

ALZHEIMER - E.I.T.

A POSSIBLE THERAPY

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In the last few years, scientific researches about dementia have surprisingly increased; they show the interest of scientists from all over the world in a “plague” which seems to increase before one’s very eyes. Nowadays it is estimated that there are 18 millions of demented people in the world and about one milion in Italy.

The prevalence of dementia increases in relation to age:

2.8% between 65 and 74

9% between 75 and 84

28% over 80

Over 90 a stabilized but still controversial prevalence of about 45% is estimated; according to the most recent statistical information 11% of people aged between 80 and 85 and 25% of those over 85 are affected by dementia.

Although age can be considered as a risk, it is clear that old age is not a cause of this disease, as a matter of fact people over 100 whose intellectual faculties are not remarkably compromised are increasing. The word “dementia” has a latin etymology (demens-entis) which means “lack of good sense”; it was used by Cicero and by Virgil in his “Bucolics” (Quae te dementia cepit?). Nowadays it is used to indicate mental alterations which lead progressively to the disgregation of basical intellectual functions, of social behaviour, of intelligence and personality.

Alzheimer is undoubtedly the most common dementia (50-60% of those affected), 10-20% is referred to vascular problems, 5-10% to mixed forms, 10-20% to reversible dementia.

A 3% prevalence of this disease is estimated in Italy among people over 60; 2.4 new cases out of 100.000 inhabitants can be found among people aged between 40 and 60 and 127 new cases out of 100.000 people over 60.

Alzheimer is a *chronic progressive degeneration dementia*: in its course, mind and knowledge faculties are more and more

compromised. Life expectation is about 7-10 years after it has started, although some patients may live even 15-20 years.

From a clinical point of view, the syndrome shows a remarkable variability because several symptoms can appear. They also concern different aspects:

CLINICAL BALANCE

Attitude

- untidy clothes;
- psycho-motory anxiety;
- **agnosia, apraxia, afasia, alexia;**
- inconstancy;
- isolation and extremely short contacts with other patients;
- dirt, neglectedness, untidiness.

Behaviour

- problems in starting any activity;
- annoyance in doing everyday activity;
- obsession with touching curtains, objects, rags, clothes edges, etc;
- obsession with cleanliness, tidiness, "filial" submission;
- poor psycho-motory initiative;
- stereotypes;
- long reaction time (problems of understanding require an effort);
- propensity to interrupt a conversation;
- disposition to mockery;
- obsessively repeated movements;
- obsessive, aimless walking;
- activity: illogical, absurd, confused, reduced or abolished;
- initiative: reduced to aboulia;
- loss of life adaptation;
- lack of self-control.

Emotional psycho-mobility

- emotional expressions incontinence;
- disposition to "runaway" and to stop doing anything;
- emotional instability;
- irritability;
- remarkable reactions to stimuli;
- temper troubles;
- aggressive reactions to frustration.

Affective psycho mobility

- competition;
- conflicts;
- groundless depression (linked to deep inferiority and inability complex);
- relationship problems;

- illogical speaking;
- they are unable to keep attention though they show relationship dependence (they don't look away from the speaker's lips);
- incoherent and incomprehensible language due to the use of neologism;
- reduced mimic expressiveness, ??????

Although further steps have been made, Alzheimer still shows several problems as far as a sure diagnosis is concerned, so epidemical doubts are countless. Consequently we still have uncertain data about social and charitable problems, social cost and also about remedies effectiveness and palliative techniques mainly used to improve patients' quality of life and to support family members and caregivers.

Outcome research still cannot determine the possibility to cure, the level of health and quality of life improvement which can be obtained through different interventions.

In order to avoid a subjective considerations and to make analysis objective and scientific, different methods have been used: several problems, however, have to be solved because studies modify the background (for example, a certain degree of understaing answers causes problems with suggesting subsequent level tests); the variation of social expectation, wich influences attitudes and requests; the difficult analysis of modofications on welfare or illness sensations felt by the patients, who cannot explain their personal experience clearly that is why some valuation standards have been defined; they must take into account:

- ?? **the structure:** it is referred to the organisation of a specific istitution to the resources that have been offered to carry out a particular plan and to administer a service (organisation functionality, space and equipment suitability, operators' number and professionalism);
- ?? **the process:** it defines interventions, aims and guidelines, how to distribute them, adaptation and comparison methods;
- ?? **the outcome:** they are in relation to the final results about treated and observed population, taking into account complex parameters and their variation.

This approach allows us to establish objective results; they are more suitable to consider chronic deseases which are slightly modified in a long time.
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Taking into account the logical aims of this therapy, which cannot concern only recovery, the analysis of any treatment efficacy, in case of Alzheimer, considers a series of results.

Among these:

- improvement of knowledge functions they include memory which is measured using simple psychometric tests;
- modifications are clinically significant;

- the impact of each progress on functionality and behaviour;
- the possibility to determine improvement of psychic and mental functions and attitudes linked to deep psycho-dynamics.

A new aspect of this approach is that we also take into account social and cultural aspects which concern patients, families, caregivers and their quality of life.

These observations briefly explain how the approach to the Alzheimer has changed: in addition to researches about pharmacokinetics and pharmacodynamics, studies about so-called palliative treatments have been developed, they allow us to coin the word "?????" in addition to "recovery", in order to revalue many psychotherapy interventions.

NON-PHARMACOLOGICAL THERAPY

In addition to the well known "reality orientation therapy" (ROT), we can consider occupational therapy, behaviour therapy, memory training, validation therapy, sensorial training and psychotherapy.

Following this kind of therapy our experience focused on basic psychological and mental functions recovery, and through several experiences such as "sensorial motory therapy", "emotional therapy" and "expression and relationship therapy", as well as the experience of "psychological drama" and "psychological dance", we created a psychotherapeutic treatment called **E.I.T. - Emotional Integrating Therapy**.

This method based on precise theoretic considerations which are founded on the psychology of ego ??????.

All psychotherapies are considered as treatments that respect people, they are aimed not only at a "cure" but also at patients' personal maturity. In addition, a

clear “mental working theory” should make them scientific, which has to support their efficacy and validity; in the age we live in it is necessary, as far as health is concerned, to respect the citizens’ right to avail themselves of excellent services because of their relevant cost.

For what concerns E.I.T. as a psychotherapeutic treatment, we can say that if we had limited ourselves to psycho-dynamic and interpretative observations, we would have fallen into superficiality and attitudes based on chance; according to these, “truth” is simply getting mainly personal meanings. In the last few years, in the field of human science inquire attitudes are getting more and more important: they tend to abolish the gap between pure interpretation and the necessity of proved validity.

E.I.T. which is part of this new psychological neurological and biological approach, takes into account and is based on precise structural connections that require a regular study and control.

This therapy is the result of medical and therapeutical observations and researches which have been applied to psychic disabled children; that is why this technique is mainly and clearly a “psychotherapy based on research”.

Theoric basis involved in the E.I.T. allowed us to create a “psychology of mind” which presupposes a regular integration of fundamental levels known as “emotion”, “affections”, “knowledge”.

Integrating process which is at the basis of human psychic development is therefore the fundamental basis of this therapy; it means that every psychic disease and even psychosomatic diseases are justified by a lack of balance in emotional integration:

E.I.T. is not based on the desire to offer patients psychologic help: because of their frustrating condition and inexorable decay, they can only be “led” to their sad destiny. Actually results we obtained with other patients, suffering from autism or serious personality troubles, allow us to expect important results even with patients affected by Alzheimer, particularly after we observed that more or less serious mental and psychological problems could be caused by ego structure troubles.

A disorder of this fundamental psychic function affects all psychological and mental performances, so we can notice:

MOTORY AREA

- ?? inability to do complex psycho-motory performances because patients seem to lose the memory of subsequent movements, which are aimed at a precise result; in addition, they do not understand how to move rhythmically;
- ?? psycho-motory initiative is reduced to usual and instinctive performances, such as walking although, even in this case, we can notice some limitations; that is why patients take short and awkward steps. They only move forward because drawing back is nearly impossible;
- ?? they tend to repeat movements, so as to show “autistic features”; they are not able to give a ball or a pillow back (receiving depends on instinct);
- ?? consciousness is impoverished as a result of reduced experience; this is caused by more and more relevant isolation.

EMOTIONAL AREA

- ?? inability to repress emotions, both because they find it difficult to understand the right meaning of events and ???
- ?? ???

AFFECTIVE AREA

- ??? leads to superficial relationship with other people, that is why their participation is reduced to more or less modest emotional reactions;

- ?? other people become “concomitant” because a “difference” is instinctively noticed. It makes relationship unbalanced; even if remarkable efforts are made to establish a relationship, it cannot keep patients’ attention for more than few moments, if it is based only on communication. This is in contrast with long “conversations” two or more patients affected by Alzheimer can have and with “working moments” they join in moved by instinctive and automatic feelings of imitation. This happens, for example, when they “read” the newspaper or when they listen to music in groups.

KNOWLEDGE AREA

- ?? way of thinking based on instinct ???
- ?? inability to choose, unless according to needs and desires;
- ?? insufficient deduction systems, far from thoughts based on concrete experience (perceptions);
- ?? impossibility to “judge” ???;
- ?? inability to recognize their own body;

- ?? ??? in complex motory actions;
- ?? serious alterations of consciousness, which cause mistakes in recalling memories and in perceptions;
- ?? attention problems; problems with keeping aims “on line”;
- ?? lack of process controlling action and, as a result, thinking, that is mental action;
- ?? problems in recognising experiences as their own.

These observations remarkably helped us to organize E.I.T., that is a practical intervention based on some guidelines: movement, emotional control, development of expressive and emotional relationships. It also focuses on the recovery of “meanings” which can link experiences and make them accessible and comprehensible.

The theoretic and conceptual sources of the E.I.T. can be found in the clinical practice which is inspired to anthropological, ethological, psychological and sociological principles. It is also based on psychodynamics, “psychological drama” and group psychotherapy; it is centred on the expansion of consciousness and on the strengthening of will. This is obtained through the revaluation of a strong and potentially creative ego. This system aims at the integration and development of emotional abilities, through different techniques, which must be appropriate to therapeutical needs; they lead to a harmonic and ??? development of ego and personality.

Integration means harmony and coherence of ego: as it is a psychic function, it requires regular adaptation to instinct and memory of Super ego, which come from experience.

In addition, the way we operate takes into account different concomitant factors, which play a fundamental role:

1) The use of music. This is essential because through rhythm, tone, a piece of music and intensity of music we can obtain reactions and determine psychological and mental attitudes precisely induced. It often happens that we must use lively rhythms to stimulate creativity and consciousness expansion; on the other hand, we can use more emotional melodies to determine “regression” or to induce “personal reflection”. To sum up, the use of music and the choice of melodies are ways to obtain good results in the E.I.T. To free oneself with music means to experience a deep and instinctive spontaneity, to break rules and

conventions, so as to feel emotions at this very moment. This allow patients to give importance to their body thanks to harmonious movement, rythm, meeting, touch, caresses the experience of simple or complex, but surely true, sensations. As a result, our body is in relation to our existence, to our awareness of existing and of our value, not only of our "will". Will is not allowance, but it means choice, self-sufficiency, self-evaluation; consequently, it establishes the real value of self-definition and personal maturity.

2) Working in groups. We must remark on the one hand the importance of the group itself because it is used to encourage confrontation, to act with other people, to enrich experiences and to give self-esteem; it is based on the importance of observing oneself and other people. On the other hand, the group is composed by a certain number of patients and by the same number (1:1) of therapists or relatives and caregivers. This number of helpers shows how hard it is to work with "difficult" patients because of their limited comprehension, action and creativity. Nevertheless, we obtain relevant results as far as "social" aspects of experience are concerned.

Relatives can learn how to observe and recognize patients' remaining abilities and also to share their motory and emotional improvement; these are often not only unexpected, but also really surprising. The structure of the group is closed or partially opened, in order to avoid refusal; if it is emotional or subconscious, it cannot be faced. Therapists and family members may be simple observers, only with the participants' permission; they are informed, however, about this request.

In the group particularly emotional and intense experiences are faced in order to free patients of an excessive burden, to create an atmosphere of "comprehension", and to make them feel that "together we can have not only pleasant, but also difficult experiences". That is why the group shows it is integrated, united and welcoming; it allows patients to feel emotions and affections and to be sure that they will always be accepted. Control and overcoming of tensions strenghten self-esteem and autonomy in a peaceful and happy atmosphere. These feelings act as a background in order to start an emotional integrated therapy because "feeling happy" is the source of energy ??? if there is no happiness, frustrations, requests and tensions will appear.

This awareness helps and is often essential in order to bear the limits the disease imposes and the modifications this therapy induces.

3) the body. E.I.T. considers body as important for psychotherapy: this acknowledgement is now universal after Reich's works (he was one of the first Freud's collaborators): It is based on the discovery that muscles' block mirrors a problem about regular flowing of energy; it led us to introduce the intervention on body in psychotherapies. Body works regularly again so authentic emotions can appear. It can be used as a communication form because relationship makes the dialogue between patients and therapists extremely easier, through genuineness, truth and mutual confidence.

Thanks to movement and rhythmic or harmonious dance, physical and emotional experiences of our deepest existence come back to our consciousness, and also the inner and sometimes hidden experiences. We mean emotional experiences which can integrate individual personality: they can develop creativity, that makes us feel both artists and poets (from the Greek words "poiein" = to do and poiesis, poiésis = parteiro = aquel que dà a luz). Finally, it makes us able to express what we feel inside, that is the "poetry of our own identity".

As Rolando Toro Arameda (the creator of the Biodanza) says, "through the courage to express our own abilities we ransom our desire, pleasure and love towards vitality and transcendence which will shape a primordial, instinctive and ??? identity; through this, life is seen as the "centre of existence" and as *real self-realization*".

4) the co-ordinator. His role is not only to lead the development of the meetings, respecting previously determined schemes, but also to encourage, to support, to lead, to stimulate; he must always take into account clear or deep dynamics he observed and remarked through patients' behaviour. In addition to his intervention and his practical demonstration, the co-ordinator uses music to address participants' expectations and desire to grow up. Then through his look, his position and his movement, he tries to reinforce emotional relationship, which is essential to achieve therapeutic, educational and rehabilitation aims.

5) purposes: In the E.I.T. we can find purposes

centred on the patients:

?? to control psychological and behaviour symptoms;

?? to restore adaptation abilities of ego;

?? to limit and control emotional reactions;

?? to strengthen emotional and relationship dispositions;

?? to recover motory and perceptive abilities;

?? to revalue modulating variabilities which are filtered by affectivity and stimulate the ability to face uneasiness and limitations;

- ?? to encourage patients to show desires of self-evaluation and will to pursuit autonomy and freedom;
- ?? to make them discover new desires of compliance;
- ?? to stop their tendency to isolation and “to be at a standstill” in a corner; as a result, to make them play a leading role.

Centred on caregivers:

- ?? to create a familiar atmosphere based on desires of maturity against nihilism and renouncement;
- ?? to focus on the useful ways to control the stimuli of the feedback;
- ?? to teach a moderate use of ???
- ?? to make positive expectations appear more easily in specific and suitable programmes;
- ?? to suggest social reintegration which can make patients overcome shame of their disablements and behaviour problems;
- ?? to avoid the damages of “burn out” and re-establish the equipe that support the interventions;
- ?? to avoid excessively pedagogical attitudes and substitute them with a professional disposition to use all their remaining abilities;
- ?? to focus again on social abilities and encourage contacts with the community, in the community;
- ?? to prevent decline and refuse inevitable hospitalization.

Aims are based on every patients’ expectations which depend mainly on the image:

1. everyone has of themselves;
2. other people has of a person (and respective relationships);
3. everyone projects on other people (everybody defines itself and act according to the image it sees in other people)

and this image also depends on:

1. internal values of ego;
2. values that mirrors the group;
3. self-confidence;
4. confidence someone receives from other people

in addition there are families and society’s expectations.

NEW PHARMACOLOGICAL THERAPIES

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COMBINED THERAPY as an INTEGRATED INTERVENTION

The desire to improve the results we obtained using psychotherapy and pharmacological therapy make us use both systems at the same time.

Preliminary research, which will allow us to carry out a survey on a vast scale, was organized like this:

7 patients: 3 women and 4 men;

- diagnosis of probable Alzheimer which started between 3 and 5 years;
- middle degree of illness;
- behaviour troubles;

- normal TAC and RM;
- ??? medicines are not taken, unless occasionally;
- good or fairly good general physical conditions;

two months of E.I.T.

- 3 patients (1 woman; 2 men) ???
- 4 patients without any specific pharmacological therapy;
- results valuation after the first month (4 E.I.T. meetings);
- results valuation after the second month (8 E.I.T. meetings).

METHOD

For a detailed analysis of the E.I.T. see a previous publication "E.I.T. - Emotional Integrating Therapy" (Romeo Lucioni).

General guidelines for the E.I.T., if it is applied to Alzheimer, are:

- to activate and restore perceptive and motory abilities, both simple and complex, not suggesting specific exercises, but stimulating initiative, following music and taking part in the integration of the group;
- to restore emotions in relationship, holding hands coming closer and parting, etc.;
- to create emotional dynamics based on quality, which lead to acknowledgement and esteem of oneself and other people through the dynamics of observation, emulation, comparison and stimulus to integration;
- to re-establish attention and resistance through tasks' evaluation, based both on games and on self-esteem, so as to stop lack of confidence, self-accusation and self-denigration;
- to restore logical links through memory recovery and making patients recognize objects and their functions, faces, voices, etc.

Each meeting is organized in order to respect the following aspects progressively:

- patients and caregivers' welcoming and recognition;
- adaptation to the setting and preparation to the activities;
- recovery of the level we obtained in the previous meetings, trying to balance areas (motory-emotional-intellectual) so as to have a harmonious development;
- levels of tasks are increased = satisfaction;
- some more objectives are suggested = stimulation;
- final greetings to remark the "value" of the meeting;
- results' analysis by the caregivers to arrange the following meetings and to prepare the valuations at the end of the month.

RESULTS' VALUATION

Valuation difficulties concern problems in quantifying subjective impressions; they also take into account different interventions because each therapist uses his own "method", has a particular "charm" and specific abilities to share and to persuade; they have also their own resistance and attention, which varies in each person. Finally they concern the possibility to create a relationship between a patient and a therapist; it is always different and influences results strongly. These considerations are typical of each psychoterapeutic intervention; in our work, we tried to avoid individual applications, changing therapists each time.

All the patients affected by Alzheimer who start emotional integrating therapy (E.I.T.) show remarkable improvements, that are regular and progressive.

Although therapeutic meetings are weekly and last only one hour, every time we notice better performances in each area.

Motory area:

All patients, although they start from different levels, acquire better abilities to do movements they were precluded from. We remark better co-ordination, efficiency, will, execution and reflex reactions speed; some functions improve: drawing back, moving sideways, maintaining static positions (??? Tai-chi-chuan), running and jumping, which was difficult at the beginning of the therapy. Attention and resistance make progress (all patients always work for a whole hour under the coordinator's control: he decides rythm and intensity of exercises) and patients show remarkable satisfactions, not only because they "understand" that "things get better", but also that their possibilities to emulate the therapists and the coordinator improve.

Emotional area:

Anxiety and excessive emotionality are rapidly controlled and patients show remarkable abilities to grow up emotionally: they take part with diligence and enthousiasm in the activities, which generally change every time, although we follow a scheme concerning:

- widening of consciousness limits;
- exploration of new or recovered functions;
- development of personal choices, of will and of desire to attempt and to grow up;
- sublimation of autistic and opposing attitudes;
- control of excessive movement and isolation:

Anxiety is reduced, feelings of anguish and fear disappear.

Affective area:

participation is more and more important; patients come to the meetings willingly, they take part with diligence and satisfaction in the activities. As weeks

passes, we remark no more relationship problems, so patients can work both with therapists and with the other participants. We observe growing satisfaction, as they understand they are working better; they are more and more willing to try to improve their performances. Better participation develops: patients are more willing to do the exercises.

Knowledge area:

comprehension and execution of orders is easier and nearly automatic: each time patients can remember the meaning of suggested experiences and can also realize “how” some complex movements can be made.

We don't notice dispositions to runaway; aimless movements and behaviours are very few.

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In order to value these personal and empirical observations, we used the following scheme:

VALUATION SCHEME OF “E.I.T.” MEETINGS

Emotionality

- ? free and uncontrolled anxiety
- ? tension
- ?? aggressive reactions
- ?? predominance of emotional reactions
- ?? feelings of fear
- ?? feelings of anguish

Affectivity

- ?? problems in personal relationship:
 - with therapists
 - with other patients
- ?? feeling of devaluation

- ?? opposition criticism
- ?? superficial and inconstant adaptation
- ?? disposition to renunciation
- ?? problems in contact with each other
- ?? problems in physical contact
- ?? devaluation of other people

Expressions

- ?? phobical and obsessive attitudes
- ?? ???
- ?? fragmentary and incoherent way of speaking
- ?? problems in the comprehension of orders
- ?? reduced attention
- ?? reduced resistance

Behaviour

- ?? ??? aimed at distracting
- ?? autism
- ?? disposition to isolation
- ?? casual execution of orders
- ?? repeated ??? movements
- ?? disposition to runaway
- ?? disposition to imitate other people
- ?? loss of initiative
- ?? aimless behaviours

Movements

- ?? problems in doing simple movements
- ?? problems in doing complex movements
- ?? difficulty in running
- ?? difficulty in jumping
- ?? easy tiredness

RESULTS

This therapy takes into account personal dispositions to the approach, as a result we always try to encourage patients' propensity and desire to act. Consequently we do not notice runaways, blocks, opposing reactions and we can establish compliance and real confidence, which lead to positive results. Among these, we must consider first of all that we can quickly control the strong emotional tension which is the consequence of the approach to an unknown and completely new environment. Creating an "atmosphere" is the coordinator and the therapists' task, with family members; it is the main element to start the therapy. It is very useful to make the starting approach "ritual", in order to arrange a "usual" way to begin, to approach; greetings we exchange to introduce ourselves take false emotional reactions away and increase the feeling of belonging and of being a recognized and esteemed person.

RESULTS TABLE

TAB. 1

TAB. 2

A = valuation at the beginning of the E.I.T.

B = valuation at the end of the first month (4 meetings)

C = valuation at the end of the second month (8 meetings)

A-B; B-C; A-C = percentage differences always showing improvement.

Datas in tables 1 and 2 refers to the valuations we obtained from **the valuation scheme of the meetings**. All the patients which benefited of the E.I.T. showed improvement both after the first and after the second month.

We can notice an average improvement of 17,76% after the first month and of 18,21% after the second month; the average improvement after two months of therapy was of 32,74%.

D.L.M. patients took a ??? at the beginning of the second month: indexes do not show any difference from the other patients but, as said in the text therapists felt a better adaptation to the exercises; it was observed even immediately after the first days they took the medicine.

COMMENT

In relation to such a complex disease as Alzheimer several aspects must be considered. They concern assistance, care, activities, rehabilitation, accompanying, sharing, quality of life, then psychic dynamics and the ones referring to the relationship with caregivers and doctors.

The themes we discuss concern:

the diagnosis, which, for many reasons, is still very imprecise, difficult and especially, not precocious at all;

genetic, which concerns the study of DNA: its spirals contain our knowledge abilities and its sphere concern the pathologic origins of Alzheimer or the delimitation of the concomitant causes which make the syndrome appear more easily;

biology, which introduce some elements referring to brain ageing, ??? plasticity and repairing abilities of the brain which act as adaptation reactions;

???, which implies the observation of ??? phenomena which shape “from outside”, everyone’s evolution and ??? destiny;

anthropology, which concerns the relationships among human beings and in this case, takes into account the dynamics among patients, families and society;

neurologic sciences, which introduce the research of psychologic, neurologic and biologic relations and ??? which are responsible for ???;

psychodynamics, which seems to have to do with the outbreak of the disease, because of some anamnestic evidence;

cell chemistry, which considers oxidization processes as very important to condition the arising of the disease and diagnosis markers;

relations with loss, which interfere with families and caregivers’ ???; of course contingent and economic problems matter to them as well;

pharmacological and psychological therapies, which are always present because on the one hand they involve efficacy problems, and pharmacokinetics; on the other hand they cause weighty ethic questions and problems about the validation of quality of life improvement, that is sometimes the main point;

donation costs of the interventions which strongly involve families but, partially, institutions, too;

the theme of prevention, which is still too premature to be discussed now that we do not know ??? causes; on the other hand it is going to be a theme which allows us to make several suggestions both validated and specific.

A certain degree of improvement always makes us think that it is only symptomatic and that as a result, it only plays the “dramatic” role to protract the disease: in one sense, it means only to protract suffering. This point, concerning the therapy in a broad sense, is very important, in our opinion, in the Alzheimer, because it imposes particular interpretations. Improvement in patients’ psychological and mental conditions can make feelings of frustration and anguish reappear, because they realize their state of deficiency better; ??? can easily

appear: before they were buried in oblivion. They upset or support emotional reactions which can be opposition, accusation and anger.

Psychiatrist's work also consists in understanding these "moments" and being able to control them, to direct them to ??? and to explain them to relatives and caregivers as well. They should not let them be carried away by sorrow, frustration and "resentment" against this therapy, which "move the stagnant water of the disease".

The ethic aspects of recovery are a spur to continue rehabilitation, so as to establish compliance which unites therapists, families and caregivers in searching for new aims.

We obtain positive results both using pharmacologic and psychological therapies separately and combining them in one integrated intervention. These results make a very complex problem appear clearly; it involves all the people whose work is centred on each patient. "Awakenings" we obtained and improvement we can reach must be useful to encourage us to take a further important step on the way to rehabilitation: It should not be considered, however, as intellective, but it should involve emotions and affections as well.

Improvement which are gained thanks to E.I.T. (they are physical, emotional, affective, intellective, social, psychological and concern autonomy) must be used as a starting point to create a new quality of life. Patients who are affected by one of the most serious chronic degeneration disease expect, in this way, to be ransomed by "new charitable strategies" which intend to modify and to control the course of the disease.

Emotionality: patients feel uneasiness and unfitness towards their disablements, so it is up to the psychologist to control crises without appeasing. Then it is up to caregivers to behave so as to stand by patients with no violence or reproach and to assume attitudes centred on sweetness and sympathy. It is up to associations to organize activities such as walks, trips, meetings.

Affectivity: patients experience that feelings of esteem increase deeply, they are expressed with tender demonstration of approval and thanksgiving: We can remark the breaking of isolation and the establishment of attitudes of dependence, accompanying and limitation: they should not be repressed but accepted and encouraged, in order to regain wider and better independence.

Intellectual abilities. The leaving of such typical and clear attitudes of regression to the primitive relationship with their mother, who is considered as a “good bosom”, allows us to re-establish more recent values; they should be used to find contracts again and to take part in “stories, anecdotes and experiences”.

In the Alzheimer we remark, as knowledge disorders:

- inability to understand and explain reality respecting a meaning, above all a shared meaning;
- inability to integrate external and internal reality; this is dominated by feelings of inefficiency isolation and ???;
- inability to find links between external stimuli and personal reactions, both emotional and affective.

Knowledge problems break links between perception and knowledge, which is at the basis of knowledge and recognizing. Lacks in deductive function induce patients to recognize globally (not using deduction processes), emotionally and instinctively; this causes illusory and interpretative distortion which cannot be corrected any more, so it allows a gap to form between reality and subjectivity, between perception and experience.

In the E.I.T., taking patients by the hand and sharing emotions which are linked to experiences, are used for supplying these gaps: sharing means reassuring and structuring. Participation by mutual consent in movement and exchange of gestures, looks, caresses and emotions leads to a validation; this does not come from an educational and didactic order, but from emotional elaboration, from inside, which support the realization of “truth”.

The feeling of confidence is the result of experiencing and bringing oneself into action and of a progressive change from shared experience into autonomous actions. These are situated in confrontation, observation and validation.

* * *

The valuation of the outcome in the therapy for Alzheimer is not only a problem, but it is turning into a real dilemma. If we take into account the modification of mental processes and of psycho dynamics, the problems about giving a clear and above all, sure answer, depend on too many variabilities; it seems as if we are always at a starting point. We can remark two fundamental phases to have a valid approach:

- to overcome the limitations of the diagnosis;
- to respect patients, who need not only "care", but also important functional recoveries. These should allow them to recover mental functions and ????. These phases, however, limit the possibility to explain ways and models of validity and effectiveness correctly.

E.I.T. (Emotional Integrating Therapy) combined with ??? proved important effectiveness to reduce peculiar deficiencies of Alzheimer. This means that the intervention is efficacious because symptoms are linked to a logical and personality disorder, which causes relationship and behaviour problems and social inadaptations.

Although this text carries datas referring to a small number of patients, they must be taken into account because they refer to previous experiences of ???; in addition, all cases were widely valued using observation tabs we prepared for this purpose.

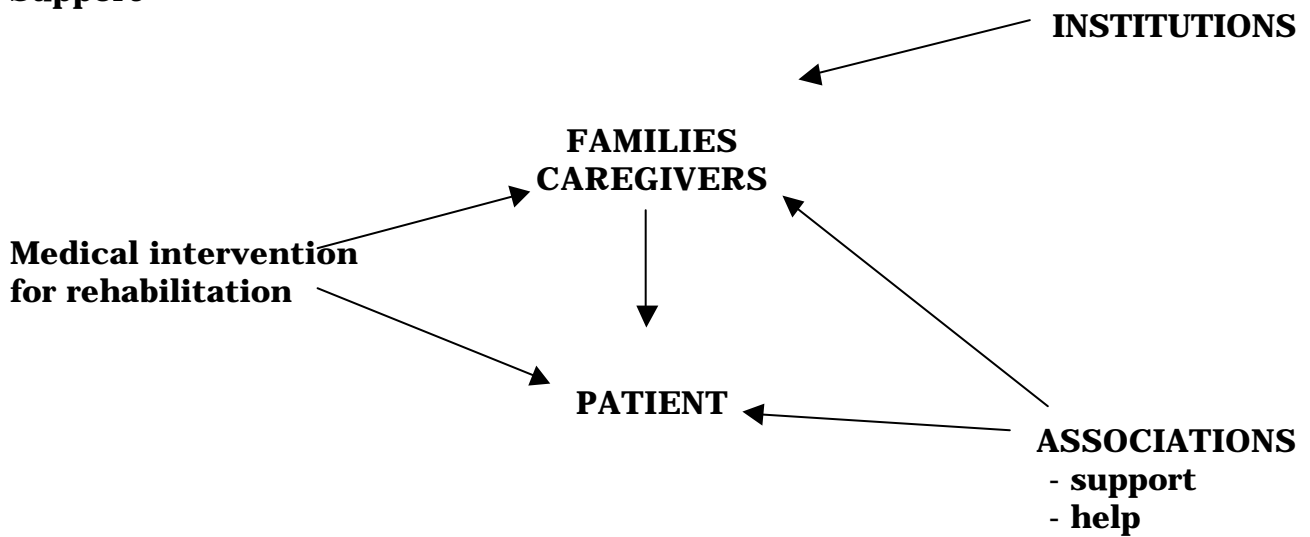
??? proved to be very efficacious in order to increase improvement we obtain using E.I.T. because:

- they make realization of patients' role easier;
- they help to reduce emotional tension;
- they allow patients to adapt better to the situation of the setting;
- they reduce opposing attitudes;
- they make the comprehension of the meetings easier.

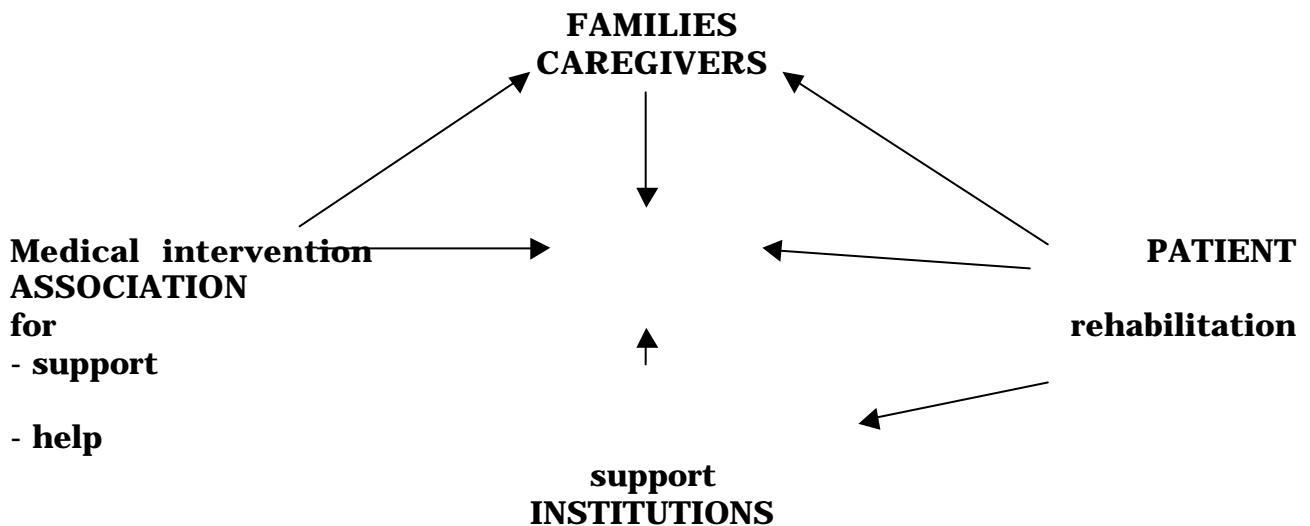
From this point of view, recovery and rehabilitation presuppose the conquer of a "new social space".

We suggest a scheme to compare the situation before and after psychotherapy combined with pharmacological support:

A
Support



B



A

Medical intervention for rehabilitation is the main point and it is centred on the subject (the patient), who must be diagnosed, valued, helped during the therapy. In this phase supporting Associations' task focuses mainly on family: they must inform and help it with legal papers, to accept loss (meeting "new friends") and to

face all necessities about legal administration (e.g. accompanying cheque) and functional one (management of contracts with specialists about diagnosis and about pharmacologic and psychotherapeutic support).

B

In the second phase Associations' purposes must be centred mainly on patients, in order to offer opportunities of socialization, sharing, relief and real social recovery; this must be carried out with the support of institutions (day hospital, day centres, social centres).

The best emotional resources and the strongest memory participation must be explained to develop psychological and mental abilities; they are still not certain, but they are considered as possible.

In its psychotherapeutic values, the application of the E.I.T. encourages us to realize that it is necessary to face not only ??? dynamics, concerning patients, but also, above all, ??? dynamics, which involve families strongly. The results of the E.I.T. can be observed in the complex dynamics that are established at different relationship levels.

This is a theme of great interest because the experiences which were carried out in the "Nuclei Alzheimer" (a project of Lombardy) remarked that the hospitalization in protected and limiting places, as far as liveliness and variety of relationships are concerned, encourages egocentrism. It turns into peace and tranquillity for what concerns the control of behaviour and emotional reactions, but it may lead to "chronicity", the control of loss and progressive deterioration is certainly a valid approach, but it implies a sort of isolation; what is too similar to the condition we can find in mental hospitals, which are now going to close down definitely. Psychological and pharmacological experiments should offer real recovery and "coming back home", though for short periods of time.

Several items are related to this problem:

- the loss of patients' intellectual and emotional "values" and as a result the necessity to base oneself on unconditional, responsible and continuous disposition;

- the importance of nihilism, which causes renouncement and the desire to go away and to be hospitalized;
 - feelings of guiltiness appear: as a result patients are instinctively ready to projection;
 - the difficulty to realize how tragic and complex this pathology is, as it does not let patients any way of escape. As a result, regressive feelings appear (denial, disposition to minimize, refusal);
-
- childish attitudes arise: they contrast with the awareness of complexity and cause mythomaniacal and irrational choices which mirror feelings based on self-meditation;
 - dynamics supporting urging requests of help and claims to institutions, supporting Associations and doctors.

CONCLUSIONS

The main purpose of a therapy based on the combination between a psychotherapy – E.I.T. – and a pharmacological treatment – ??? – is to reduce a “psychological and social rehabilitation”. It is a therapeutical approach to patients using procedures centred both on the subject and on the support of environment. Rehabilitation includes two phases:

1. **psychological** rehabilitation, which aims at overcoming brain damages: it modifies the structures ??? activated; it restore EGO using appropriate psychotherapeutical techniques and controlling emotional crises (medical phase);
2. **psychological and social** rehabilitation, which we can have if we improve environmental supports (social phase).

This kind of rehabilitation has a repairing and various approach, which aims at changing both the patient and his environment. From an operative point of view, “psychological and social rehabilitation” concerns mainly:

- ?? specialist’s activity (neurologist-psychiatrist), who decides the diagnosis, patient’s decay level and limits, prognosis guidelines for recovery. He takes into account both the patient’s potentialities and resources of the family, of the environment, of supporting institutional or voluntary groups;
- ?? psychotherapy – E.I.T. – led and controlled by the psychiatrist, who must involve families and caregivers;
- ?? pharmacological prophylaxis, using ??? under specialist’s constant control; it must include correcting psychological or pharmacological interventions (using mainly ???), which should not depress the recovered psychological and mental functions;
- ?? co-ordination of a psychiatrist (or a specialist) with families, caregivers and psychological and environmental support, in order to improve efforts of socialization and to obtain a total rehabilitation approach.

Modifications integrated therapy induces – psychological and pharmacological therapy – must encourage useful changes in families, in protect laboratories, in communities and in psychological social centres.

All these interventions, known as psychological and social, must be carried out from the start or as soon as possible: the first years of the disease are more and more important to maintain the resources, to control deterioration and to make rehabilitation efforts easier in the future.

On this subject we must remark that in rehabilitation therapies, as in the E.I.T., three phases must be respected:

1. clinical valuation to make a plan;
2. carry out psychotherapy;
3. verify results and suggest purposes again.

We can suggest an operative scheme concerning:

1. valuation and diagnosis;
2. introduction in a rehabilitation programme;
3. carry out psychotherapy;
4. start a therapy using ???;
5. control consults;
6. suitable pharmacological therapy for modified symptoms;
7. introduction in a programme of psychological and social treatment.

This operative scheme also requires:

- ?? observation based not only on lacks and behaviour problems, but also on possible investments, on patients' qualities and interests;
- ?? therapeutical continuity and integration;
- ?? global responsibility for patients;
- ?? exploitation of functional changes and of the improvement of patients' and families' quality of life.

A rehabilitation programme cannot end if social institutions are not reinforced: if they are missing, the "journey" does not go on and is not completed; then with no social support, a person is, in any case, disabled. The improvement of social abilities is, as far as Alzheimer is concerned, the best way to relieve the oppression of disorders and invalidity. As far as socialization is concerned, we must take into account not only personal relationships, but also assertion, which shows the ability to communicate needs and expectations.

For what concerns Alzheimer, the purpose is probably not to come to autonomy which encourage patients to ask for introduction in the society: they should not work any more, then the main features of the ??? personality were the disposition to isolation and loneliness. Recovered patients, however, can "hear" the strong emotional stimulus of social meetings, which, as a result, can (and must) be suggested and arranged.

On this subject we must realize that several difficulties must be overcome:

- ?? prejudice of the society against the fact that a demented patient can "join in social life" with no tension or causing annoyance and upsetting;

- ?? prejudice of the families, who prefer "shutting up" to showing themselves, even if we often notice expressions such as "...I prefer him/her to be quiet on a chair at home (or in a hospital) rather than looking anxious or distressed";
- ?? prejudice of institutions, which should arrange suitable excursions, meetings or activities for people affected by knowledge problems;
- ?? inadequate associations, which prefer directing their organizing efforts towards families and caregivers;
- ?? volunteers, who are not suitably prepared, are "alone" and must face too weighly problems;
- ?? inability of medical and assisting resources to go beyond initiatives aimed at controlling symtomes.

As it is difficult to take into account intervention of socialization and to consider them as possible, it is clear that we renounce to all patients' possibilities and resources and to the development of the social net in which we are all involved and in which we involuntarily create obstacles.

According to the principles of biological ecology, we must take into account:

- ?? **the principle of adaptation**, which claims that improvement patients achieved must concern all the involved people: families, caregivers and concomitant and supporting social group;
- ?? **the principle of recycling resources**, which claims that a change in the patient implies a change in the features of organization as well; they include sanitary operators, assistance, support and accompanying. This imposes a modification of the doctor's participation, which must be not only ideological, but also based on knowledge and emotions. The purpose is to use all the resources which are aimed at improving clinical situation and quality of life;
- ?? **the principle of continuity**, which claims that in each stage of therapeutical and charitable development we must consider the principles of patients' respect and central position in the organization of the intervention; we must look for new, original and emancipatory ways, which should be appropriate to singleness (overcoming of general and approximative practice). Finally, we must use patients' abilities and the resources of the environment.

TO SUM UP

This contribution allows us to make new theoretic and practical observations, which are supported by the positive results we obtain for what concerns therapy and rehabilitation of patients affected by Alzheimer.

We remark:

1. the improvement after two months of E.I.T. (Emotional Integrating Therapy), applied alone and combined with pharmacological therapy using ???. The best performances of all patients prove that psychotherapy we used is efficacious even from the first meetings, so it shows that a good emotional approach can encourage patients' psychological and mental functions;
2. pharmacological therapy using ??? is efficacious in order to make psychotherapy easier;
3. positive results we obtained allow us to consider that new psychological and social interventions are necessary in order to continue rehabilitation process and to improve the quality of life. These results concern both the control of positive symptoms (emotional and behaviour disorders) and stimulating participation in personal relationship; it develops adaptation abilities and volition and proposing attitudes;

4. the possibility to recover psychological and social functions, as far as rehabilitation is concerned, implies the necessity to establish new relationships between patients and their families, between patients and caregivers, or supporting voluntary groups;
5. the improvement of psychological and mental conditions we obtained using psychotherapy combined with ??? (as a support and maintenance) indicates that it is necessary to use supporting and adapting medicines; they must not stop, however, patients' improved disposition to development;
6. as far as prevention and decay are concerned, the institutions, helped by the Associations of volunteer support, must intervene in order to reduce costs previously linked to aggravation; they also must try to avoid hospitalization and isolation;
7. as far as **diagnosis** is concerned, we remarked psychodynamic qualitative data which help us to delimitate Alzheimer;
8. taking into account **biological dynamics**, we remarked a strong intervention in emotional and affective area; it allows us to obtain results using ??? which concern brain plasticity;
9. as far as **??? study** is concerned, this essay indicated some psychodynamic features, which may be included in the researches, above all in order to find possible causes of the disease;
10. **???** must take into account the improvements we obtain using this psychotherapy, in order to study the psychological, ??? and biological principles they are based on;
11. we remarked ??? processes, in particular the ??? and relationship ones which involve patients and families; realizing the loss and accepting possible improvement impose them important conflicts and the necessity to take decisions;
12. we observed that pharmacological and psychological therapies can be integrated in a rehabilitation process; this may play a fundamental role to analyse donation costs, the relation between cost and benefit and dynamics of prevention;
13. psychological and social rehabilitation is a possible aim, but we will obtain it only if we organize interventions involving families, caregivers, voluntary association, institutions. This must act with sanitary operators and use a method centred on patients, who must be considered globally and ???.