Annals of Case Reports & Reviews

Case Report

doi: 10.39127/2574-5747/ACRR:1000390
Tomasello L, et al. (2024) Annal Cas Rep Rev: ACRR-390

The Protection of People with Alzheimer's Disease and Their Families: Psychological, Clinical and Forensic Aspects

Letteria Tomasello[1*], Miriana Ranno[2], Claudia Pitrone[3]

[1]Department of Cognitive Sciences, Pyschology, Education, and Cultural Studies University of Messina, 98122 Messina, Italy
[2]Department of Mental Health ASP Siracusa
[3]Department of Biomedical and Dental Sciences, Morphological and Functional Images University of Messina

[*]**Corresponding author:** Letteria Tomasello, Department of Cognitive Sciences, Pyschology, Education, and Cultural Studies University of Messina, 98122 Messina, Italy. Email: ltomasello@unime.it

Citation: Tomasello L, Ranno M, Pitrone C (2024) The Protection of People with Alzheimer's Disease and Their Families: Psychological, Clinical and Forensic Aspects. Annal Cas Rep Rev: ACRR-390.

Received Date: 05 May, 2024; **Accepted Date:** 10 May, 2024; **Published Date:** 17 May, 2024

Abstract

Alzheimer Disease (AD, Alzheimer Disease), the fifth cause of death in the elderly population, is a progressive and irreversible neurodegenerative pathology, with insidious onset, characterized by the loss of cognitive functions, behavioral and affective disorders [1]. With the ageing of the population, Alzheimer's disease has become a relevant disease to public health: to date it is estimated that about 50 million people suffer from dementia, 50-60% of whom suffer from Alzheimer's and about 3 million are people directly or indirectly involved in the care of their loved ones. In particular, in Italy, the eighth among the countries with the largest number of people affected, there are an estimated 1.4 million dementia patients, more than 600,000 of whom are affected by AD [2]. It is the most common form of dementia and is a clinical condition caused by an impairment of brain function which implies serious difficulties for the patient in conducting normal daily activities. It affects memory and cognitive functions, affects the ability to speak and think, but it can also cause other problems, including mental confusion, mood changes and spatial-temporal disorientation. The course of the disease is slow and on average patients can live up to 8-10 years after the diagnosis of the disease, the objective of this review is to examine the clinical aspects of the disease, focusing on aspects relating to clinical and forensic evaluation, for the protection of the patient and his family.

Keywords: *Alzheimer's disease, clinical and forensic aspect.*

Dementia

The World Health Organization defines dementia as a syndrome in which there is a deterioration of memory, It is a disease with degenerative and increasing progression of both cognitive and behavioural functions, up to a personality alteration [3].

Although it mainly affects elderly people, it should not be considered a normal development condition due to aging is therefore considered a pathological condition.

In the world there are about 47 million people suffering from a form of dementia, 60% of cases are Alzheimer's disease, it is estimated that in 2030 there will be about 75 million dementia patients and in 2050 the number will be tripled. The incidence of the disease doubles every 5 years from the age of 60. In Italy, in 2015, there are 600,000 people affected by Alzheimer's disease, the increase is closely linked to the aging of the population [4].

Alzheimer's is the most common form of dementia, and refers to severe and progressive memory loss and other intellectual abilities that interfere with normal daily life [5]. It affects the ability to communicate verbally and think, but it can also cause other problems, including confusion, mood changes, and spatio-temporal disorientation. AD accounts for 50-80% of dementia cases, and symptoms generally develop slowly and worsen over time, becoming so severe that they interfere with daily activities. Alzheimer's disease is not part of the normal aging process, although the risk factor is increasing in age, particularly from the age of 65 onwards. In 5% of people suffering from this disease, there may be an early onset, in the age group between forty and sixty. Today it is estimated that about 50 million *people* suffer from dementia, 50-60% suffer from Alzheimer's, the percentage increases with age, subjects between 65 and 74 years of age is estimated at 3%, the age group 75-84 is at 17%, while the over 85 have a probability of 32% [5].

Pathology is more frequent in women than in men. According to the WHO, 6 to 7 million new cases of Alzheimer's (10 million new cases of dementia in total) are reported every year worldwide, with forecasts reaching 78 million by 2030 [6].

The disease is named after Alois Alzheimer, a German neurologist who in 1907, during the histological examination of the brain of a patient suffering from an unknown disease, noticed agglomerations and fibers tangled in the brain tissue. These agglomerations will then be called amyloid plaques, and the fibrepreters will be called neuro-fibrillary.

Alzheimer's disease is a degenerative disease. In the initial stages, the symptoms are mild, as opposed to the late phase, where subjects with the disease cannot conduct a conversation, no longer recognize their loved ones and their environment, and are no longer self-sufficient. The course of Alzheimer's disease is unique for every individual. The average duration is estimated to be between 8 and 20 years, although the periods vary from person to person and in many cases one can overlap the other. The stages described below give a general idea of how abilities change during the course of the disease. AD symptoms can vary greatly, and not everyone will experience the same symptoms or have the same course.

Cognitive symptoms in Alzheimer's disease

From what has emerged so far, in Alzheimer's disease there is an impairment of superior cognitive functions and in particular it is possible to talk about: Memory disorders: the cognitive function of memory is rapidly and severely damaged.

There may be short- and long-term memory deficits; they are a key feature for pathology as well as an important element for diagnosis [7].

In the onset of Alzheimer's disease short-term memory is impaired: there are alterations of an amnesic type that are characterized by an increasing difficulty in recalling memories related to recent events; This is followed by the difficulty of learning new information. With the progression of the disease to be involved is also long-term memory; in fact, if at first recent facts and information are forgotten, in later stages of the disease, the events of the past are remembered with difficulty by the patient, leading to a forgetfulness of childhood memories [8].

We can see just how the autobiographical memory is affected, in which there is an inability to remember the past experience, arriving at a relative forgetfulness of one's life and the closest people.

Semantic memory (the acquisition of information and knowledge) is also strongly altered; Alzheimer's disease sufferer is not able to properly use certain objects from the moment they do not remember their function.

Long-term memory alteration also leads to a deterioration of procedural memory. It is a type of memory that allows the subject to perform a series of more or less complex actions in a stereotypical way, starting from a certain stimulus. The patient may no longer be able to ride a bicycle or drive a car, as it may be difficult to do this [7].

The typical form of Alzheimer's is the amnesic form that initially manifests itself with memory disorders, but the spread of lesions in the cerebral cortex invades the regions in charge of speech.

Speech disorders: they occur from the initial stages of the disease. Initially, anomies of various kinds are frequent, but the most common ones concern the names of people and objects used in daily life [7].

The patient may have difficulties in the production phase, where in trying to describe a simple concept, he uses many turns of words. With the evolution of the disease, the patient uses words like 'the thing', 'the thing', defined Passepartout words, addressing something or someone [8]. Later, lexical impoverishment, reduction of spontaneous language, difficulty of reading and writing are found [7].

However, aspects such as tone, gestures, time of communication, gaze, posture tend to have an impact in communication even in the most severe phases so that the subject can communicate with the other. In this way, the one who takes care of the sick (the caregiver), is able to understand him.

The communicative power of subjects with Alzheimer's is impoverished in the terminal phase, until it disappears. At this time of the disease, there is a noticeable impairment in the ability to communicate with the surrounding world: the patient has difficulties in understanding and producing language. These communication errors can lead to frustration, irritability, aggressive reactions, closure and withdrawal [8].

Apraxia: there are many praxia disorders that can be associated with Alzheimer's disease. The ideo-motor apraxia that, despite being infrequent, when manifested is serious and intrusive. This is the inability of the individual to transform the motor sequence in his mind into the exact motor program. For example, the patient has difficulty in performing simple activities of daily life such as using cutlery.

Ideational apraxia is manifested quite frequently at the beginning of pathology. Here we talk about the impossibility of manifesting a mental representation of the gesture or of performing a movement in the correct motor sequence.

Apraxia of clothing in which the sick person is not able to dress himself because either he does not remember the correct sequence of clothing to wear or presents difficulties in the spatial coincidence of the position of the limb-garment. This deficit is linked to spatial orientation and cognition.

Attention disorders: the patient has a difficulty in focusing attention on a task and maintaining it until the end of its course [7] the subject may have difficulty following a speech that requires a certain type of attention for a long period of time and later, may find difficulties in managing multiple stimuli that occur simultaneously [8]. When the disease evolves, the individual is no longer able to act intentionally, only giving reflex responses to environmental stimuli.

Disorders of thought: the patient presents difficulties in abstract and logical reasoning and changes in judgment. The subject makes mistakes in recognizing numbers and in performing even simple calculations [7].

Space-time disorientation: there is a loss on the part of the patient because he does not recognize the usual environment [9].

Agnosie: Initially there are difficulties in the recognition of common stimuli and objects with which the individual has little familiarity, but then the patient goes to the **prosopoagnosia:** the patient cannot recognize the faces, not even the most dear people. This can progress so far that the subject cannot recognize himself by looking in the mirror [7].

It is important to emphasize that memory and recognition of familiar faces, as well as being cognitive abilities, are the basis of interpersonal relationships. The idea of not being known or being confused with another person causes much suffering for family members [8].

Non-cognitive symptoms in Alzheimer's disease

Behavioral and Psychological Symptoms of Dementia (BPSD) can be defined as a group of non-cognitive symptoms and behaviors that occur in dementia patients and occur in more than 90% of patients [10].

Early recognition and management of these symptoms is crucial, as they are associated with increased risk of impairment in daily functioning, reduced quality of life and faster progression to severe dementia [11].

BPSD shall include:

- Mood changes: depression, emotional lability, euphoria;
- Anxiety;
- Psychotic symptoms: delusions, hallucinations;
- Neurovegetative symptoms: changes in sleep-wake rhythm, appetite, sexual behavior;
- Personality disorders: apathy, disinhibition, irritability;
- Disorders of psychomotor activity: vagrancy, aphnalistic fatiguing;
- Specific behaviours: agitation, verbal or physical aggression, persistent vocalization.

Diagnosis

For Alzheimer's disease, there are currently no biological and/or instrumental markers that can, can diagnose the disease with certainty. Today, the only way to make a definite diagnosis of Alzheimer's dementia is through the identification of amyloid plaques in the brain tissue, only possible with the patient's postmortem autopsy.

The diagnostic process consists of a first screening phase, a second diagnostic confirmation phase and a third phase of differential diagnosis.

Alzheimer's Diagnostic Criteria DSM-5 Neurocognitive Disorder

In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Alzheimer's is considered part of the criteria for major neurocognitive disorder, which was previously termed dementia in DSM-IV [12].

These criteria note that there must be evidence of significant cognitive decline from a previous level of performance in one of more cognitive domains [2,13]

- learning and memory: includes recall, learning new information, and long-term memory
- language: includes word finding, fluency, grammar and syntax, and object naming
- executive function: includes planning, decision making, working memory, and mental flexibility
- complex attention: includes sustained attention, selective attention, and information processing speed
- perceptual-motor: includes visual perception, visuoconstructional reasoning, and perceptual-motor coordination
- social cognition: includes recognition of emotions, theory of mind, recognizing people, using information in a social context to connect with others

For diagnosis, the cognitive deficits should interfere with independence in everyday activities. At a minimum, assistance should be required with complex instrumental activities of daily living, such as managing medications or handling financial responsibilities such as paying bills [12].

These cognitive deficits should not occur exclusively in the context of a delirium, and should not be better explained by another mental disorder such as schizophrenia or major depressive disorder (MDD) [12].

The DSM-5 also recognizes a less severe level of cognitive impairment, termed mild neurocognitive disorder, with four criteria: [14]

- cognitive changes
- functional activities
- exclusion of delirium
- absence of competing mental disorders

Mild or Major Neurocognitive Disorder Assessment

Diagnosing mild or major neurocognitive disorder should include an assessment of potential causes in order to assign a subtype such as Alzheimer's [14] Specific diagnostic guidelines for Alzheimer's were developed by the National Institute of Aging and the Alzheimer's Association and include three phases of Alzheimer's:

- preclinical: the disease is present in the brain but there are no symptoms
- mild cognitive impairment: also called prodromal Alzheimer's, with some symptoms

Dementia caused by Alzheimer's: includes memory, thinking, and behavioral symptoms that impair a person's ability to function in daily life.

In addition to a thorough medical history and mental status evaluation, the guidelines suggest looking at a combination of biomarkers such as injured or degenerating nerve cells in the brain and beta-amyloid accumulation in the brain [14].

Since biomarkers are measurable, the guidelines state they can often be reliable predictors of a disease process and may allow for earlier diagnosis [14].

Alzheimer's Disease and Common Misdiagnoses

According to the American Psychiatric Association, there are a number of medical issues that can be mistaken for Alzheimer's, particularly if a person is older and has memory impairment. These causes, which are unrelated to dementia but could mimic symptoms, can include: [1]

- head trauma
- brain tumor
- stroke
- depression
- thyroid conditions
- urinary tract infections or other infections
- vitamin deficiencies or malnutrition
- reactions to medications or drug interactions

For example, benzodiazepines and anticonvulsants have been associated with memory impairment as a side effect (15).

First stage- screening

Medical history (Personal and family history): consists in the collection of data patient history by the general practitioner, particularly in the assessment of the presence of serious systemic diseases, of conditions that may reduce cognitive functions, from alcohol or other substance abuse, from exposure to toxic substances, from the presence of psychiatric pathologies to past head trauma or other neurological diseases. In particular, the medical history should focus on drugs taken by the patient that can both worsen and simulate dementia.

Objective examination (General and neurological examination): Careful research of signs of disease

Neuropsychological tests (Cognitive evaluation)

Using specific and standardized tools to assess individual cognitive functions and their deficits.

Cognitive assessment

The MMSE consists of thirty items that assess orientation, short and long-term memory, language, attention, visuospatial skills, and the ability to follow simple verbal and written commands. This easy-to-use and relatively quick neuropsychological test is often employed to assess the overall cognitive status We referred to norms for the Italian population considering age and education corrections (16).

HAM-D investigates different areas for assessing the depressive state of a subject. It cannot be used as a diagnostic tool for depression, but it allows to quantitatively assess the severity of the subject's conditions and to document the modifications of these conditions, for example during a psychotherapeutic treatment. The HAM-D consists of 21 items. The severity cut-off is ≥25 severe depression, 18-24 moderate depression, 8-17 mild depression, ≤7 absence of depression. (17).

Clinical Dementia Rating (CDR) scale. The necessary information was collected through a family member or operator who knows the subject and through an assessment of the patient's cognitive functions. Each aspect must be evaluated independently from the others. Memory is considered a primary category; the others are secondary. If at least three secondary categories get the same of memory score, then the CDR is equal to the score obtained in the memory. If three or more secondary categories obtain a higher or lower value of the memory, then the CDR score corresponds to that obtained in most secondary categories. If two categories obtain a higher value and two a lower value than that obtained from the memory, the CDR value corresponds to that of the memory. The scale was later extended to classify the more advanced stages of dementia with better precision (Hayman et al. 1987). Patients can therefore be classified in stage 4 (very severe dementia) and stage 5 (terminal dementia) when they require total assistance because they are completely incapable of communicating, in a vegetative state, bedridden or incontinent (18).

Milan Overall Dementia Assessment (MODA): The M.O.D.A. is a test designed in 1985 based on studies related to the cognitive framework of neuropsychological deficits of Alzheimer's disease, with the aim of completing, in quantitative terms, Neuropsychological description of a patient being examined for suspected dementia. It is useful both as a screening tool and for follow-up. It has been built on the paradigm of Alzheimer's dementia, which provides more information about the patient's cognitive functions.

It should be kept in mind that screening tests are not instruments that alone allow the diagnosis of dementia, but they can still give indication, if the patient needs further study [19].

Functional evaluation, is necessary to evaluate the residual capacities of the patient in order to compensate for deficits and to maintain the longest autonomy. The examination consists in the assessment of autonomy in basic daily life activities and autonomy in the instrumental activities of daily life.

Activity Daily Living Scale (ADL) is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring, continence, and feeding. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment (20).

Instrumental Activities of Daily Living Scale (IADL)

IADL is an appropriate instrument to assess independent living skills. These skills are considered more complex than the basic activities of daily living as measured by the Katz. The instrument is most useful for identifying how a person is functioning at the present time. There are eight domains of function measured with the Lawton IADL scale. Clients are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women, and 0 through 5 for men. It should be kept in mind that screening tests are not instruments that alone allow the diagnosis of dementia, but they can still give indication, if the patient needs further study [21].

Psychiatric behavioral assessment

Neuropsychiatric inventory is a validated clinical rating instrument specifically to provide a comprehensive evaluation of neuropsychiatric symptomatology in demented patients. It is based on caregiver reporting of 10 domains of neuropsychiatric symptoms and includes both

symptom frequency and severity ratings, comprising independent measures of symptom attributes, as well as a composite symptom score (frequency × severity) [22].

Laboratory tests: blood count, electrolytes, ESR, blood sugar, azotemia, blood creatinine, urine test, thyroid function test, vitamin blood levels B12 and folate.

Brain neuroimaging

EEG (electroencephalogram): records the electrical activity present in the brain.

Useful tool in the diagnosis of acute confusional state and to highlight an abnormal functioning of the brain, but often results in normal in a person with dementia.

X-RAY: Exclusion of chronic obstructive respiratory disease.

CT scan (computed axial tomography): X-ray examination providing an image of the brain; specifically measures the thickness of the cortex that in patients suffering from Alzheimer's disease is atrophic, that is thinned (widening of the cortical grooves and dilation of the lateral ventricles).

MRI (nuclear magnetic resonance) high-definition brain: instrument diagnostic that uses magnetic energy instead of X-rays; offers a detailed three-dimensional representation of the topography of the brain. The disease of Alzheimer's changes brain structure. Nerve cell loss occurs in particularly in a small structure, the hippocampus, which plays a crucial role in

memory consolidation. The NMR and can detect tissue loss which accompanies the progression of the disease. PET/SPECT (positron emission tomography): provides information functional metabolic activity of the brain, highlighting active brain areas and therefore, more functional. In Alzheimer's disease, the accumulation of amyloid beta protein leads, even before neuronal death, to difficulty of neurons to use the glucose, necessary for their functioning, in particular in temporo-parietal regions and the posterior crawler (areas involved in higher cognitive functions). In PET the Weakly radioactive glucose is injected intravenously and a series of very sensitive radioactivity detectors allow to follow the use of glucose from part of the brain. TAC AND MRI are not specific and may be normal in the early stages of disease, but are useful neuroradiological examinations to exclude other causes such as problems of thyroid, adverse reactions to drugs, depression, brain tumors, but also diseases of the cerebral blood vessels.

Rachicentesis: Alzheimer's disease modifies brain biochemistry, or the whole machine of enzymes and proteins necessary for the transmission of the stimulus nervous. to detect biochemical abnormalities of the brain is necessary to take fluid

cephalorachidian with a lumbar puncture. Through the liqueur dosage is detected, so the concentration of amyloid beta (variant Abeta42) and another indicator protein of neuronal cytoskeletal damage, the tau protein. Elderly people with Alzheimer's has low Abeta42 levels and high Tau levels. In cases of familial evidence of an autosomal dominant transmission, a genetic investigation is carried out to identify mutations in the genes of the precursor protein of amyloid (APP) or Presenilin 1 and 2 (PS1 and PS2).

Treatment

Alzheimer's disease does not have a specific cure, the drugs used can relieve the milder symptoms of the disease, especially during the early stages of the disease, but are not able to block its progression, some medications may help improve symptoms by increasing neurotransmitters in the brain. They can be distinguished in drugs for Alzheimer's disease and drugs for behavioral disorders. The "symptomatic" drugs, that is, aimed at the attenuation of the clinical manifestations of the disease are: acetylcholinesterase inhibitors, memantine and antioxidants. Acetylcholinesterase inhibitors increase the amount of acetylcholine in the synaptic space: overcoming the blood-brain barrier, they reach the Central Nervous System exercising their therapeutic activity. These drugs are used in the treatment of Alzheimer's during the early stages, where symptoms occur from mild to moderate; in particular, they are aimed at improving cognitive symptoms such as memory loss and attention; along with behavioral ones such as agitation, apathy and hallucinations.

As for the pharmacological treatment of behavioral and psychological disorders of the patient with dementia, the most widely used pharmaceutical classes are: antidepressants, anxiolytics and hypnotics and antipsychotics. Behavioral disorders, mood disorders and psychotic symptoms, which generate most stress in the family and increase the burden of care, are not only caused by brain degeneration but also by the way in which the patient adapts to his progressive incapacity. Assistance for patients with Alzheimer's disease

Assessing and assisting a person with advanced dementia is not easy: the main areas of challenge identified are knowledge and skills in direct care provision, knowledge of dementia as a disorder and knowledge of end-of-life care. Below is the Charter of the Rights of Alzheimer's Patients, which was approved by the general assemblies of Alzheimer's Disease International (ADI), Alzheimer Europe and Alzheimer Italy in 1999.

The highlights are:

- The patient's right to a respect and dignity equal to that of every other citizen;
- The patient's right to be informed of his disease and its foreseeable development;
- The right of the sick person (or the legal representative) to participate, as far as possible, in decisions concerning the type of treatment and future and present assistance;
- The right of the sick person to have access to any health service and/or assistance like any other citizen;
- The right to have specialized services specifically addressing the problems of dementia;
- The right of the sick person and of those who take care of him or her to choose between the various treatment/assistance options that may arise;
- The patient's right, given his vulnerability, to a special protection and guarantee against physical and patrimonial abuse;
- The right, in the absence of legal representatives, or in the event that potential legal representatives refuse

protection, to have by law an official guardian chosen by the court.

Protecting people with Alzheimer's disease and their families

There are three legal protection measures available to people with Alzheimer's disease or other dementias: support management, interdiction and incapacitation [24].

The support administrator

The Law 9 January 2004, n. 6 of the Civil Code introduces a new figure of legal protection, that of the support administration; this figure acts without completely limit the capacity to act of persons in need of temporary or permanent support.

Pursuant to Article 404 of the Civil Code "a person who, as a result of an illness or a physical or mental disability, is unable, even partially or temporarily, to provide for his own interests, may be assisted by a support administrator, appointed by the national court of the place of residence or domicile". The role of supporting administrator may be filled by a spouse, a relative, a non-family member living with a partner or other persons deemed suitable by the court to protect; the administrator represents his assisted only in some acts of life that are decided by the court to protect by a special decree. The court shall carry out an individualized measure appropriate to the situation of the person, specifying: the acts which the beneficiary may carry out alone or with the assistance of the administrator, those which are the sole responsibility of the administrator, the duration of the appointment and the periodicity with which the administrator must report to the court.

The Civil Cassation with judgment n. 25366/2006 recognizes the administrator of support as the instrument to be preferred in the protection of non-autonomous persons, against interdiction and incapacitation.

The prohibition and incapacitation

Interdiction: Before Law 6/2004, the interdiction judgment led to the total loss of the person's ability to act by ascertaining the inability to understand and want; to date, the interdiction measure is applied are for more serious cases, in the case of persons with serious disabilities, of a psychic or progressive dementia type, in which the purpose is to protect a person without autonomy. According to art. 417 of the Civil Code the prohibition can be requested by the person concerned or by the spouse, the cohabiting partner, relatives within the fourth grade (brothers, sisters, grandparents, uncles) or by the like within the second grade (brother-in-law) or the Public Prosecutor's Office by means of a report from Social Services. The Court of residence of the person concerned will first appoint a temporary guardian and then the sentence of interdiction will be pronounced with the appointment of the definitive guardian. The guardian is the one who has the care of the interdict, is the representative of the same in all civil acts, with the exception of those very personal (e.g. make a will, contract marriage), and administers the property of the person concerned.

Incapacitation: presupposes an illness of mind not so serious as to require interdiction; the inability to act concerns the acts of extraordinary administration, that is those of disposition of capital, which need, for their management, the intervention of a curator. The incapacitated person may instead continue to exercise the acts of ordinary administration, that is, those acts that have a negligible impact on the personal and patrimonial sphere of the subject.

Verification and assessment of disability

Law No 104 of 5 February 1992 "Framework Law for Social Welfare, Social Integration and the rights of handicapped persons" can also apply to sick persons of Alzheimer [25].

Art. 3: "A disabled person is a person with a physical, mental or sensory handicap, either stabilized or progressive, which causes learning difficulties, relationships or job integration and is likely to lead to a process of social disadvantage or marginalization. The disabled person is entitled to the benefits established in his favor in relation to the nature and extent of the disability, the overall residual individual capacity and the effectiveness of rehabilitation therapies."

Art. 3, paragraph 3: "If the handicap, single or multiple, has reduced personal autonomy, related to age, so as to make it necessary to intervene permanent, continuous and global assistance in the individual or relational sphere, the situation takes on a serious connotation.

The situations recognized as serious determine priorities in public service programmers and interventions".

The recognition of invalid conditions is the responsibility of the Medical Commission established pursuant to art. 4 of the same law at the local health authorities.

Art. 33, paragraph 3: "Provided that the disabled person is not admitted full-time, the employee, public or private, who assists the disabled person in a serious situation, spouse, relative or similar by the second grade, or by the third degree if the parents or the spouse of the person with a disability in a serious situation have reached the age of 65 or are also suffering from disabling diseases or have died or are missing, is entitled to three days of paid monthly leave covered by an imputed contribution, also on a continuous basis. This right may not be granted to more than one employee for assistance to the same disabled person in a serious situation."

Ascertainment of conditions of invalidity

Law no. 289 of 27 December 2002.

Art. 94, paragraph 3: "To ascertain the conditions of invalidity and the consequent payment of benefits, according to the law in force, of persons affected from Alzheimer's disease, the committees are required to accept diagnoses produced according to the criteria of the DSM-V by medical specialists of the Health Service national or Alzheimer's assessment units."

The accompanying allowance

Law No. 18 of 11 February 1980, as amended by Art. 1 of Law 508/1988 and Law 289/1990.

Art. 1, paragraph 2, letter b: "The accompanying allowance is granted: to nationals in respect of whom total incapacity for work has been established for physical ailments or psychic and that they are unable to walk without permanent help of an accompanying person or, not being able to perform the daily acts of life, need continuous assistance.

The approach to the patient suffering from dementia must be based according to a principle of sharing both objectives and care plans. Needs the analysis must be carried out within the "social assistance triangle", a person with dementia - informal caregivers - formal caregivers, and allows us to deal with numerous ethical dilemmas that emerge during the course of the disease in compliance with the art principles of autonomy, self-determination, charity and sociability justice [25].

Health professionals must be aware of their intrusion into a system whose balance is threatened by the change caused by the disease. There is in fact a painful anticipation of loss both in the patient and caregiver, with a wide range of intense emotions and complex interactions. On the one hand, if without memory there is no self, however, for those who are not recognized by the beloved, after a life together, runs the risk of feeling deprived of their relationship and their emotional background (25). The temptation of the current cultural world is that the dignity of the subject with dementia is dissolved, but the man, as a "person", has his original dignity in every stage of existence. The patient with dementia is a "person" and in any relationship with him it's worthy to recognize this dignity [25].

References

1. Cheever, K. H., & Hinkle, J. L. (2017). Infermieristica Medico-Chirurgica. Brunner Suddarth. (pagine 223-227)
2. https://www.airalzh.it/i-numeri/ "I numeri dell'Alzheimer"
3. http://www.who.int/mediacentre/factsheets/fs362/en/, aggiornato a maggio 2017
4. World Alzheimer Report 2021
5. Alzheimer's Association: 2020 Alzheimer's Disease Facts and Figures.Alzheimers Dement 16 (3):391–460, 2020. https://doi.org/10.1002/alz.12068
6. https://www.centroalzheimer.org/rapporto-mondiale-alzheimer-2021-un- complicato-viaggio-verso-la-diagnosi-di-demenza/ "Rapporto mondiale Alzheimer 2021: un (complicato) viaggio verso la diagnosi di demenza"
7. Pellegrini M, Alfano V, & Palma, F. La malattia di Alzheimer. Aspetti biologici e psicologici. Studi Urbinati, B-Scienze umane e sociali, 75, 145-160. 2005
8. Izzicupo F, Chattat R, Vanacore N. Alzheimer: conoscere la malattia per saperla affrontare. Roma: Il Pensiero Scientifico Editore 2009
9. Bressi C, Invernizzi G. Psichiatria e psicologia clinica (5e). Milano: Mc Graw Hil Education 201700
10. Bonvicini C, Scassellati C. Mechanism of Action of Risperidone and Quetiapine in the Treatment of Agitation, Aggression and Psychosis in Alzheimer's Disease Patients. Encyclopedia of Behavioral Neuroscienze (2nd edition): Editor Sergio della Sala, 2022.
11. Deardoff WJ., Grossberg GT. Behavioral and psychological symptoms in Alzheimer's dementia and vascular dementia. Handb Clin Neurol: 2019
12. UpToDate. DSM-IV and DSM-5 criteria for dementia. 2022. Available at: https://www.uptodate.com/contents/image Accessed August 2022.
13. Dementia Australia. Diagnostic criteria for dementia. Reviewed 2018. Accessed August 2022.
14. Stokin GB, Krell-Roesch J, Petersen RC, Geda YE. Mild Neurocognitive Disorder: An Old Wine in a New Bottle. *Harv Rev Psychiatry*. 2015;23(5):368-376. doi:10.1097/HRP.0000000000000084
15. Chavant F, Favrelière S, Lafay-Chebassier C, et al. Memory disorders associated with consumption of drugs: updating through a case/noncase study in the French Pharmaco Vigilance Database. *Br J Clin Pharmacol*. 2011;72(6):898-904. doi:10.1111/j.1365-2125. 2011.04009.x
16. Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975; 12:189-198
17. Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62
18. Morris, J. C. (1997). Clinical Dementia Rating: a reliable and valid diagnostic and staging measure for dementia of the Alzheimer type. International Psychogeriatrics, 9: 173176
19. Brazzelli M., Capitani E., Della Sala S., Spinnler H, Zuffi M.O.D.A. : Milan Overall Dementia Assessment Edizione: 1994, O.S. – Firenze.
20. Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. JAGS, 31(12), 721-726.
21. Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. The Gerontologist, 9(3), 179-186.
22. Cummings JL, Mega M, Gray K, Rosenberg-Thompson S, Carusi DA, Gornbein J. The Neuropsychiatric Inventory: comprehensive assessment of psychopathology in dementia. Neurology. 1994; 44(12):2308–2314.
23. Wortmann M. Dementia: a global health priority-highlights from ad ADI and World Health Organization report. 2012
24. Buffone G. La protezione giuridica dell'adulto incapace: l'anziano e l'amministratore di sostegno, in Giur. Merito, 2011, pp. 2907.
25. Tomasello L. Toscano G. Raffaele M. Dignità e sacralità della vita del paziente con Demenza di Alzheimer: la "Persona" al centro delle Neuroscienze e del Diritto Rivista di Bioetica, morale della persona e medical humanities
26. Bio-ethos n.18 maggio-agosto 2013 ISSN 1972-6341 Istituto di Studi Bioetici "Salvatore Privitera" Palermo.