

Stigma of dementia in three European countries - the MeetingDem project

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PROJECTS SUPPORTED BY JPND

MEETINGDEM

Adaptive Implementation and Validation of the positively evaluated Meeting Centers Support Programme for people with dementia and their carers in Europe



MeetingDem Project

Stigma around dementias' exists due to the lack of public awareness and understanding of the disease, **limits access** to:

Seeking medical treatment when symptoms are present

Receiving an early diagnosis and available treatments

Living the best QoL possible

Making plans for their future

Developing a support system

Stigma in dementia

1. What is the **level of stigma experienced by persons** with dementia?
2. Are **background characteristics** variables such as: age, gender, marital status, level of education, country of living and stage of the disease **associated factors for stigma**?
3. Is there a relationship between
 - **social support** and **stigma** in dementia?
 - **satisfaction with the family relationship** and **stigma** in dementia?



Research questions

level of experienced stigma in three countries (I, PL, UK)

by Stigma Impact Scale
(SIS; Burgener & Berger, 2008)

- **background characteristics questionnaire**
 - age, marital status, level of education
- **stage of the disease**
 - Global Deterioration Scale (GDS; Reisberg et al., 1982)
- **social support**
 - Duke Social Support Index (SSI, 1993)

Methods

Nationality

Polish	Italian	British
N=16 (40%)	N=12 (30%)	N=12 (30%)

Marital status

Married	Widowed	Single
N=24 (60%)	N= 13 (32,5%)	N= 3 (7,5%)

Education

Higher Education	Level 3	Level 2	Level 1	No qualification
N=16 (41%)	N= 10 (25,6%)	N=5 (12,8%)	N=6 (15,4%)	N=2 (5,2%)

Age

Mean	SD	Med.	Min	Max
78.16	6.56	69	65	93

Participants

Stigma Impact Scale (n=40)

	Mean	SD	Median	Min	Max	Max in scale
Internalised Shame	7.72	3.46	8	0	14	20
Social Isolation	12.95	5.44	13	0	23	28
Social Rejection	11.97	3.94	12	0	21	36
Total SIS	32.65	11.76	31	0	55	84

Preliminary results

Global Deterioration Scale (n=40) (min=1, max=7)

2	3	4	5	6
N=6 (15%)	N=9 (22,5%)	N=12 (30%)	N=10 (25%)	N=3 (7,5%)

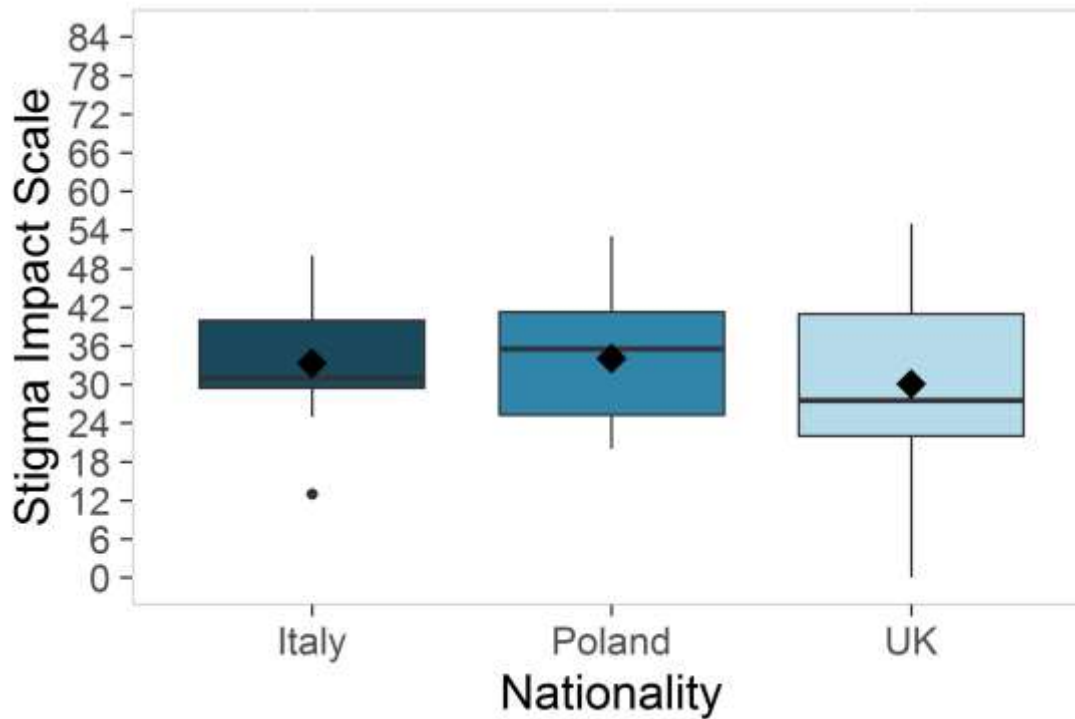
Duke Social Support Inv (n=40) (max=21)

Mean	SD	Med.	Min	Max
17.02	3.02	17	8	21

7. of DUKE: Satisfaction with relationships (n=40)

Dissatisfied	Somewhat dissatisfied	Satisfied
N= 0 (0%)	N= 6 (15%)	N= 34 (85%)

Preliminary results

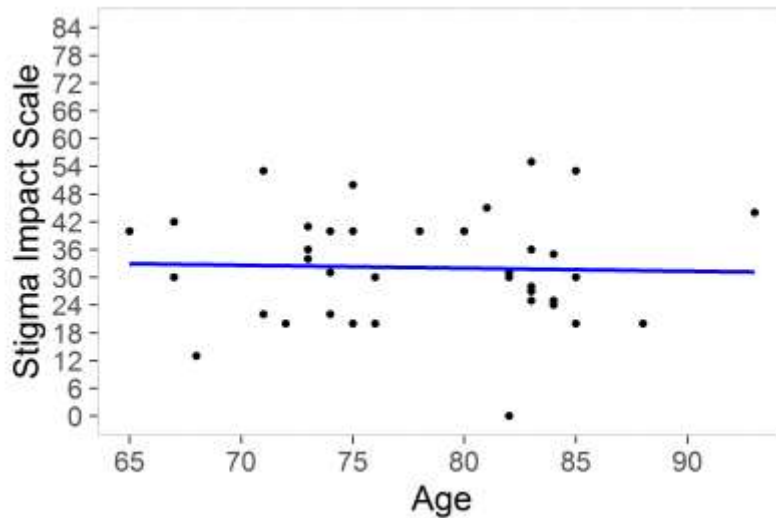


There's no link between the level of stigma and nationality ($p= 0. 4586$)

Preliminary results

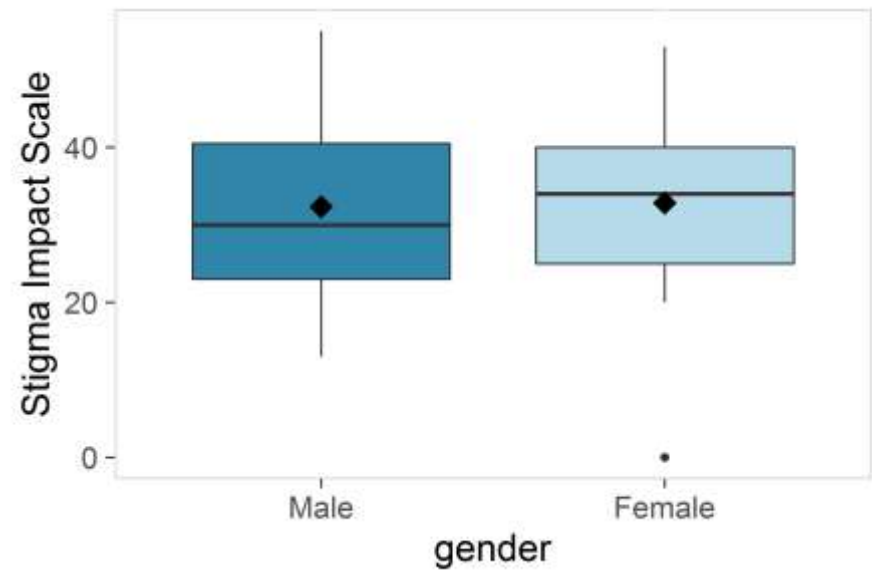
No correlation between stigma and age

$p= 0. 61$



No differences in stigma between the sexes

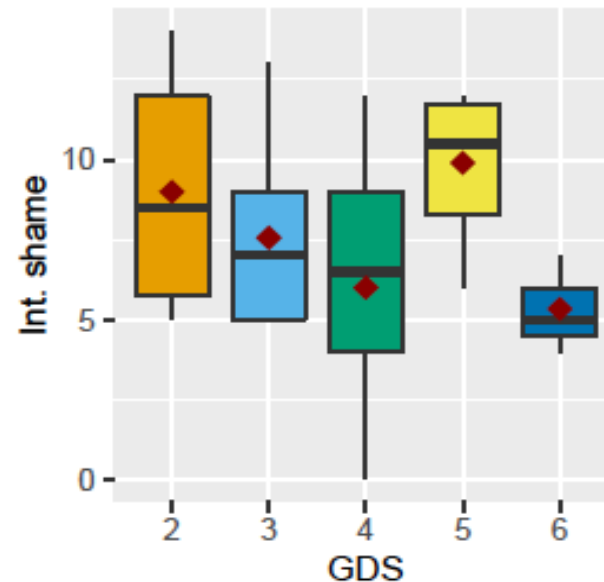
$p=0. 7901$



Preliminary results

Internalised shame:

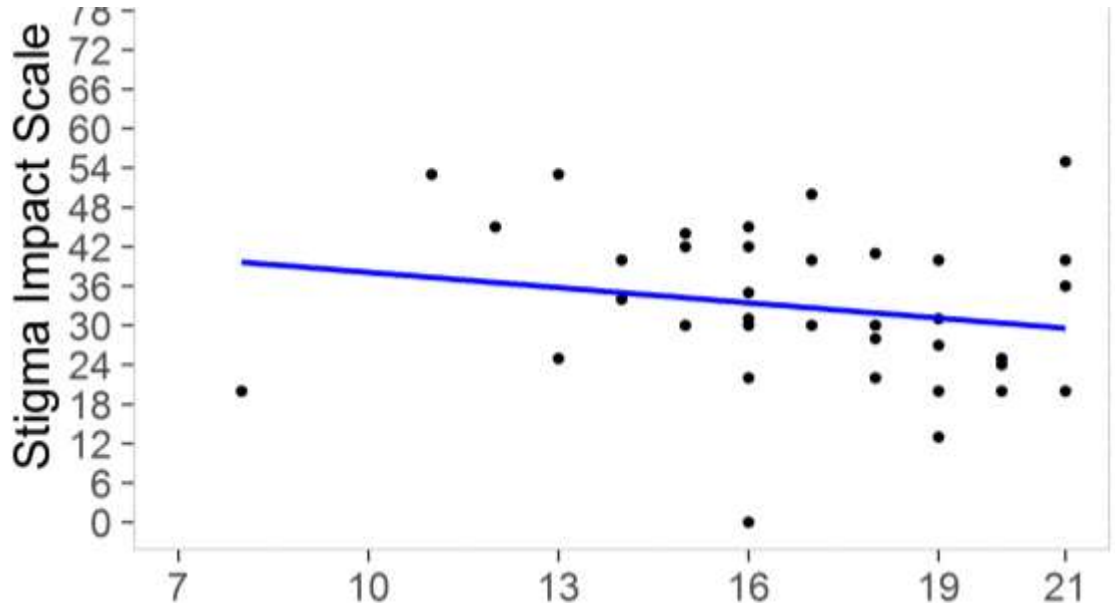
- higher in persons with minor cognitive deficits
- lower in medium deficits
- second peak with higher deficits
- the lowest in more severe cognitive deficits



$p=0.0515$

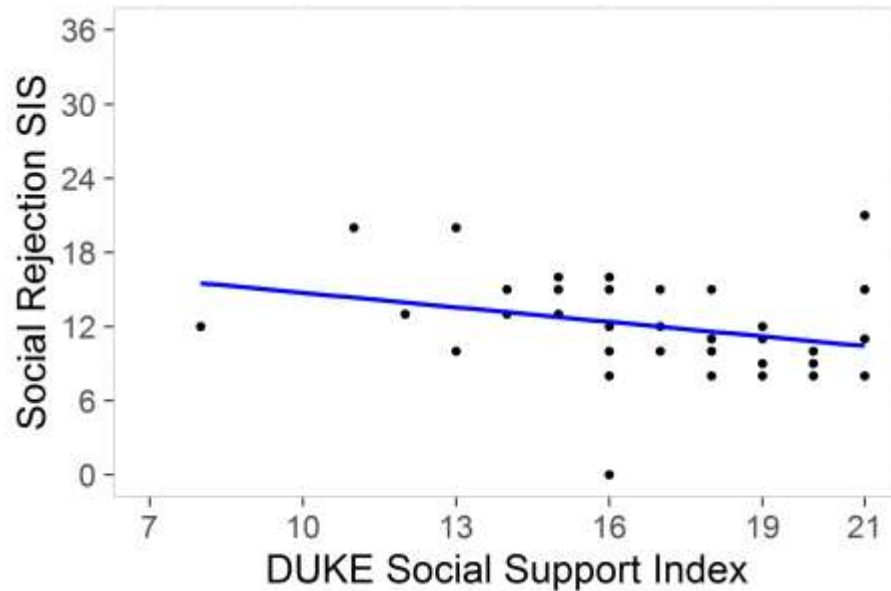
Figure 30: Int. shame a GDS

Preliminary results: internalised shame (of SIS) & GDS



p=0.0782

Preliminary results: Total social support (DUKE) & stigma



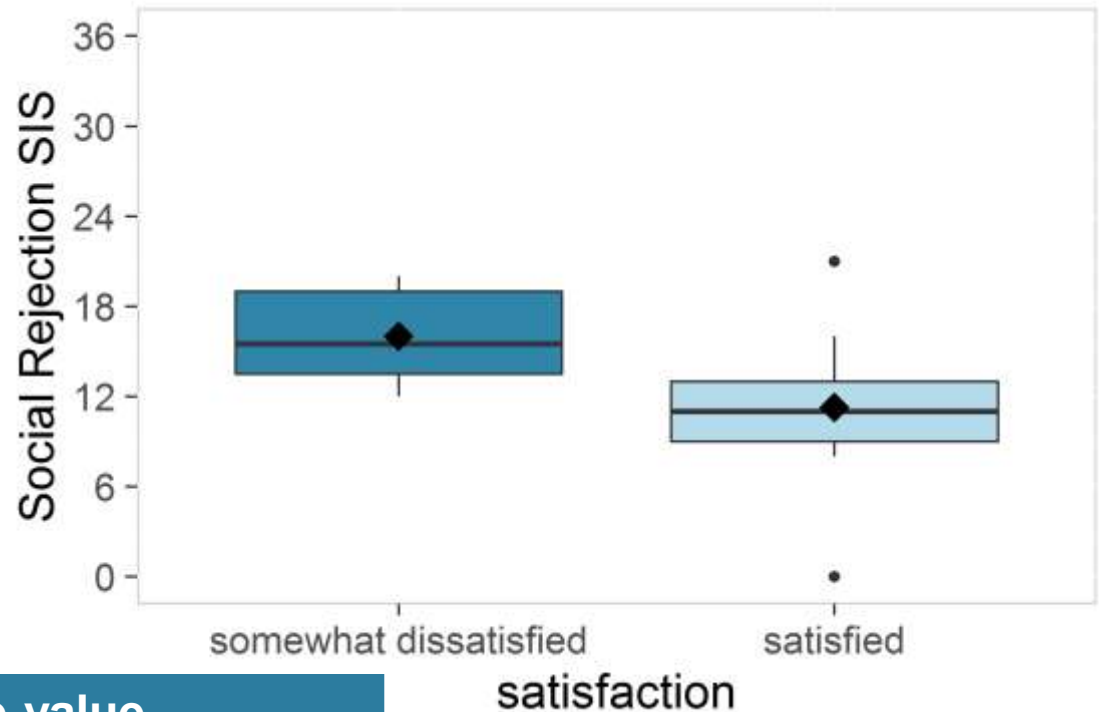
Lower overall social support

- significant correlation with higher level of subscale of social rejection
- tendency to higher:
 - social isolation
 - overall stigma

	correlation	P-value
Social rejection	-0.4104	0.0085
Internal shame	-0.1014	0.5334
Social isolation	-0.2748	0.0861
Stigma total	-0.2817	0.0782

Preliminary results: Social rejection (of DUKE) & stigma

- Significantly lower level of social rejection in persons satisfied with their social relations



	p-value
Social rejection	0.007
Internal shame	0.7314
Social isolation	0.6482
Stigma total	0.3234

Preliminary results: stigma & relations' satisfaction (of DUKE)

- Experienced stigma is independent of age, gender, marital status and nationality.
- Social rejection, one of the stigma components, is related to
 - social support experienced and also to
 - satisfaction with social relationships.
- Experienced stigma can be reduced by the social reintegration and rehabilitation.
- Reintegration builds good relationships and actions improving social contacts of person with dementia which counteract being/feeling stigmatized.
- The Dutch model of Meeting Centers is based on three care strategy: resocialization, reactivation and improving emotional functioning.

Conclusions

More information?

www.meetingdem.eu

centrumspotkan.pl

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This is an EU Joint Programme - Neurodegenerative Disease Research (JPND) project. The project is supported through the following funding organisations under the aegis of JPND: Italy, Ministry of Education and Ministry of Health; Netherlands, ZonMw; Poland, Narodowe Centrum Badań i Rozwoju; UK, Economic and Social Research Council.
