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Interventions aimed to increase independence and well-being in patients with Alzheimer's disease: Review of some interventions in the Italian context

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ABSTRACT

Background: Alzheimer's disease (AD) represents a huge social and economic burden for the society and caring for individuals with AD is a complex and challenging task that requires a multidisciplinary approach. Studies have shown that several interventions provide beneficial results, but some non-pharmacological interventions have not yet been studied in depth and clinical trials using them are still pending. This review provides a summary of interventions based on paradigms aimed to increase independence and well-being in people with AD, as well as those interventions that decrease caregiver burden in long-term facilties for AD patients in Italy.
Methods: Narrative review regarding the theoretical bases and analysis of available studies related to new interventions implemented in long-term facilities for AD patients in Italy.
Results: Community Occupational Therapy in Dementia (COTiD), and clinical interventions based on the 'enabling approach', the Gentlecare paradigms, have been implemented and suggest their utility to decrease caregiver burden and improve quality of life of patients. A major role of social workers for patients withADand their caregivers should also encouraged. A need of clinical trials is warranted in order to support the effectiveness of these interventions on a large scale.
Conclusions: The best care of patients with AD and families requires a multidisciplinary approach which should take into account all these methodologies. Furthermore, clinical studies will be required to validate these interventions using different paradigms, both alone or in combination, in order to improve the care of thepatients and their families.

1. Introduction

Dementias encompass a group of chronic and degenerative diseases that cause behavioral problems and difficulties in participating in social activities, and disorders/loss of memory, initiative, and independent functioning in daily activities; Alzheimer disease (AD) is the most prevalent form of dementia (Winblad et al., 2016). The worldwide prevalence of dementia has recently been estimated at 47 million people (Winblad et al., 2016). Recent epidemiological studies on secular trends in dementia incidence showed a moderately consistent evidence to suggest that the incidence of dementia may be declining and the number of people with dementia can remain stable despite population ageing in high-income countries. However, the declining incidence may be balanced by longer survival with dementia with a huge social burden and costs. There is some evidence to suggest increasing prevalence in East Asia, consistent with worsening cardiovascular risk factor profiles, although secular changes in diagnostic criteria may also have contributed to such increase (Hall et al., 2009; Hebert et al., 2013; Melis et al., 2014; Prince et al., 2016). The huge number of people affected by AD or other kinds of degenerative cognitive

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disorders is supposed to progressively impacts both the economic and social structure of societies (Hall et al., 2009; Hebert et al., 2013; Melis et al., 2014; Prince et al., 2016). The symptoms of dementias decrease the quality of life of the affected person and caregivers (CGs) often experience feelings of helplessness, social isolation, and loss of autonomy. People with cognitive disorders are usually prone to lose their independence in the activities of daily living and this can significantly impact their quality of life and mood, as well as producing a progressive increase in care-related costs. Considering the substantial burden for people with dementia (PWD), their CGs, and society, in addition to the symptomatic pharmacological treatments available, it is also important to implement new effective healthcare interventions that increase the independence and well-being of PWD and decrease the CG burden, resulting in a more efficient use of healthcare resources (Livingston et al., 2017). Although such strategies are generally more time-consuming than pharmacological therapies, they seem to reduce symptoms and produce similar or larger effect sizes in terms of patient behavior without any side effects (DeRubeis et al., 2008; McLaren et al., 2013; Shub et al., 2009; Smart et al., 2017).

Because dementia affects multiple cognitive and non-cognitive domains, among other comorbidities it often also affects nutrition and gait, and can also impact the health of CGs. Treatments often consist of multiple components which target different outcomes, and such tailored multiple-discipline interventions seem to increase the likelihood of success more effectively than general interventions (Smits et al., 2007). In addition, multicomponent interventions implemented by CGs in conjunction with the provision of individualized support, information, and skills training have shown to be more effective than traditional pharmacological therapy alone (Vernooij-Dassen & Downs, 2005). Indeed, complex or multicomponent interventions for older PWD and their CGs which are tailored to the priorities of the individual, are often more effective than single-component interventions, as outlined by a recent Cochrane systematic review (Vernooij-Dassen & Downs, 2005).

The aim of the present narrative review was to analyse the literature about some of the recent programs used in some long-stay centers in Italy based on paradigms aimed to increase independence and well-being in people with Alzheimer's disease and their caregivers. The interventions reviewed are the program Community Occupational Therapy in Dementia (CotiD), the 'enabling approach'®, Gentlecare® paradigms and the effect of social worker on caregivers of patients with AD. These paradigms have also been presented and discussed in the meeting "New psycho-social models for the treatment and prevention in frail older individuals" which took place in Guspini (Italy) in september 2017, by the authors with a large professional trajectory specialized in these clinical interventions which are currently implemented in several centers for the care of patients with AD in long-stay institutions in Italy and in other countries.

2. Methodology

We analyzed scientific reports in the PubMed/Medline, PsycINFO and Scopus electronic bibliographic databases, published up until December 2017, that met the following inclusion criteria: (1) full text in English, Italian, Spanish, or Portuguese; (2) related to community occupational therapy in dementia, the enabling approach, gentlecare paradigms and the utility of social worker in reducing caregivers' burden of patients with AD; and (3) analysis of the effects in patients with AD or other types of dementia and/or their caregivers. To determine which articles to include, we analyzed their title and abstract, and the full text was then retrieved for articles that fulfilled the inclusion criteria. Finally, the reference lists of all the relevant articles were manually cross-referenced to identify any additional articles. The search terms used were one of these terms 'community occupational therapy', or 'enabling approach', or 'gentlecare', or 'social work*' AND 'dementia' or 'Alzheimer's disease'.

3. Results

The professional experience of authors of the review and the analysis of the literature show that the clinical interventions currently used in long-stay centers in Italy for patients with PWD (AD in the most of the cases) are based on OT implemented mainly by occupational therapists, enabling approach by psychologists and Gentlecare® approaches by occupational therapists as well as other professional such as nurses. The role of social workers is particular useful not only for PWD, but in particular for their GCs and the professional team caring to these individuals (nurses and medical doctors).

3.1. Utility of occupational therapy programs for behavioral symptoms in people with dementia

OT is an international discipline which was formally born in early 1900 (Radomski & Latham, 2008). It has since been scientifically developed by applying theoretical models generated by a branch of research referred to as occupational science, and by using internationally-validated and standardized assessments. The OT profession focusses on the occupation of the patient and OT practitioners are usually involved in maintaining or restoring people's ability to remain independent. OT rehabilitation treatment for elderly people focusses both on age-related impairment and on the physical, neurological, psychological, or cognitive conditions that affect their quality of life (Kielhofner, 2009). Over the past few decades OT has progressively raised societal awareness of the problems experienced by PWD and their CGs. Behavioral psychological symptoms of dementia (BPSD) are often a consequence of the dementia and they can become a significant challenge in providing daily care. Moreover, CGs are also usually affected by the disease in terms of increased burden related to the provision of care (Ferri et al., 2005).

OT has developed some interventions for PWD and their CGs, as shown by the increasing number of papers published in international journals related to the topic. One of the most effective OT interventions so far reported is the 'Tailored Activity Program' (TAP) for PWD which was developed by Gitlin et al. in the USA. Scientific evidence suggests that it significantly benefits both PWD and CGs by slowing or reducing the occurrence of unwanted behaviors and that it may also delay the need for institutionalization (Gitlin et al., 2010; Gitlin et al., 2008; Gitlin et al., 2009). TAP is a home-based OT program involving 8 sessions comprising 6 home visits (lasting 90 min) by an OT trained both in dementia care and the TAP program, over a period of 4 months. First the OT practitioner assesses the PWD, their environment, and their CGs. During these initial sessions the occupational therapist gathers information about the meaningful current occupation, past occupations, and previous activities of the PWD, as well as obtaining data regarding their current functional and cognitive abilities. The assessment of the CG is based on the presence of the stresses and challenges usually associated with care-giving. The environment is also assessed in terms of barriers and facilitators to activity and to check the PWD's risk of falling.

Next the occupational therapist develops some 'activity prescriptions' which are tailored to the executive functional ability and physical skills of the PWD. These activities match the specific background and preferences of the PWD and can be graduated from multitask occupations (e.g., making a sandwich or folding clothes), simple one-task activities (such as sorting objects or playing a simple game), or sensory-based activities (listening to music, for example). The prescriptions are also shared with the CG, and the therapist trains the CG on effectively communicating with the PWD, preparing the setting for activities, and in stress-reduction techniques. Activity prescriptions are usually increased as the sessions go on, and they can be further elaborated over time via telephone conversations between the occupational therapist and the CG. The main outcome of the TAP intervention is a significant reduction in the BPSD, and a subsequent reduction in the CG's burden.

The TAP program has also been shown to be cost-effective which favors its implementation (Gitlin et al., 2010).

Previous studies have shown that community-based OT administered in the home of the PWD helps to improve their functional independence and autonomy and to decrease the burden experienced by CGs (Gitlin et al., 2009). However, community-based OT for older PWD and their primary CGs is such a multicomponent intervention it must also be tailored to individual needs (Graff et al., 2003). Several studies have shown that multicomponent interventions which are tailor-made and focused on the needs of the patients and CGs and which provide feasible goals, are most effective treatments for dementia in these settings. The Community Occupational Therapy in Dementia program (COTiD) is a multicomponent client-centered system which provides interventions containing almost all the components of effective psychosocial interventions in dementia (Brodaty et al., 2003; De Coninck et al., 2017; Spijker et al., 2008; Van Mierlo et al., 2010). It systematically integrates tailored everyday activities to the patients' occupational preferences and cognitive abilities with environmental adaptations, technical aids, and CG support to help PDW achieve feasible goals (Graff et al., 2009). The COTiD program aims to improve the daily functioning and quality of life of both patients and their primary CGs. Treating PWD with the COTiD focuses on enabling the successful performance of meaningful daily activities.

The intervention-focus for CGs is the enhancement of successful interactions with the PWD by improving the CG's communication, supervision, and problem solving skills. In addition, the CG is supported in caring for their own wellbeing by enabling their participation in meaningful daily recreational activities. After the patient and CG first prioritize their proposed activities together, the therapist defines compensatory strategies and environmental adaptations to adjust the activities and physical and social environment to the patient's habits and cognitive abilities. Patients and CGs are taught to use and optimize these compensatory and environmental strategies to improve their performance of these daily activities. The CG is trained in effective supervision skills, problem solving, and coping strategies, and receives practical and emotional support in order to sustain both their own autonomy and social participation as well as that of the PWD. Evidence from the COTiD program indicated that both PWD and their CGs showed improved functionality in their daily activities, and in terms of the CG's sense of competency, and the mood, quality of life, and health-status of both the patients and their CGs; thus, every successful treatment also resulted in a cost saving in relation to [pharamaceutical internetions/the delayed decline of patients…] (De Coninck et al., 2017; Döpp et al., 2011; Graff et al., 2009; Graff et al., 2008; Graff et al., 2006; Spijker et al., 2008; Van Mierlo et al., 2010). Furthermore, a recent multi-center, parallel-group, pragmatic randomized trial performed in UK showed that COTiD is a valuable evidence-based person-centered intervention that reflects the current priority of enabling PWD to remain in their own homes by improving their capabilities whilst reducing the burdens of CGs (Wenborn et al., 2016).

3.2. The enabling approach and Gentlecare® approaches for caring and their relationship to people with Alzheimer disease

The enabling approach (ApproccioCapacitante®) is an interpersonal relationship modality based on recognizing the interlocutor's basic abilities, which was introduced and patented by the Italian physician and psychotherapist Dr. Vigorelli (Vigorelli, 2004). The theoretical starting points of the approach are represented by communication theory, (Watzlawick & Beavin, 1967) speech act theory, (Austin & Urmson, 1962) and others. It also explains the important contributions of authors such as Ploton (Ploton & Laroque, 1990) and Kitwood, (Kitwood, 1997) and the capability approach (Amartya & Amartya, 2009; Sen Amartya, 1999). These theoretical bases assert that PWD can aspire to their own happiness, can still talk and communicate with satisfaction, and the CG can have a positive influence through effective interventions. The main goal is a 'happy-enough' coexistence between both parties. In the field of geriatrics, the enabling approach is a professional intervention that seeks to create an enabling environment where frail elderly people, with or without dementia, live. Within this context they can exercise their basic abilities, especially speech, to the best of their current abilities without worrying about making mistakes, and with the only aim of feeling content in performing their activities, whatever they may be. The enabling approach focusses on abilities which are still and/or always present in PWD, even in the most critical stages of the disease, not on their deficiencies.

As in almost every situation, people better express their capabilities when they find themselves in a favorable environment, (Ploton & Laroque, 1990) and even more so when the person presents cognitive impairment that can be associated to an advanced age and/or state of frailty. The enabling approach pays utmost attention to every form of expression by elderly PWD, as it manifests itself, with a listening, accepting, and non-judgmental attitude. An important characteristic of this approach is that it can be done by simply using speech (Vigorelli, 2010). The founding idea of the enabling approach is the recognition of basic abilities (to speak and communicate, capacity for emotions, and to negotiate and decide), of people's multiple identities (i.e., as more than merely a person requiring assistance or someone with a disease), and of possible worlds where the person lives, thus legitimizing them. By learning how to choose the words to address PWD, the CG can help them keep their basic abilities alive or make them reappear if they are hidden. The ultimate goal is to create a happy-enough coexistence between the elderly PWD, their family members, and the CG (Vigorelli, 2010).

Communication with individuals with cognitive deficiencies such those with chronic dementia is not only possible, but is unavoidable, and it is important to be aware of this (Vigorelli, 2015). Through speech, the enabling approach offers family members, operators, and volunteers the possibility of accessing the signals sent by PWD to express emotions, needs, desires, and fears and which manifest themselves in various ways. Recognition of these basic abilities is an effective means of communication and, at times, is its only purpose. It is important to know that certain techniques can facilitate verbal exchange (Table 1) to facilitate these goals. Additionally, informal CGs, especially family members, can become experts in the use of the speech (Vigorelli, 2010, 2011). In the group, CGs learn to use speech as the best way to develop a relationship that could allow the patient to reach a state of 'possible happiness'. In the application of the enabling approach, an additional step is taken at the organizational level to expose them to projects that can effectively maintain the abilities of the elderly, frail, sick, or those with dementia. Thus, the ability to speak is maintained and grown (Amici et al., 2009) and becomes the instrument of a happier relational exchange.

3.3. The Gentlecare model

The patented Gentlecare® program was developed by the Canadian

Table 1
Techniques for facilitating the verbal exchange.

Conversational techniques
Listen in silence
Respect slowness and breaks
Do not correct
Do not interrupt
Do not complete pending sentences
Do not ask questions or ask few open questions
Answer questions
Echoing
Return the narrative motif
Provide relevant parts of own biography

occupational therapist, Moyra Jones, to support the long-term care and understanding of individuals with dementia; its concept is based on delivering 'prosthetic' care to PWD and represents paradigm shift in care philosophy. It creates a uniform standard model of care for clients with multiple positive outcomes (Caspar et al., 2009; Jones, 1996) which has been formally adopted and endorsed by the British Columbia Ministry of Health (Gnaedinger, 2003). The Gentlecare® program helps to limit the impact of the progressive deterioration of functional, cognitive, and motor abilities of patients with AD; ensure specific healthcare, care-giving, and social actions are carried out in a prompt and integrated way; control and repress behavioral disorders by limiting the use of means of physical and pharmacological coercion; and rationalize the stress of CGs. Implementation of the program requires a physical residential and/or hospital space, sufficient, recognizable, and well-trained staff, and 24-hour operation carried out in an interactive and dynamic way.

Gentlecare® also teaches that nutrition can be used to support client function, not only in terms of the food itself, but also the environment in which people eat. In this sense, the program leverages people instinctive understanding of the environment; for example, an open-plan room with its edges lined with chairs and only a few tables in the middle does not project the idea of a dining room. However, dressing the tables with table cloths, cutlery, and glasses facilitates an unconscious understanding of the place's function and associations of it being a space in which one eats. Focus on the client, with the prime aim of finding and safeguarding their existential continuity, is at the root of the Gentlecare® program. The theoretical concept of the model is that PWD can obtain information they are otherwise deprived of because of their disease (and which cannot be recovered) from their external environment (Caspar et al., 2009; Jones & Bartorelli, 2007). The 'prosthetic model' identifies any deficits caused by the disease on the cognitive, functional, or behavioral levels and, based on this, builds an individual 'prosthesis of care' which aims to compensate for the client's lost abilities. The objective is not functional or cognitive recovery, but rather, the development of a new 'wellbeing condition' for the PWD which, when there are no signs of stress, could be defined as an improved functional level.

The Gentlecare® paradigm leverages three elements to create the prosthesis: people with whom the client interacts, the involvement of PWD in programs and activities, and the physical space in which PWD live. The three elements are dynamically related to each other, therefore the prosthesis only works effectively in the presence of all three. The paradigm considers that most dysfunctional behaviors in PWD are caused by an imbalance between the their residual abilities and requests coming from their environment; the increasing deficit caused by their disease cannot be modified, however, the stress experienced by PWD can be reduced by making suitable environmental adjustments (i.e., the 'physical space prosthesis'), having the CGs adopt the right approach (the 'people prosthesis'), and with a daily routine adjusted to them (the 'programs prosthesis'). One of the key steps is to successfully engage the family in the therapeutic partnership and to educate all the therapeutic agent(s), including the family. Family members are one of the most important resources and they are involved throughout the whole care journey to create a real therapeutic approach in which they are a resource and may even become future volunteers. Two observational studies analyzed the gentlecare paradigm in patients with AD and their caregiver burden (Caspar et al., 2009; Gallese & Stobbione, 2013). Caspar et al. (2009) demonstrated that empowerment and individualized care responses were highest among caregivers staff working in facilities in Canada that had implemented the GentleCare paradigm suggesting a plausible broad acceptance for the workers frequently suffering from burn-out conditions due to the difficulties of caring of these patients. Unfortunately, to date no clinical trials evaluating the effectiveness of the Gentlecare® model have been published yet (Caspar et al., 2009). In Italy, Gallese and Stobbione (Gallese & Stobbione, 2013) perfomed an observational study in Italy by a qualitative methodology through the use of semi-structured interview of caregivers (nurses) of patients with AD. This study identified the most important needs of patients and suggest clinical interventions to manage it at home, according to the pattern of analysis based on the GentleCare paradigm which also well fits the conceptual model of nursing called "Need-driven Dementia-compromised Behaviour Model", validated and tested in the United States (Mitty & Flores, 2007; Penrod et al., 2007). This study besides characterizing the level of the dependence of patients from their caregiver for numerous activities of daily living, revealed a poor level of information and lack of support from professionals who can help caregivers in their everyday life and suggested the GentleCare as paradigm for clinical interventions in these patients.

3.4. The role of social workers for patients with Alzheimer's disease and their caregivers

Social workers in diverse service systems throughout western countries encounter many opportunities for improving the quality of life of PWD and their families (Brodaty et al., 2005; Dreier-Wolfgramm et al., 2017; Gridley et al., 2014). Yet practice within this population is not clearly defined and a core set of competencies for social work practice does not yet exist. Instead, it is shaped by the roles of social workers with aging patients and different healthcare systems and is informed by a biomedical disease model of dementia. Analyzing elderly PWD means approaching all the dimensions of their personal, familiar, and contextual lives, paying special attention to the bio-psycho-social aspects, (Gagliese et al., 2017; Ownsworth et al., 2006; Zwijsen et al., 2016) and not only to the disease conditions. The patient's family background, which varies from case to case, can affect their continuity of care (Dreier-Wolfgramm et al., 2017); family may be totally absent or present, or could be present but in a disadvantageous way. Social workers should also work to emphasize their essential contributions within the multidisciplinary treatment context while additionally explaining the importance of employing professionally-trained social work practitioners in such care settings (Kaplan & Andersen, 2013). Home healthcare practice with cognitively-impaired older individuals and their families often raises difficult clinical and ethical issues for social workers. Indeed, a pioneering study found that the influence of safety, caregiver burden, and diagnostic labels were significantly related to social workers' support for the autonomy of PWD (Healy, 2000). There were also interactive effects between safety, CG burden, and diagnosis, and identification of the influence that diagnostic labels had on social workers' support for the autonomy of PWD was an especially important factor. For instance, social workers supported less autonomy for older PWD when they were diagnosed with AD rather than with stroke (Healy, 2000).

Publications regarding the multidisciplinary approach and working network with other professionals or local participants are becoming more common in discussions of this topic in literature (Kaplan & Andersen, 2013). Therefore, because we treat increasingly complex situations and problems, it is important to recognize the inescapability of taking these multicomponent approaches. Caring for PWD is one of the most problematic activities among the geriatric population, in particular, when this care is administered at home in the setting of people's private lives, the situation requires constant careful thought (Clarkson, Davies et al., 2017; Clarkson, Hughes et al., 2017; Mole et al., 2018). Social services contribute to co-building (building with others) a realistic representation of the possibility and potential for finding resources for PWD (which may still be unexplored by patients and their CGs), especially within their relational (personal, familiar, and social) network where the patient is likely to have significant bonds (Dreier-Wolfgramm et al., 2017; Gridley et al., 2014). Multidisciplinary analysis can identify the most appropriate and helpful ways of providing care, guarantees the continuity and proximity of points of reference to patients and their relatives, reduces disruptions in the provision of care,

Table 2
Conceptual tools for a network multidisciplinary approach.

1) What languages do we speak? Recognizing the “others” as experts of their own knowledge involves the necessity of using a comprehensible language, avoiding typical closure of excessive professionalization, considering differences and also asking to ourselves how to treat those differences.
2) Attention to coherence in the functions of social services where new and continuous solid, demanding, suffocating procedures might become a constraint to fulfil rather than making projects.
3) Comparing the orientations, try to search convergences on things to do, leaving implicit our orientations: a real process of co-construction starts only when we share the theory that guides every professional.
4) Confidence is necessary: it is not given for granted, therefore it must be built up paying attention how consensus is created, how to empower all the individuals in maintaining an innovation process, how to come to collective decisions.
5) A plurality of individuals can contribute to building “something” in common, but on the other hand this implies to give up some of our certainties. It’s important to create representation of problems that can activate shareable planning.
6) Supportability in time is an element to consider since the beginning, and this requests to pay attention to evaluation, predicting tools and object of analysis, because what we are doing is not always good in every single case.
7) Recognize in the own work, also a social mandate: that is acknowledge a political role, the necessity and value of social bonds that needs to be tracked, seen, cultivated, going further detection of problems.
8) Share the object of working, of our way of taking care, building up places of confrontation and discussion.

and easily connects to the social, territorial social-sanitary, and hospital services (Gagliese et al., 2017; Ownsworth et al., 2006; Zwijsen et al., 2016). Obviously, all of the services providing care to individuals with AD and other dementias are integrated and require both evaluation and intervention at the clinical, rehabilitative, social, educational, and surveillance levels. Monitoring and planning the care of PWD requires the contribution of many individuals, however the identification and use of some conceptual tools can help guarantee better results within this multidisciplinary network approach (Table 2). Studies involving interviews with social workers demonstrated that the characteristics of AD are perceived as affecting the survey on both the personal and professional levels; the participants expressed negative feelings towards AD and stated that these perceptions and feelings had led them to burnout (Shinan-Altman et al., 2016). Thus, professionals’ perceptions of the disease patients have (‘illness representations’) are a major factor influencing the quality of the treatment they provide or recommend. One recent study examined and compared AD illness representations among two key professional groups who provide care to patients with AD: nurses and social workers. The participants all perceived AD as a chronic disease with severe consequences. Yet, despite some similarities between social workers and nurses, there were significant differences between the two groups regarding the representation of AD: nurses attributed psychological symptoms to AD more strongly than social workers, while in contrast, compared to nurses, social workers perceived AD as more chronic with severe consequences. Therefore, the continued distribution of educational materials about AD to professionals is recommended and should accommodate the unique characteristics of each professional group. Furthermore, these findings should encourage the development of training and support programs that not only deal with the organizational and instrumental levels of treating AD patients, but that can also handle the assessment and consequences of professionals’ illness representations (Shinan-Altman et al., 2016).

4. Conclusions

Several interventions based on biopsychosocial model such as occupational, behavioral, and cognitive interventions can improve the well-being of patients with AD living either in residential care or at home and also reduce CG distress (DeRubeis et al., 2008; McLaren et al., 2013; Shub et al., 2009; Smart et al., 2017). Interventions based on OT such as the COTiD program have produced results which are promising for maintaining patient autonomy and well-being and are applicable in different settings. However, further follow-up studies will be required to explore the long-lasting effects of the COTiD program. The Gentlecare® paradigm, already widely used in Canada and now becoming more popular in other countries, (Jones, 1999) suggests an alternative approach to caring for individuals with AD that stresses dignity and self-respect, and discusses recreation, bathing, nutrition, and room layout. The ‘enabling approach’ (Vigorelli, 2004) shares a focus with Gentlecare® in terms of stimulating and using patients’ residual abilities rather than focusing on their disabilities, and emphasizes the goal of ‘possible welfare’ rather than ‘impossible’ functional recovery. Above all, these approaches consider the CG’s ability to transform and tailor their relationship with the patient to be the primary tool for reducing the damage caused by the PWD’s condition and for increasing their quality of life. These are the tools of reference for stimulating patients’ ability to use their powers of speech and conversation to meet their need to express themselves, their deep-seated emotions, be heard and respected, and be recognized as individuals, thus allowing them to recover their status in society. We also should consider that these approaches do not only apply to patients with AD or patients with moderate to severe dementias as such, but they can also be useful in the management of patients with other types of neurocognitive disorders (Fortinsky et al., 2016) however due to lower prevalence of these disorders the experience in this field is much lower compared to AD patients.

It is also important for professionals to focus on these aspects and to offer support to the relatives involved in providing care to elderly people, for example, with mutual help groups or Alzheimer Cafes, conducted by professionals. Working in a network requires social services to participate in the multidisciplinary professional teams needed to provide global care to individuals with AD. This could emerge from self-referential modalities, and would require the adoption of more networked modalities that value other people’s resources and which break the cage of competition to focus on problems at the global rather than individual organization level. However, professionals tend to make judgements based only on their own limited definition of the possibilities and hence facilitation of this process would be necessary.

The biomedical model remains the most authoritative and widely-accepted model for understanding AD among healthcare and social service professionals, as well as among the general public. A primary concern for relying exclusively on this viewpoint is its overwhelming focus on recovery and cure. There have been medical advances every year for the past several decades, but to date, there are still no viable technologies that can serve as a cure, prevention, or treatment to stop the progression of AD (Parker, 2001). The optimistic focus on solving the mysteries of these diseases detracts from society’s investment in shoring up its ability to provide meaningful social and emotional support services and appropriate care environments, and major investment is clearly needed to guarantee the human rights for better health for both patients and relatives.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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Author contributions

For research articles with several authors, a short paragraph specifying their individual contributions must be provided. The following statements should be used “Conceptualization, All authors; Validation, All authors; Writing-Original Draft Preparation, AL and OC; Writing-Review & Editing, All authors.

Ethical statement

Authors declare the manuscript meets all the necessary ethical concerns.

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