The aging process is considered a worldwide phenomenon, and it is observed that the population has aged, where there is an inversion in the age pyramid resulting from the increase in life expectancy. This phenomenon has been investigated by several national and international studies. As results, there are some justifications that are being cited. Among these, are the presence of some demographic factors such as a reduction in fertility, fecundity and mortality rate over the years, in addition, we highlight the technological advances in health and improvement in the quality of life of individuals\(^1,2\). Consequently, with the presence of these influencing factors, some studies highlight an epidemiological transition, where infectious diseases are being replaced by chronic-degenerative, as the main cause of morbidity and mortality, giving emphasis on dementia syndromes.

In addition of aging, are expected physical, psychological and social changes that lead to changes in the life of each elderly. At this stage of life, in addition to chronic conditions, the decline in cognitive functions, such as changes in memory, speed of reasoning, and attention seem to take on a broader dimension. Thus, with the decline of these and other functions, several difficulties can be observed in the execution of activities of daily living of the elderly, implying difficulties in their “coming and going”, that is, in their autonomy and self-care.
Dementia

Dementia is understood as a syndrome characterized by cognitive decline in memory, associated with a deficit in another cognitive function, such as: executive functions, Language, and others and thus involves deficits in a complex set of cognitive domains that are altered (SADOCK; KAPLAN, 2017)\(^1\), causing impairment in the social and/or professional performance in the individual (SADOCK; KAPLAN, 2017)\(^3\). It is also characterized by an acquired condition and presents a progressive or static course; Permanent or reversible, where the identification of the syndromic condition and clinical examinations are essential in the diagnosis (SADOCK; KAPLAN, 2017)\(^3\). However, it is noteworthy that the presence of the criterion of alteration in memory can remove other cognitive variables present, as in cases where this cognitive domain may be altered or not initially, or not stand out in the course of the disorder Neurocognitive of frontotemporal origin or Lewy bodies, possible etiologies within neurocognitive disorders (MERRIT, 2011)\(^2\).

The term dementia has a number of distinct classifications throughout history. Merrit (2011)\(^4\), comments that the oldest proposed classification highlights the presence of senile and pre-senile dementia, besides this, other classifications are highlighted by the author also derived from old texts, referred to treatable and untreated dementia, being a parcel focused on specific treatments in cases of hypothyroidism and deficiency in vitamin B\(_{12}\) and another for individuals who had chronic degenerative diseases, including Alzheimer's disease. This classification is no longer used, due to the development of treatment models for dementia cases that were previously seen as untreatable. Another possible nosological classification highlighted by the author relates to the Dementias considered of genetic origin and those of "sporadic" condition. However, this classificatory possibility was also poorly efficient, due to the strong evidence of genetic factors that influenced the onset of dementias considered "sporadic", in which they are relevant in the probability of Development of the syndromic condition, in the patterns of symptoms and in its course (MERRIT, 2011)\(^4\).

Despite this series of classifications that were being used throughout history, from 2014 onwards, with the 5th edition of the Diagnostic and statistical Manual of Mental Disorders (DSM-5) elaborated by the American Psychiatric Association, Proposes a new conception of the classification model of dementia, characterizing neurocognitive disorders. In the manual, the continuity of dementia terminology is observed to be used in contexts where physicians and patients are accustomed to the term. However, it is noteworthy that the use of the Nomenclature neurocognitive major disorder is preferably used, because it addresses the disorder in a broader way, where dementia would be incorporated to this term (AMERICAN PSYCHIATRIC ASSOCIATION, 2014). In addition to the major neurocognitive disorder, mild neurocognitive disorder is highlighted, or also known in other manuals, such as mild cognitive impairment (MCI) (BARBOSA et al., 2015)\(^3\), with the most commonly highlighted major or mild etiological subtypes, these being: neurocognitive or dementia disorder due to Alzheimer's disease, Vascular dementia, dementia with Lewy bodies and Frontotemporal dementia (AMERICAN PSYCHIATRIC ASSOCIATION, 2014; MERRIT, 2011)\(^4\), mixed dementia (FREITAS; PY, 2016)\(^5\), in addition to these subtypes, highlights the importance of discussing Pseudodementia (GREENBERG; AMINOFF SIMON, 2014)\(^6\).

Dementia is considered a public health problem because it causes direct and indirect expenditures, with retirements, medications, hospitalizations, family spending with caregivers and family reorganization as well as repercussions on active workers by involvement of relatives who require their care.

Types, etiology and epidemiology of dementia

IJOAR: https://escipub.com/international-journal-of-aging-research/
Despite the wide variety of possible dementia frameworks, the main types of dementia, which affect individuals, are: mild cognitive impairment (MCI), Alzheimer’s disease, Vascular dementia, Lewy bodies, dementia Frontotemporal and Pseudodementia, to which they will be discussed about their main characteristics.

One of the first types of cognitive decline characteristic in the geriatric clinic includes mild cognitive impairment (MCI) or mild neurocognitive disorder, which is considered as a possible transition phase between the commitment Characteristic of the healthy aging process, characterized by a subjective complaint of a decline in memory and other cognitive functions, however, in the diagnostic evaluation, the other functions of activities of daily living and functioning Cognitive global should be preserved. However, after revisions to the concept, the same was subdivided into amnestic and non-amnestic MCI (FICHMAN et al., 2013).

Another nosological entity characteristic of the aging period, which has gained rather more notoriety, is Alzheimer’s disease. This neurocognitive disorder presents some characteristic cognitive and behavioral symptoms, such as: changes in memory as the main complaint and in other cognitive domains, in the executive functions, language, Visuospatial abilities, among others, where to characterize the diagnosis the alterations should be in at least two of these aforementioned cognitive domains, in addition, interfere significantly in the activities Socio-occupational of the individual (FREITAS; PY, 2016)⁶.

Vascular Dementia (VD) is a progressive disease resulting from a change in cerebral blood flow, resulting from different possible vascular damage, which influence the onset of neurocognitive disorder. The diagnostic criteria considered to characterize this particular pathology are: impairment in memory and alterations in one or more cognitive domains, which have a significant impact on the basic activities of the subject (FREITAS; PY, 2016)⁶.

Moreover, it is observed that the main cognitive functions altered, besides memory, are attention, executive functions, Perception skills and visuoconstruction (TEIXEIRA; DINIZ MALLOY-DNIZ, 2017)⁷.

Dementia of Lewy bodies (DLB), characterized by a progressive cognitive decline and with sufficient impact to significantly interfere in the social functioning of the subject, where memory can correspond to a cognitive function In which it is not altered in the early stages of the pathology. However, it is observed that the attentional, executive and visuospatial deficits are predominant and prominent in these cases. Moreover, another important feature is the presence of detailed and well-formed recurrent visual hallucinations, in addition to a fluctuation in attentional cognition and vigilance of the elderly (TEIXEIXA; DINIZ MALLOY-DINIZ, 2017)⁸.

Frontotemporal Dementia (FTD) consists of a complex pathology that involves a group of heterogeneous alterations, which cause degeneration in the frontal and temporal lobes of the subject, where they mainly affect the language and behavior. It is observed that, in cases of possibility of this particular pathology, the subject presents a disinhibition of behavior, that is, a behavior considered socially inappropriate, impulsive, besides the loss of sympathy and empathy, Presence of apathy or inertia. In addition, they may present cognitive alterations in the executive functioning and relative preservation of episodic memory and visuospatial functions (GREENBERG; AMINOFF SIMON, 2014; TEIXEIRA; DINIZ MALLOY-DINIZ, 2017)⁷,⁸.

Finally, depression is a very recurrent psychopathology nowadays, and in some cases it is misinterpreted as dementia, where, in view of this, the term Pseudodementia is classified. In the observable clinical criteria, it is noteworthy that both in dementia and in depression, some characteristics such as irritability, slowness in the processing of information, apathy, recollection, difficulty of memory and
concentration, alterations in behavior and personality, they are clinical conditions observed in both pathology, in which they can directly influence the clinical diagnosis of the health professional. However, some characteristics of dementia, such as its progressive onset, variable affection, alterations in laboratory tests and absence of somatic complaints, are also factors that influence a better clinical diagnosis (GREENBERG; AMINOFF SIMON, 2014)⁷.

There is a wide variety of causes that can provide the emergence of a dementia. Among the main highlights, the gradual cognitive decline of a patient in the course of its aging process, especially in patients with age equal to or greater than 65 years. Although age is an important factor related to the onset of dementia, there are cases in which patients begin to present indications of a possible dementia at 45 years, but with a low probability that it can be diagnosed as an Alzheimer’s disease or vascular dementia. In cases such as these, it is important to consider another variety of neurodegenerative, inflammatory and infectious pathologies (GREENBERG; AMINOFF SIMON, 2014)⁷.

However, it is noteworthy that some dementia analyzed in clinical contexts can be seen as reversible dementias, from metabolic alterations, such as in cases of hypothyroidism, nutritional deficiencies, vitamin B12 deficits, or caused by a depressive disorder, as is known as Pseudodementia, as mentioned above. In addition to these possible causes, intracranial lesions, hydrocephalus and neurosyphilis can also generate a dementia (GREENBERG; AMINOFF SIMON, 2014; SADOCK KAPLAN, 2017)³,⁷.

Therefore, it is important to consider that the dementias develop through multifactorial pathophysiological mechanisms, thus several factors may be influencing the onset of a dementia, such as age, family history, Cardiovascular diseases, in addition to mutations in some cases, such as in Alzheimer's, vascular and frontotemporal dementia (FREITAS PY, 2016; LOY et al., 2014)⁶,⁸.

There is a case where cerebrovascular diseases can trigger dementia. This type of dementia has the same risk factors related to atherogenesis and related diseases: age, arterial hypertension, diabetes, dyslipidemia, smoking, brain and cardiovascular diseases, among others (CARAMELLI; BARBOSA, 2002)⁹.

As the world population grows older, the number of elderly people presenting some type of dementia has been increasingly observed. For Sadock and Kaplan (2017) ³, the prevalence of dementia in cases of moderate to severe is represented by 5% in the population aged 65 years or older. According to the authors, with the passing of time, these numbers can reach from 20% to 40% in the elderly aged over 85 years. The authors also emphasize that, in outpatient clinics, the numbers of cases of dementia are 15% to 20% and this number more than doubles in institutions for the care of chronic cases.

In a report by the World Health Organization (WHO), published in 2012, it is observed that the main data found regarding the number of people who were affected by dementia, reveal that the African continent was the region that presented lower prevalence of dementia with 2.1% of cases identified, however, the same report indicates that the region of Latin America was configured as the prevalent in cases of dementia, with 8.5% in individuals aged 60 years or older (WORLD HEALTH ORGANIZATION, 2012)¹⁰.

However, in a review conducted by the organization Alzheimer's disease International, in the year 2015, it is perceived through the results the presence of 46.8 million cases of dementia in the world, with estimates that, still in the same year, about 9.9 million new cases would arise, the equivalent of one case every three seconds. The aforementioned report also points out that by the year 2050, estimates indicate that twice the elderly are diagnosed with dementia in relation to the year 2015.
ALZHEIMER’s Disease INTERNATIONAL, 2015). This demonstrates that, by the year 2050, about 22 % of the world population will present a dementia, where about 79 % of the cases are and countries that have low incomes, in which resources for identification of diagnoses and possible interventive measures are scarce due to little access to health and difficulty in identifying risk factors (FROTA et al., 2016; PRINCE et al., 2013). On the other hand, in places with higher incomes, such as the United Kingdom, the rate of non-identification of a dementia is 52 %, while in low-and middle-income countries this margin can reach up to 90 % of the cases (FREITAS; PY, 2016).

Nevertheless, other studies showed higher prevalence rates. In a study conducted in seven rural areas of Japan, with the objective of investigating the prevalence of dementia and possible diseases causing dementia in people aged 65 years or more, it consisted of a survey of more than 420,000 inhabitants, where of these 768 had Some dementia, representing about 18.25 % of the sample studied (IKEJIMA et al., 2012). Another cross-sectional study conducted in Australia with the objective of determining the prevalence of dementia, with 336 elderly individuals aged 60 years or older, identified that, 13.4 % had a dementia, and with advancing age, it was estimated that it could Reach 21 % of the sample (RADFORD et al., 2015).

Consequently, Brazil due to population ageing also presents a considerable increase in the number of diagnoses of dementia. In the review study elaborated in 2012 by the WHO, it was estimated that the 1 million of Brazilians had a dementia (WORLD HEALTH ORGANIZATION, 2012). According to the data collected by Alzheimer's Disease International, it was estimated that in 2015, about 1.6 million of Brazilians had some type OF dementia (ALZHEIMER's disease International, 2015), it was observed that in a three-year period, a significant increase in the number of cases of dementia confirmed from the reports of the aforementioned organisations. With this in mind, a study conducted in São José dos Campos, from the records of patients who had 65 years or more who used anthcholinergic medications, in primary health care services, estimated that about 77 % of the patients Could not have a diagnosis of dementia, where extrapolating to Brazil, about 800,000 people may not have the diagnosis of dementia and, consequently, are without treatment (NAKAMURA et al., 2015). From this perspective, the epidemiological profiles of the types of dementia are very varied, but it has aroused the interest of organizations and authors in researching their prevalence in the world and Brazil. For Sadock and Kaplan (2017), of all patients with some type of dementia, about 50 % to 60 % of them, present the type considered as the most common, Alzheimer's disease, emphasizing the increase of its prevalence with the advancing years. The second most common type is vascular dementia and its interrelationship with cerebrovascular diseases. For the authors, this type occurs in 15 % to 30 % of the cases and has a higher propensity of occurrence in the elderly with 60 to 70 years of age. The other types of dementia, ranging from 1 % to 5 % resulting from other pathologies, such as traumatic cranial injuries, Hunnington disease and Parkinson’s. In other North American studies, the prevalence of Alzheimer's can range from 60 % to 80 %, followed by dementia of Lewy bodies and frontotemporal dementia (WRIGHT et al., 2016).

In Brazil, a clinical pathological population study, aiming to evaluate the distribution of the main subtypes of dementia in the country with 1129 participants, demonstrated the most prevalent subtypes: Alzheimer (35.4 %), vascular dementia (21.2 %), Mixed dementia (13.1 %) and other causes of dementia (30.1 %) (GRINBERG et al., 2013). It is observed a higher rate of diagnoses of vascular dementia and a lower Alzheimer's, when compared to other studies, these findings can be discussed thinking that this factor may be associated with
limited access of the population researched to adequate means of control of the risk of cardiovascular problems (FREITAS; PY, 2016)  

Identification, signs and symptoms from the perspective of psychology

The complaints of dementia can reach the health professional in two ways. One when the patient perceives differences related to difficulties with memory, symptoms of lack of attention, forgetfulness and/or behavioral changes. Another when a relative perceives the symptoms. This second case is common in situations in which cognitive decline is more advanced (PAMERA; NITRINI, 1994).

Thus, neuropsychological evaluation assumes a crucial importance to assist in the early diagnosis of dementia. Researches emphasize the relevance of this method to assist in the diagnosis of dementia and in the comprehension of the cognitive decreases resulting from aging (NITRINI et al, 2005).

A neuropsychological evaluation focuses on the investigation of cognitive functions, identifying those that are preserved and those that are compromised, through the use of standardized instruments to evaluate these functions. (CARAMELLI; BARBOSA, 2002)

In addition to the use of tests for the diagnosis and recognition of cognitive impairment, it is important to use the priority of regional scores, which are more sensitive in differentiating from control cases, being a preferable measure compared to scores of more recent studies. The use of memory tests and executive functions may decrease the cases of false positives of MCI (KLEKOCIUK et al., 2014).

Still in this context, the test of the clock design was not efficient in differentiating patients from controls of patients with compromised, and this study suggested that combined tests improve the efficiency of the neuropsychological diagnosis. In it, the result of the clock design was improved when performed in conjunction with the Mini Mental State Examination (Mmme) (RUBÍNOVÁ et al., 2014). As shown above, the study by Cook and others (2013) suggests that neuropsychological tests have prognostic value and for follow-up in relation to cognitive impairments. Against departure, the criteria for identification of MCI is susceptible to false positives and the main studies of MCI may be decreasing the importance of biomarkers (SALVADORI et al., 2016).

Another tool for observation and analysis of the patient and its clinical picture is the evaluation of activities of daily living (ADL) that can be divided into basic activities of daily living (BADLs) and instrumental activities of daily living (IADL). The BAVD are those activities that include personal care, such as bathing, food and hygiene, while IADLS contemplate more complex activities, which allow the interaction of the individual with the environment in which he lives. In this way, the IADL includes, for example, the ability to perform financial transactions, use the telephone and use transportation. (MALLOY-DINIZ et al., 2018).

The clinical observation of ADLs is an important factor because to the patient practice them he needs cognitive functions and depending on the area involved in the cognitive decline, the professional can evaluate the impact of cognitive decline in the patient's routine.

Behavioral changes are common in patients with dementia syndromes. It is possible to verify personality changes, such as apathy, disinhibition, impulsiveness, loss of empathy, before the symptoms of cognitive decline. In dementia with Lewy bodies, hallucinations and neurological decline may arise. In the dementia of Parkinson's disease the tremors are signs that evidence the pathology and cause embarrassment in the patient and loss of good functionality of the limb resulting in basic difficulties as in the use of cutlery. (PAMERA; NITRINI, 1994)

The diagnosis of dementia syndromes should be multifactorial, considering biological aspects and neuropsychological outcomes. In the latter, the
test batteries are more efficient than isolated tests and one should investigate not only memory, but also attention, abstraction and judgment. Furthermore, it is necessary to investigate the executive functions, which is shown as a determinant and central factor in the development of the commitment.

**Mental health interfaces**

In the initial phase of the disease it is common for the family to start worrying about the risks of accidents, develop feelings of insecurity in relation to the patient, experience weirdings related to different and/or inadequate behaviors, emerge Fantasies related to symptoms and their possible evolution leading family members to develop fear, anxiety, tension and attitudes of overprotection and prejudices. Other factors can be observed in these cases. One of them is the difficulty experienced by the patient to accept the emergence of limitations and another related to the stigma faced by the family and patients in the face of chronic degenerative and progressive diseases. This period of coping experienced by all sometimes may delay the initiation of treatment, develop depressive conditions and destabilize the patient and family dynamics.

It is not easy for the patient or for his family to accept and adapt to a diagnosis of dementia. Some cases of coping and care in daily life can result in crises in family relationships and compromise the affective and social bonds of their members. The disease represents conditions of aging and progressive loss of autonomy difficult to cope with. It is known that each type of dementia and its development will result in symptoms that require acceptance, adaptation and resilience on the part of all involved. It is also known that the quality of information and support are of great importance and often determinant for the mental health of all.

There is an area of psychology, named by psychological assessment where the professional invests in the process of identifying signs and symptoms, the impact on the activities of the patient and family and the identification and validation of the symptoms presented. In this context, in addition to the psychometric tests for screening, it is due to use the clinical evaluation to observe the functioning of the person in their daily activities. Some stages can be developed in the evaluation process by the psychology professional in view of these tables:

1. Knowing the history of the patient in depth using an enlarged anamnesis, listening to the family and other professionals who are involved in the case.
2. Conducting observation and evaluation with reference to the ecological perspective is a good strategy.
3. Use psychological tests to trace symptoms and/or validate clinically revealing aspects of cognitive decline and behavioral changes in the patient (ZIMMERMANN et al., 2015; LOPES, 2017).

In these cases, caregivers, who are usually family members, assume help and care tasks that are being extended throughout the evolution of the disease demanding more tasks and responsibilities (HAMDAN, 2008).

Patients with dementia or MCI are often committed by a depressive disorder. Thus, a systematic review of the Cochrane platform (ORGETA et al., 2014) sought to evaluate the effectiveness of psychological interventions in reducing anxiety and depression in patients with dementia or MCI. In this study, randomized experimental research was selected. In this review, no studies were found with MCI, but 439 patients with dementia were included. Cognitive behavioral therapy, interpersonal therapy and counseling were used. Two studies with multiprofessional interventions that included psychotherapy were also included in the review.

The caregiving team should keep in mind that they need to work on the afflictions they go through in the course of treatment and care. This requires professionals to empathize and cooperate with the needs of the elderly, assisting in the provision of self-care, offering them encouragement. This ability to take care of oneself is a process that requires attitudes that
will foster treatment success (RUDNICKI; KRATZ; SEABRA, 2018)\textsuperscript{20}.

In general, it is clear that the assessment of cognitive functions has been one of the main resources used to help in the possible diagnosis of dementia. However, the clinician has been facing a series of limitations regarding the standardization of instruments for the Brazilian population, both regarding the lack of evidence of validity for the population with this condition, as well as the lack of instruments that consider aspects. Such as low education, socioeconomic status and physical characteristics of the elderly (FERREIRA; BARBOSA; ALCHIERI, 2018)\textsuperscript{21}.

The autonomy of the elderly and the adequate performance of daily activities, important for their well-being, are aspects commonly investigated by mental health professionals. These are qualitative data and usually appear in investigations of what the elderly do throughout their day, in the description of their relationships with family, friends or other people around them. This information is beyond the numbers of the normative scale scores or the timed time for test performance. The participation of family members and caregivers in this process is vital because information can be opposed and clarification will be the key to understanding the framework and planning interventions (FERREIRA; BARBOSA; ALCHIERI, 2018)\textsuperscript{22}.

**Forms of coping and impact of diagnosis in patients and families**

Chronic diseases are usually incurable and disabling. Thus, among the various concerns of the scientific community, the assessment of the quality of care, its understanding of severe chronic conditions, self-care of chronic patients, educational models for health care and the patient's quality of life and the level of care provided (KAHN et al., 2007)\textsuperscript{22} becomes preponderant.

Dementia, a chronic and progressive condition, requires attention from a caregiver. Most often the caregiver, who is responsible for organizing or giving the necessary care to the patient, feels overwhelmed and needs support to keep his health preserved. By these characteristics, it can generate a disruption of personal, financial and emotional relationships (FREITAS PY, 2016; RIZZO SCHALL, 2008)\textsuperscript{6,23}.

However, with the growth of the elderly population and popularization of the sources of information, the inclusion of the elderly in moments of interaction with relatives is increasing. This interaction and adaptation of the family assists in the well-being and better functioning of the family nucleus. The information obtained by the family about the disease and the way this theme is treated and discussed among the relatives will help in the way that this individual will be seen by the family, reflecting directly in the care of the patient and in the family relationships (RIZZO SCHALL, 2008)\textsuperscript{24}.

The study by Rizzo and Schall (2008)\textsuperscript{24} that had as one of the objectives to understand the way the relatives of the patient with dementia recognize and experience the Dementia syndrome brings that the caregivers designate meanings to the cause of dementia linked to life experiences Of the patients, being present to relate dementia with affective and amorous experiences. Another factor found in this study is to put dementia as a stereotype of aging or as a supporting factor of preexisting health framework. It was concluded in this investigation that psychological interventions in conjunction with traditional care can reduce the symptoms of depression and anxiety in people with dementia, thus increasing well-being.

Despite the incurability of dementias, treatments are possible and for this it takes a multidisciplinary approach. In addition to drug treatment, different non-pharmacological approaches are possible at different stages of the disease. Among these approaches are included cognitive stimulation, memory training, art therapy, dance, music therapy, among others. Despite the scarcity of scientific studies, these activities are related to a global improvement of the patient, in addition to relating
to a reduction in the stress of caregivers (FREITAS; PY, 2016). The psychology of health, an area of psychology that interfaces with public health. It is believed in the importance of this area of psychology to promote the health care of the elderly and their relatives. To promote interventions to raise awareness of the family and society about the early identification of dementia and the confrontation of relatives related to this situation is of great importance. The stimulation of physical activities, the use of music and the work of promoting care for caregivers should be stimulated. The use of new technologies in favor of this population, either to promote stimulation exercises or to stimulate sociabilization or even as leisure is of great help for this population.

The training of cognitive functions can help in the delay of cognitive losses in addition to presenting improvements in functions already impaired. Multidisciplinary protocols, with activities that encompass global domains, present better results in the improvement of cognitive functions.

Studies have shown at some level improvement of at least one cognitive function. Among the results, different interventions presented different responses. In the memory specificity training (MEST), an improvement in the operational and prospective memory was observed, which was maintained by the three months of follow-up of the study (EMSAMI; NESHATDOOST; TAVAKOLI; BAREKATAIN, 2017). This can be explained by the intervention focusing on transforming generalized memory into more specific memories. In another study (PANTONI et al., 2017), in which a memory processing training intervention (APT-II) was applied, no significant improvement was presented in Quality of life of the participants, but it was possible to observe beneficial effects on focused attention and working memory, which were domains focused on the intervention. Considering the results described above, it is possible to observe that interventions in specific domains tend to be beneficial in a restricted way to the stimulated domains.

On the other hand, other studies carried out multidomain interventions in an integral way. Among these interventions are health education, based on active strategies and group dynamics, which resulted in improvement in attention, orientation, memory and language (CASEMIRO et al., 2018). In another multidisciplinary rehabilitation program, patients with MCI also presented improvement in cognitive performance besides improvement of depressive symptoms (SANTOS et al., 2015). Another integral intervention that included dance, music therapy, art therapy, horticulture, crafts, recreational therapy and physiotherapy, among others, showed delay in cognitive decline (LIANG et al., 2017).

A chronic condition requires a complex network of care. This context is highlighted in the elderly, a group that would naturally already be “expected” to deal with some kind of limitation as they age. One of the delicate moments for family members involves learning to deal with someone’s new, previously active, referral setting that now requires care; In addition, while chronic conditions may accompany many people for a lifetime, in the elderly, to some degree, this may lead to unrealistic thoughts of frailty or an approximation to finitude, leading to overprotective behavior and excessive worry. In chronic illness, health psychology may benefit the entire patient support network. In an attempt to maintain their well-being condition, they may develop strategies to alleviate possible worsening of the current condition with information on the clinical condition and also favor the insertion of healthy habits physically and emotionally as an adequate understanding of the disease is established. It is elementary to inform how a multidisciplinary team working in an integrated way can be fundamental in this process. Nevertheless, the family, community, and health support network perspective are
Care in conditions of chronic illness is challenging. Experiences with Health and Disease permeate the objective and subjective, personal and collective, universal and cultural dimensions. The subjective dimension leads us to an understanding of Health Care as an attitude and space for the construction of subjectivities, an open exercise of a practical wisdom for Health Psychology, supported by, but not limited to, advances in science. In this sense, Health Psychology involves the use of concepts, theories, methods and techniques derived from psychology, applying them to health care, considering their possibilities of acting at different levels of public health, private, in education contexts, developing strategies for individual, group intervention, among others (BARBOSA et al, 2018).

Psychological practices need to be constantly revisited and reviewed. Revisited to have a critical and ethical look at the development of psychology and revised to reflect on the state of the art in relation to current scientific production and the alliance between theory and psychological doing. Professional supervision with case discussion is an important task for professionals to consider. In the context of public health, actions with emphasis on primary health care have shown that early detection of vulnerability situations takes priority. It is in this context that the psychological assessment in the hospital is highlighted, whether in the professional performance in wards, emergency and emergency services or even in specialized outpatient clinics. The experience of human pain and suffering seems to be common both for the person affected by the illness, as well as for their families and caregivers. This includes the health team because, due to constant contact with the suffering of the other, can develop strategies of inadequate management and coping as defense mechanisms to live with such situation. Thus, the psychologist acting in this context must remain attentive to different information and phenomena presented during patient follow-up (BARBOSA; ALBUQUERQUE; MAIA; MELO, 2020).

Conclusion
The elderly population is growing and it is a layer of society that starts to have new concerns from the advances in health care, which allows for a longer life and new illnesses appear. Thus, it should be sought to provide a good quality of life for this population.

In the context of dementia syndromes, multifactorial and interdisciplinary care is evident from the moment of diagnosis to treatment. The impossibility of curing these conditions requires care to promote the quality of life of the patient, as well as care for the family and caregivers. As has been seen, the family can also suffer the consequences of dementias, being the care of those people close to the patient as important as the care with this, because a healthy environment that provides good care tends to result in a better quality of life to all people close to the patient.

It is challenging for the health's professionals and for the family build a environment that helps the patient’s quality of life and keep the family structured, however, it is that structure that are going to help increase the patient’s health. As seen, dementia syndromes has a multidisciplinary approach and interdisciplinary treatment, then, to get the full beneficence of it, it is important that the whole health crew have a good communication that provides the best of the treatment for the patient and his family.

At last, more studies has to be done to improve the treatment, specially about non pharmacological approach which has shown a good potential.

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