been depicted here – may prevent social distancing. The consequences of this finding are evident: Lay people should be informed about Alzheimer's disease and this even more so because the disease represents a "weakly scripted" phenomenon, to borrow a term from cognitive psychology.

Differentiated scripts for this disease may not be elaborated at the layperson level because the causes for AD are still not known and a remedy or a treatment that decelerates disease progression does not yet exist. Moreover, AD can happen to anyone and academics, actors, writers, presidents succumb to the disease. This may lead to "subjective theories" about the disease that still have to be investigated in their consequences for individual behavior towards persons affected with AD. Here is one of the directions of further psychogerontological research.

There are some methodological limitations of the study which should be noted. Although the samples were controlled for gender and – as far as possible – for age, ethnicity and educational background were not considered. Another possible limitation might be that the respondents answered the questions in a "theoretical" way. A real encounter with a person with AD might elicit more emotions; however, the vignette method is often used in research regarding persons with disorders in mental health (e.g., Werner & Davidson, 2004) and allows researchers at least to estimate the potential reactions towards a person with AD.

In line with this and as a final point we like to underline that this study addressed attitudes and social representations but not actual behavior towards patients affected with AD. Because the link between attitudes and behavior is not necessarily clear-cut, future research should also focus

on research strategies that allow for the unbiased assessment of “manifest” behavior towards patient affected with AD and set this into relation to attitudes and representations.

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Appendix

Vignette Used in the Questionnaire (version “Mr. M.”)

Mr. M. is 75 years old and is a widower since 7 years. Since the last few years, Mr. M. has suffered from heavy forgetfulness and concentration difficulties, so he went to the doctor on request of his daughter. The doctor carried out different tests and analyses with him and diagnosed him with Alzheimer’s dementia. Although his family declares that Mr. M. is still able to live at his home and is able to take care of himself on his own, he lives in a home for the aged. Meanwhile, his forgetfulness worsened and he has problems with learning new content; however old memory contents are barely affected. He has difficulties with organizing activities and daily tasks; it is also noticeable that he has strong calculating problems. Although on first impressions, Mr. M. may not seem to have communication difficulties, his language is faltering and less precise than in the past. He often feels overstrained, he is irritable and seems depressive and anxious; but he does not have physical complaints.

Table 1

Cross Tabulation of Participants According to (a) Familiarity with Persons with AD and (b)

Target Person's Gender

Familiarity	Target Person - Gender	Respondent's gender		Total
		Female	Male	
Layperson	Male	29	9	38
	Female	26	8	34
Professional	Male	35	13	48
	Female	46	19	65
Total		136	49	185

Table 2

Factors loadings obtained in principal axis analysis

Right of privacy and information ($\alpha = .66$, $k = 8$ items)	
1. Even if Mrs./Mr. M. does not like her/his nurse, it is not necessary that another person is assigned to his/her care.	.60
2. The world-view, religious affiliation and practicing of religious activities of Mrs./Mr. M. should be accepted, even if this will complicate her/his care.	.44
3. Every caretaker in the nursing home should be allowed to read her/his letters without their consent.	.44
4. It is not really necessary to knock on the door or ring the bell of Mrs./Mr. M. before entering her/his room	.43
5. The people involved in the caretaking and treatment of Mrs./Mr. M. should make all the decisions for her/him.	.40
6. Mrs. Mr. M. should not drink alcohol.	.38
7. The nursing staff does not have to explain to Mrs./Mr. M, for what the medication is for.	.35
8. Mrs./Mr. M. should not have the possibility to inspect her/his medical records.	.32
Right of autonomous living ($\alpha = .69$, $k = 4$ items)	
9. Mrs./Mr. M. should have an autonomous life, even if this includes certain risks	.83
10. If Mrs./Mr. M. wants to, she/he may be left on her/his own.	.53
11. Mrs./Mr. M. may move freely.	.53
12. The caretaking and nursing staff of Mrs./Mr. M. should arrange that her/his daily life can be organised according to her/his wishes.	.37
Human and citizen rights ($\alpha = .66$, $k = 5$ items)	
13. If Mrs. /Mr. M. has the need for it, she/he should be allowed to have a sexual relationship.	.69
14. Mrs./Mr. M. should be held legally responsible by law.	.54
15. Mrs./Mr. M. should decide for her/himself if she/he wishes to donate her/his organs after death.	.49
16. Mrs./Mr. M. may take part in governmental elections, if she/he would like to.	.47
17. Mrs. /Mr. M. should not be allowed to drive a car.	.39
Right of self-determination and self-responsibility ($\alpha = .65$, $k = 5$ items)	
18. Mrs./Mr. M.'s physical condition deteriorated. She/he could die if certain measures are not carried out. Here, Mrs./Mr. M. may decide for her/himself to which extent the treatment should be carried out.	.58
19. Mrs./Mr. M. may write an authorisation wherein it is stated which medical measures should be taken and which person should be assigned later as caretaker.	.53
20. Medical diagnostics and treatments should be explained to Mrs./Mr. M as well as possible risks and alternatives.	.53
21. Mrs./Mr. M. should manage her/his finances herself/himself.	.46
22. If artificial nutrition becomes necessary with Mrs./Mr. M, it should also be implemented against her/his will.	.39
Decision making by significant others ($\alpha = .69$, $k = 3$ items)	
23. The persons involved Mrs./Mr. M.'s care, assistance, and treatment should make all	.69

- the decisions for her/him.
24. Mrs./Mr. M. gets the possibility to take part in a treatment where effectiveness and safety are not scientifically proven yet. Here, the doctor and the family should make the decision if she/he should take part. .58
25. The family and/or the caretakers of Mrs./Mr. M. should decide where he/she should live. .54
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Table 3

Means, Standard Deviations, and relative response frequencies of Social Distance indicators.

	M	SD	High Distance	Neutral	Low Distance
Social Distance - total score	2.08	.67	/	/	/
To have their child married to the person's child	1.59	.74	1.1%	11.9%	87%
To spend an evening socializing with the person	1.82	.81	3.2%	13.6%	83.2%
To live near the person depicted in the vignette	1.84	.77	.5%	21.2%	78.3%
Willingness to support the person	2.10	.89	5.4	26.6	68%
To make friends with the person	2.24	1.00	11.4%	26.6%	61.9%
To ask the person for a favor	2.92	1.13	31.5%	34.8%	33.7%

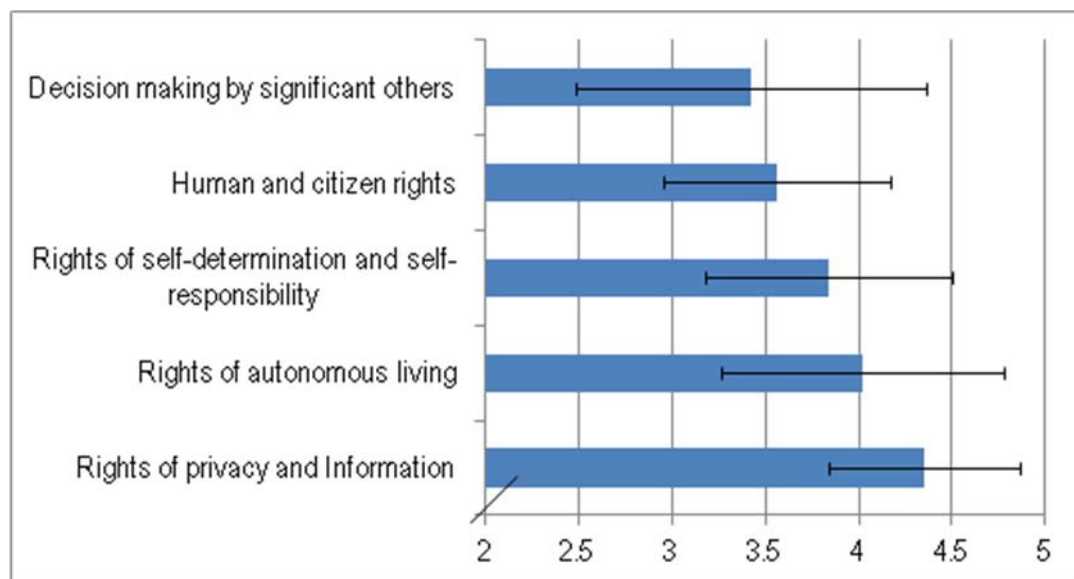


Figure 1. Mean and standard deviations of the five factor-analytical scales on the “perceived rights”.

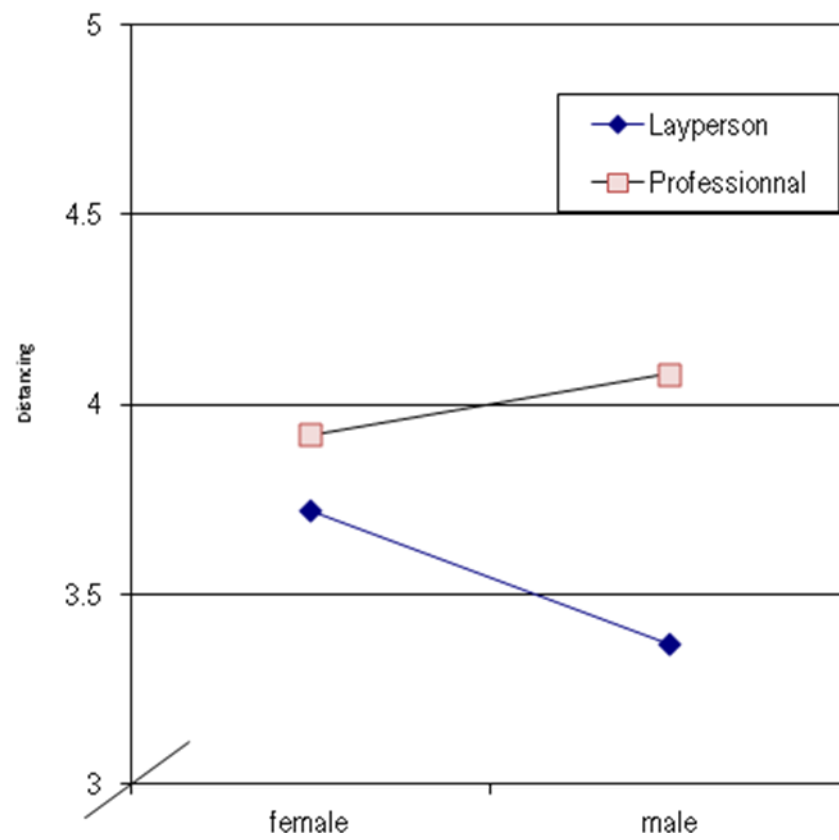


Figure 2. Interaction effects of familiarity and respondent's gender on social distancing.