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SOCIAL AFFECTION DETERMINANTS AND QUALITY OF LIFE TO OLD AGE PERSON AFFECTED WITH ALZHEIMER

A dissertation submitted and defended on the 28th July 2023 in fulfilment of the requirements for the award of a master's degree in Special education.

Option: *Special Education*

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SUMMARY

To

Mr CLEYTUS JUMCODA RIFOR

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LISTE DES ACRONYMES, SIGLES ET ABRÉVIATIONS

AD	:	Alzheimer disease
ADAScog	:	Alzheimer disease assessment Scale Cognitive
ADL	:	Alzheimer disease living
ADRQOL	:	Alzheimer disease related quality of life
BUCREP	:	Bureau Camerounais de recesement de la population Cameroonian of the
DCM	:	Dementia care mapping
DQOL	;	Dementia quality of life
FACT	:	Functional assessment cancer treatment
FLIC	:	Functional living Index cancer
HRQOL	:	Health related quality of life
ICD	:	International classification disability
ICDH	:	International classification disable handicap
ICEAP-o	:	InveStigating choice experience for elderly people index for older Adults
IFC	:	International functioning classification
MMES	:	Mini mental status examination
NCDs	:	Non communicating disease
QOL	:	Quality of life
SWB	:	Subjective well-being
TSST	:	Experimental psychological stress situation
UN	:	United Nation
USA	:	United state of America
WHO	:	World health organization

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ABSTRACT

Our research carries on “Social affection determinant and quality of life to old age person affected with Alzheimer “. It is written in the field of Special Education, most precisely in Mental Handicap, Mental abilities and Advice and pose a problem on the determinant of quality of life of old age person affected with Alzheimer.

The general objective was to boost the quality of life old age person affected with Alzheimer. As a reading scale of the problem pose, we had as an appeal to theoretical approach which was insisting on the psychological, physiological and social relationship with the environment affectionately link to the needs and well-being of the old age person in order to contribute to the improvement of the quality of life of old age person which are view in quality of life components; which are life satisfaction, happiness and subjective well-being. research question which was a drive to our investigation was formulated as follows: Does social affection determinant influence the quality of life of old age person affected with Alzheimer? The hypothesis was formulated as such: Social affection determinant influences the quality of life of old age person affected with Alzheimer

To experience this hypothesis, we had appearance in methodological steps, we had to appeal to qualitative method. It consists of selecting a sample of six Alzheimer subjects fulfilling the criteria of inclusion fixed at the beginning. These old age persons with Alzheimer where observed on their interactions with their close family, medical personnel’s and visitors to three months at the central hospital (geriatric service). The collection of date was done through an interview guide and a participative observation. The analysis of data harvested was through contain analysis and observation scale.

The results show that extreme vulnerability of Alzheimer’s patient we meet, the many risks they take, and consequences of their daily exposure to factors that make their situation more complex to understand, very often give rise to a tension between respect for their lifestyle, professional responsibility and ethical rules, ethical and moral conscience of practitioners. It’s not always a comfortable position to be especially when, there is further a referral to a health specialist service and difficulties approaching the third party who are not sufficiently aware of or trained in dealing with this population, and who fail to deal with people who are easily stigmatized or shunned.

We can see from the results, of our participant that, the psycho-affective dimension is everything to do with emotions, relationships, with oneself and with others, which leads the patient to have self-confidence, to develop skills and be committed. Establishing a therapeutic relationship and a climate of trust. It is this that enables progress to be made and the patient to agree and share. We can therefore states that as far as individuals experience adequate satisfaction of their needs and achieve a certain level of performance in fulfilling their roles, they are adapted to their environment and enjoy a good quality of life.

Keywords: Alzheimer, social affection, quality of life.

RÉSUMÉ

Notre recherche porte sur "Les déterminants de l'affection sociale et la qualité de vie des personnes âgées atteintes de la maladie d'Alzheimer". Elle s'inscrit dans le champ de l'Education Spéciale, plus précisément dans le domaine du Handicap Mental, des Capacités Mentales et du Conseil et pose une problématique sur le déterminant de la qualité de vie de la personne âgée atteinte de la maladie d'Alzheimer.

L'objectif général était d'améliorer la qualité de vie des personnes âgées atteintes de la maladie d'Alzheimer. Comme grille de lecture du problème posé, nous avons fait appel à l'approche théorique qui insiste sur la relation psychologique, physiologique et sociale avec l'environnement en lien affectif avec les besoins et le bien-être de la personne âgée afin de contribuer à l'amélioration de la qualité de vie de la personne âgée qui se traduit par les composantes de la qualité de vie que sont la satisfaction de la vie, le bonheur et le bien-être subjectif : Le déterminant de l'affection sociale influence-t-il la qualité de vie des personnes âgées atteintes de la maladie d'Alzheimer ? L'hypothèse a été formulée comme suit : Le déterminant de l'affection sociale influence la qualité de vie des personnes âgées atteintes de la maladie d'Alzheimer.

Pour expérimenter cette hypothèse, nous avons eu recours à des étapes méthodologiques, nous avons dû faire appel à la méthode qualitative. Elle consiste à sélectionner un échantillon de six sujets atteints d'Alzheimer remplissant les critères d'inclusion fixés au départ. Ces personnes âgées atteintes d'Alzheimer ont été observées sur leurs interactions avec leur famille proche, le personnel médical et les visiteurs pendant trois mois à l'hôpital central (service de gériatrie). La collecte des données s'est faite à l'aide d'un guide d'entretien et d'une observation participative. L'analyse des données récoltées s'est faite par le biais d'une analyse de contenu et d'une échelle d'observation.

Les résultats montrent que l'extrême vulnérabilité des patients Alzheimer que nous rencontrons, les nombreux risques qu'ils prennent, et les conséquences de leur exposition quotidienne à des facteurs qui rendent leur situation plus complexe à appréhender, donnent très souvent lieu à une tension entre le respect de leur mode de vie, la responsabilité professionnelle et les règles éthiques, la conscience éthique et morale des praticiens. Ce n'est pas toujours une position confortable, surtout lorsqu'il s'agit de s'adresser à un service de santé spécialisé et qu'il est difficile de s'adresser à un tiers qui n'est pas suffisamment sensibilisé ou formé à la prise en charge de cette population, et qui ne sait pas s'y prendre avec des personnes qui sont facilement stigmatisées ou mises au ban de la société.

Nous pouvons constater, à partir des résultats de notre participant, que la dimension psycho-affective est tout ce qui concerne les émotions, les relations, avec soi-même et avec les autres, ce qui amène le patient à avoir confiance en lui, à développer des compétences et à s'engager. L'établissement d'une relation thérapeutique et d'un climat de confiance. C'est ce qui permet d'avancer et au patient d'accepter et de partager. On peut donc affirmer que dans la mesure où les individus éprouvent une satisfaction adéquate de leurs besoins et atteignent un certain niveau de performance dans l'accomplissement de leurs rôles, ils sont adaptés à leur environnement et jouissent d'une bonne qualité de vie.

Mots-clés : Alzheimer, affection sociale, qualité de vie.

GENERALE INTRODUCTION

GENERAL INTRODUCTION

This research is born from some mental health experience in the family that is when, we decided to carried out study on mental disabilities to understand the cause of mental pathologies. Most of the mental disabilities are caused by unresolved psychological conflicts and could be treated through support action and follow-up. Authors like Alois (1906) noticed changes in the brain tissue of a woman who died of an unsual mental illness. After her dead he examine her brain and found many abnormal clumps called amyloid plaques. These plaques and tangles in the brain which are considered as main features of Alzheimer’s disease.

Quandagno (2020) “Depressive manifestation is mostly present to ageing population living with dementia. The hypotonia is built in them by the damage that occurs in the areas of the brain that control language, reasoning conscious thought and sensory processing such as the ability to correctly detect sounds and smells. Memory loss and confusion grow worse, and people have problem recognizing family and friends. They may, be unable to learn new things, carry out multi-step tasks such as getting dressed, or cope with new situations. People at this stage have hallucinations, delusion, paranoia and behave impulsive, sleep dis-order at night.

In relation to cognitive manifestation, one of the sign that is most visible is; remembering people’s name after introducing self, mis-placing of common objects, planning or organizing, inability to recall home address, telephone number, names of people, names of family and friends, with this disease other neurocognitive disorder progresses. The person with this disease loses many skills that are considered essential to quality of life. As long as the neurocognitive dis-order increases, he needs good environment to present his quality of life. Anxiety and depression is mostly raise among general population of aging people. The initial stage of the illness is mostly link to symptoms such as hyperactivity or aggressiveness hence lead to the deteriorate quality of life due to the disease. Terry & Logdon (1991) Logdon & Terri (1997)” Alzheimer disease affects individual quality of life in a profound way as cognitive and functional abilities are lost, individual with dementia becomes unable to engage in activities that once gave him pleasure. Behaviours and social skills may also deteriorate, precipitating interpersonal conflict that may cause an individual with Alzheimer disease to become isolated”.

The difficulties presented is that they can't live alone, they need a direct and individual person to live with; the problem of pathology is defined as a biological or physical abnormality; physical such as (difficulty in walking, using hands and fingers), sensory (difficulties of seeing, hearing), Mental (alteration of intellectual and reasoning capacities). Activity restriction refers to the difficulties to carrying out daily activities due to physical or health problems. Activities restriction takes into consideration the environment in which the individual lives. Loss of autonomy link to affect the cognition, reduces the social role to be fulfilled. This person enters into a new role, that of a sick person especially having to do with an irreversible and degenerative disease.

The approach use is encouraging communication, being listen to and understood are important value to quality of life. Positive responses to challenging behaviour, although confusion, memory loss, impaired executive functioning can trigger very challenging behaviour, how we respond to this can significantly impact the quality of life.

We noticed that this old age person affected with Alzheimer manifest anxiety, anger, depression, isolation. If these strategies are put in place, positive behaviour of the families such as; caring, touching and social support are showed in affectionate memory, therefore social interaction by implication will be the need to adapt inclusively.

That is the reason why we decided to undertake this research, in order to comprehend and to learn the aspect of clinical therapy and psychological support action by questioning on the interaction with the seniors.

In this framework of this research we got interested to Social affection determinants and quality of life to old age person affected with Alzheimer. In order to have a clarity on our steps, we carried out study in the first part on Alzheimer disease its aspects of manifestation, social affection determinant, then we stop at quality of life in order to decried the theoretical foundation on quality of life of old age person affected with Alzheimer disease. We then presented our experimentation, through descriptive study. Finally, through six cases, we analyzed the interest and pertinence of social affection determinant and quality of life of old age person affected with Alzheimer and equally the limits of the pathologies on old age person of our study.

It was question whether social affection determinant influence the quality of life of old age person affected with Alzheimer. We came out with a research hypothesis as follows;

social affection determinant influences the quality of life of old age person affected with Alzheimer. Moreover, thanks to clinical test and observation scale, we illustrated the contribution of support action of Alzheimer patient and finally insisted on their quality of life.

The study framework was carried out in Yaoundé I, Mfoundi subdivision, Central region, Geriatric service central hospital in Cameroon and is counted at the heart of the environment, important community of elderly persons. The central hospital is a perfect place of study because it welcomes old age persons and is one of a kind that is rare in the town. It offers minimum comfort to satisfy the patients in matter of housing of fragile people for a period of time. Also we could easily have access to old age person with no distinction of sex.

We note here that at the end of the study we shall present the results, the limits, and perspectives of the study.

PART 1. THEORITICAL FRAMEWORK OF THE STUDY

CHAPTER 1: PROBLEMATICSS OF THE STUDY

In this chapter of our research, we shall present the context and justification of our study, formulate and pose a tentative problem that will give a solution to our research. We will also present the interest and objectives followed by the study, the body of the hypotheses that, we will try to solve and the delimitation.

1.1. CONTEXT AND JUSTIFICATION OF STUDY

1.1.1. CONTEXT OF THE STUDY

According to Macmillan dictionary defines context as the general situation in which something happens, which help to explain. In the case of our work, the context that we presenting will be articulated around Authors in the continents and the interior of some countries in which we shall take our stand. The problem of Alzheimer disease offers more of sufferings and pains in the daily living. We shall find causes of the pathology. Travelling and work on the epidemiology plan. We gathered information (data) of persons, of the daily living and their causes notably in the USA, in France.

In America more than 6 million Americans age 65 and more than may have Alzheimer’s disease. This is because increasing age is the most important known risks for Alzheimer disease.

In 2019, over 400 thousand people were treated with Alzheimer’s disease in France. With roughly 404 thousand patients, the vast majority of Alzheimer’s patients were aged 75 and older. Nonetheless, just under 35 thousand people were treated for Alzheimer’s disease were aged 65 to 70 during that year.

Recently, in Canada more than 402 seniors 65 years and older are living with Alzheimer. This represents a prevalence of 7.1%. About 2/3 are of Canadians seniors living with Dementia are women.

In sub-Sahara Africa studies shows that in 1992 impaired cognition of 293 were aged of 65 years above. In 2012/13, a two- phase cross- sectional survey of six villages was conducted in the rural Hai district of Tanzania (subjects aged 70 years and above) using two different diagnostic tools for dementia.

According to South Africa in 2011 census, there are approximately 2.2 million people in south Africa who live with Dementia. In 2013, there were an estimated 44.4 million people with dementia worldwide. This number will increase to an estimated 75.6 million in 2030, and 135.5 million in 2050. This will rise to 71%.

In Africa what is the statistics the situation can be more alarming than Europe and we observe trauma from people suffering from Alzheimer disease. The etiology of Africa North Africa, in Central Africa Cameroon in our hospital at the geriatrics, in institutions there are many cases observed who are affected with this disease which is traumatizing the family members. Alzheimer disease is named after Dr Alzheimer (1906), noticed changes in the brain tissue of a woman who had died of an usual mental illness. Her symptoms included memory loss, Language problem and unpredictable behavior. After she died, he examined her brain and found many abnormal clumps. (Now called amyloid plaques) and tangled bundles of fibers (called neurofibrillary).

STATISTICS ON DISORDER OF ALZHEIMER IN CAMEROON

Alzheimer constitute a severe threat to the population of Cameroon. According to studies carried out at BUCREP during the 3rd central population and Habitat Census of 2005 and following the demographic growth rate evaluated at 2.6%, the population of Cameroon is estimated at 19406100 million inhabitants at 1st January 2010, older persons aged 60 years and above represent 5% of the population.

In this there are 7 to 14% of old age people if they remove 10 million it represents nothing. If there is a percentage that is elevated is in the northern countries due to industrialization but in Cameroon there are dementia problem.

The factors that shows that Alzheimer is elevated in Cameroon is as follows Cameroon has a heavy burden on neurocognitive disease. According to recent estimates, the prevalence of cognitive disease in the overall adult population of Cameroon is 5.1%, with the prevalence of 8.3% in large metropolitan areas like Yaoundé, 7. 4% among women, and 26.4% are women female workers. With this rate of vulnerability percentage, special educators need to intervene in support-action and follow up of this elderly people for a good quality of life.

These plaques and tangles in the brain are still considered as some of the main features of Alzheimer’s disease. Another feature is the brain. Neurons transmit messages between different parts of the brain, and from the brain to muscles and organs. Scientist continue to unravel the complex brain changes involved in Alzheimer disease changes in the brain may begin a decades or more before symptoms appear. During this very early stage of Alzheimer's toxic, changes are taking place in the brain, including abnormal build ups of proteins that form amyloid plaques and tau tangles. Hence neurons stop functioning, lose connections with neurons, and die. The damage initially appears to take place in the hippocampus and the entorhinal cortex, which are parts of the brain that are essential in forming memories. As more neurons, additional parts of the brain are.

OLDER PERSON

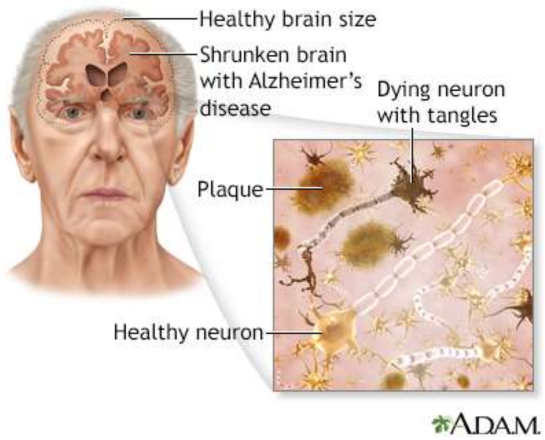
An older person, for a common sense is any person whose age is advanced and has the social attributes of old age person as a stated by the society. Any person aged sixty and above is considered as an older person. Thus, it is customary distinguish as the third age people, that is to say from 60-65 to 75-80 years and those of the Fourth age (75-80 years and above) Socially somebody who have ceased to be productive or retired would be considered an older person

OLD AGE

Old age is an ultimate age which comes after middle age, also Euphemistically called the third age. It is a state most often seen in the seventh decade of life because it is at this time that the consciousness of ageing is most acute. There is real biological age known as old age but there exist a range that usually begins around the age of sixth five (65) and corresponds to be a period of life when most people are remove from active society Mishana &Riegal (1984) "old age is inevitable and a natural period of life characterized by a decline in physical function, loss of social role as an adult. Changes in physical appearance and gradual route to decrease in capacity".

AGEING

According to the WORLD HEALTH ORGANISATION (WHO), ageing is " a gradual and irreversible process of changing structures and functions of the body, resulting from the passage of time". For the universal dictionary, ageing is "All the process and mechanism that accompany the degeneration of the human body over time until death". Ageing is a continuous and irreversible process that is part of temporality of an individual, from the beginning to the end of his life. This is not characteristics of old age but belongs to the whole life process.



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Alzheimer damage occurs in areas of the brain that control language, reasoning conscious thought, and sensory processing, such as the ability to correctly detect sounds and smells. Memory loss and confusion grow worse, and people begin to have problems recognizing family and friends. They may be unable to learn new things, carry out multi step tasks such as getting dressed, or cope with new situations. In addition, people at this stage have hallucinations, delusions and paranoia and may behave impulsive.

ALZHEIMER DISEASE IS A NEUROCOGNITIVE DISORDER THE MOST SPREAD.

Alzheimer disease is a killer disease which may affect an individual on a day or the other aspects of life of a person: His way of thinking, to feel and to react. Alzheimer disease is progressive. It’s described habitually the stages that indicate it gravity of its symptoms. There exist **three stages of Alzheimer**

The light stage; a person at this stage is fully conscious and does not need help just a minimum if he or she asks

Moderate stage; symptoms begin to be more perceptible. The person will need more help to be able to do his daily activities.

Advance stage; the person will be incapable to communicate verbally or take care of her or himself.

Early stage: In the early stage of Alzheimer’s, you will begin to notice changes in your memory. Thinking or reasoning that interfere with daily life. You will still be able to perform many of your daily responsibilities or routines. But these tasks may become more difficult over time. Friends, family or co-workers may notice changes. Common difficulties in the early stage may include:

- Problems coming up with the right word or name.
- Trouble remembering people’s names after introduced
- Greater difficulty performing tasks in social settings.
- Forgetting material that was just read
- Losing misplacing common objects.
- Difficulty planning or organizing.

Middle stage: As the disease progresses into the middle stage, significant details about oneself and family may still be recalled, but gaps in memory and thinking are noticeable and assistance with daily tasks is required. Safety needs should be addressed, if measures are not already in place. Changes in the middle stage may include:

- Inability to recall home address, telephone number or the names of family and friends.
- Confusion about time or place.
- Difficulty choosing appropriate clothing for the season or occasion.
- Requiring some assistance with eating or toileting.

Late stage: In the late stage of the disease, losses include the abilities to communicate (respond to environment and carry on a conversation). Assistance or supervision is required to complete most daily personal care, including eating and toileting. Reflexes will become abnormal, muscles grow rigid and swallowing becomes impaired.

According to recent years’ scientist have made tremendous progress in better understanding Alzheimer and it momentum continues to grow. people with Alzheimer disease may occur over decades. The causes probably include a combination of genetics, environmental, and lifestyle factors. Most people with Alzheimer’s have the late onset form of the disease in which symptoms becomes, apparent in their mid-60s or later. Estimate shows that all over the world and countries many people do suffer from this disease.

Alzheimer disease accounts for 60-80% of cases. Vascular dementia, which occurs because of microscopic bleeding and blood vessel blockage in the brain, the second most common cause of dementia. Those who experience the brain changes of multiple types of dementia simultaneously have mixed dementia. There are many other conditions that can cause symptoms of dementia, including some that are reversible, such as thyroid problems and vitamin deficiencies.

People who have Alzheimer disease needs others to care for them, and many of those providing care are not paid for their time and services. Each year more than 16 million Americans, usually family and friends, provide unpaid care for someone with Alzheimer disease and dementia Alzheimer is on the rise throughout the world. Worldwide, at least 50 million people are believed to be living with Alzheimer disease or other dementia. According to the United Nation, that is more the population of Columbia. If breakthrough is not discovered, rates could exceed 152 million by 2050. A recent study found that Alzheimer’s mortality rate to be five to six times higher than official estimates, suggesting that Alzheimer’s may be responsible for more than 500.000 annual deaths in the United states. If applied to the general population, these findings would make Alzheimer’s the third leading cause of the death in the United States, behind heart disease and cancer.

Recent studies show that, part of people who were practicing moderate physical activities could ameliorate their memory disorder and some people that were regularly practicing physical activity are declare a less frequently to have Alzheimer disease.

Moreover, most studies were realized concerning the feeding of close person affected with Alzheimer disease. The consumption of vegetable and olive oil fruits and a lesser consumption of wine had less risk to develop the disease. And this regime was associated with a weak cognitive decline. The acid fat in omega-3 present in fish seems to be a particular protector.

The currently available scientific literature acknowledges that the person with Alzheimer's disease loses many abilities that are considered essential for a good quality of life. We believe that the person affected deserve that he should be treated with love, respect, integrity, compassion and dignity, He or she should be taken care of his intimacy and security. He needs good environment to present his quality of life. Anxiety and depression are complication that is been observe among ageing people. This complication can affect an individual and his quality of life.

The prevalence of depression is mostly raise among general population of ageing people. The initial stage of dementia is known as the loss of an autonomous manner or to live a mode of life mostly independent which is a difficulty. Therefore, people affected can really be destabilized specifically at the initial stage of the illness and it's mostly link to symptoms of hyperactivity or aggressive behaviour, apathy, delusion and hallucination. Depressive symptoms such as anxiety and sleep disorder by so doing will lead to deterioration of quality of life due to the disease.

Contribution of Nervous system to sensory area and motor sensory area of an Alzheimer patient at the third stage.

- Difficulty of writing
- Have difficulty of sitting and standing still
- Take risks and have no sense of danger
- Drowsiness

The exact function motor cortex and the other areas of the frontal lobe associated with motor function remain a mystery. At the heart of this, are numerous experimental example of correlation between the electrophysiological activity of neurons recorded in motor cortex and various parameters of movement including muscles force, direction, speed and modulation of activity with different postures. Thus movements requiring a high level of dexterity, like a pincer grasp, are severely disrupted by damage to motor cortex.

The function of sensory cortex is intimately connected to the input it receives from mechanoreceptors in the skin, muscle and joints. The function of sensory cortex is processing this afferent information resulting in the detection of the mechanical stimuli giving rise to a sense of touch, position and movement. Not only is sensory cortex responsible for detecting the presence and magnitude of a sensory stimulus but also locality on the body surface. The most complex processing occurs when the afferent information from different sensory sources is integrated to produce a coherent perception of a sensory experience such as sterognosis, the ability to recognize an object's size and shape by shape alone.

To attained specific objectives of the presence study, semi-directed interview will be carried 0ut. According to Zacjc (2003), semi-directed interview is defined as follows "semi-directed interview consists to a verbal interaction animated in a soft manner, by the researcher. The one will be aloud with a guided rhythmic and unique content of exchange. In the light of meeting in a mode which resemble a conversation. The general theme wishes to explore with the participant of the research, thanks to this interaction, a rich understanding of the phenomena of the study jointly with the interviewer "(p.296) semi- directive interview has as aim to know what the person thinks and to know his feelings, his ideas and his intentions. Deslauriers (1991) "interviews in qualitative research will permit to furnish an internal follow up in which the person to be study has the possibility to express their comprehension on events in their real terms "The fact of this phenomena will ameliorate the quality of life of old age person affected with Alzheimer disease, to develop Competences that will build social-affective memory which will help him to feel the presence of others in the environment

1.1.2. JUSTIFICATION OF THE STUDY

We shall be studying social –affection determinant and quality of life of old age person affected with Alzheimer. Others have used environmental factor such as social sustenance to ameliorate their quality of life. Several dimension such as affective manifestation, environmental, social participation and quality of life were explored. Several factors are determining factors in quality of life and social relations. According to (Quandagno,2020." Depressive manifestation is mostly present to ageing population living with dementia ". (Blazer, &Williaimas,1980; Absher & Cummings,1993). "Events existing such as mourning, sickness can modify the physical functioning, social and psychological of the person. "The light cognitive affected presence can lead to consequences at the organic view and behavioural affecting social relation with individual, with social environment and by extension his psychological wellbeing and his social functioning. Relationship appears to be reciprocal, the symptoms observed in social functioning of an individual:

Loss of autonomy link to affected cognition reduces social roles to be fulfilled.

When diagnosis of light cognitive affection is being posed or when loss of memory is observed in old age person, this one enters into a new role, that of sick person especially a person having an irreversible and degenerative disease. (Di Notte, Yliff & Fontaine, 2004). In fact, we observe that to this population, affectionate manifestation such as anxiety, anger, shame, sign of depression to name a few. The idea of "successful ageing " (Baltes and Baltes 1990 At the beginning there is a gradual reduction and sudden acute affecting the central visual and the recognition of details. Eventually low vision becomes more worrying leading to important difficulties in the realization of many activities such as reading and the driving of automobile. Social-affection, the fact to always come back each time, there is a certain feeling by touching; the person will recognise people's touching because touching is an affectionate link. Therefore, social interaction is by implication; the need to adapt for inclusion. Talking of affective observation, there is emotional memory.

Functional health is defined as consequences of disabling disease on daily life and quality of life (Cambois and Sermet, 2006). In this approach, dependences characterise people who require human assistance in carrying out some of their daily activities, and it emerges at the end of a dynamic process in several stages, from pathology to activity restrictions. However, it is now known that the process leading to disability consists of four stages:

Pathology is defined as a biological or physiological abnormality detected by a medical diagnosis, whereas impairment is a dysfunction or structural abnormality in a specific body system, resulting in consequences for physical for physical or mental functions and social participation. It is the onset of impairment that allows the diagnosis of pathologies, even though pathology may exist without impairment. Furthermore, as Nagi (1976) points out, functional limitations are the translation of physical, mental and sensory alterations on the body's performance. They may be physical (difficulties in walking, using hands and fingers, etc.), sensory (difficulties in seeing, hearing, etc.) or mental (alteration of intellectual and reasoning capacities).

Activity restriction refers to the difficulties encountered in carrying out certain daily activities due to physical or health problems. Activity restrictions take into account the environment in which the individual lives. It is a process resulting from a mismatch between individual capacities and environmental requirements. It should therefore be pointed out here that not all functional limitations lead to activity restrictions if they can be compensated for by treatments, housing adjustments or technical aids, and that not all individuals experience the same level of disability depending on the physical and social environment in which they live (Laurence and Jette, 1996),

However, It should be remembered that the importance of taking the environment into account in the analysis of disability was reaffirmed from the 1980s onwards, particularly by Menaire (1983), who developed the concept of 'situational disability". For this author, disability does not characterise a person but rather an interaction between an individual and his or her environment, in other words, one is not disabled in the absolute, but disabled for something. Following these debates on the role of the environment, WHO, as Cambois and Robine (2003) point out, introduced a new classification (International Classification of

Functioning-IFC) in 2001 to replace the ICDH and thus take better account of t of contextual factors in the conceptualisation of activity and incapacity, In order to keep in line with this overriding concern, we have worded our topic as follows; Social affection determinants and quality of life in older people with Alzheimer's disease .Indeed, in approaching this research, we believe that the person with Alzheimer disease deserves to be treated with respect, integrity ,compassion, and dignity, and to have privacy and safety. People with mild to moderate symptoms may need opportunities to improve their quality of life. Therefore, the fact of this phenomenon will help to ameliorate the quality of life of old age person affected with Alzheimer disease to develop competences that will built social –affective memory which will help him feel to presence of others in the environment.

1.2. FORMULATION AND POSITION OF PROBLEM

1.2.1. THEORETICAL CONTEXT

There are two main area of work in medical ethics that fit this criterion. The first is to work on ethical frame works for medical treatment decision-making in a clinical context, including accounts of informed consent and life

The second is the development of valuable measures out comes of health care treatments and programmes; theses outcomes measures are designed to guide health policy and so must be able to be applied to substantial numbers of people, including across or even between whole societies. Sometimes a notion of “health” is employed, particularly in its broader interpretations, as exemplified in the world Health Organisation definition of “health” as a state of complete physical, mental, and social well-being. Another conceptual framework commonly employed for evaluating health care outcome is the assessment of the benefits and burdens of that care for the patient (and sometimes for others as well). Still another common conceptual framework often looks to the effects of health care on patients' interests, they have in common their use in evaluating health care outcomes for patients and their employment as at least part of a comprehensive account of a good life for persons. We shall freely draw here on each of these conceptual frameworks, and others, indicating where differences between them become important.

Huei-Ling & al (2015) “Family caregivers ‘caregiving activities were related to patients' stages of dementia. For patients with mild dementia, caregivers provided more assistance in transportation and housekeeping”. In addition to these two activities, family caregivers of patients with moderate dementia provided more assistance with mobility and for patient with severe dementia, family caregivers provided more assistance with personal care, mobility and protection, transportation, and housekeeping. Overall, family caregivers reported having some preparation to provide care; the most difficult caregiving activity was identified as managing behavioural problems.

The person's preferences happen to be. The question of whether accounts of a good life are objective or subjective is, then, an explicitly normative issue about what it is.

In an article, the number of individual at risks for dementia will probably increase in ageing societies as will be the array of preventive.

Biomedical measures are appropriate to determine the consequences of disease on specific medically relevant symptoms. For oncological diseases may include the size of the tumours or the number and region of the metastases. In order to assess the impact on the patient's everyday life these biomedical measures need to be supplemented by other measures relating to everyday life such as the quality of life or pain. For dementing disorders specific symptoms of disease such as cerebral atrophy can be measured in much the same way as the size of tumours. Beyond this, several symptoms of dementia, e.g. the impairment of memory, can be measured with standardized instruments, whose relevance for the everyday life is obvious. Over the course of Alzheimer's dementia, the burden of disease is not primarily reflected by diminishing cognitive functions of patients, but also by a variety of behavioural problems and physical handicaps. There is however, a great deal of heterogeneity regarding the manifestation of, and the coping with these non-cognitive symptoms.

Therefore, more comprehensive instruments are required to take account of such causes and their effects within the context of family or professional care. Biomedical instruments for assessing dementia: Dementia is a frequent disorder in the elderly and its prevalence Increases age. The most frequent cause is AD. At onset of AD the medial temporal lobe is affected resulting in episodic memory deficit as the early clinical hall mark. As the disease spreads, other brain regions are affected as well. The parietal cortex mediates functions such as spatial orientation and visual spatial functions, the frontal cortex executive functions, planning, attention, and working memory spread of AD beyond the temporal lobe thus is characterized by in functional terms by accruing deficits of spatial orientation, attention and executive functions as well as working memory and language beyond initial temporal lobe type memory deficits. This can be visualized using advanced imaging method.

For clinical study purposes test batteries are used, most commonly the mini mental status examination (MMSE) and Alzheimer’s disease Assessment scale (ADAScog). Cognitive scales such as the MMSE or cognitive sub-scale of the ADAScog mingle the results of several cognitive functions into one composite score. While any of the assessed symptoms might be present at one time at a point or the other during the course of an individual’s disease they will not be present all at once at a given stage of disease. Moreover, the dynamic range (Brod &al., 2000) “A significant proportion of persons with Alzheimer’s disease – and the majority of long –term care residents with the disease either cannot respond or provide responses of questionable validity due to lack of memory, inability to concentrate, lack of the capacity for introspection, unawareness of their impairments and disabilities, inadequate or absent language skills, thought disorders”

Approaches encourage communication being listened to and understood are important values for quality of life. Positive responses to challenging behaviours, although confusion, memory loss, a loss of inhibition and impaired executive functioning can trigger very challenging behaviours, how we respond to this can significantly impact the quality of life.

Lack of Social Affection Determinant of old age person affected with Alzheimer disease will have a negative impact on the quality of life.

1.2.2 EMPIRICAL CONTEXT

According to (WHO) 1947. Defines health and QOL as a “state of complete, physical, mental and social wellbeing, and not merely the absence of disease and infirmity. These three dimension in any scale or index purposing to measure health or QOL, namely physical function, mental status, the ability to engage in a normative social interaction.

What every physician wants for every one of his patients old or young, is not just the absence of the death but a vibrant quality that we associate with vigorous youth. This is nothing but a humanistic biology that is concerned, not with material mechanism alone, but with the wholeness of human life, with the spiritual quality of life that is unique to man. World Health organization (W.H.O) defines health as a “state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity.

According to Aaronson, there are common threads in the structure and onset of measures that carry the QOL label. First, such measures tend to reflect a multidimensional conceptual approach. Four broad health dimensions are frequently incorporated:

1. Physical health, that is, somatic sensation, disease symptoms, treatment side effects
2. Mental health, ranging from a positive sense of wellbeing to no pathological forms of psychological distress to diagnosable psychiatry disorder.
3. Social health, including assessment of both quantitative and qualitative aspects of social contacts and interactions
4. Functional health, including both physical functioning in terms of self-care, mobility, and physical activity level and social role functioning in relation family and work.

Dickers proposed a comprehensive model of aspects of QOL and its evaluation. The main distinction is made among three major groups: QOL as subjective well-being (SWB), QOL as utility. Achievement reflects the current situation of the individual involved. This situation can be against individual, norms and values, resulting in a certain level of (SWB) or against societal norms and value resulting in a utility rating.

CONDITION OF LIFE WITH OLD AGE PERSONS, HOW THEY EXPERIENCE THEIR DISEASE.

Psychological and cognitive memories

Mild short-term memory loss, word-finding difficult, and slower processing speed are normal parts of aging that are often noticeable by age 85. Changes from normal brain aging can affect driving safety and increase risk for financial exploration. These changes can also reduce capacity to complicated medical information.

Dementia; rate of dementia increase with age. People with dementia need opportunities for cognitive stimulation.

Depression

Depression is not a normal consequence of aging, grief can be a normal response to life events that occur with aging such as bereavement; retirement/loss of income and loss of physical, social, or cognitive function from illness. Major depression is common throughout adulthood. Depression prevalence for adults over age 85 is double the rate seen at 70-74. Depression is even more common among adult with disabilities.

Social/ Environmental:

Social isolation predicts mortality and other adverse outcome in adults. 5% of older adult are home bound, rarely living the home except for important medical appointments.

Most of these adults are 80 years above. These older adults who live alone and are in poor health are vulnerable during a natural disaster. Approximately 13% of women and 8% of men over age 85 live in nursing facilities and institutional setting.

Older adults with dementia have the highest needs for care recipient.
Functional deterioration in an elderly person can also arise from social and mental health problems." Awareness of these problems may prevent age- related deterioration, such as attention to depression and suicide risk in men during the first year following the death of a spouse or stroke" by Jaul & Barron (2017).

Supportive physical and social environments also enable people to do what is important to them, despite losses in capacity. The availability of safe and accessible public building and transport and places that are easy to walk around, are example of supportive environments.

According to the United Nations statistics, the number of older persons that was 600 million in the year 2000 will be 2 billion in the year 2050. In most developing countries, the proportion of older persons, now estimated at 6% will be 21% in the year 2050. The demographic growth in developing countries (3%) and the progress of medicine shall certainly contribute to increase this figure in years to come.

In sub-Saharan Africa, due to diminishing life expectancy related to socio-economic difficulties, with the charge of older persons caring and other vulnerability, the demographic transition will be more rapid. The number of older persons shall be superior to that of youths.

In developing countries, the ageing of the population is more rapid than was the case of the developed world. If it took more than 100 years for the European aged 65 years and above to double from 7 to 14%, it shall take only 25 years for countries on their way to emergence to know the same growth in their aged population. This means they have less time to prepare this ageing of the social changes such as population

Demographic evolution requires radical social changes such as policies and programmes enabling older persons to continue to play an active role in the society. While avoiding to aggravate the inequalities often at the origin of health problems in an advance aged. Ageing cannot be limited only to questions and reflections on sanitary or social health however essential. There is also the loss of autonomy. Evidently, the stretching of life expectancy should be apprehended in all dimensions so that it is lived as an extraordinary progress of civilization.

Population ageing comes with challenges as well as with new opportunities to be exploited. It weighs on the social security systems and retirement. As such, it necessitates the creation of an environment that favours the accessibility of persons advancing in age to health facilities as the result of the growth in the demand of acute and primary health care. Older persons losing their autonomy will multiply. They will not be able to live by themselves because they will have movement difficulties, will be fragile or will have other physical and mental health problems. A great number of them will need self-adapted care (home care, community care, and care from health support stall for daily tasks, lodging in specialized establishments or prolonged hospitalisation).

According to studies carried out by BUCREP during the 3rd central population and Habitat Census of 2005 and following the demographic growth rate evaluated at 2.6%, the population of Cameroon is estimated at 19406100 inhabitants at 1st January 2010, older persons aged 60 years and above represent 5% of the population, that is 1067 336 inhabitants.

In Cameroon the problem of ageing for long is diffused, considered as a minor institutional pre-occupation. The preconized option is the familial care delivery to all vulnerable persons and older aged persons principally. Faced with the all growing number of abandoned older persons and the incapacity of general institutional mechanisms and the capacity of families to deliver correct care to them, the Government, in the context of the implementation of the social inclusion policy for the support of the president of the Republic saw the necessity to come up with a specific framework and efficient to deliver care to older persons. This is why the ministry of social Affairs, with the support of its partners, in 2012 elaborated a Document on policy for the protection and promotion of Older person; which was approved by the Government for implementation

1.2.3 PROBLEM STAMENT

Alzheimer disease (AD) affects individual’s quality of life in a profound way. As cognitive and functional abilities are lost, individuals with dementia become unable to engage in many of the activities that once gave him a sense of pleasure. Behaviors and social skills may also deteriorate, precipitating interpersonal conflict that may cause an individual with AD to become socially isolated (Logsdon & Terri, (1997); Terri & Logsdon, (1991).

When a patient suffers from AD, there will be a lot of risk in life; changes in human brain affects memory, language, action and many factors. Memory loss; the important risk of memory loss may be the failure to remember the way to go back home, which will cause the patient not to go back home timely. Poor language ability; the patient cannot use concise language to express their thoughts. Their language will be difficult to understand. This will add the risk that others will not understand what the patient really want to say and this may have a serious consequence in the environment (Zhao Yi & Zhao Jiaying, (2018)

The daily living of people with AD, aggressiveness was mentioned as one of the difficulties encountered by family caregivers. A study conducted in a referral center for Alzheimer's disease care with 208 family caregivers of elderly individuals with this disease in the city of Curitiba, in the state of Parana, southern Brazil, showed that caregivers are afraid due to the changes in behavior and personality of these elderly people. They reported that such changes pose risks to the well-being of both caregivers and elderly individuals. Similar result was found in the present study. Family caregivers must know the signs and symptoms of Alzheimer's disease very well and use care strategies that support this process.

It is important for family caregiver to understand and manage the elderly individual's aggressiveness and not to take their verbal and physical aggression. Care for elderly individuals with AD was found to be associated with the maintenance of physical safety and reduction in anxiety and restlessness, among other factors. It is known that elderly individuals with AD reject what is new and do not adapt to new conditions easily. As a result forcing them to perform unknown activities can lead to irritation.

Thus, it should be emphasized that one should work on the uniqueness of each elderly individual with AD, recognizing and valuing their habits, culture and history. (Scola Anna Nery,(2016).

Dementia can be define as an acquired syndrome of decline in memory and other cognitive functions sufficient to affects the daily life in an alert patient. Alzheimer disease is characterized by a gradual onset and progressive decline in cognitive functioning; motor and sensory functions are spared until late stages. Memory impairment is a core symptom of any dementia, and AD it is present in the earliest stages. AD patient demonstrate difficulty learning new information and retaining it for more than a few minutes. In later disease stages their ability to learn shows even greater compromise, and patients are unable to access older, more distant memories. Aphasia, apraxia, disorientation, Visio spatial dysfunction, and impaired judgment and executive functioning are also present (DSM-IV diagnostic criteria.). The cognitive impairment of dementia eventually has a profound effect on the patient’s daily life. Difficulty in planning meals, managing finances or medications, using a telephone, and driving without getting lost are more uncommon. Such function impairments may first alert others

That a problem is emerging. Numerous functions are maintained in patients with AD of mild to moderate severity, including such activities of daily living as eating. Bathing and grooming. Many patients remain socially appropriate during the early disease stages. Behavior and mood changes are common, including personality alterations, irritability, anxiety, or depression. During the middle and late stages of the disease, delusion, hallucinations, aggression, and wandering may develop. These behaviors are extremely troubling to caregivers and often result in family distress and nursing-home placement. Although the cause of AD are variable, the progression of AD often follows a sequential clinical and functional pattern of decline. Dementia recognition may be complicated by the presence of either delirium or depression.

Delirium has been defined as a syndrome of acquired impairment of attention, alertness, and perception. Delirium and dementia are in some ways similar: both are characterized by global cognitive impairment.

The primary treatment goals for patients with dementia are to enhance quality of life and maximize functional performance by improving cognition, mood, and behavior. The use for pharmacologic treatment for behavioral problems is recommended only after non pharmacologic ones prove ineffective or there is an emergent need for them example risk of danger, extreme patient distress (Gifford & al, (1999).

After carrying out our literature on the social affection determinant and quality of life of person affected with Alzheimer disease, we noticed that the authors did not mention some essential factors from which can favors the memory of a person suffering with Alzheimer disease.

While on the field, we observe that, is mostly the physical, mental and social wellbeing that is taking care of. Quality of life medically has become increasing in recent years. Also, we observe a multidimensional appreciation of physical health, mental health, social functional health in terms of mobility, physical activity, social role that has to do with relationship with family. We observe that, most programs have been put in place to cater for older people. Older person suffering with dementia should benefit from convenient families and institution that takes care of old people. Most at time they are pick up from the street because they don’t have any person to take care of them so, they are taking to institutions to take care of their physical and social wellbeing. Empirically other aspects where absent.

My problem is the determinant of quality of life of old age person affected with Alzheimer is a gap between what authors have said about Alzheimer disease in the literature, they mention cognitive, social, scientific factors. On the field, they mention social, physical wellbeing factors. The situation of person with dementia and the quality of life with person living with Alzheimer is that of cognitive, physical, social memory and scientific evolution factors have been mentioned but the Authors did not mention the determinant of quality of life which has drawn my attention to states that, if this determinant are put in place, it will enhance the life of the person affected with Alzheimer’s disease. These factors put in place are strategies to favors the quality of life of the person as presented in our subsequent.

Caring the fact that the nurses are coming around to administer care to the patient each day in and out and the quality of care shown to the person will make the person to develop feelings of love shown to him and this will go along to enhance the longevity of living and the quality of life of the person affected with Alzheimer

Touching each time that one of his close relative is always coming back and touching the person on a particular part of the body will make the cognitive impaired person will feel a special touch each this person will develop an affectionation memory and the old age person will feel love through the fact that, this special person whenever around, the touching is a sign of love to him or her and will ameliorate his quality of life no matter the impaired memory.

Social actions; looking has a great impact and the fact that when talking to the person and looking at him directly in the eyes will favor his cognitive impairment or the early stage of dementia and help maintain his longevity of life and favoring the affective memory.

Peace is very primordial in quality of life. If a person with an impaired memory live in an environment that is calm, eat well, have a conveyable relationship with the divinity and have access to his fundamental needs this will go along to ameliorate quality of life. This person will develop an affective memory due to the fact all his needs are available, he or she will have a calm mind and this will go along to have a positive impact on the person quality of life.

Love is a strong and positive emotional and mental states of human, ranging from the most sublime virtues, deep interpersonal affection, and simple pleasure. You know that given little names to a cognitive impairment person makes the person feel love and this favors the person’s life. No matter who you are, loving and being loved are the things that bring happiness. It’s a beautiful healing quotes to help you get through the taught times. Love is a feeling support by a decision to care for another person unconditionally. As we earlier said this factors will favor a person suffering from Alzheimer to develop an affective memory that will improve his quality of life.

Old age person should be a cause of celebration relating to disability and dependence. Dependence arises from disability represents only a limitation in the performance of activities of daily living example cooking, shopping, laundry, house hold, washing, dressing, toileting and eating. The limitation may mean that the person may take longer to do his task, or experience or discomfort. Thus disability may be experienced without dependence but dependence may imply some degree of disability usually of a more severe form. Since disabilities arises from a health condition, then dependence also requires the presence of one more health conditions to account for the underlying disability.

1.2.4. RESEARCH QUESTION

Does social affection determinant influence the quality of life of old age person affected with Alzheimer?

1.2.5. GENERAL HYPOTHESIS

Social affected determinant influences the quality of life of old age person affected with Alzheimer

SPECIFIC HYPOTHESIS **1**

Caring influences the quality of life of old age person affected with Alzheimer

1.2.6. SPECIFIC HYPOTHESIS 2

Social action influences the quality of life of old age person affected with Alzheimer

1.2.7. SPECFIC HYPOTHESIS 3

Love influences the quality of life of old age person affected with Alzheimer

1.3. GENERAL OBJECTIVES

To re-enforced the quality of life of old age person affected with Alzheimer through the special follow-up

1.3.1. SPECIFIC OBJECTIVE 1

To show that caring influences the quality of life of old age person affected with **Alzheimer**

1.3.2. SPECIFIC OBJECTIVE 2

To show that love influences the quality of life of old age person affected with Alzheimer

1.3.3. SPECIFIC OBJECTIVE 3

To show that social affection influences the quality of life old age person affected with alzheimer

1.4. THEMATIC AND SCIENTIFIC INTEREST:

The interest of the study is to find in what and whom this study is important. Also we situate the interest of our study on many aspects.

1.4.1. SOCIAL INTEREST:

Brings mostly great measure where it changes the social conception of disability also intellectual deficiency. Instead of disable people and even those of intellectual deficiency continued to be considered as invalid in participating socially. Through the support of determinant, these people are capable to integrate in social milieu and help their family to execute daily duties and make effort to become autonomous and independent. The society and even family members will have free time for them to vacate for their normal duty. For the old age person intellectual deficiency those suffering from Alzheimer will themselves be fulfilled and have access to well-being.

1.4.2. PROFESSIONAL INTEREST AND PRACTICE

Through this study we want to ameliorate support action of old age person affected with Alzheimer disease and their caregivers. And people with intellectual deficiency to accept their concept and move on with life. We want to change the conception of intellectual deficiency, because the society looks at them as intellectual deficient people but let them be capable to participate in their daily life activities, if there is a support action for the quality of life.

1.4.3. THEORICAL INTEREST

This study permits us to understand new approach of the disease. When a patient suffers from Alzheimer disease, there will be a lot of risk in life, changes in human brain affects the memory, language, action and many factors. Memory loss, the important risk of memory loss may be the failure to remember the way to go back home, which will cause the patient not to go back home timely. Poor language ability, the patient cannot use coincide language to express their thoughts. Their language will be difficult to understand. This will add the risk that others will understand what the patient really wants to say and this may have a serious consequence in their environment. (Zhao Yi & Zhao Jiang, 2018)

1.4.4. INSTITUTIONAL INTEREST

This study gives us the opportunity of putting in place a measures in the university of Yaoundé I, a whole theoretical and thorough practice concerning intellectual deficiency and adequate support action through a follow –up of person affected with Alzheimer and their quality of life.

1.4.5. PERSONAL INTEREST

In this research as a student of special education, we are learning more in acquiring knowledge in the area of follow up of old person affected with Alzheimer. This study has permitted us to benefit from a greater information as far as intellectual deficiency is concerned, it causes, it strategies and factors put in place to help the patients to live a fulfilled life to the end of his days. It helps us in the amelioration of the conception of mental deficiency and to give hope to the person presenting a deficiency and his family. We shall proceed with delimitation of our studies.

1.5. DELIMITATION OF STUDY

To limits means for Grawitz (1996:499)" to determine the means that the researcher dispose taking into consideration the obstacle to meet". Also to limit: spatial and geography, temporal, history, theorical demographic delimitation.

1.5.1. SPATIAL OR GEOGRAPHIC DELIMITATION

We carried out our research in central hospital Yaoundé at the service of Geriatric and gerontology. Yaoundé I Sub-division, Mfoundi division, central region.

1.5.2. TEMPORAL HISTORY DELIMITATION

We would have love to take more time to better realize our study, but reason that the duration of our training is two years to obtain Master II. We effectively carried out our studies along this period of two years.

1.5.3. THEORETICAL DELIMITATION

Our topic of research brought us to use theoretical model in quality of life of people affected with Alzheimer social action, caregiving, showing love, living in calmness

1.5.4. DEMOGRAPHIC AND SOCIAL DELIMITATION

We would have wished to work with adolescent affected with Alzheimer or neurocognitive disease, but we choose to work with the old age person which age varies from 60- 75 years. Finally, we were supposed to present our topic, justification, his explanation, object of the study, context, and formulation of research question, objectives, interest and delimitation of the study. The chapter that follows will permit us to expatiate on our studies.

In the case of our study, we are interested on Social affection determination and quality of life to old age person affected with Alzheimer. We shall then present our experimentation through the quality of life of old age person affected with Alzheimer disease. We shall continue with the second parts. Title: Theoretical basis and conceptual of the study

CHAPTER 2: CONCEPTUAL FOUNDATION AND THEORY OF THE STUDY

In this part, it has to do with gathering of writings that will give account of our problem. That is the reason in which we shall lay emphasis on theory aspects which will give account on the quality of life of old age person affected with Alzheimer. We will begin with the definition of basic concepts of our study.

2.1 AUTHORS IN PSYCHOLOGIE AND DISABILITY

In the past, the typical clinical trial utilized self –report and clinician rated measures of symptom severity as primary indices of outcome. However more recently, strategies for assessing and treating disorders have been expanded to include cognitive and biological variables example executive functions, indices of neurological, aspects of brain function; studies have been carried out to examine symptom and diagnosis specific brain-behaviour relations, linking distinct neurocognitive profile to cognitive example worry, cognitive distortions, emotional example fear, rumination, depressed mood, behavioral dysfunction example inattention, impulsivity, compulsive behaviours as well as symptom severity, comorbidity, and treatment response. Roy & al., (2008); Reddy, & Mohlman (2012) mood dis-orders. Recent studies have extended these findings, demonstrating the clinical utility of neurocognitive assessment in differential diagnosis.

The study suggests that Social relationship is not only important in their own right, but are also catalysts for well- being and other aspects of life, including physical health and psychological well-being. Therefore, to enhance well-being and reduce vulnerability among people living with dementia, supporting relationships and social inclusion should be high on the policy agenda.

Well-being and quality of life in the field of health psychology also focus on positive subjective. According to Rains & Black (2007) “this focus on the single domain of subjective or psychological well-being “, they tend to be multifaceted; that is they include feelings of satisfaction in various life domains example satisfaction with health, satisfaction with social relationship, as well as global satisfaction or contentedness Bro & al (1999); Trigg & al (2007); Claire and al (2008).

An exclusive focus on subjective experience is sometimes criticized because a positive psychological state can co-exist with objective dis-advantage, as people adapt and develop coping mechanism to deal with hardship. Sen (1988). The paradox" of happiness in hardship" means that subjective and objective well-being can 'come apart', and that subjective well-being is not always a reliable indicator of objective quality of life Austin (2015). This suggest that, from a policy point of view, while people's subjective feelings about their lives are important, objective well- being should be taken into consideration.

According to (ICD) International Classification disability and (WHO) World Health Organization, disability is conceived in three notions; a deficiency, an incapacity and a disadvantage. Deficiency apprehend the corporal alteration of organics or functioning. Incapacity apprehend the partial reduction or total. This limit the capacity which permit an individual to perform an activity. The disadvantage is the result of the deficiency and the incapacity. Banindjel (2021). "The person himself can produce obstacle which will lead him in a dis-able situation instead of the environment ".

2.1.1. MENTAL DISABILITY

The emergence of the notion of mental disability is now a challenge for the society in general and the world in particular. Due to mental disorder, a certain number of people find themselves in a situation of disability in their personal and professional life. In 1970, at the request of the WHO, the British epidemiologist Philip Wood worked on a conceptual clarification of the definition of disability by specifically questioning rehabilitation and compensation needs. He then defined disability as the consequence of diseases and traumas on the person and proposed to understand them from three' plane of experience': impairment (alteration of an anatomical physiology or psychological structure or function), physiological must old people have change digestive system. They don't drink water except it's stimulated, they have eating problem and psychologically they have swallowing problem. Incapacity total (way partial or total reduction in the ability to carry out an activity in a normal).

According to (WHO) World Health Organization, mental disability is a stop of mental development or an incomplete development at the level of cognitive functioning, motor language and social performance.

The development of interventions that may effectively reduce the burden of disability in older population is a major concern for the social and health care system of all European and non-European countries. In spite of abundance of observational data, evidence that age-associated disability can be prevented or delayed is scarce and limited. THE BURDIS network is presenting recommendation concerning the conduct of both clinical trials and large-scale trials of interventions aimed at preventing or delaying disability in older persons:

- Trials aimed at prevention of disability in old age should be considered a priority in the allocation of resources for health and social care research.
- Standard criteria should be develop and validated for the identification of older person at high risks of disability, and a standard operational definition of frailty should be developed
- Given the multifactorial origin of disability, multi-component intervention of need to be develop and tested
- Disability-related measures should be systematically introduced among the primary outcomes of intervention trials that target the kinds of diseases and health events that are highly prevalent among the old population.
- Because in significant part the predictors of old age disability stem from earlier phases of life, it is important to examine the predictors and risk factors also from the life- course perspective and not only rely on the relation to prevailing living conditions and behavioral factors.

According to the disablement model, distresses are the main cause of impairments and functional decline which ultimately may lead to disability. People aged 70 years and over usually have two to three chronic conditions, which accounts for around two third of total national health care expenditure about 90% of all 75 year olds have some clinical diagnosis. Intervention should, therefore, aim at the prevention and effective management of chronic illness. Also sensory dis-orders and particularly vision and hearing impairment are important causes of problem in carrying out daily activities West 7 al (2002). Depressive symptoms are more frequent among the oldest old, but the higher frequency is explained by factors associated with ageing, such as a higher proportion of women, more physically disability, co-morbidity, more cognitive impairment, and lower economic status. Many underlying causes of depressive mood have a social, economic or environmental background example emotional and social loneliness, poverty, poor living conditions and negative life events including losses of all kinds. It seems that depressive symptoms and dis-orders can result from functional limitation as well as causes

2.1.2. SPECIALE EDUCATION

Special education also called special needs education, it serves children with emotional, behavioral, or cognitive impairments or with intellectual, hearing, vision, speech, or learning disabilities; gifted children with advance academic abilities; and children with neurological impairments.

Special education the individual with disabilities define special education as instruction that is designed specially to respond to the learning needs of an individual with disabilities regardless his environment, whether in a classroom, home, or hospital. Special education is ‘special’ because it has a distinct place in the education of not only individuals with disabilities but also diverse learners, including those who are at risk. Special education is composed of a range of teaching practices specifically designed for the needs of individuals with disabilities, who have special needs that are implemented by well- trained special education teachers and not normally seen (Educ. Sci. 2020)

In 2006, the United Nations adopted the Convention on the rights of persons with Disabilities reflecting a shift in how the world view individuals with disabilities as person with rights and fundamental freedom. As the shift in paradigm occurred, contemporary special education practices came to be influenced by perspectives of social justice, human rights, and education equity. Special education is often seen as a way to provide equity for individuals with disabilities; however, it may seem that the current way special education is structured does not pave the way to that equity.

2.2. AUTHORS OF QUALITY OF LIFE AND WELL-BEING

Dementia is defined by the world Health Organization as “a syndrome, usually of a chronic or progressive nature, caused by a variety of brain illnesses that affect memory, thinking, behaviour and ability to perform everyday activities” (WHO, 2013). Symptoms typically involve “a progressive deterioration in cognitive function, resulting eventually in severe cognitive impairment. The individual with dementia experiences a gradual decline in their ability to understand, remember, reason, communicate and use learned skills” (Alzheimer’s society 2010). World health organization definition of “health” as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity. These three dimension in any scale or index purposing to measure health or quality of life, namely physical function, mental status, the ability to engage in a normative social interaction.

According to UN statistics, the number of older persons was 600 million in the year 2000. It will increase to 2 billion in 2050. In most developing countries, the proportion of older persons currently estimated at 6% will reach 21% in 2050. This population growth is followed by a precariousness of their situation. The population growth is 3% in developing countries and medical advancements will certainly help increase that number in the coming years. Hence, the older population has to quadruple over the next 50 years.

In 2010, the UN establish a working group on ageing, to address the gaps in existing human rights standards in relation to older people, and because "throughout the world, large numbers of older persons face challenges such as discrimination, poverty and abuse that severely restrict their human rights and their contribution to society" (UN 2012).

According to l'Insee, from the first January 2014, France counted 66 million number of habitants. Old age persons of 65 years represented 18% of the population that is a progression of 3, 4 points in twenty years. From the projections of population in 2060, an estimate of 26, 7% as part of 65 years and at most 19, 64 million of persons. The augmentation of life experience at birth to old age generation of baby-boom is then responsible for ageing of the French population. Due to the fact of augmenting the number old age persons.

In developing countries, the ageing of the population is more rapid than was the case of the developed world. If it took more than 100 years for the European aged 65 years and above to double from 7 to 14%, it shall take only 25 years for the countries on their way to emerged to know the same growth in their aged population. This means they have less time to prepare this ageing of the social changes as the population

In sub-Saharan Africa, due to diminishing life expectancy related to socio-economic difficulties. With the charge of older persons' caring and other vulnerability, the demography transition will be more rapid. The number of older persons shall be superior to that of the youths. In developing countries, the ageing of the population is more rapid than the case of the develop world. If it took more than 100 years for the European age 65 years and above to double from 7 to 14%, it shall take only 25 years for countries on their way to emerge to know the same growth in their aged population. This means they have less time to prepare this ageing of social changes in term of population.

Demographic evolution requires radical social changes in policies and programs enabling older persons to continue to play an active in the society. While avoiding to aggravate the inequalities often at the origin of health problems in an advance aged. Ageing cannot be limited only on sanitary or social health however essential. There is also loss of autonomy evidently the stretching of life expectancy should be seen in all dimensions so that it is lived as an extraordinary in progress of civilization. Population ageing comes with challenges as well as with new opportunities to be exploited. It weighs on social security systems and retirement. As such it necessitates the creation of an environment that favours the accessibility of persons advancing in age to health facilities as the result of growth in the demand of acute and primary health care. Older person losing their autonomy will multiply. They will not be able to live by themselves because they will have movement difficulties, will be fragile or will have physical and mental health problems. A great number will need self-adapted care (home care, community care, and care from health support stall for daily tasks, lodging in specialized establishments or prolonged hospitalization).

Bennett (1980) “portrayed long-term care quality of life in terms of satisfaction of basic human needs; physiological, safety and security, self –esteem and accomplishment.” Some have argued that the resident’s subjective point of view should take precedence, and several instruments have been developed specially for administration to persons with the disease. (Brod, Logsdon, Gibbons, Mc Curry& Terri (2000) “A significant proportion of persons with Alzheimer’s disease and majority of long term care residents with the disease either cannot respond or provide respond or provide responses of questionable validity due to lack of memory, inability to concentrate, lack of the capacity for introspection, unawareness of their impairments and disabilities, inadequate or absent of language skills, through disorders”.

Measuring quality of life LAWTON (1991) “defines quality of life as the multidimensional evaluation, by both intrapersonal and social- normative criteria, of the person’s environment system of the individual”

The primary treatment goal of patients with dementia are to enhance quality of life and maximize functional performance by improving cognition, mood, and behaviour. The use for pharmacologic treatment for behavioral problems is recommended only after non pharmacologic ones prove ineffective or there is an emergent need for them example risk of danger, extreme patient distress. (Gifford & al 1999).

A report review published on issues affecting women in relation to dementia from international perspective. Women make up a larger proportion of older population. In 2014, women were accounted for 62% of people aged over 80. Ageing population is rapidly in Africa, Latin America, the Caribbean, and Asia. The prevalence of dementia worldwide is increasing. By 2050 over 71% of people with dementia will live in low and middle income countries. The impact on women will be greater than men. It is noted that, women mostly live with dementia than men and risks are more severe. Women provided a substantial proportion of informal care to people with dementia, with around two third of primary care givers are women

Quality of life has become increasing in recent years. Also we observe a multidimensional appreciation of physical health, mental health, social functional health in terms of mobility, physical activity, social role that has to do with relationship with family. We observe that most programs have been put in place to cater for older people. Older person suffering with dementia should benefit from convenient families and institution that takes care of old people. Most at time taking to institutions to take care of their physical and social well-being.

Anxiety and depression are complications that is been observe among ageing people. It is noted that, the prevalence of depression is mostly raise among general population. Social sustenance is a means of coping to a chronic disease. Many research has shown the positive effect of social sustenance, physical and mental health of a sick person. It helps to contribute to help the sick person to manage difficult aspect of the sickness. The effect of social sustenance resides in the quality of relationship and how individual perceives it Tarquinii & Fisher (2002).

For clinical study purposes test batteries status are used, most commonly the mini mental status examination (MMSE) and Alzheimer’s disease Assessment Scale (ADAScog). Cognitive scales such as the (MMSE) or cognitive sub-scale of the ADAScog mingle the results of several cognitive functions into one composite score. While any of the assessed symptoms might be present at one time at a point or the other during the course of an individual’s disease they will not be present all at once at a given stage of disease. Moreover, the dynamic range for observation of change is not the whole centered around the observed scored.

The concept of QOL related according to Lawton (1997) “characterized five domains pertaining to QOL for subjects with dementing illnesses to comprise the same areas as in people in general (cognitive functioning, ability to perform activities of daily living, being able to engage in meaningful time use, social behaviour, as well favorable balance between positive emotion and absence of negative emotion”).

People with mild dementia and even those with mild cognitive impairment (MCI) frequently demonstrate decreased awareness of their cognitive impairments and change of behaviour. In particular, decreased awareness of deficits manifests as poor awareness of deficits in activities of daily living (ADL).

Alzheimer disease related quality of life (ADRQL), according to Rabins & al (2000) “construct an instrument that is consist of 47 items, completed by care provider, that describe behaviours that were judged by focus group of family caregivers and professionals to be of importance to health- related quality of life in Alzheimer’s disease” .

The items address the following five domains: social interaction, awareness of self, feelings and mood, enjoyment of activities, and response to surroundings. The various domains contain 5-15 items, each of which is rated and scored as either agree or disagree. Items are assigned weights, ranging from 9.15 to 13.51, which were designed to reflect the extent to which the item influences quality of life.

A second approach encourage communication being listened to and understood are important values for quality of life. Positive responses to challenging behaviours, although confusion, memory loss, a loss of inhibition and impaired executive functioning can trigger very challenging behaviours. How we respond to this can significantly impact the quality of life

2.2.1. FACTORS OF A QUALITY OF LIFE AND IMPACT

Positive factors

A decent level of income maintaining as good as possible health status; physical, cognitive, and emotional. Access to necessary and affordable healthcare services such as including ambulance service, visits from family Doctor or several visits per month by the family doctor. Care for adequate Nutrition to health status, a good relation with the family members; involvement in social activities.

The development of disability in old age is regarded as a dynamic social phenomenon that relates to individual physiological, psychological and medical conditions as well as socio-economic position, cultural norms and environment. There are many theories about disability. The disablement model was used as the starting framework, the main pathway in the disablements process proceeds from the acquisition of pathology disease, injuries to impairments; physiology or mental abnormalities which generate functional limitations in basic physical and mental actions, ultimately leading to disability; cessation or restriction in carrying out activities of daily living and other social roles. The disablement process is modified by factors related to life style, availability and use of services, ageing processes, and characteristics of the social and physical environment. The most commonly used measures of disability are self-reports of basic activities of daily living such as mobility and self-care and instrumental activity of daily living such as preparing meals, shopping, telephoning, management, management money, taking medication.

Most studies applying the disablement model have focused on chronic somatic conditions as causes of impairments and functional decline, attempts are made to also explore the role of the psychological and mental health factors together with the environmental factors as predictors of old age disability.

Negative factors

Health status deterioration (especially mental). The loss of the ability to move independently. The lack of age- friendly houses and buildings (example residential building without elevators). The lack of relatives or the distance to the family members. The weak involvement of the family (especially from the emotional point of view) in the care process.

Fragility is a geriatric syndrome which is characterized by negative health outcomes such as decrease in physiological reserves and body mass index, physical deformity, slowness, weakness, lower level of physical activity and stress intolerance, burnout, and may result in death Wehbe & al (2013); Forman & Alexandra (2016). Sick and fragile elder individuals become more sensitive toward geriatric syndromes. The rate of fragility is 20-30% in individuals aged 75 years and older and 30-40% in individuals aged 85 years and older. Fragility prevalence increases with age and it has been reported that being a woman and having a lower socio economic level increase fragility.

SOCIAL MODEL OF DEMENTIA

The individual with impairment is also disable by the barriers created by material and social environment. Consequently, in addition to individual-level medical care, policies and practices based on a social model of disability would aim to alter the external environment to remove socially constructed barriers and enable people with impairments to function as well as possible. This definition see disability as resulting from combination of the difficulties that people face in their daily life. Functional level limitations (both physical and cognitive) features on the social environment (crow 2010).

The social model is a useful tool for thinking about ageing and dementia. It is a kind to the "person environment fit model" used by world health organization in their world report on ageing and health (WHO 2015), and many researchers have argued that dementia is best understood in social context Robinson & al (2011); Ward & al (2012).

In the case of the home care services, the social services providers mentioned the risk of inadequate care despite the good intensions of the caregiver. Residential care was considered to be able to contribute to a better quality of life for dependent elderly people, as it facilitates access to adequate medication, staff, and medical care despite the social stigma associated with institutionalization of older family member.

Respect for the privacy of a dependent elderly person is important regardless of where the services that are provided, the provider having the responsibility to ensure the training of staff in this regard. A first step in this process is to understand the meaning of privacy for dependent person. Respecting the privacy of an elderly person implies respect for his or her religion beliefs, and in the case of home care services, it is important to respect the wishes of and restriction imposed by the person during the provision of services .Improving the health of and health services for older people by ;promoting physical activity through inter-sectorial collaboration, comprehensive geriatric services: increasing clinical skills in geriatric medicine, screening for frail elderly people in the community, improving social support for elderly people; providing adequate housing and pensions for older people, preventing prejudice and discrimination.

PSYCHOLOGICAL THEME OF WELL-BEING

Three major themes were identified on living well with dementia. Contentedness, living well with dementia focuses on the subjective experience of the individual with dementia, and emphasizes positive psychological states. For example, the contented dementia trust advocates a method that priorities subjective contentedness in people with dementia; the goal is that the person with dementia feels content. Within contentedness of people with dementia Definition of well-being and quality of life in the field of health psychology focuses on positive subjective states Robin & black (2007) " while these remain focused the single domain of subjective or psychological well-being, they tend to be multifaceted; that is, they include feelings of satisfaction in various life domains example satisfaction with health, satisfaction with social relationships), as well as global satisfaction or contentedness" Clare & al (2008). Psychological definition of well-being include mood, agitation and withdrawal which focuses on 'personal growth, sense of agency, confidence and hope' safety and security; safety and security themes relates to the prioritization of safety and security in the definition of' living well with dementia' Clarke & al (2010). This definition focuses predominantly on the individual with dementia, and gives priority to single central domain. Safety and security often tend to be more medicalized, using language around 'risks management' and 'problem behaviours' (Camberg & al (1999).

An important example of a social flourishing approach to dementia is the Alzheimer's society's dementia friendly communities program (Alzheimer 's society 2013), which works to involve people with dementia and all members of the communities to create a social environment in which people can live well with dementia Campton & al (2012),

MUL-TIDIMENSIONAL WELL-BEING

Social definition of living well with dementia should contain disease-specific elements In order to be sensitive to particular challenges faced by people living with dementia Bro & al (1999) .

The domains of wellbeing that are important to people in general remain important for people with dementia; therefore, definition of well-being should avoid being over health focused Trigg & al 2007; Coast & al (2014).

In the capabilities approach, well-being is characterized in terms of capabilities to achieve central human functioning. Functioning are a matter of what people are able to be and do Stephens & al (2015). Functioning might include being healthy, being in control of one's own life, being mobile, having good social relationships, participating in a community and having self-respect.

Capabilities refers to freedoms and opportunities individual have to achieve these valuable states and activities. A central claim of the capabilities approach is that capabilities and functioning, rather than resources, should provide the measure of well-being. This is because the resources can result in very different outcomes

For example, the resource of a person with a physical impairment will require to achieve mobility will be greater than that of an able- bodied person. Personal, social and environmental factors all affect how resources convert into living well Lindley & al (2011).

Personal physical impairment, social norms, relationships and structures, and the physical layout of the built environment all affect the extent to which resources enable a person to live well. According to Nussbaum (2000) the capabilities approach was designed originally as a general theoretical approach to extends the theory with a list of ten central 'Human Functional capabilities', labelled; life, bodily health, bodily integrity, senses, imagination and thought, emotion, practical reason, affiliation, other species, play and control over one's environment.

CONCEPTIONS OF LIVING WELL WITH DEMENTIA

This evaluate the well-being and quality of life. These frame work were designed primarily as measurement instruments for assessing quality of life in dementia. Each framework is rooted in a substantive theoretical or empirical definition of what constitutes a good life with dementia. It is this underlying theories of well-being that are the main focus of the analysis below.

Table 01. Table of capability cited by Nussbaum (2000)

Box 1: frameworks of well-being in Dementia	
‘ My name is not Dementia’ (Alzheimer’s Society)2010	Dementia Quality of life (DEMQOL) (Smith & al 2015)
1.Relationships or someone to talk to 2.Environment 3.Physical health 4.sense of humor 5.Independent 6.Ability to communicate 7.Sense of personal identity 8. Ability to practice faith and religion 9. Ability or opportunity to engage in activities 10. Experience of stigma	1. Daily activities and looking after yourself 2. Health and well-being 3. Cognitive functioning 4. Social relationships 5. Self- concept
Dementia Quality of life (DQOL) (Brod & al 1999)	Bath Assessment of Quality of life in Dementia (Trigg & al 2007)
1.Physical functioning 2.Daily activities 3.Discretional activities 4.Mobility: Activity to travel out of the house 5.Social interaction: social relationships 6.Interaction capacity: Ability to interact with the environment 7.Bodily well-being: symptoms and bodily states reflecting physical comforting, discomfort 8.Sense of well-being: positive and negative emotional/affective states and perceptions of self	How satisfied are you with: • Your health? • Your ability to look after yourself? • Your level of energy? • Your enthusiasm for doing things? • The way you usually spend your day? • Your level of independence? • Your personal relationship? • Your ability to talk to other people? • To what extend are you able to: • Move around your local community? • Do all the activities that you want to? • Do things that you enjoy? • To what extent do you feel:

9.Sense of Aesthetics: Sensory awareness 10. Overall perceptions: Summary ratings and evaluations about one's health and overall life situation	• You have the choice to do the things that you want to do? • Useful? • Happy?
Dementia Care Mapping (DCM) (Brooker 2005)	(Investigating choice Experience for older people Capability Index for older Adults) ICEAP-O(Coast & al 2008)
1. Demonstrating assertiveness 2. Bodily relaxation 3. Sensitivity to the needs of others 4. Humour 5. Creative self-expression 6. Showing pleasure 7. Helpfulness 8. Initiating social contact 9. Showing affection 10. Signs of self-respect 11. Expression of a range of emotions	1. Attachment (love and friendship) 2. Security (thinking about that makes you feel valued) 3. Role (doing things that makes you feel valued) 4. Enjoyment (enjoyment and pleasure) 5. Control (independence)

The three theme of living well with dementia identified in the literature are contentedness, safety-security, social flourishing. The Alzheimer's society list in box 1 constitute the importance of a good life with dementia was also used as a prompt discussion. The Alzheimer society list was developed through research with people with dementia; therefore, using this as a starting point for the discussion meant that the perspectives of person with dementia were central to the discussion.

The list is specified at an abstract level; the analysis below aims to expand and refined the central capabilities in relation to people with dementia. It is noted that every domain on Nussbaum's list was covered during the discussions, despite not being explicitly introduced to participants. This lends some support to the claim that these domains are of universal importance to human beings.

Given the theoretical importance of social connection in the social model of dementia, this domain is analyzed first. Following affiliation are the domains of 'emotion, bodily integrity, control over the environment, practical reason, senses, imagination and thought, other species and play. Affiliation (Being able to live with and towards others). The domain of affiliation includes both social connectedness in general, plus the social bases of self- respect (Nussbaum 2000), refers to recognition by society of each individual personal hood and dignity. It is noted that dignity is one of the features that the UN (2012) has emphasized as a human right in old age.

There was consensus on the fundamental role of affiliation in the lives of person living with dementia. We "think that relationships and social connections is the most is the one that probably stands out for me as well, we think that it got a lot of different level in terms of getting that cognitive stimulation.

Social connectedness; in relation to social connectedness, both close personal relationships and a great wider social ties affiliation emerged as important. Participant agreed that close relationships with families and friends, and family caregivers, constitute a central part of living well with dementia. Persons with dementia and family caregiver have both specific individual needs, and many shared needs and goals relating to the capability to live well together. The highlight the vital role of support for family caregivers, in terms of their own individual needs and goals, as well as shared needs and goals, including their capability to care for the person with dementia.

A common challenge for people in living well with dementia is adjusting to change in role and relationships. Family members often experience a sense of loss in their love one begins to change, and participants highlighted the tension that can arise between family members' desire to stay connected with the former person, and need of the person with dementia to live and to be as they are now, perhaps mainly" in the moment."

This shows that it is not only the person with dementia whose self-identity may be fragile and need support, and the inter-relationships between people, is required for living well with dementia together.

2.2.2. PSYCHOLOGICAL IMPACT

There are adverse effects on caregivers' personal health, but the effect on psychological well-being is most frequently studied. Ninety-three studies comparing depression symptoms between caregivers, non-caregivers Meta –analysed, and show significantly higher symptom levels among caregivers, the difference being larger for studies that focus on exclusively on dementia care givers. A review of ten studies assessing major depressive disorder among caregivers of people with dementia using structured clinical interviews, reported a prevalence of 15% and 32%, 3 out of 39 times higher. Older people with dementia have high increase of psychological morbidity in co-residents. Living with older person with physical condition and depression was also strongly independently associated with co-resident psychological morbidity, and the effects were only partly mediated by the demand of caring. Other mechanisms must also be involved, including perhaps the costs of purchasing health care and the worries of living with an older person in declining health. Some psychological symptoms of dementia are depression, anxiety, hallucination, delusion, wandering, agitation, aggression, and that over half of people with dementia remain agitated, and distressed towards the end of life.

2.2.3. ECONOMIC IMPACT

In an analysis of European and North American survey data conducted by the OECD of caregivers of older people (not dementia caregiver specifically) a one percent increase in hours of care was associated with a reduction in the employment rate of care givers by around 10%. In a survey of American caregivers conducted by the Alzheimer's association (US), 13% had to go from working full- to part –time, 11% had to take a less demanding job, and 11% had to give up work entirely. In the 10/66 dementia research group studies in Latin America, India and China, the median proportion of caregivers who had given up or cut back on work to care across 11 sites was 33.3%. Cutting back or giving up on work to care was associated with higher caregiver strain, while strain was reduced by hiring a paid caregiver, or having additional informal support.

Nutrition and changes in quality of life in older person. The relationships between nutrition, aging, and quality of life are recursive. Ageing –associated factors alter certain aspects of nutrition, such as the sense of smell and taste, ability to chew and swallow, and gastrointestinal and bowel function, and theses in turn may influence quality of life. At time, poor nutrition and lack of physical activity can lead to lack of appetite, inability to perform ADLs changes in quality of life, morbidity, and mortality. Benefits of food and nutrition on quality of life. Good nutrition improves HRQOL by promoting health, preventing dietary deficiency disease, and ameliorating or associated with other disease. Food and nutrition are essential components of "good life". Good food is a sensory and psychology pleasure in its own right. Meal may add a sense of security, meaning, order, and structure to an elderly person’s day, boost that person with feelings of independence, control, and a sense of mastery over his or her environment; provide opportunity for making food choices. Eating with others may increase social interactions. When the social aspects of eating are attended to, food consumption may improve nutritional aspects of eating are important pleasures of life. Tools for measuring quality of life. Many measures and scales have been used to address and quantify the impact of HRQOL. Until recently, most were used only in research studies. Today they are used increasingly in clinical settings as well.

2.2.4. OLD AGE PERSON

Older age is an ultimate age which comes after middle age, also euphemistically called the third age. It is a state most often seen in the seventh decade of life because it is at that time that the consciousness of ageing is most acute. The is real biological age known as old age but there exist a range that usually begins around the of sixth five and corresponds to be a period of life when most people are remove from active society.

2.2.5 BODY FUNCTIONS OF OLD AGE PERSON

Mental functions; various experiences triggered a range of negative emotions in participants in the analyzed studies. Diagnostic tests and the diagnosis process were described by many participants as stressful time due to uncertainties. Symptom such as hallucinations and breathlessness also left participants with negative feelings such as anxiety, worry, frustration and fear. Participant in several studies expressed fears and worries of losing independence and being burden on others, with feelings such as depression, loss of pride and emotional pain. Uncertainty about the future, particularly in conditions with poor prognosis (dementia, and other comorbidity) These also triggered negative emotion such as loss of confidence in one’s abilities, despair and fear.

Physical functions, interpersonal interactions, community and social life. Social isolation and feeling of loneliness were reported by participant. Some participants reported that physical impairments such as physical frailty, lack of independence, or ill-health reduced their ability to sustain relationships and hence contributed to social isolation. Abilities to hobby and leisure activities, some participant become dependent on their close relatives for or friends of boredom or social isolation. Indeed, loses of close relatives or friends were reported by many participants to contribute to their feelings of loneliness and social isolation.

Main findings: Mobility as well as problems they encountered in involving in social and community life. Self- care describes tasks about caring for oneself such as washing, dressing and maintaining one’s health, domestic tasks such as household cleaning and shopping. We shall discuss strategies used by participant to manage their own physical and mental health.

- Self-care and domestic life, participant in several studies reported having difficulties in carrying out self-care and domestic life tasks. However, there are studies provided some details on a tasks were affected. Washing, dressing and toileting were the main tasks
- That the participants reported having problems with bathing due to stream, or difficulty standing. Participant with dementia were reported to have problems with dressing, bathing and continence from early stages of disease onwards.
- Mobility, many participants reported having problems with mobility. These included difficulties with walking, changing body position, lifting and carrying objects, hand and arm use. Participant inability to change and maintain body positions like kneeling, bending, standing, was reported to affect their abilities to perform domestic activities such as cooking, cleaning the home and shopping.

Environmental factors, it has to do with social and physical factors that participants interact with, which may act as facilitators or barriers to their lives. “Support and action relationships” described the support, relationship and attitude, services and products and technology. ‘support and relationships’ describe the support provided to participants by their close relatives, friends, peers, professionals, community and their attitude. The importance of the support provided by family and friends was demonstrated in findings.

Family caregivers offered support to participant by finding information and coordinating services for them, assisting them with daily activities and offering them company. Participant reported feeling of happiness, joy and pleasure when interacting with family and friends, valued peer support as an important source of information and companionship, and identified with relationships with family and friends as the most important thing in their lives

In spite of these positive contributions to their lives, some participant reported feelings of being patronized, stigmatized, not understood by family and friends and were perceived differently after a period of increased vulnerability. Concerns is raise regarding participants who live alone who might not have access to an informal social support system. Geographical spread of family and friends made it difficult for someone participants to keep in touch with them.

Risks factors of disability in old age. The risks factors for the onset of disability by applying the disablement model originally developed by Nagi (1976).” The main pathway of the model consists of four components: pathology, functional impairments, functional limitation, and disability.

In old age, pathology causes impairments example decreased in muscles strength, poor balance, and low oxygen consumption. Impairments predisposed people to functional limitations example slow walking speech, inability to grasp with hands which lead to disabilities example difficulties in mobility and self-care. Old age related disease such as functional imitations, poor coping strategies, sedentary lifestyles and other unhealthy behaviours, as well as the definition of the situation of the others, and their reactions and expectations, and characteristics of their environment and the degree to which it is free from or encumbered with physical and social barriers” Nagi (1991); Laurence & al (1996); stuck & al(1999) “ The amount and quantity of social support network also significantly modify the development and effect stability”.

Products and technology; some participants reported using equipment and technology to cope with physical difficulties. The use of mobility aids such wheel chairs, walking sticks and walking frame reported by some participants with history of falls and fractures, dementia. However, the use of these aids was not always perceived positively, with some participant refusing to use them due to seeing it as a markers of loss of independence. Seeing as being bulky and expensive and some instances not usable due to the presence memory impairment.

It is shown that in spite of the physical challenges faced, many older adults demonstrated a desire to cope with their illness and maintain independence. This was demonstrated in developing self-care strategies, using mobility aids and home adaptation equipment and continuing to perform activities despite them being physically difficult. The importance of maintaining independence and supporting older adults to remain mobile and care for themselves are, indeed, well recognize priorities to official bodies, as well as, to older adults themselves Abdi & al (2019).

2.2.6 OLD AGE AND AGEING

Old age is a natural process which starts with intra- uterine life, continues until death and is caused by irreversible degeneration of cells and systems (Ozel & al, 2014). Old age is not a pathological process and it consist of physiological, sociological and chronological changes. The definition of old age is quite broad and complex. Physiological old age is used for expressing structural and functional losses; psychological old age for expressing the decreases in perception, learning and problem solving ability; and sociological old age for expressing the decreases and losses of values given by society to individual Tekin & Kara, (2018).

According to the World Health Organization (WHO), old age denote the decrease in an individual's environmental compliance ability out of her/his control and chronological defines individual aged 65 years and older. Chronological old age is classified as follows: 65-75 years define young old ages and transition period from working life to retirement; 75-85 years define advanced old ages and period where functional losses begin to be observed; 85 years and older define very advanced old ages and a period that requires special care and support. Beger & al; (2014).

2.2.7 OLD AGE EPITHEMOLOGY IN THE WORLD

In 2015, the population older than 65 years constituted 8, 5% of 617 million of the world population. According to the report “an ageing World; 2015”, it is estimated that this rate will increase to 17% and the number of elderly people will reach 1.6 billion in 2050. The population older than 65 years which is 48 million in the USA is estimated to reach 88 million in 2050. In European Union countries, on the other hand, the rate of the population older than 65 years within the total population was 18% in 2010 and is estimated to reach 30% in 2060. Japan was determine to be the oldest country (83, 7) years in 2015.

According to World Health Organization, 12% of the world population 900 million consisted of the population aged 60 years and older in 2015. It is estimated that the world population 2 billion will increase to 22% in 2050. It is also indicated that the rate of the population aged 60 years and older will be higher than the rate of the child population younger than 5 years in 2050. 13.8% of the population aged 60 years and older in 2015 were 80 years and older. It is indicated that 21, 7% of the world population will consist of the population aged 80 years and older 6% of them will be in China in 2050. It is estimated that

80% of the elderly population will live in low and middle income countries in 2050 (World Health Organization; 2018)

Aging brings along a decrease of functional reserves in organs and systems, as well as geriatric syndromes that emerge with multifactorial parameters, incontinence, sleep disorders, malnutrition, delirium, pressure sores, pain and falls, which are associated with mortality Liange & al; (2018). Aging population is a global reality, a consequence of the drop in fertility and mortality rates, which entails an extension of the population's life expectancy. As the representation of elderly people in Brazil 2018 was 9.2%, and projects indicates that, by the year 2060, it will reach the range of 32.16%.

Although the human aging process does not mean living with disease, the life increase in the expectancy inevitably contributes to the emergence of chronic non communicable disease (NCDs) and neurodegenerative diseases, such as Alzheimer's disease (AD)

B- PSYCHOLOGICAL SUPPORT

Including identification and management of comorbid symptoms such as pain and delirium. Socially and cognitive engagement, additional studies suggest that remaining socially and mentally active throughout life may support brain health and possibly reduce the risks of Alzheimer's and other dementias. Socially and cognitively stimulating activity might help build cognitive reserve. However, it is also possible that undetected cognitive impairment deceases one's interest in and ability to participate in activities involving social and cognitive skills.

Many older people developed psychological strategies to overcome difficulties. These includes accepting limitations caused by their conditions, changing attitude towards life and being positive, mental distraction and occupying time with activities, spirituality and humour. Some old people however, used strategies that might not necessarily be positive, such as denial.

2.2.8. PROBLEMS AND DIFFICULTIES OF OLD AGE PERSONS

The economic problem arises when old age people are not able to sustain themselves financially. Therefore, lose the financial independence because of increasing competition from young generation. It is often said that majority of old age people are not having the capacity to be productive. During the old age phase, metabolism, process slows down, and to individuals become physically and mentally weak. They are more prone to sickness, diseases.

They are experiencing difficulty in recalling memories; and weakness to bone disease. Many times old age people are used economically, emotionally and mentally for various reasons in different ways it is observed that the one person faces all the above stated problems.

Difficulties related to mood change; among the difficulties reported by family members/ caregivers, it was mentioned that elderly people with AD, during the course of the disease, have difficulties related to mood changes, with episode of aggression. When she is not having a good day, he gets very annoyed, he gives some more confused answer.

Difficulties linked to behaviour change

Behaviour change was reported by family caregivers as an experienced difficulty. Elderly people AD, at some stage of the disease, lose track of time and have impairments in visual-spatial function. Some days everything is perfect, but in a short time, there are blackouts, incredible burns of things like food, she forgets the gas. She doesn't accept things, nothing we say.

Difficulty related to the lack of knowledge and acceptance of Alzheimer's disease

The none-acceptance of the disease is still part of the family life of elderly people with AD, making the relationship between family member or caregivers difficult moment:

Difficulties with forgetting people, objects and places;

Family members/ caregivers report that elderly people with AD, at some point in the disease, have undermined visual-spatial function and forget about people, objects and places, even though they are close by and part of the routine, according to the reports: Suddenly, we started notice that she got lost from home and then we got started to notice that she started not wanting to go out anymore, and I got really lost.

Another difficulty revealed in the present study was that elderly people with AD, at some point during the illness, forget people, objects and routine place. A study identified that the loss of memory of a person with AD is experienced with great distress by family members, who can associate it with a loss of the person. Ad- related forgetfulness happens in the stages of the disease, when recent memory loss occurs, leading to the forgetfulness of objects and people with whom the elderly person does not live on a daily basis, progressing to difficulty in performing ADLs.

Social protection, which seeks to reduce individuals' vulnerability, is a necessity for older people across sub-Saharan Africa, especially for people living with dementia. We examined the development of social protection in SSA, mainly based on cash-transfers and health insurance, and assessed its effects on the health of older people by looking at South Africa. South Africa has an established system of non-contributory pensions, disability benefits and grant-in – Aids benefits for older people aged over 60-65, adults with chronic conditions or who 'requires a regular care'. However, the geographical distribution of the benefits remains uneven. A system of non-contributory cash transfer also exist and has been put forward as an example of "best practice" for other developing countries. It has been claimed that it does not just benefit older people, but the entire households, which may increase the authority of older people and hence the potential willingness of family members to care frail older relative.

To better understand this elderly people, we had to observe some elements which will be view on the observation scale.

OBSERVATION SCALE

In this scale, we want to observe elements which have to do with:

1- Social affection determinant
2- Of the quality of life of old age persons
3- Of the Alzheimer disease

I--We shall observe the following elements:

a- Emotions of old age persons
b- Type of relationship and quality
c- Obedient behavior to rules and instructions having to do with the environment of the subject of the same age, their disease in relation with others
d- Re-enforcement of confidence of these persons observed

a-Strong emotions b- Weak emotions

Type: positive Type: Negative

b-Type of relationship:

Push relationship ☐ Sympathy relationship ☐
Proximity relationship ☐ avoidance relationship ☐
Antipathy relationship ☐

````````````````````````````````

Neutrality relationship ☐

**Quality of relationship:** ☐

Very bad ☐ bad ☐

Good ☐ averagely Good ☐ Very Good ☐

Excellent ☐ others…. ☐

c- **Obedient behaviour to rules and instructions:**

- Obedient to medical personnel's rules ☐
- Do not obey to medical personnel's rules ☐
- Obedient to requirement link to intake of medication, at the port of cleanliness, to consumption of medication and of Knowledge ☐
- To games instructions, jokes and of hobbies. ☐
- To requirement having to do with their age, dis-order and compared with different environment. ☐

**d-Re-enforcement of confidence:**

1-Push confidence ☐ 2- very push 3- total confidence
````````````````````````````````

_With the family ☐ ☐

_With the medical structure ☐

_On visitors, Friends/close friends ☐

_ Colleagues ☐

II—Quality of life

a- Do they eat well:

Good ☐ bad ☐ insufficient ☐

Equilibrate ☐ Not equilibrate ☐

b- Do they have other diseases?

Comorbidity opportunist passing

Bedsores ☐ mobility problems ☐ Anorexia ☐

III- Alzheimer disease

Manifestations:

Aggressive behavior ☐ agitation ☐ apathy ☐

Hallucination ☐ Delirium ☐

Anxiety ☐ sleep dis-order ☐

Isolation mourn

Frontal- temporal pains:

Regular ☐ Not regular ☐ very regular ☐

Social affection determinant	Quality of life to old age person	Of Alzheimer disease	Frequency (1-10)	Numbering (1-20)	Percentage (5a 100)	Cotation (0 a 100)	Observation
Social affection determinant	a- Do they eat well	+	7	10	55	55/100	Acceptable
Of the quality of life of old age persons	b-Do they have Other disease	+	8	15	80	80/100	Acceptable
Alzheimer disease	c-manifestation	+	7	12	90	90/100	Not acceptable
	d-isolation	+	9	16	95	95/100	Not acceptable
	e-Of relationship Type	+	5	10	50	50/100	Acceptable
	f- obedient to rules	+	6	12	70	70/100	Not acceptable

2.2.8.1. THE LIMITS OF PATHOLOGIES OF OLD AGE PERSON

The limitation of this disease refer to the questions inherent to qualitative research which by nature does not intend to generalize its results, as they are unique experiences of a group of caregiver. The research allows us to understand the potentialities, weaknesses and strategies experience by caregivers of elderly people with AD. As a potentiality, the family unity based on AD was highlighted; as weaknesses, changes in mood and behaviour of the elderly person with AD; the difficulty of self-care of family members/ caregivers and the lack of support; the lack of knowledge and difficulty in accepting AD, As well as the forgetful of people, objects and places by elderly person.

Strategies, family members/ caregivers mentioned: the need for care alteration; the establishment and maintenance of routine; adaptations at home for the care and safety of the elderly person; the implementation of games, painting and other manual activities; the use of music and pets as stimuli for the elderly person. The data presented here directly contribute to the practice of care, since they can serve as a basis for implementing care strategies for people who experience realities similar to those of the participants of this research. Nevertheless, it is understood that more research needs to be developed, given the complexity of care and daily coexistence with an elderly person with AD.

2.2.8.2. LIMITATIONS

The main limitation was that it explored the meaning and the determinants of quality of life of older persons from the perspective of providers, reflecting only one facet of the issue. Another limitation of the study was that providers of the residential services were greater in number compared to home care providers, and thus a less comprehensive picture for understanding the influences of social services on the quality of life beneficiaries resulted. However, this study contributes to a better understanding of the role of social services providers in ensuring the quality of life of dependent older beneficiaries of social services, and these results could also serve as an evidence base to improve policies regarding older persons.

Our findings revealed aspects related to the objectives of quality of life of older dependent persons, quality of care, freedoms of decision, control, sense of security, respect for privacy, the role of communication and social interactions, and social participation or activities. With respect to the quality of life, measure of quality of life that support social policies and programs, as they capture the effects of such interventions. Studies argues that objective measures do not reveal the individual perspective. However, the assessment of quality of life cannot remain a purely subjective matter, especially when it is used in a particular social policy context. One of the most important objectives in caring for older persons, quality of life of dependent older persons is related to the ability of each person to be able to satisfy their needs and have access to social and health services; it also includes attention to their emotional state.

Multiple positive factors are pointed by the participations as being related to a good quality of life in old age: an adequate level of income, a healthy life style, access to necessary and affordable healthcare services, good relationships with family members and involvement in social activities. Certain advantages of residential care compared to home to home care, for instance, despite their good intensions, family caregivers do not possess the knowledge to provide adequate care. These findings suggest the need for the training and education of caregivers and family members using various methods such as videos and internet. Inform and train them on how to perform caring tasks, as other studies related to older persons. In our study, residential care was found to contribute to a better quality of life for dependent elderly people, as it facilitates access to adequate medication. Studies shows that the results suggested that elderly residents are more likely to experience a deterioration in quality of life due to changes in their living conditions, impaired health, reduced fundamental autonomy, and decreased social interaction.

Negative factors impact on quality of life related to the physical and mental health of older persons, the characteristics of their environment, and the limited availability of social services, especially in small towns and rural areas. The negative impact of burn out on the level of stress of staff, as well as the quality of care. The influence of the quality of care on the quality of life beneficiaries is under constant measure for quality if services delivered, as well as for the quality of life of beneficiaries. The process of service delivery becomes an important indicator for outcomes in terms of satisfaction with quality of life of beneficiaries.

Communication and social participation improved the quality of life of older dependent persons and reduce social isolation in old age, but the scarcity of occupational therapist, physiotherapists, and psychologists is common to both residential and home care providers. The result in this study are consistent with previous national and international studies, according to which social participation has proven to be an important explanatory factor for the quality of life of the elderly. Providers argued that social interactions with the family and the community maintain and improve the emotional well-being of older persons, as other studies provide.

The factors limiting the social services providers, the factors that limit the participation of dependent elderly people in social activities are: the existence of different health problems (including depression), their limited physical capacity, their previous social status, their previous life style, their interest in involvement in social activities, the characteristics of those with whom they would interact, the attitude of the community towards them.

The availability of and access to health services across most of sub-Saharan Africa being extremely limited, the capacity of social pensions to have a significant impact on the health status of older people will remain very limited unless substantial improvements are made to the suitability, quality and accessibility of these services.

Functional limitation: recently, it has suggested that measuring function at the level of the whole aspects of health, particularly in cross- cultural settings. Functional limitation measures independent of environmental influences, and may thus clarify the causes of changes in functional limitation values show consideration spread. Example functional limitations, include walking a given distance, lifting and carrying a given weight and climbing stairs.

Impairment refers to the consequences of disease or injury to an organ system. Examples of impairment include muscle.

CHAPTER 3: THEORETICAL INSERTION OF THE STUDY AND INFORMATION ON QUALITY OF LIFE

3.1. GENERALITIES OF QUALITY OF LIFE

The term quality of life (QoL) emerged in the United States in the mid-1960s. It is a multidimensional concept defined as

> It is a very broad concept that can be influenced in a complex way by the person's physical health, psychological state and level of independence, social relationships and relationship to the essential elements of the environment" (World Health Organisation, 2005). It is a very broad concept that can be influenced in complex ways by the person's physical health, psychological state and level of independence, social relationships and relationship to the essential elements of the environment" (World Health Organization, 1993).

The QOL is assessed both from objective aspects (symptoms, autonomy, etc.) and subjective aspects (psychological aspects, social life, etc.) and must be evaluated by the patient him/herself, except when the patient's condition affects the understanding or reading of the questions (Schraub and Mercier, 2002). It is measured by questionnaire-type tools.

More specifically, some authors have proposed to restrict the definition of HRQoL to health-related aspects: it is then referred to as a measure of health-related quality of life, with questions grouped for analysis into dimensions or concepts, and a score per dimension. The integration of the following three domains (dimensions) is essential: physical, psychological and social quality of life. However, this assessment is normative, i.e. it does not take into account the actual impact on quality of life of the existence of a symptom. The absence of repercussions can in fact be explained by the implementation of adaptation phenomena or by a change in the patients' references (op.cit., 2002).

The measurement of health-related HRQoL is mainly used as a secondary endpoint in therapeutic trials, the primary endpoint being overall or recurrence-free survival. As a secondary endpoint, it can be used to compare two or more groups, to compare different therapies, or to assess the impact of a therapy. It can also be used to detect patient needs or, when there is equivalence for the primary endpoint, to help in medical decision-making (therapeutic choice).

On the other hand, the measurement of HRQoL can also be the primary endpoint when there is no survival benefit from treatment. This is the case, for example, in the evaluation and comparison of palliative treatments, or in the evaluation of psychological factors.

Specific modules of different trials Multicentric therapies have required the creation of international questionnaires. In the field of cancer, the three main ones are, in North America, the FLIC (Functional living index cancer: Schipper, Clinch, McMurray and Levitt, 1984), then the FACT (Functional assessment cancer treatment: Cella, Tulsky, Gray, Sarafian, Linn, Bonomi et al, 1993), and in Europe the QLQ-C30 (Aaronson, Ahmedzai, Bergman, Bullinger,

Cull, Duez & al., 1993), a questionnaire of the European Organisation for Research in Cancer Treatment (EORTC). These questionnaires include a central part with general dimensions of HRQOL and organs or symptoms.

These psychometric tools consist of closed-ended questions of a dichotomous (yes/no) or qualitative (intensity or frequency) type, or are in the form of a visual analogue scale. They must have well-established psychometric qualities, such as validity, sensitivity, and reliability.

From a pragmatic point of view, patients participating in a study that includes the measurement of quality of life receive the information from the responsible physician (investigator). In a second step, another person (normally from the health care team) administers the questionnaire, the timing of which is consistent with the objectives of the study. The analysis of the data and the interpretation of the results are subject to rigorous instructions, notably on the management of missing data and on the statistical methods used (Schraub & al., 2002).

However, the assessment of the HRQoL proposed by these questionnaires is designed with reference to an individual in good health. It is relevant for a group of individuals, i.e. at the collective level. On the other hand, individual factors are not taken into account, nor their impact, which may change over time. Indeed, the patient's perception of his or her QOL depends on the meaning he or she gives to his or her experience, according to new needs, interests and expectations. In a way, the patient becomes his own reference (Rodary, 2002). This is why new patient-centred tools, closer to the design of satisfaction questionnaires, have emerged, such as the SEIQoL (McGee & al., 1991) and the PGI (Ruta & al., 1994), which are still under development. In this sense, a review of the literature by Borreani & al, (2004) shows an increase - since the 1990s - in the use of qualitative methods in the field of quality of life assessment in oncology and palliative care.

3.2. THEORETICAL MODELS OF QUALITY OF LIFE

It is not easy to define the concept of quality of life and to develop a clear and precise definition that would meet with the approval of all scientific circles. However, some researchers have attempted to formulate theories of what constitutes quality of life and to identify the factors responsible. Among the analytical frameworks proposed, there are several orientations, and we will consider only four of them in this work: an ecological model (Bubolz & al., 1980); a model in which quality of life is associated with the adjustment between the individual's needs and resources, on the one hand, and between his or her performance in fulfilling roles and expectations, on the other (Bigelow & al, 1982); a model that closely links the notion of control with the concept of quality of life (Reich and Zautra, 1984); a model that places great emphasis on the psychological variables of quality of life (Abbey and Andrews, 1985).

3.2.1. THE MODEL OF BUBOLZ AND HER COLLEAGUES (1980)

The conceptual framework presented by Bubolz & al. (1980) is largely based on the main principles of urban ecology. In their view, quality of life is considered in a very general sense to describe the well-being or ill-being of people and/or the environment in which they live. From the point of view of the individual, quality of life consists of the degree to which their basic physical, biological, psychological, economic and social needs are fulfilled or satisfied. These needs are met by the resources of the environment. Quality of life is the degree to which the environment has the capacity to provide the resources necessary to satisfy needs. The level of quality of life is assessed in a normative way, either in relation to a standard, from which needs should be met, or in relation to a standard of required resources.

The basic components of a human ecosystem help to clarify which human phenomena should be described and which data should be chosen as indicators. Indicators can describe or measure something about the conditions or status of people (human environment), the resources of the environment (natural, built or behavioural environment), or the interaction of people with the environment and its resources (the use of that environment). Both objective and subjective indicators can be used to assess the quality of life in an ecosystem.

3.2.2. THE BIGELOW AND AL. MODEL (1982)

The development of the Bigelow and al. (1982) model is based on two theoretical positions: a quality of life theory (Bigelow and al., 1982) and a role theory (Sarbin and Allen, 1986). The quality of life of an individual is based on two elements: the general feeling of well-being (satisfaction of needs) and performance (actualisation of skills). The needs considered are taken from Maslow (1943): basic needs (physiological and safety), needs for affiliation, esteem, autonomy and self-actualisation. The environment provides opportunities to satisfy these needs, both material (food, shelter, etc.) and social (friend, spouse, work, etc.). However, the opportunities offered by the environment are associated with expectations or demands for performance. The individual has to respond to the demands of society with cognitive, affective, behavioural and perceptual skills. To the extent that the individual experiences adequate satisfaction of his or her needs and achieves a certain performance in the fulfilment of his or her roles, he or she is adapted to his or her environment and enjoys a good quality of life.

3.2.3. THE REICH AND ZAUTRA MODEL (1984)

The theoretical development by Reich and Zautra (1983, 1984) is based on the belief that the quality of a person's life is related to the types of events he or she experiences (Block and Zautra, 1981; Bloom, 1971). This model focuses on the affective and cognitive impact that events have on quality of life. According to the proposed approach, the experience of events can be divided into two distinct domains depending on whether we cause them ourselves or whether they occur beyond our control.

The general theoretical principle that supports this approach is that of cognitive control and the intrinsic and extrinsic reasons that motivate engagement in certain actions. People do things because they want to do them, and this freedom of choice has an important impact on how they interpret the course of their lives. Positive affect tends to be associated with events over which the individual has some control.

In addition, the individual's efforts to cope with the demands of life and to integrate his or her needs and desires into daily life have outcomes that also have a strong influence on the quality of life. The aim here is to identify patterns of causality in the daily lives of individuals following event-activity-determination sequences.

Operationally, the role of events in quality of life is conceptualised as an evaluation process with three components.

Initially, there are two types of possible events. Unchosen pressures, those originating from the environment (demands) and pressures chosen by the individual (desires). The second component refers, if applicable, to the response(s) to these events. Finally, the satisfaction/dissatisfaction experienced by the individual with the outcomes of these events and the responses given to them is a component of the evaluative process.

3.2.4. THE ABBEY AND ANDREWS MODEL (1985)

The conceptual framework proposed by Abbey and Andrews (1985) links self-perceived well-being with concepts from the social indicator movement and concepts studied in psychology. The work of Costa and McCrea (1980), Dupuy (1977) and Kamman and al. (1979) provided a springboard for Abbey and Andrews' theoretical development.

The authors assume "that individuals' interactions with their social world will affect a number of psychosociological factors, which will then affect their internal states of depression and anxiety, which in turn will affect their sense of well-being" (Abbey and Andrews, 1985, p.3). The key elements of this model are: five psychosociological constructs (stress, control over one's own life, control by others over one's own life, social support and performance), two psychological constructs (depression and anxiety) and five separate quality of life assessments.

Based on these concepts, the authors define their hypothesis that stress, perceived control, social support, and performance influence an individual's anxiety and depression, and that these two emotional states, in turn, affect quality of life. Anxiety and depression are negative affects that should have a direct impact on the negative affect component of quality of life.

Overall, the results obtained by Abbey and Andrews (1985) indicate that stress and depression are strongly related to negative perceptions of quality of life. Internal control, performance and social support are moderately related to positive perceptions of QoL. The relationships between positive affect and internal control, social support and performance are stronger than the relationships between these same concepts and negative affect. It would appear, again according to Abbey and Andrews, that when individuals try to determine the extent to which they enjoy their lives, they focus on the positive determinants of well-being, namely internal control and social support. Conversely, when trying to determine how emotionally upset they are, they focus on negative determinants of well-being such as stress or control by others.

3.3. QUALITY OF LIFE AND SOCIAL SUPPORT

A cross-reading of quality of life and social support means looking at the human condition and, in particular, at the ontological fragility of human beings. Indeed, man is the only being born without the means to satisfy his needs. Thus, all humans are dependent on each other, and as Fiat (2006) pointed out, "We owe our humanity to others".

Beyond the necessary human presence for survival at birth, it is worth recalling and mentioning the important place of social relationships in the child's development and in particular the importance of attachment behaviours that enable the development of a feeling of security and self-esteem from birth (Bowlby, 1969). At the same time, Spitz (1968) demonstrated that the "mere" lack of affection in young children placed in institutions in the first eighteen months of life resulted in impaired mental and physical development that could lead to death (hospitalism). We can also recall the work of Maslow (theory of motivation, 1943) and his "pyramid of needs". This researcher places social needs immediately after physiological (life support) and psychological (security) needs. These social needs include affectivity, esteem and recognition by others, and a sense of belonging.

From a more pragmatic perspective, social exchange theory studies social relations in relation to their benefits (Homans, 1961; Thibaut and Kelley, 1959, cited by Vaux, 1988). Thus, individuals engage in social behaviours likely to satisfy them through an exchange of resources. These resources can take various forms, such as love, recognition, exchange of information, money, goods or services (Foa, 1971, cited by Vaux, 1988). In line with these authors, social relationships begin with exchanges of tangible and universal resources, but 'close relationships' are marked by particular symbolic exchanges (e.g. signs of affection) in which the identity of the participants is of crucial importance.

In social health psychology, research on these necessary human interactions is part of the study of the concept of social support. Researchers are particularly interested in the effects of these interactions, whether in everyday life or in vulnerable situations.

In order to situate ourselves in the field of research on social support, we will first attempt to define the concept of social support and to recall the different terminologies inherent to its study. Secondly, we will present the different approaches to the study of social relationships. We will conclude with the study of social support (in relation to health) with the presentation of theoretical models, mechanisms of action and empirical work.

3.3.1. CONCEPTUALISATION AND MEASUREMENT

The research currents mentioned in the previous chapter are a prerequisite for attempting to define social support. Indeed, there is not one definition of social support but several, depending on the theoretical perspective adopted by the researcher, or at least on the aspects that seem relevant to his or her research field. The same is true of 'the' measure of social support, which exists only in relation to theoretical assumptions.

The conceptualisation of social support is generally based on a widely accepted distinction between structural (quantity, availability) and functional (quality) aspects of support. This is why, in the previous chapter, we particularly developed the sociological approach, which differs from the other three. Indeed, as we have specified, sociological or epidemiological researchers have not systematically highlighted and studied the characteristics of the 'support' provided by human relationships, the basic assumption being that social interactions are inherently beneficial for the individual. This approach focuses on the structural characteristics of the network, i.e. the quantitative aspect of social support with the concepts of social integration and network. However, we can point out that these "quantitative" aspects operate through subjective psychological constructs theorised by Thoits (1983) in terms of self-esteem, recognition, and identity.

However, for Schwarzer and al (2003), the network or social integration is only the basis, the foundation for developing relationships that can be identified as supportive relationships. Thus, social integration would be the necessary but not sufficient condition to establish the real existence of social support as functional or "qualitative" support. This support is evaluated by the availability of material and psychological resources in the context of interpersonal relationships (Rodriguez and Cohen, 1998).

Other authors acknowledge the existence of different 'levels' of relationships of a person to his or her environment (Lin, 1986): the community, the social network and the intimate and confidential relationships. The relative importance of these different levels of social ties - between very broad network ties and intimate confidants - is still open to debate.

Finally, some researchers have focused on the quality of social relationships in terms of availability, satisfaction, and the type of resources involved in the relationships that allow the individual to feel loved and valued (House, 1981; Sarason and al., 1983; Rodriguez and al., 1998). Others view social support as an exchange of resources that promotes the well-being of the receiver (Shumaker and Brownell, 1984). But social support can also be conceptualised as an aid to coping or "interpersonal coping" (Thoits, 1986; Greenglass, 1993) or as a resource for coping (Endler and Parker, 1990).

With these distinctions clearly established, we can now briefly introduce the typologies and terminology that are now standard in the study of social support.

3.3.2. TYPOLOGIES AND TERMINOLOGY

The typologies of social support reflect the research streams outlined above. As a result, the discussions and divergences between researchers reflect the diversity of the underlying theoretical approaches.

3.3.2.1. THE DIMENSIONS OR FUNCTIONS OF SOCIAL SUPPORT

The dimensions of social support are the different elements conveyed by supportive relationships. In the sociological tradition, it was not necessary to focus on the characteristics of the support provided by the network, but on the supposedly 'universal' and 'naturally' present characteristics of social contacts. Research on social support, on the other hand, will try to specify and dissociate the 'content' of social relations.

Today, the commonly used classification is derived from House's (1981) definition of social support:

> "An interpersonal transaction involving one or more of the following dimensions: (1) emotional interest (love, friendship, empathy), (2) instrumental or material help (goods or services), (3) information (about the environment), or (4) esteem (information about self-esteem)" (House, 1981, p. 39).

Some authors, such as Rodriguez and al (1998, p. 536), identify only three types of support: informational, material and emotional.

> "Informational support, which refers to the provision of relevant information to help the individual cope with common difficulties and usually takes the form of recommendations or advice on how to deal with a problem; instrumental support, which involves the possibility of material help, for

> example, financial assistance or help with tasks of daily living; emotional support, which involves the expression of empathy, the idea of "caring", reassurance and trust, and allows for the expression of emotion and emotional release.

We can see that this conception is quite similar to that of House (1981), with emotional support being considered as esteem support.

We also find in the literature the terms tangible (material, informational) and intangible (emotional) help, or instrumental help as opposed to expressive help.

3.3.2.2. SUPPORT RECEIVED AND PERCEIVED SUPPORT

Support actually receive is a helping behaviour that includes specific acts generally recognised as intentional efforts to help a person, either spontaneously or on request. Perceived or subjective support (perceive available support) is an indicator of the appreciation of support which can take various forms such as availability, satisfaction, feeling cared for, attached, respected or involved, feeling good, or feeling in a covenant relationship (Vaux, 1988).

In reality, objective, concrete support (received support) is not necessarily evaluated and felt by the person as help (perceived support). Specifying objective supportive behaviours is not sufficient to assess what is actually perceived; Turner, Frankel and Levin (1983, p. 74, cited by Vaux, 1988) state in this regard that "social support should be viewed as a personal experience rather than as a set of objective circumstances or even as a set of interactional processes". In this sense, perceived social support can be defined as "the subjective impact of the help provided by those around an individual and the extent to which the individual feels that his or her needs and expectations are being met" (Procidiano and Heller, 1983, cited by Bruchon-Schweitzer, 2002, p. 333).

In contrast, Cohen (1991) sees perceived support as a reflection of available support: 'perceived support is not a crude and biased estimate of available support but rather a rough representation of the support available in the environment' (op.cit., 1991, p. 231).

Another distinction is proposed by Schwarzer and al (2003). These authors (op.cit., 2003) consider that perceived support depends on the help that can be expected in case of need, and is therefore often prospective; whereas received support refers to the help provided in a given period, and is therefore always retrospective.

3.3.2.3. SOURCES OF SUPPORT

Carers" can be divided into two main classes: formal and informal carers. Formal sources of support are professional helpers, public structures, organisations, support groups (the list is not exhaustive) while informal sources are relatives, friends, colleagues, etc. (Streeter and Franklin, 1992). Most of the work on social support focuses on the work of informal carers or support groups in the intervention tradition.

Weiss (1974, cited by Vaux, 1988) presented ideas that have influenced many researchers on social support by distinguishing between different sources of support. He suggests that some individuals maintain their relationships in order to secure their needs and that specific needs require specific relationships. We now present the five needs identified by this author (op.cit., 1974), the kinds of relationships they imply (sources of support), and the emotional consequences created by their absence.

To conclude on these different conceptualisations, we propose to rely on the broad definition of social support presented by Rodriguez et al (1998, p.535): social support is "a multidimensional concept that refers to the characteristics and functions of social relationships; the material and psychological resources available to individuals through their interpersonal relationships".

3.3.3. THE DIFFERENT APPROACHES

Our interest will focus on the work on the effects of social support in the context of health, quality of life and well-being, which began to develop in the 1970s. In order to situate ourselves in the various research currents, we feel it is interesting to present the analysis of Cohen and al (2000), who distinguish four paradigms that have fed this work: the sociological approach, the cognitive approach, the interpersonal processes approach and the interventionist approach.

3.3.3.1. THE SOCIOLOGICAL TRADITION

More than a century ago, Durkheim (1897-1951) postulated that the breakdown of family, social and professional ties caused by migration to industrial areas appeared to be deleterious to psychological well-being. Durkheim (1967) also observed that suicide occurs more often among people with few social relationships, with the dissolution of social roles and norms leading to what he termed the "state of anomie".

In the studies that followed these initial findings, we frequently find the terms social networks and social integration in the literature. We will now try to explain these concepts and their differences using the analysis of Brissette, Cohen and Seeman (2000).

❖ The concept of social integration

Social integration refers to the degree of integration and involvement in a society. It is a multidimensional construct including behavioural components (active engagement in a variety of social activities and relationships) and cognitive components (sense of community and identification with social roles). These cognitive aspects are related to the subjective perception of integration related to the sense of belonging, mutual obligation, and intimacy (Schwartzer, Knoll and Rieckmann, 2003). The most explicit theory concerning the positive influence of social integration on health and well-being is that of Thoits (1983), a theory strongly influenced by the tradition of symbolic interactionism (Mead, 1934). Thoits (1983) postulates that identity depends on the social positions or roles occupied by individuals in a social context. It is this identity constructed by social roles that is indirectly linked to health and well-being.

In contrast, some researchers (Goode 1960; Coser 1974) emphasise the negative aspects of social relationships, particularly in terms of role strain. This has two components: on the one hand, conflicts linked to these roles, and on the other hand, the 'overloads' linked to these roles (of parent, spouse, etc.) whose interests may be divergent or even irreconcilable (Goode, 1960). Wills and Fegan (2001), while acknowledging the existence of negative aspects of social relationships, suggest that social integration and therefore the accumulation of roles brings more benefit than stress.

❖ The social network approach

For Brissette et al (2000), social network analysis (social networks or social system support) allows for the measurement of social integration; the term network referring to the ties linking a collection of individuals or social entities (groups, families, corporations). Therefore, social network analysis is complementary to social integration analysis and represents the objective basis in terms of the number of people or potential support offered to a given individual in his/her environment. Network analysis is a quantitative means of describing the relationships between different members of an individual's social network (op.cit., 2000). The structural characteristics of the social network describe the stable patterns of relationships and the existence and interconnections between social relationships (op.cit., 2000).

The approach presented here does not refer to the distinction between support network and social network. This may pose a problem in terms of what is measured: is it a question of quantifying the importance of social relationships (in number, frequency, etc.) or the importance of a subset of significant relationships? In reaction to this undefined approach, some researchers (Barrera, 1981; Wilcox, 1981, cited by Vaux, 1988) were quick to argue the need for specification. Indeed, this lack of distinction suggests that all social relationships are 'supportive'. Thus, we find in this perspective the hypotheses concerning the concept of role, identity, and "meaningful" social context already exposed.

Conversely, some researchers distinguish between social network and support network. For example, Vaux (1988) considers the network as a subset of a large social network that can provide assistance (or that provides this assistance spontaneously) in the face of certain constraints or objectives. These constraints or objectives may arise in everyday life (dealing with a car problem) or emerge following a dramatic event (e.g. the death of a relative). This support network would be stable in its structure and composition, except during specific periods of life change (marriage, divorce, redundancy...). The aspects of the support network depend on its resources, sensitivity, accessibility, and ability to be a source of help.

3.3.3.2. THE COGNITIVE TRADITION

The conceptualisation of social support from a cognitive perspective is derived from studies on perceived stress, which emphasise the notion of resources and adjustment to stress generating constraints. This approach emerged in the 1970s through the influence of three main researchers: Caplan (1974), Cassel (1974; 1976) and Cobb (1976).

Cassel (1976), a physician and epidemiologist, considers that psychosocial processes play a significant role in the etiology of disease and that social support, in particular, plays a key role in stress-related disorders. In his research on understanding urban living disorders, Cassel (1974) considers that the breakdown of meaningful connections produced by stressful environmental conditions leaves the individual with inadequate or confused social responses, resulting in a high vulnerability to disease. He suggests that support is provided primarily by those who are most important to the individual, and that support has a protective function, serving to "buffer" the somatic or psychological impact of stressful experiences.

Caplan (1974) uses the term 'support system' and notes the importance of reciprocity and duration of social relationships. It is then evident that the support system is not limited to family and friends, but incorporates support groups, informal services provided by the neighbourhood, and help provided by the clergy. This aggregation of continuous social relationships provides the opportunity for feedback and response according to one's identity and capabilities. Caplan (op.cit., 1974) emphasises the importance of the support system, especially the informal one, for the well-being of individuals in everyday life, but also at times of crisis and life transitions.

In the same perspective, the psychiatrist Cobb (1976) tries to further clarify what social support is: he considers that it acts as information signifying to the individual that he is loved, valued, esteemed and belongs to a network of communication and mutual obligations. This perception is protective as it is thought to facilitate coping and adaptation. Cobb (op.cit., 1976) suggests that this information has two functions: the fulfilment of social needs and protection from the negative consequences of crises and stressors. Cobb (op.cit., 1976) emphasises the moderating role of social support ('stress-buffer') and demonstrates in numerous studies that the existence and quality of social relationships, or the lack of them, seem to be involved in well-being throughout life. He concludes that adequate social support protects individuals from a variety of physical and psychological disorders during crises, probably through the development of coping strategies.

3.3.3.3. THE INTERPERSONAL PROCESS APPROACH

Since the 1980s, researchers have been interested in the processes involved in helping behaviour under stressful circumstances (Cohen and al., 2000). The objective is to observe and study the types of helping behaviour (Interpersonal process tradition). These approaches are often experimental and make it possible to propose very detailed analyses in the evaluation of social support and especially supportive social interaction. In this perspective, Burleson (2003) defines emotional support as a specific mode of communication aimed at helping an individual to cope effectively with emotional stress. The issue in this situation is the importance of emotional change: the messages are primarily aimed at helping the person to work through and cope with difficult emotions. Burleson and colleagues (Albrecht and Burleson, 1992; Burleson, 2003) have studied emotional support, its measurement, characteristics and relationship quality, and have identified factors that differentiate individuals in terms of support provision

Work in this field of research shows that the materialisation and benefits of social support are strongly influenced by the personal, relational, situational and emotional characteristics of the interactional context (Cohen et al., 2000). Contemporary techniques of daily recording of social interactions are used to assess these processes.

3.3.3.4. THE TRADITIONAL APPROACH TO INTERVENTION

In this perspective, the researchers' priorities are in line with a proactive policy of making social resources available to the population, in particular by developing informal assistance skills in all individuals. This approach is developed in three phases.

First, Cassel (1976) and Cobb (1976) suggest that there is an urgent need to increase and develop social support rather than to reduce stress, and that this requires teaching sick and well people, but also informal 'helpers' (teachers, police, clergy, etc.) how to receive and give support in the face of stressful events. Indeed, it seems possible for these authors to "train" individuals to develop, maintain and mobilise their natural support network, or to learn to recognise and respond concretely to the needs of a person facing a stressful event.

The establishment of supportive interventions is therefore the first interventionist approach. However, it is a delicate task, as it involves creating the conditions for supportive relationships. Indeed, social support is not a variable, it is a process that occurs during social interactions. It is not an "item" that can be delivered outside of its relational context. For example, the initiation phase of close relationships is based on attraction, and positive affect increases when partners perceive similarity, fairness in the exchange, and reciprocal secrecy of personal information (Hendrick and Hendrick, 1992, cited in Cohen and al., 2000). In addition, efforts should be made to identify the characteristics of those who need support. For some, the network is sufficient, while for others it is necessary to exchange with new sources of support, or peers.

The second 'interventionist' approach developed in the late 1970s with the creation of 'support groups'. In practice, these interventions often led to the creation of a new network of people who had experienced the same stressful event; they therefore involved the creation of a social aggregate of 'peers'. These support groups are thus based on the assumption that only 'experienced' people are able to provide a sufficient level of empathy and understanding, and that social comparison with peers can increase coping and encourage adaptation. In particular, the process of comparison facilitates the expression of negative affect, offers validation of a new identity and role, and reduces threat assessment for current and future stressors. This "stress buffer" aspect seems to play a central role in producing positive effects on cognitive, affective, behavioural and physiological functioning. This includes various stages: creating conditions for expressing support needs, teaching group members to recognise and respond to requests for support, promoting the provision of support, increasing the 'repertory' of coping skills, increasing self-esteem and self-efficiency by helping others, increasing the sense of community and belonging (not available in traditional individual interventions), and evaluating the impact of support transactions (Cohen and al., 2000).

On the other hand, participation in these groups involves confronting distressed individuals with others who are also experiencing a high level of distress. This can lead to negative emotional reactions between group members, which in turn can lead to a negative assessment of their own ability to cope. These reactions may also be the result of critical interactions experienced in a defensive atmosphere that is not conducive to an exchange of mutual support and acceptance of others.

However, there is considerable evidence to suggest that participation in these groups is associated with better psychological adjustment to life changes and better mental health in people with a variety of illnesses. In addition, these groups allow many people to increase their well-being simultaneously on their own, without the involvement of any "professionals".

The third approach outlined by Cohen and al (2000) concerns the creation of one-ot-one mentoring and coaching programs. The aim of these interventions is to increase the quality and quantity of social resources, to increase interactions or to optimise the match between the needs of individuals and the provision of resources. They are a kind of "referral" person who can provide expertise when needed, for example by setting up a "Big Brothers" or "Big Sisters" programme to compensate for the absence of a parent.

The aim of this presentation was to highlight different approaches and therefore different conceptualisations of social support. We note that, depending on the different theoretical paradigms, the aspects studied differ considerably, and it seems important to be able to situate oneself in these different currents in order to understand the countless research studies in this field. This epistemological 'mapping' will now allow us to define and therefore present measurement tools specific to these different currents.

3.3.4. THE RELATIONSHIP BETWEEN SOCIAL SUPPORT AND HEALTH

Social support in relation to health is a field of research that is constantly being fed by new perspectives. We therefore feel it is necessary to outline the main theoretical models and present the explanatory hypotheses concerning the mechanisms of action of social support.

As we have already pointed out, the conceptualisation of social support is based on a widely accepted distinction between structural and functional aspects. Firstly, the structural aspect of support includes the concepts of social integration and social network. Secondly, the functional aspect of support is a more qualitative approach that focuses on the different functions of support.

Today, it would seem that a third concept is emerging in the study of social constructs in relation to health: 'negative interactions', which are 'sources of psychological stress with behavioural and physiological consequences that increase the risk of disease' (Cohen, 2004, p. 677). This concept emphasises both the existence of conflict or dissatisfaction in social relationships, and 'social isolation' and loneliness

However, the analysis of the effects of social support on health depends on the contexts in which the models are used in terms of structural or functional support, and therefore on the theoretical perspective. Thus, initially, the measurement of structural support (social integration and social network) aimed to quantify the social integration of an individual and to measure the effects of this variable on health. This approach was mainly used from a sociological and epidemiological perspective. At the same time, the measurement of functional support was mainly used from a cognitive perspective and in a stress assessment context. This distinction foreshadows the opposition between direct and indirect effects. Thus, it appears that the effects of social support depend on the nature of the measure used: direct effects are found with measures assessing the degree of integration (structural aspect) in a large social network, while the cushioning effect is highlighted in work assessing the perceived availability (functional aspect) of social support (Cohen, 1991).

This distinction is generally found in the recent models we wish to present. However, we shall see that the terminology is not exactly the same (which can lead to confusion), particularly with regard to the term 'indirect', used in French to characterise the cushioning effect of social support, whereas in English it characterises the effect of social support mediated by other variables.

3.3.4.1. THE DIRECT VERSUS INDIRECT EFFECT MODEL

As stated, this first model suggests that social support has a beneficial effect on wellbeing independently of stress levels. The direct effect model thus prefigures a causal model where the independent variable (IV) - in this case support - varies the dependent variable - in this case criteria - notwithstanding the maintenance or control of all other variables included in the model set by the researcher. A variant of this model (indirect effect) suggests that the effect of the independent variable on the dependent variable is mediated by a third variable, the so-called mediator variable.

Baron and Kenny (1986) show that "mediating variables explain how or why they [certain effects] occur" (Rascle and Irachabal, 2001, p. 99), while Muller, Judd and Yzerbyt, (2005) consider that the issue of mediation is about the mechanisms responsible for the relationship between the independent and dependent variable. More specifically, Brauer (2000) proposes a definition of the mediating variable:

"A mediator variable (M) is a variable that intervenes between the independent variable (X) and the dependent variable (Y) so that the independent variable has an effect on the mediator variable and the mediator variable has an effect on the dependent variable. The effect of the independent variable on the dependent variable is indirect because it is transmitted by the mediating variable. If one were to 'eliminate' the effect of the mediating variable, one would no longer observe a relationship between the independent variable and the dependent variable" (Brauer, 2000, p. 663).

This 'complete' mediation assumes four conditions: (1) X has an effect on Y, (2) X has an effect on M, (3) M has an effect on Y if we statistically control for the effect of X on Y, (4) the effect of X on Y disappears if we statistically control for the effect of M on Y (Brauer, 2000, p. 665). In the case of partial mediation, the fourth condition is not fulfilled because there is a direct causal link between X and Y, with only part of the effect of X being mediated by M. The situation can also become more complex when there are two mediating variables, one of which has not been identified and measured.

In this sense, Wills and al. (2001) suggest three types of effect between social support and health: (A) a direct effect model in which support is a predictor directly linked to beneficial effects on health (B); an indirect effect model in which the effect of social support is mediated by an intermediate variable whose effect is fully mediated; (C) an indirect effect model in which the effect of social support is mediated by an intermediate variable whose effect is partially mediated. Wills and al. point out that cumulative effects between direct and indirect effects are possible and that in all cases, social support is linked to better health.

In fact, this model allows us to note that there is little or no really direct effect of social support on health. In fact, social support is linked to physical and psychiatric illness through multiple "mediating" variables (social influence, access to services, information, etc.) which are linked to biological parameters and the neuroendocrine response. The action of these mediating variables will be developed in the next chapter ("The mechanisms of action of social support").

Finally, Uchino (2004) proposes a 'revised' direct effect model that also includes many mediating variables such as perceived control, esteem and the meaning given to feelings of integration and support.

The first specificity of this model compared to the previous ones is the simultaneous consideration of functional and structural support. Indeed, Uchino (2004) argues that studies should emphasise an integrative and dynamic approach combining these two perspectives. On the other hand, his second particularity lies in the addition of the effects of isolation. In this respect, the author (op.cit., 2004) distinguishes between two types of isolation: 1) social loneliness, which results from a general lack of social interactions and connections; 2) emotional loneliness, which is the consequence of an absence of close relationships with a confidant or significant other.

In addition, Uchino (2004) highlights the importance of social roles and connections for identity formation (R1); and the importance of feelings of isolation conceived as the perceived gap between desired and actual relationships (R2).

Through these different models, we see that the action of social support independently of a stressful context is very often mediated by other variables.

3.3.4.2. MODELS OF THE BUFFERING EFFECT OF SUPPORT

The action of social support as a stress buffer has been highlighted from the cognitive perspective in connection with research on perceived stress. These different works from the cognitive tradition are thus linked to the transactional approach to stress and coping (Lazarus, 1991).

In 1976, John Cassel put forward the hypothesis of a mechanism explaining the influence of social support on health: the stress-buffering hypothesis. In the presence of a stressful event, support would serve as a buffer or protector against the deleterious effects of stress on health. The buffering role of social support is a determining factor in the perception of potentially stressful events (limiting the perceived importance of the problem) and in the responses of individuals to these events. In this sense, social support acts as a kind of "adapter" that increases coping resources (help in managing the problem, adoption of health behaviours). The corollary of this model is that social support would have no effect on health in the absence of stress. In 1985, the synthesis including more than 40 correlational studies by Cohen et al. confirmed the protective or buffering role of social support on the negative consequences of stress (stress-buffering effect).

In this context of stress, social support would have an action at different levels as explained by Rodriguez et al, (1998, p.537) for which:

> "Perceived support can intervene primarily between the onset of a potentially stressful event and the experience of a physiological and psychological stress response by influencing stress appraisal. In this case, perceived support therefore improves the individual's perceptions of his or her ability to cope with the demands imposed by the event, which is considered less stressful. Secondly, perceived support can intervene between the experience of a stress response following a stressful event and the onset of a disease process (psychological or physiological) by reducing or eliminating the stress response. Here, support can reduce stress responses by increasing coping efforts to manage the practical and emotional consequences of the event and reduce its perceived importance.

From a methodological point of view, we speak of a cushioning or 'buffer' effect when one variable modulates the intensity of one variable on another (moderator variable1). In the case of the effect of social support, the effect of a variable X (stress) on a variable Y (physical and psychological health) is buffered by a third moderator variable (social support) that modifies the link between the predictor (X) and the criterion (Y).

More precisely, Brauer (2000) proposes a definition of the modulating variable:

> "A moderator variable Z is a variable that modulates the effect of the independent variable on the dependent variable. The effect of the independent variable on the dependent variable depends on the modulator variable because the effect of the independent variable on the dependent variable is different at different levels of the modulator variable. Modulation in the terminology of causal models is interaction in statistical language. If Z modulates the effect of X on Y, we say that X and Z have an interaction effect on Y" (Brauer, 2000, pp. 663-664).

Therefore, as Muller et al (2005) point out, the issue of modulation is about the factors that affect the size of the effect between a predictor and a criterion. These modulating variables may be related to personality factors, for example, or belong to the context of the situation under study. Ultimately, "a moderator variable explains when and under what conditions a certain effect occurs" (Brauer, 2000, p. 664).

This model of the buffering effect can take three forms (Wills and al., 2001): (1) when support acts as the main effect, its action is comparable whether the level of stress is low or high; (2) when support acts as a total buffering effect, the impact of stressful events is 'totally' buffered when the level of social support is high; (3) when support acts as a partial buffering effect, the impact of stressful events is partially buffered by social support. This 'moderate' or 'partial' version suggests that support (even high support) dampens the effects of stress but does not provide full protection.

Finally, the 'revised' model of stress-related support proposed by Uchino (2004) reconciles the different forms of support (structural and functional support, deteriorating support).

This revised model also emphasises the links between social support and stress-related processes, while incorporating the possibility of deterioration of support as a result of stress. Thus, stressors may result in a mobilisation of received support and/or a deterioration of available support. According to Uchino (2004), received support can prevent the deterioration of perceived support with positive influences on esteem, perceived control and other coping processes. Recall that perceived control is another coping resource. These beneficial effects of functional support may ultimately influence the association between stress and health in two ways: through a preventive effect on stress (relationship 1) or through a decrease in the stress response when it occurs (relationship 2). Finally, social integration allows access to functional support and can independently influence processes related to esteem, control or coping.

Thus, through these models we see the action of social support as a stress buffer. Cohen and al (2000), in agreement with Wethington and Kessler (1986), note that the foundations of this cognitive approach are based on the importance of the perception of available support in times of need:

> "The key component of this approach is the perception that others will provide the necessary resources when needed. Ultimately, the evidence suggests that it is not so much the actual resources that are important for health and coping but the belief in the availability of that support" (Cohen and al., 2000, p.14)

3.3.5. THE MECHANISMS OF ACTION OF SOCIAL SUPPORT IN QUALITY OF LIFE

The models illustrated above allow us to understand that the perception of the availability of social support has been associated with both the direct effect and the buffering effect. In this sense, the sense of security provided by the availability of others in times of need may promote positive affective and cognitive states. On the other hand, the analysis of Cohen and al. (2000) suggests that what is measured as direct effect may be in the context of non-assessed stressful situations (e.g. daily stressors). Thus, the direct effect of perceived support could be attributed partly or entirely to the use of inadequate or insufficient measures of stressful events. Consequently, the explanatory hypotheses concerning the links between social support and health cannot be distinguished according to the theoretical models. This is in line with the analysis made by Uchino (2004) for whom structural support and functional support should be integrated in a single approach.

From this perspective, we will now look at the action of social support in relation to health at different levels. We will distinguish, still in relation to social support, (1) the 'subjective' or psychological consequences of social support with models of identity and selfesteem; (2) behaviours (models of social influence); (3) physiological pathways with biological models; (4) models of material and informational resources.

3.3.5.1. THE 'SUBJECTIVE' OR PSYCHOLOGICAL CONSEQUENCES OF SOCIAL SUPPORT

Socially integrated individuals are likely to receive more feedback from those around them. Multiple social roles are thought to be a factor in building identity and promoting feelings of self-worth, predictability, stability, and control in life (Thoits, 1983). These role identities are also the source of expectations about how individuals are expected to act (e.g. health behaviours). In addition, they provide information to the individual by allowing him or her to know who he or she is in the existential sense of the term, by giving meaning and purpose.

In the same vein, Rook (1990) sees health and well-being as a consequence of a 'meaningful' social context, which gives meaning by enabling individuals to mobilise to give back, all of which helps to create bonds. This author (op.cit., 1990) uses the term companionship to express the idea of belonging to a harmonious network of mutual support and obligation, where this social and positive world may be more important than the actual provision of support.

Finally, social integration would allow the development of several self-concepts in relation to the social position occupied. This multiplicity in the self-concept would influence the way in which individuals evaluate negative life events and the way in which they respond to negative information about the self (Linville, 1985, cited by Brissette et al., 2000). Also, social integration, by making it possible to improve self-esteem and the feeling of personal value, would be a factor likely to promote adaptation to stressful events, positive affects and the prevention of depression (Cohen, 1988).

From the perspective of the role played by social support as a stress buffer, Cohen and Pressman (2004) suggest three levels of action at the psychological level. First, social support would intervene between the stressful event and the stress reaction by attenuating or preventing the intensity of the perceived stress. More specifically, the feeling of being able to count on someone will make it possible to redefine the difficulty of the situation and to reinforce the perceived capacity (perceived control) to face it. This mediating variable could be particularly powerful in its stress-damping effect (Uchino, 2004). Second, the feeling and belief about this support could reduce or eliminate the mal-adaptive affective, physiological or behavioural response. Finally, the availability of someone to talk to about the problem could reduce intrusive and damaging thoughts.

2.3.2.2. SOCIAL SUPPORT IN RELATION TO HEALTH BEHAVIOUR

The impact of social support on health behaviours can be described at different levels: at the intra-individual (perceived social support) or inter-individual (social integration and social network) level.

Thus, perceived social support - in the form of feeling valued and esteemed and the associated positive states - may increase motivation to take care of oneself (health behaviours, compliance), or at least will enable the individual not to engage in destructive or health damaging behaviours. This assumption is called the "identity accumulation hypothesis" (Thoits, 1983).

On the other hand, the social and normative pressure linked to integration into a group (social influence) would also be likely to stimulate the adoption of health behaviours, slow down the progression of diseases, or influence the recovery process. Physical exercise, for example, is one of the health behaviours positively correlated with social integration and social support. However, some researchers disagree with this assertion, considering that certain reference groups may on the contrary favour risk behaviours, such as alcohol consumption.

Regarding the social network, a large number of social contacts can also have a negative impact on health by increasing exposure to infectious agents. Nevertheless, Cohen, Hamrick, Rodriguez, Feldman, Rabin and Manuck (2002) showed in a prospective study of healthy students that stress and diversity of social contacts interact. Diversity of contacts is associated with more illness in those with the most stressful events, and slightly less illness in those with few stressful events. Note that these associations are maintained after controlling for neuroticism.

Nevertheless, it is not certain that health behaviours really explain a state of health. Indeed, while preventive health campaigns aim to encourage individuals to adopt healthy lifestyle behaviours, it is not uninteresting to quote Cohen (2001, p.6) who takes stock 20 years after the publication of the first studies on the effects of social integration on health:

> "Unfortunately, more than 20 years later, we know little about how our social environment influences our health and well-being. However, we are beginning to understand. It is increasingly clear (as Berkman and Syme [1979] reported) that actual health practices are not the main factor. Studies looking at these behaviours have concluded that health practices are responsible for only a small proportion of the variance explained.

2.3.2.3. PHYSIOLOGICAL PROCESSES RELATED TO SOCIAL SUPPORT

The current state of knowledge allows us to affirm that social support acts on the functioning of biological systems such as endocrine function (Seeman et al., 1994), cardiovascular function (Uchino and al., 1996), blood pressure (Holt-Lunstad and al., 2003) and also on the capacity of the immune system to fight infectious diseases (Cohen and al., 1997).

Hormones and neurotransmitters play an important physiological role in diseases related to stress and the ageing process. These aspects mediate cardiovascular and immune functions (Cohen and al., 1994). Cortisol is an important hormone that is released during stress, linked to the disease process and has immunosuppressive effects. However, there is currently insufficient evidence to draw conclusions about the effect of social support on this hormone.

However, there is recent research (DeVries et al., 2003; Grewen et al., 2005) on the role of oxytocin in relation to social support. Oxytocin is a neuropeptide known for its role in lactation and uterine contractions during childbirth. This hormone also appears to vary with social stimuli such as touch or massage, and has a stress-reducing and anxiolytic effect. At the same time, it seems to promote social interaction. The release of oxytocins is associated with decreasing levels of cortisone, blood pressure, sympathetic nervous system activity, and increasing parasympathetic nervous system activity. This would therefore be a key variable regulating the effects of social support on stress through its influence on other physiological systems (Knox and Uvnas-Moberg, 1998). There is therefore an experimentally demonstrated effect of social support on physiological reactivity to stress.

For example, Heinrichs et al (2003) tested the effects of social support and oxytocin on endocrine, mood, and anxiety responses in the Trier Social Stress Test (TSST by Kirschbaum, Pirke and Hellhammer, 1993). The TSST is an experimental psychosocial stress situation that involves public speaking or mental performance. The 37 participants in this experimental study (2X2 factorial design) were divided into 4 groups, with oxytocin / with placebo and with social support from a friend / without social support. Scores of depression, anxiety, mood and availability of social support of the different participants were assessed with scales before and during the stress exposure. These scores before the experiment were homogeneous and in the middle range compared to the general population. The results showed that participants who received both social support from their friend and a dose of oxytocin had the lowest levels of cortisol concentration during the stress exposure, while the subjects in the "placebo + no support" group had the highest cortisol levels. In addition, the results of the psychological test measures were consistent. In summary, the effectiveness of social support would depend on or at least be optimised by oxytocin production.

On the other hand, an already old hypothesis, the 'hard-wiring' hypothesis (Bovard, 1959, cited by Cohen and al., 2000), has recently been the subject of interest. It is derived from work on the synchronisation of our biological clock. This hypothesis suggests that the regularity provided by social interactions may play an important role in the training and synchronisation of our biological clock. Conversely, the absence of regularity (desynchronisation) could be deleterious to homeostatic and adaptive functioning. Thus, isolated people would increase their risk of disease through the loss of biological rhythms associated with social integration. Consequently, the effects of our social environment on health would not be mediated by internal processes (emotions, affective states, possibilities of control, behaviours) but would be, in a way, responses of our "hard drive" to our environment.

However, Bovard (quoted in House, Landis and Umberson, 1988) continued his work and proposed a psychophysiological theory (Bovard, 1985) integrating internal processes and explaining the links between social relations and health. This author (op.cit., 1985) reviewed numerous studies of humans and animals. The findings of these studies suggest that social relationships and contact, via the amygdala, activate the anterior hypothalamic area (stimulating the release of growth hormones) and inhibit the posterior hypothalamic area (and thus the secretion of corticotropic hormones - ACTH -, cortisol, and catecholamines). Wills and al (2001) add that this theory is consistent with the sociobiological processes of species survival and genetic selection, which show that people with social contacts are favoured over those who lack them.

Consequently, whether under stress or not, social relationships are associated with positive changes in psychological states (affect, perceived control, self-esteem) that influence the neuroendocrine response. The reduced hormone levels are thought to influence disease pathogenesis (cancer, HIV, infectious diseases) through their effects on the immune system. The association between social support and good immune function is one of the strongest noted by Uchino and al (1996), especially in the elderly. Conversely, bereavement is followed by immune depression which can compromise natural killer cell activity and cellular immunity, making individuals more vulnerable (Herbert and Cohen, 1993). These immune processes also have important implications for cardiovascular disease and atherosclerosis processes.

3.3.5.4. Material and information resource models

Social integration promotes the increase of material resources directly related to living conditions, and protects against the risk of exposure to stressors through the provision of information or advice. All this can influence the adoption of preventive measures to avoid stressful or risky situations. But some work has also emphasised the potentially negative aspects of this influence (McKinley, 1973, cited by Cohen, 1988). Moreover, we could object that access to information is currently facilitated by the increasing proportion of preventive health campaigns widely disseminated by the media and the Internet.

On the other hand, material assistance from others appears to be a key factor in preventing certain stress reactions in a particular context, such as illness (Hawkley and al., 2003) or caregiving (Kima and al., 2006)

PART 2: METHODOLOGICAL AND EMPIRICAL FRAMEWORK OF STUDY

CHAPTER 4: METHODOLOGY OF STUDY

In this chapter we shall present the methodology of our research we shall recall the problem the research question and research hypothesis we shall present our site of research population of research instrument the analytic approach and the interpretation at the end solution of my result.

4.1 RECALL OF THE RESEARCH QUESTION

Through this research we shall explore the link which can be existed between the depressive living to old age placed in institution, or because of dependency and his quality of life in Yaoundé town according to psychoanalyses axis. Therefore, the establishment of dependency relationship that can exist between the depressive experience of the elderly people placed in institution due to their health situation and their quality of life, has let to formulate a research question which is as follow "Does social affection determinant influence the quality of life of old age person affected with Alzheimer?".

According to Grawitz (1990) "hypothesis is a propose answer to a question posed. It turns to form a relationship between significant act ".

Our work carries two types of hypotheses which are general hypotheses and research hypotheses.

4.2.1 RECALL GENERAL HYPOTHESIS

In this work, general hypothesis which help us also as work hypothesis is as follow:" social affection determinant influences the quality of life of old age person affected with Alzheimer". This general hypothesis clear two types of variable:

An independent variable (IV) and a dependent variable (DV). Our independent variable (IV) of study is: Social affection determinant; It has three modalities which are:

Modality 1: Close affective relationships contribute to the improvement of quality of life in elderly people suffering from Alzheimer's disease

Indicator 1: Positive social-emotional signs

Areas of Interests:

- Gestures of tenderness
- Manifestation of solidarity
- Manifestation of relaxation

Indicator 2: negative social-emotional signs

Areas of Interests:

- Disapproves
- Manifestation of tension
- Manifestation of antagonism

Modality 2: The importance of living together in the construction of projects contributes to the improvement of the quality of life of elderly people with Alzheimer's disease

Indicator: Getting involved together to share the daily routine

Areas of Interests:

- The complicity,
- Attention to each other,
- Being able to confide in each other,
- Making a suggestion
- To give an opinion
- Providing information
- Asking for information
- Ask for an opinion
- Ask for a suggestion

Modality 3: Social support helps to improve the quality of life of elderly people with Alzheimer's

Indicator: types and nature of support

Areas of Interests:

- Emotional
- Instrumental/ Material help
- Informational
- Social support

VD: Quality of life

Indicator: Perception of QOL components

Areas of Interests:

- Life satisfaction
- Happiness
- Subjective well-being

From where the logical structure of general hypotheses below

Table 02: Logical structure of research hypotheses

(IV) SOCIAL AFFECTION DETERMENANT		**(DV) Quality of life of old Age person affected With Alzheimer**
Modality1: Close affective Relationship	→	Perception of Quality-of-life components
Modality2:The importance of living together in in the construction of projects	→	
Modality3:Social support	→	

From this logical structure of general hypothesis runs the research hypotheses.

4.2.2 RESEARCH HYPOTHESES

Research hypotheses are more concrete than general hypothesis. They are proposing responses to particular aspects of general hypothesis in a form which is easily measured, advanced to guide an investigation; it’s built for this reason an operationalization of general hypothesis.

For this reason, three research hypotheses that one will recapitulate in a synoptique table below were formulated in the framework of this study.

It’s about:

RH1: Close affective relationships contribute to the improvement of quality of life in elderly people suffering from Alzheimer's disease

RH2: The importance of living together in the construction of projects contributes to the improvement of the quality of life of elderly people with Alzheimer's disease

RH3: Social support helps to improve the quality of life of elderly people with Alzheimer's

Table 03: Synoptic description of variables, modalities, indicators and center of interest of research

General Hypothesis	**Independent variables**	**Modalities**	**Indicators**	**Indices**	**Dependent variables**	**Modalities**	**Indicators**	**Indices**
Social affection determinant influences the quality of life of old age person affected with Alzheimer	Social affection determinant	RH1 Close affective relationships	Positive social-emotional signs	❖ Gestures of tenderness ❖ Manifestation of solidarity ❖ Manifestation of relaxation	Quality of life of old age person affected with Alzheimer	Life situation	Perception of quality-of-life components	❖ Life satisfaction ❖ Happiness ❖ Subjective well-being
			Negative social-emotional signs	❖ Disapproves ❖ Manifestation of tension ❖ Manifestation of antagonism				
		RH2 The importance o living together in the construction of projects	Getting involved together to share the daily routine	❖ The complicity, ❖ Attention to each other, ❖ Being able to confide in each other, ❖ Making a suggestion ❖ To give an opinion ❖ Providing information ❖ Asking for information ❖ Ask for an opinion ❖ Ask for a suggestion				
		RH3 Social support	Types and nature of support	❖ Emotional ❖ Instrumental/ Materia help ❖ Informational ❖ Social support				

4.3 TYPE OF RESEARCH

There exist many types of scientific research and notably, in social science. We can cite experimental research, descriptive, etc. Each one of them obeys to a scientific logic which necessitates at times methodology amendment according to specificity of the research type without going to the dialectic scientific margin. It is by obeying to these methodological a precept that we are saying of our research that it is the descriptive type.

Descriptive in the fact that it searches to explain a link between social affection determinant and quality of life of old age person affected with Alzheimer. The descriptive paradigm inclusively privileges the factorial explaining the phenomena. It explains the use of observation method or put in places plans in order to examine a change in an explained situation (Dependent variable). When they submit one of other variables to variation (Independent variable).

At the look of what can be descriptive, forces are given to notice that our study is qualitative seeing the nature of research variables. It's entitled in psychology in the domain of pathology psychology and or clinical psychology.

4.4 SITE OF THE STUDY: CENTRAL HOSPITAL

Under this title, we shall present Central hospital, the geriatric service. We see through our presentation the geographic situation, the history and the growth of the central hospital and the geriatric service.

4.4.1 HISTORY

The central hospital is situated at the heart of the town in Yaoundé I Mfoundi subdivision central region. To put in place, the physical frame work of our place of research. It is necessary for us to recount its history and its creation up till today.

Central hospital was created in the year 1933, Simon Pierre Tchoungui was the old prime minister of east Cameroon was a medical superintendent of the hospital in 1990 before being appointed as minister of health 1961.

In effect, central hospital is a place of excellent. It is the place where we can find all type of people suffering from diverse disease. Since it is situated at the heart of the town with different services as far as health problem is concerned most especially the geriatric service that caters for third age people. Making them to regain their health, answering to the needs of population precisely the elderly people and carrier of disease at the terminal phase. It is then an establishment which enter into the framework of public health and has as order to help persons in needs of treatment and others self-fulfillment.

4.4.2. THE MISSION OF CENTRAL HOSPITAL

The central hospital was created with the aim to answer to the health needs of the population precisely, the elderly in third age at the end of life and carriers of terminal disease. It permits the management of results axis in order to do a better support action. In a specific manner, this establishment proposes to assure a warm welcome to elderly persons at the hospital. Hospitalization is done in short terms of ten days but there are exceptions. There are patients who can go above ten days. It is a service of third age elderly people toward the end of life. The full participation of elderly people, in the family and their community.

4.4.3. FUNCTIONING OF THE CENTRAL HOSPITAL

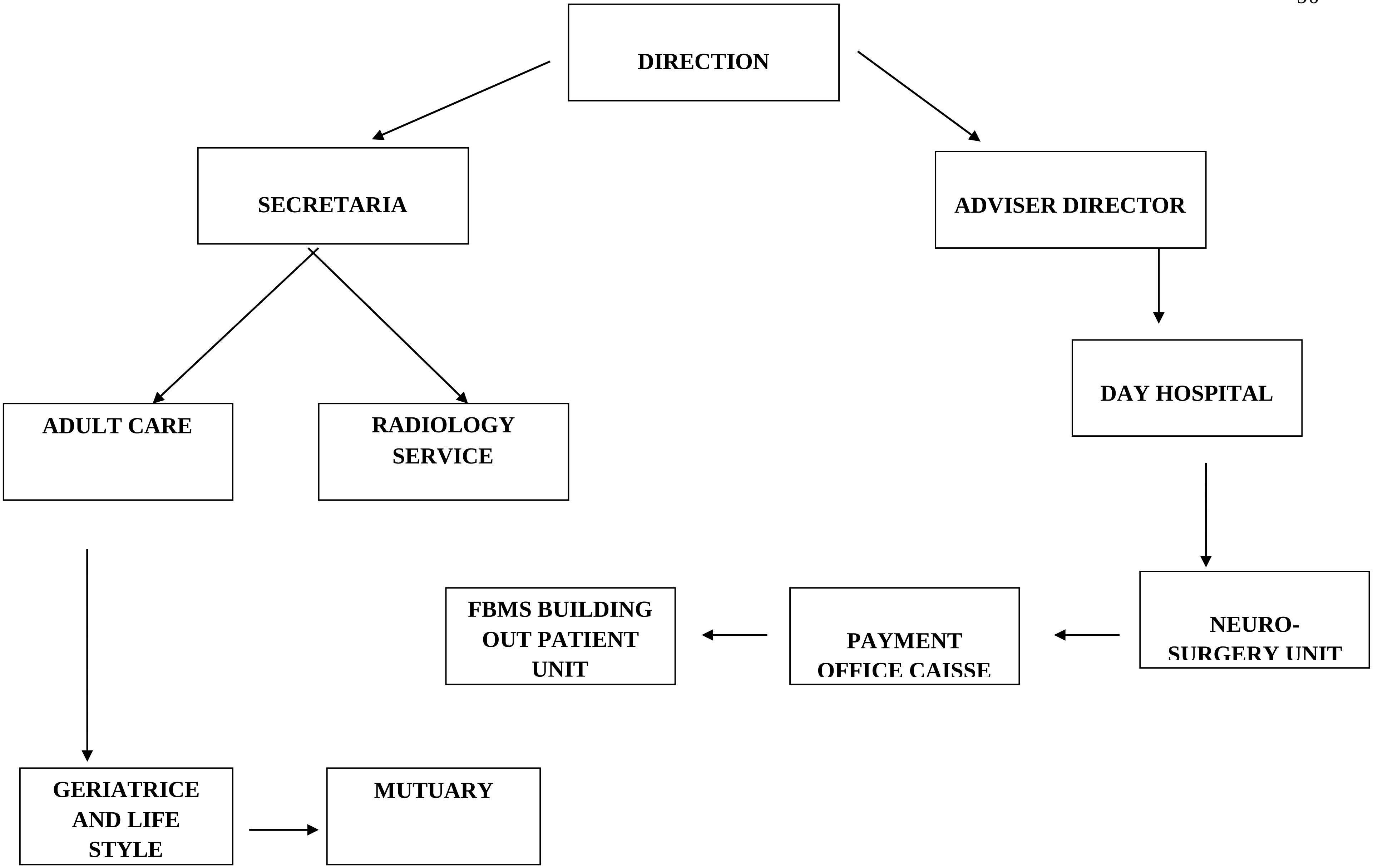
Central hospital disposes:

- A medical division declined in specialized medicals service
- A nursing division built with the general majors of service;
- An administrative unit and finance with a specific service;
- A social service action helping the director to the management of patients and needy

4.4.3.1. ORGANIGRAM OF THE CENTRAL HOSPITAL

The central hospital is a structure

Having as a head an administrator and doted administrative personnel in charge of various services guards and drivers.



CENTRAL HOSPITAL FUNCTIONING ORGANIGRAM

4.4.3.2. FUNCTIONING OF THE CENTRAL HOSPITAL

The geriatric service chief of service Dr. Ntsama Essomba Marie-Josiane is in charge of the service. She is the one who accept patients at the geriatric service. Apart from her, the one that has the ability to admit patient in the geriatric is the emergency. The patient age must be 65 years and each patient have its caregivers. -Hours of visitation are 6:00 to 8:00 am; from 12:00 to 2:00 pm.

-The treatment service team is organized by the majors

-The team is 24/24 hours when nurses administer treatment.

-Each patient who comes into the service are evaluated based on an evaluation scale on health, to establish objectives according to needs.

Hospitalization is done In short terms of ten days but there are exceptions. There are patients who can go above ten days. It is a service of third age elderly people toward the end of life.

4.4.4 STATUS AND INTERNAL REGULATIONS

For the good functioning; the administration of the establishment must dispose consecutive and juridical documents with (internal regulations and status) which advices on the following information.

4.4.4.1 THE CARACTER OF THE CENTRAL HOSPITAL

The nature of the central hospital (public)

-General considerations

-Budget and hospital account

-A look at colleagues

-Collections and agents

-Obligations and specific rights

- Conditions and admission modalities and the outing of patients at the central hospital Yaoundé.

- Social action services

- interned and resident doctors

-Partners, consultants and auxiliary personnel.

- Ecclesiastics personnel

4.4.4.2 ESSENTIAL SERVICES

* At the level of elderly, individual health document the preliminary diagnostics carried out an evaluation scale and interview report at the arrival, observation report, and follow-up report…

* At the level of health / feeding

It's about:

- Preventive visitation of patient link to ageing.
- Of administration of geriatrics treatment
- Of the promotion of adapted dietician
- Home visitation for the case of elderly people
- Individual follow-up

- Dressing assistance and beddings

-Cleaning up of the patients

-Sore matrasses

-Hygiene measure and security

-Toilet and bathing for the elderly and caregivers

-Document on medical needs

-A daily report on health of the patients' internal cleanliness of the building and its surroundings.

-Drainage of used waters

-Maintaining of green environment

Dealing with all psychological handling activities, developed by the supervisory technics to assured the psychosomatic equilibrium of patients.

4.4.5. JUSTIFICATION OF THE CHOICE OF THE FIELD OF STUDY

The study was done in Yaoundé I, Mfoundi sub-division, central region.

Mfoundi is made of cosmopolitan population originated from the ten regions of Cameroon and is counted at the heart of the environment, important community of elderly persons. We choose the central hospital as a framework of our study for many reasons. This hospital welcome old age persons and is one of a kind that is rare in the town of Yaoundé and the heart of the town.

Moreover, this hospital has a minimum of comfort to satisfy the patient in matter of housing of fragile people. It techniques are far interesting. Our choice for the service is due to the fact that, it's a place where we can easily have access to old age person without no distinction of sex. This service takes total changes for old age persons suffering from diverse disease. Furthermore, for this reason it helps us to draw a study population presented all characteristics in which we shall bring out the following analyses of our study.

4.5. POPULATION OF STUDY AND SAMPLING/CIBLE POPULATION

Under this title, we shall begin to present the population of study before interesting to the sample it-self

4.5.1. POPULATION OF STUDY/ ACCESSIBLE POPULATION

Population study is a group of individual taken from the general population who share common characteristics, such as age, sex, or health condition.

Accessible population is the portion of the target population that the researcher can access

Our population of study is built up of old age person affected with Alzheimer. Living in our families, and in our communities frequently visiting our hospitals. We situated this population within the range of 60 -65, 70-75 and 80- 85 years and moreover, people of this age belongs to different societal category, religion settings and most concerned of our research and consequently they or their caregivers are well placed to answer our interview guide. The criteria shall be of great importance in the analysis of the results of the research.

4.5.2. STUDY SAMPLING AND INCLUSION CRITERIA

Our sample study is made up of men and women respectively of 65, 70 and 89 years and above suffering from mental impairment.

To build it, we had to draw our sampling techniques a choice of reasoning. This technique is tributary to the fact that, the period of our descending to the field corresponds to the period when we finished our internship, after sorting out patients with dementia problems who were admitted at the hospital precisely the geriatrics service. Each time the patient was leaving the hospital we got their address from their caregivers to be able to carry out scene of interview concerning their health, the caregiver was open to receive us. Our inclusion criteria were the patients; we have access to do support action we did follow -up with them at the hospital. It was sufficient for them not only to manifest a voluntary to our interview to be obtained, but to participate to the section of interview (03) in which they were supposed to meet with the researcher.

These techniques permitted us to jot down sample of which presented by major characteristics of the parent population. Also, we have met 10 subjects and only 06 were retained for the study, this study has answered to all our interviews.

The no 03 table below illustrate the composition of our sampling study.

Table 04: Presentation of participants

Case	Age in years	Quality of life	Matrimonial situation	Family situation	Hospital motive	Level of Alzheimer
Cecile	88	Bad	Widow	Problem	Alzheimer	Last stage
Pierre	75	Very bad	Married	Problem	Alzheimer	Last stage
Susan	92	Bad	Widow	Harmonious	Alzheimer	Last stage
Ondomo	85	Not too bad	Widower	Harmonious	Alzheimer	Last stage
Mekwa	84	Not too bad	Widow	Harmonious	Alzheimer	Last stage
Julienne	90	Very bad	Widow	Problem	Alzheimer	Last stage

We want to precise here that, the pronoun used in the framework of this research they are essential pronoun borrowed to preserved the

Anonym of our subject and their personnel who takes care of them.

4.6. COLLECTING INSTRUMENT OF THE STUDY

In this study we have to use semi- directive clinical interview guide and observation scale on quality of life of patients on two scale as instrument of collecting of data.

4.6.1 OBSERVATION SCALE OF ELDERLY PERSON SUFFERING WITH ALZHEIMER.

The observation scale is a popular performance appraisal method because it is reliable and easy to use. It focuses on the behaviour rather than the results Gary Latham and Ken Wexley (1970)

In our study we carry out an observation using an observation scale on old age person affected with Alzheimer. We were observing certain elements related to their social condition and related to their disease. In the course of observing these elements, we did not have some details information around their disease so, we had to collect this information from caregivers since they spend most of the time with then participant. Then we mounted an interview guide in order to collect some detailed information from their caregivers because they live with our participant and they were well place to give us answers related to our study in our subsequent we present the second instrument.

4.6.2 INTERVIEW GUIDE AND SEMI- DIRECTIVE CLINICAL INTERVIEW

According to Blanchet (1987), interview of research is a meeting of two persons, an interview and an interviewee conducted and register by the interviewer. This one having as objectives to favor the production of a linear speech of the interviewee on a theme well define in the framework of research.

A semi-directive interview is a tool which permit the researcher to harvest subjective data in form of liberty.

An interview is a situation of conversation or exchange in which extract, on information from the investigation or the patient, initially information is written in other's biography.

At the clinical plan, interview design a communication of people to people or we speak, listen and observe. Communication is verbal also non-verbal, silence aptitude, emotional and also looking, tells in a long word.

Psychology is frequently let to work on objective and subjective identities, social and cultural or professionals. An individual, alone or in groups, is also an objects of research. To obtain necessary information toward his work, the psychologist will maintain interview principle. He /she needs to detect values of subject, sources of his self-esteem and confidence.

Gathering of data is principally through interview. This permit to give immediately, objective information (name, lodging, dresses, level recount his story, his origin, his sentiment and also event that marks his life.

Ideological pre-occupations, belief and his vision of the world and that of the subject that appears beat by beat. Also, the level of eventual isolation or socialization is being felt. All information which human-being in the world built, are psychological material. It formed identity, feelings of an individual to continue.

The psychologist needs to be able of situation and to adapt to an individual or a group, according to the demand. According to Pole employs that psychologist “studies affective life phenomenon and intellects of persons”. They conceive and put in place specific method of analysis.

Clinical interview is therefore, always oriented by the subjectivity of the patient. The psychologist will privilege the reality of what the patient undergoes by knowing pertinently that life doesn’t have an objective reality.

An event can be invented or modify consciously or unconsciously because all of these are needs of the subject.

The psychologist can influence the process of the interview by multiple inductive verbal factors and para-verbal, by nature of questions for example. The clinician avoid commentary and keep his opinion, he avoids judgement.

Interpretations are made at the psychological level and non-moral. In an ideal, the clinician must be conscious of all actions and re-actions. Clinical interview must be free, jotting down notes is always problematic. The fact of writing restricts attention; patient can be irritated and punish the psychologist by refusing to express themselves much or less.

Each clinician should find for each patient situation that perturb less.

In the framework of our study. We have chosen to do make usage of semi-directive interview. We choose this model of interview not only for it specify, but equally, to the subject to study and the quality of data that we want to collect. We mention a qualitative study and consequently necessitate a data collection which is easily handled. In their contain meanwhile, the quality of information searching depends on the manner that different points of view can be met. Therefore, the interviewee needs to be guided toward the situation and described behaviour.

Normally, we have all by respecting the guide, allow freely the subjects to introduce aspect they want to talk about. We harvest the whole points theoretically and elaborate a psychological protocol found at the annex, they were mostly open. That is soliciting answer by “Yes” or “No” and where not presuming possible responses of the interviewee.

The answers of this questions could be profound by different exploratory techniques (if not, why do you always talk alone) do they pose question? Also when we were collecting data with the interview guide, most of the elderly people could not gives us all necessary responds due to their health challenges on which we had to mount an observation scale that help us to observe some detailed elements relating to Alzheimer disease and quality of life.

4.6.3 OBSERVATION SCALE

We use an observation scale to observe the emotions of old age person suffering with Alzheimer disease, type of relationship and quality, behaviour to rules and instructions having to do with the environment of the subject, re-enforcement of confidence, in their quality of life do they eat well, do they have other disease. Alzheimer disease manifestation.

4.6.4 THE PROCEDURE OF COLLECTION

At this tittle, our work will be divisible in two phases: one is pre- validation of of the interview guide which is validated by the researcher's director; then follow immediately the phase of collection properly said.

4.6.3.1 PRE-INVESTIGATION

We realized our pre-investigation beside 4 age subject brought in to consultation at the hospital. On the basis of area of interest at which we have submitted our pre-investigation permitted us to measure the pertinence of our research topic and for a recall of the reformulation did not posed any comprehension problem to the population concerned by study.

4.6.3.2 INVESTIGATION

Generally, investigation is carried out with an aim to elucidate or explained a given situation. It is carried out from the month of January 2023 at the central hospital situated at the heart of the town Yaoundé I, Mfoundi sub-division, central region. In fact, according to our sampling, which was built of 3 subjects, the passing of interview were carried out in a good condition, with the aid of caregivers at the geriatric service.

Also we had 10 subjects; though we work effectively only with o6. In which inclusion responded to all our criteria.

4.7. TECHNIQUES ANALYSES OF RESULTS

The different articulations which made -up our instruments of collection permitted us at the moment of unfolding to have qualitative analysis. What gave us the occasion on what is to do analysis which made us to allow calculation and oriented us to psychological analysis of observation of harvested. Thanks to it, we were interested to certain phenomenon less or non-negligible.

In fact, the method that we adopted, from which it is difficult to generalized, it is pertinent to our opinion "put in evidence new facts and difficult access to science." Our objectives through this step of analysis, was to give account, in a profound, "Divers aspects of situation to be able to make significance elements to appears and links in which unite them, in an effort to handle dynamic particularity".

Mucchielli (1996) to this act, we had used method of codification and of categorization which have permitted us to segment divers passages of interview and interview in categories clearly to our object. These categories are somehow bribe of responses to our questioning. Also" the aim of qualitative analyses give sense to understand social phenomena and human complex Consequently, the risks of qualitative analysis are those of argumentative walk on reformulation, explicitly or theorization testimony, experiences or practices" Mukamurera& al (2006) p.111.

Moreover, analyses of framework of old age person will permit us on the first interested principal voice and to handle a particular dynamic knowledge of ageing and perception of life supported action in the establishment.

4.7.1 ANALYSIS TECHNIQUE

To analyses qualitative data of this study, we did contain analysis.

By contain analysis, one can hear, research method takes into account what it is said by the interviewee in a most objective manner to be positively verifiable.

For Berelson (1952), it is defined as "a research technique for descriptive objective, systematic manifest communication". In psychology and clinics, the objective is to analyze the investigation material interview or individual interview: behavior, words, gestures, what is not said and what is heard.

Bardin (1977), state that, "contain analyses is a whole techniques of communication". According to this author, the procedure understands generally the transformation of an oral text speech, then a construction of an instrument of analysis, to study the proposed significance. Then, there is an intervention in charge of the study to use the analyzed instrument and to decode what was said.

Finally, establish a sense of analysis of the speech. Most at time the difficulties are to gather the ambiguous, in completed and contradictory information interpret the similarities and the differences in between the answers and to arrive at an objective analysis.

4.7.2 CONTENT OF STUDY ANALYSES

The specific choice technique and the sense of interpretation lies on the nature of the document, the questions which structure the research also on the epistemology where by, content analysis is a techniques of treating pre-existing data by sorting, clarification and quantification of the body line.

Concerning this study, we proceeded in three essential steps: the transcription of data coding of information and the treatment of data. Before beginning with the analysis, the first makes the inventory of the information harvested and put them in the form of writings. This text (called verbatim) represent rough data of investigation. The transcription organize the material of investigation under a format which is directly registered with audio or video, it is preferable to measure them flat by writing to facilitate reading and to have faithful traces. Aurerbac and Silverstein (2003)" qualitative data is presented under the form of a text": words, phrase, expression of language, or symbolic information (gestures, tongue of the voice, impressions…)

It's can correspond to a transcription of an interview, to observation notes on a nature (recitation, given an account, responding to questions). According to the study objectives, these data are destined, one time it is analyzed, documented, described, and evaluated in detail a situation, a phenomenon or a decision, to compared, to put in relation and to explained causes, to predict behavior and factors of success and failures.

In the perspective, we shall Transcript our interview.

At the end of this chapter in which it was question to highlights the methodology of the study, we adopted the contain analyses taking into consideration data which were ours. Presently we shall proceed with the presentation analyses of our results.

CHAPTER 5: PRESENTATION AND ANALYSIS OF RESULTS

This chapter is both descriptive and analytical. In its descriptive aspects, it gives a brutal presentation of the data collected in the field. Its analytical dimension presents the various content analyses that led us to our final results. We shall present the various cases of our study, we shall do analysis of our results.

5.1 DETERMINING THE PARTICIPANT'S SOCIO-DEMOGRAPHIC INFORMATION

The old age person suffering from cognitive degeneration “characterized by social origin and diverse families “with “diverse multiple itinerary “.

5.2 ABOUT THE HISTORY OF THE PARTICIPANT

During our study, we carry out observation on participant to have certain elements related to their social condition around their disease, those elements observed we shall present them on each case. After observing these elements, in the course of carrying out this activity we realize a lot of manifestation and reactions around these people suffering from Alzheimer disease which made us to gather much information and to research more on this study to come out with a better result of our problem.

Elements mounted on the observation scale are:

- The emotions of old age persons
- Relationship of the participant
- Obedient behaviour to rules and instructions having to do with the environment of the subject
- Renforcement of confidence
- Manifestation of Alzheimer disease
- Quality of life in term of feeding and in term of other disease

5.2.1. CASE OF CECILE

With this case we observe she had a very weak emotion, her relationship was a push relationship he was not obedient to medical personnel’s rules, was aggressive, re-enforcement of confidence was push confidence, quality of life in terms of eating well was good, and in terms of other disease she had comorbidity, manifestation of Alzheimer disease, hallucination

5.2.2. CASE OF PIERRE

With this patient, we were observing the same elements since all were in the same category, he had a strong emotion. We notice a relationship of proximity with his entourage, was obedient to medical personnel's rules, the re-enforcement of confidence was total confidence, quality of life eating habit was good in terms of other disease was opportunist, Alzheimer disease manifestation was agitation.

5.2.3. CASE OF SUSAN

The emotions were weak type negative, the relationship was sympathy relationship, the quality of relationship was averagely good. She was obedient to medical personnel's rules, re-enforcement of confidence was very push with visitors, manifestation of the disease there was apathy and the quality of life in feeding her eating habit is insufficient.

5.2.4. CASE OF ONDOMO

We were still observing this participant with same elements mention already. This case had very weak motions type of relationship was neutrality relationship, obedient behaviour to rules and instruction to environment, was not obedient to rules, re-enforcement of confidence was push confidence with the family she could eat well, quality of life in terms of feeding was good, the manifestation of the disease was hallucination".

5.2.5. CASE OF MEKWA

In this case we noticed that the participant had strong emotions type positive and the type of relationship was that of proximity relationship, obedient behaviour to rules and instructions in his environment having to do with the subject, the elderly was obedient to requirement link to intake of medication and cleanliness, re-enforcement of confidence was push with family, quality of life in terms of feeding was good then the manifestation of the disease was agitation

5.2.6. CASE OF JULIENNE

We observe he has a very weak emotion, his relationship was a proximity relationship type, obedient behaviour to medical personnel's rules, had an obedient behaviour, re-enforcement of confidence was very push with medical structure, and the quality of life in eating was bad other disease were passing and the disease manifestation was apathy.

5.3 ANALYSIS OF DATA CASE BY CASE

Case of Cecile:

- Emotion of old age person; she had a very weak emotion
- Type of relationship and quality; the relationship was a push relationship
- Obedient behaviour to rules and instructions having to do with the environment of the subject; she was not obedient to medical personnel's rules; she was aggressive
- Re-enforcement of confidence; she had a very push confidence with medical structure
- Quality of life in terms of feeding was good and in terms of other disease she had comorbidity
- Alzheimer disease manifestation she is in a state of apathy.

Case of Pierre

- Emotion of old age person; he had a very strong emotion
- Type of relationship and quality; he had a relationship of proximity with his entourage
- Obedient behaviour to rules and instruction having to do with the environment of the subject; he was obedient to medical personnel's rules
- Re-enforcement of confidence; the patient had a total confidence with his family
- Quality of life in terms of feeding; was good and in terms of other disease; she had opportunist
- Alzheimer disease manifestation; he was agitated

Case of Susan

- Emotion of old age person; the emotion was weak type negative
- Type of relationship and quality; she had a sympathy relationship the quality was averagely goo
- Obedient behaviour to rules and instructions having to do with the environment of the subject; she was obedient to medical personnel's rules
- Re-enforcement of confidence; the confidence was very push with visitors
- Quality of life in terms of feeding was insufficient and in terms of other disease were comorbidity
- Alzheimer disease manifestation; aggressive behaviour
-

Case of Ondomo

- Emotion of old age person; it was very weak emotions
- Type of relationship and quality; the relationship was that of neutrality relationship
- Obedient behaviour to rules and instructions having to do with the environment of the subject; he was obedient to rules from medical personnel's and even in his environment
- Re-enforcement of confidence, he had a very push confidence with his family
- Quality of life in terms of feeding was insufficient and in terms of other disease was passing
- Alzheimer disease manifestation; was apathy

Case of MEKWA

- Emotion of old age person; we notice the participant had strong emotions
- Type of relationship and quality; the relationship was that of proximity relationship
- Obedient behaviour to rules and instruction having to do with the environment of the subject; she was obedient to requirement regarding the intake of medication and cleanliness
- Re-enforcement of confidence; the elderly person had a push confidence with the family.
- Quality of life in terms of feeding was good and in terms of other disease; there were opportunist
- Alzheimer disease manifestation; was hallucination

Case of Julienne

- Emotions of old person; we observe she had a very weak emotion
- Type of relationship and quality; was that of approximate relationship
- Obedient behaviour to rules and instructions having to do with the environment of the subject; the patient had an obedient behaviour toward the medical personnel's
- Re-enforcement of confidence; the confidence was very push with the medical structure
- Quality of life in terms of feeding was bad and in terms of other disease she had comorbidity

- Alzheimer disease manifestation was apathy.

5.3.1. ANALYSIS ON OBSERVATION SCALE ON OLD AGE PERSON AFFECTED WITH ALZHEIMER

Analyzing behaviour on old age person suffering from Alzheimer admitted at the geriatric service

On six cases observe on a specific period of time this were their reactions:

- Two of the age persons asks questions why was I standing by his site
- six age person observe, four were very calm and two were agitated
- During this moment the care givers were quiet
- One from a duration of 4 seconds
- Three from a duration of 6 seconds
- Two from a duration of 7 seconds

5.3.2. STRUCTURE OF THEMATIC ANALYSIS OF OBSERVATION SCALE

In this service, we had some major elements we were observing directly on the participant

- The emotions

"The way the old persons suffering from mental impairment could express his emotion"

- Type of relationship and quality

"how they could relate with others and how was the quality of relationship maintain push, very push or total with his family, medical personnel's, visitors"

- Obedient behaviour to rules and instructions having to do with the environment of the subject

"in terms of intake of medication, cleanliness "

- Re-enforcement of confidence

"How was their confidence manifested is it good, bad or total this has to do with self-esteem of the elderly person"

- Quality of life in terms of feeding

"Do they eat well good, bad, insufficiently

- Alzheimer disease manifestation

"Aggressive, hallucinating, agitation, sleep dis-order"

5.3.3. RELATIONSHIP IN SITUATION OF TREATMENT

To understand a relationship, you need to situate yourself in the context that is preferable. To study a relationship, it is primordial to take into consideration the context in which it takes it form to grow. In effect the context reveals the social character of the relationship.

- "Type of behaviour adopted by an individual following a certain social norms and responses that is expected in a specific milieu" Fisher (1999) Therefore there are social norms, but each one plays his role at his own manner.

- Interaction myth: these are structure rules of interaction in a certain context. It permit to each " a ritual of exchange in an important functions to save a face in the presence of another " Fischer (1999)

5.3.4. THE SITUATION OF CARING OF OLD AGE PERSONS: REPRESENTION AND REALITY

Working with old age, whatever be the place of exercise, is still perplex because support action of old age person still remains global and globalizing, to this is equally associated a negative image which is rested on representation as:

- A heavy and charge repetitive work
- A loss of skills
- A complicated confrontation with ageing due to loss of autonomy as a consequence, loss of mental faculties, degradation of capacity in terms of communication….)

The elderly person suffering from cognitive degeneration "characterised by a diverse social and family background" with "multiple itineraries".

5.4. ABOUT THE PARTICIPANT'S STORY

During this interview, we discussed with the participants certain events linked to the social condition surrounding their illness, i.e. we asked each of them to tell us a little about themselves and their illness.

5.4.1. CASE OF CECILE

The most painful event was the staph the girl suffered in front of her. After two weeks, she started forgetting things and hallucinating.

"The first case involved a 90-year-old woman from the west region. During the interview, we noticed that this was a person who had experienced some very sad moments in her life. Throughout her life, she had lived odds with others, there had been antagonisms, she had lived a life of conflict, and her experience had led her to live in bitterness. Despite all this suffering, she still had something positive to say, even though she had lost close people in her life and all this had a negative impact on her life".

We conducted the interview scene in the presence of the carers. She spent the most time with the patient and was best placed to give information because the two were inseparable and the participant had always lived with her.

5.4.2. CASE OF PIERRE

After two weeks, she had two of malaise where she began to forget often and refused to eat.

"The second case is 92 years old and comes from the central region; used to be head of a nursery school. She started having hallucinations recently and has become very aggressive, shows antagonism with others, gives opinion, is also friendly, makes suggestions when necessary. Does not ask for information. Lives a positive life because she takes all her medication, satisfied with her life and the help she has given to those in need. Wants to live again".

We conducted the interview scene in the presence of the care assistant who looks after her and who is more familiar with the participant's experience and can respond to the guide as she is familiar with the participant's day-to-day experiences.

5.4.3. CASE OF SUSAN

When she lost her sister, after two weeks she started having delision.

"She can't leave the house alone and go out, she's disapproved of, there's always tension, when she's happy she gives her opinion or makes suggestions. She's very thoughtful and has a negative outlook on life, she says she'd rather die".

We conducted the interview scene to observe the pain that close relatives or carers go through because of the state of their loved one's health. In the end, these participants prefer to die because life is becoming very negative and everything is going wrong.

5.4.4. CASE OF ONDOMO

After completing his baccalauréat, he was recruited to the civil service to review files and worked in the West and Centre regions.

"The case of a 75-year-old man from the central region who lived in Cameroon, then went to France where he worked in a school, before returning to Cameroon. He owns a school here. The people I've worked with who know I'm ill often check up on me. He approves of ideas with others, in the area of tension not always, by sharing his daily life with no one, there is the manifestation of antagonism, the participant is attached to the carer who is the wife, he confides in her trust, asks to know the others. The perception of quality of life is satisfied and positive, but the participant is not satisfied with his subjective well-being, which is negative because there is a problem with his frontal face.

During the interview, we noticed that this participant was very attached to his wife and that she was also the carer. She took part in the interview because he was close to her and could give correct information about the participant's experience.

5.4.5. CASE MEKWA

A development officer with an advanced level of education and two years' postgraduate study at a professional institution.

"The case of an 85-year-old man from the central region who lost his mother when he was 6 and his father when he was 16. He has struggled to become a man and integrate into society. He is sometimes aggressive, shows solidarity but cannot go out alone, uses a wheelchair, is not antagonistic, cooperates, sees life on the positive side, his children show him love and support him materially. He is satisfied, even if he sometimes cries. He says he wants to live again".

During the interview, we were surprised by this participant who was so positive that he answered the interview accompanied by his carer. He was very positive. He was in a positive frame of mind because his relationship with the children was very satisfactory.

5.4.6. CASE JULIENNE

A secondary school teacher in a state of delirium and oblivion, she isolates herself because she has just lost her elderly son.

"The sixth case is an 88-year-old woman who lost her 50-year-old son, the central region, her first son, and since then she has been isolating herself and crying. She has lost her state of delirium and forgetfulness. She was a teacher in a school in the Centre region all her life. She is sometimes aggressive, not antagonistic, gives her opinion, doesn't ask for information, is happy when she listens to Christian music, shows solidarity, lives in negativity because of the co-morbidity which is so painful".

During the interview, the participant's carer, her daughter-in-law, looked after her and was familiar with her experience; she was able to answer the interview guide correctly and noted that it was the wounds she had now that made her live in sadness, whereas before she could play with her grandchildren.

5.5. STUDY VARIABLES

5.5.1. CLOSE AFFECTIVE RELATIONSHIPS/POSITIVE SOCIO-AFFECTIVE SIGNS

The socio-affective signs are numerous and all revolve around the notion of love. Yet this very notion is characterised by a plurality of concepts, each just as vague as the next: venal, sublime, platonic, generous, self-interested love; love is a bohemian child, let's love one another, everything good that is done is done out of love,.... This series of commonplaces and stereotypes is proof enough that the term 'love' is used in many different ways. We often speak of 'states of love' in the plural, and English speakers use two verbs for 'to love': *to love* and *to like*. The former refers to 'romantic' love and sexual attraction, while the latter expresses feelings of sympathy and friendly attraction towards people, situations, things or animals.

According to Ferry (1996), love as we conceive it today seems to be a recent invention, although the model of passionate love, later redeveloped by the Romantics, originated at the turn of the eleventh^{è} and twelfth^{è} centuries, blossoming in the Middle Ages with courtly love and the courts of love, Since then, and right up to the present day, it has inspired almost all literary and artistic production through a process that some people, from Freud onwards, have called sublimation, by which they mean that all creative activity uses energy that was initially produced by sexual impulses and therefore diverted from its primitive, consuming purpose.

It therefore follows that the affective dimension plays an important role in improving the quality of life of people suffering from Alzheimer's disease. Indeed, if we accept that social species are characterised by "the social fact" defined by Rabaud (1927) as a "phenomenon of mutual attraction", we come to accept that they are driven by a "herd instinct″, or by an "affiliative drive″ to use the psychoanalyst's term. This latter expression indicates that individuals belonging to a social species are driven by a force that pushes them to seek contact with their fellow creatures (induction of similarity) and to contract with them bonds of different types that are essential for the survival of the group, as well as for that of the individual. This leads us to believe that the human species is a social species, and that human beings are driven by the affiliative impulsese, which translates into the existence of friendly interpersonal bonds,

Speaking of gestures of tenderness, the results show that all 6 of our participants make aggressive gestures. Cecile acknowledged this, admitting that it was occasional without specifying the circumstances: "Aggressive sometimes", he said, while for Susan and Julienne these aggressive gestures only appeared at specific times: "during crises" for Susan and "during health challenges" as Julienne said. For participant Pierre, Ondomo and Mekwa, these aggressive gestures are not justified despite their existence.

Moreover, where poverty and unresolved conflicts are rampant or destructive, shouldn't we be linking up to rebuild, reconstruct and repair? Breaking out of isolation, developing a sense of belonging, giving ourselves space and time to share ideas and resources, exchanging tools, encouraging reflection and putting things into perspective, etc., all presuppose forgeing links, nurturing alliances, affiliating to counter disaffiliation. With this in mind, solidarity and collaboration have become a necessity, in order to counter the risks of first impressions or flabbergasting and avoid getting bogged down in common places, prejudice, discouragement, or even despair or resignation (Aubin, 2002) . Indeed, in relation to manifestations of solidarity (Sub-theme 2), our participants all acknowledged gestures of solidarity shown towards them. For Pierre and Ondomo, these were occasional gestures (not always) and (sometimes), while for Mekwa they were frequent (often). For Cecile and Julienne, although the frequency is not known, we do know from the results that the gestures of solidarity towards them come from professional relationships: "In a global manner people with whom I have worked they usually pass and check on me" states Cecile and "my colleague I have worked with" states Pierre.

The aim of relaxation is not only to relieve common physical aches and pains, but also to achieve exceptional relaxation that affects the whole body. In psychophysiology, relaxation refers to the voluntary loosening of muscle tone. In psychiatry, relaxation is understood as a therapeutic method which, using well-defined techniques producing a state of more or less voluntary muscular relaxation, seeks to reduce tension, anxiety and emotional imbalance in a subject by acting specifically on myotonic activity and the neuro vegetative system (Bloch et al., 1997) . While it is acknowledged that there are several types of relaxation, there are two characteristic elements in common: on the one hand, the establishment of a state of physiological relaxation that is antagonistic to that of stress or anxiety, and on the other, the induction of a state of consciousness a kind to hypnosis. The data from our participants show that only participant 4 stated that he did not benefit from moments of relaxation either at home or in hospital. On the other hand, all the other participants enjoy moments of relaxation in different ways. Cecile did so in the vicinity of the place where he was and never outside his living space. She explains: "I do it around the enclosure and not outside, and if I have to go out, I'll be accompanied". While participant Susan admitted that he sometimes didn't benefit from it (sometimes no), this was not the case for participants Pierre, Mekwa and Julienne, who only practised it at home. Participant Susan says that he does it "only in the house" (Pierre) or "only within the house" (Julienne), while Mekwa does it on a chair. He said: "at times on wheel chair".

Simply put, the aim of relaxation for our participants is to "obtain calm in the psychic domain". In other words, to put the cortex to rest by reducing excessive cerebra-neuro-muscular functioning by directly relaxing the peripheral part of this circuit. The patient trains himself to observe his tension patterns and to release them by focusing his attention on the states of muscular tension that he provokes; he learns to identify these tensions and then stops his effort and turns his attention to the new sensations which are then identified as those of relaxation. Repetition after repetition, he tries to deepen the states of muscular relaxation. His idea is that by reducing these so-called "residual" tensions, the emotional impact is lessened.

5.5.2. CLOSE AFFECTIVE RELATIONSHIPS/NEGATIVE SOCIO-AFFECTIVE SIGNS

Interpersonal attraction and affinity are the result of the affiliative impulse. However, it is important to note that this drive varies from person to person and from circumstance to circumstance, although in general people find it important to have friends and to share emotional experiences with them. We could say that they are intrinsically motivated to establish relationships. Our results show that, with equal parity, our participants have different opinions about negative social-emotional signs in their close affective relationships. Participants Pierre, Susan and Ondomo are those for whom disapproval is high, whereas participants Cecile, Mekwa and Julienne are more likely to approve.

At this stage of our analysis, therefore, we can put forward the hypothesis that neighbourliness, the invisible intermediary of inter-individual relationships, is a function of the patient's personality, because in order to function, the affiliative drive needs favourable if not necessary conditions, in particular the possibility of a positive mutual evaluation of the two potential friends, i.e. the existence of affinities.

Family tensions, and indeed the tensions and conflicts involved in social relationships, are also an important component of negative interactions for Alzheimer's sufferers. Indeed, Cohen et al (1998) have shown that people subjected to conflict are twice as likely to develop a cold as those who do not have to put up with chronic stressors. These effects can be mediated by immune, endocrine and cardiac changes and by 'unhealthy' behaviours associated with these deleterious environments. The results of our study show that all our participants admit to having experienced tension. However, while participants Susan and Mekwa did not explain when these symptoms occurred, and participant Pierre who said "more often" only gave the frequency, participant Cecile said it was when he was impatient. So he says "at times impatient". The same applies to participant 4 when he is in crisis "in moment of crises" or participant Julienne when he is in pain "when I am in pain because I have sores".

These results show that the extreme vulnerability of the Alzheimer's patients we meet, the many risks they take, and the consequences of their daily exposure to factors that make their situation more complex to understand, very often give rise to a tension between respect for their rights and lifestyle, professional responsibility and ethical rules, and the ethical and moral conscience of practitioners. It's not always a comfortable position to be in, especially when there are further impediments or referral to specialist health services, and difficulties in approaching third parties who are not sufficiently aware of or trained in dealing with this population, and who fail to deal with people who are easily stigmatised or shunned.

As far as antagonistic manifestations are concerned, it's worth remembering that each person reacts on the 3 ″verbal-viscera-motor″ levels, but with personal organisations: some react in a privileged way using speech, others are very motorised, some have very few visceral (emotional) reactions, while others have many. The results show that all the participants acknowledge having had antagonistic manifestations. Of course, for participants Pierre, Ondomo, Mekwa and Julienne, the frequency and time of occurrence are not known. However, it appears that for participant Susan the frequency is relative and occasional (sometimes), whereas for participant Cecile the antagonistic manifestations appear during the crisis period, which is why he specifies "during crises".

It is therefore easy to understand why, in Alzheimer's patients, there is a frequent antagonism between visceral reactions and verbal and motor behaviour: speech and gestures often have a rapid reducing effect on vegetative emotional reactions. We can therefore speak of the "balancing phenomenon", which is in fact a coordinated activity (verbal and/or motor) that controls and moderates emotional activity.

We can see from the results of our participants that the psycho-affective dimension is everything to do with emotions, relationships with oneself and with others, which leads the patient to have self-confidence, to develop skills and to be committed. Establishing a therapeutic relationship and a climate of trust is just as important as the technique, because it is this that enables progress to be made and the patient to agree and share.

5.5.3. THE IMPORTANCE OF COHABITATION IN CONSTRUCTION PROJECTS

The level of social cohesion helps to promote synergies within organisations and the quality of life of the members of societies, if social relations are experienced positively by the individuals making up the organisation or society. But it can also be detrimental to innovation, because of its tendency to create strong links between members and few links with the outside world; less cohesion, leaving room for "structural holes", encourages innovation. Too much social cohesion can also lead to withdrawal and further maintain the segregation of gender roles. Under these conditions, social cohesion is the state in which society functions properly, where solidarity between individuals and collective awareness are expressed.

5.5.3.1. Engaging with each other to share everyday life

Community and/or societal ties emerge when certain similarities are established between individuals (differences and complementarities for modern societies); these characteristics may be enough to reveal a social cohesion that is a source of solidarity. In this respect, social exchange as an exchange of social and material resources is considered fundamental to human interaction, resulting in a commitment between parties based on trust.

Analysed through the prism of engagement together to share daily life, the results show that only Cecile does not benefit from engagement with others. This is illustrated by the words "No (since he suffering from the health he does not work he sleeps a lot in the day at night he does not)". Moreover, the verbatim reports show that all the others interact with the environment. Pierre also states "at home I can clean by sweeping". We can see that this desire is shared by Susan, who still thinks he can feel the movements of his hand. He said: "Yes, I can feel that I'm working with my hands", whereas case 4 did share his daily life, "but not too often". On the other hand, for participants Mekwa and Julienne, this willingness to get involved is shown by the constant thought of his planting. He said: "Yes, I always talk about my cocoa farm". Only Mekwa did not seem concerned by this preoccupation. For him, the relationship with his grandsons is important. He says: "My grandchildren have already felt sick".

5.5.3.2. Complicity

Interpersonal relations in the context of Alzheimer's also play an important role, since the influence of one person on another leads to imbalances in exchanges. In this respect, we would point out the complexity of all discourse, hence the importance of its interpretation for approximate understanding. Analysed from the point of view of complexity, the results show that this relationship is experienced in different ways by our participants depending on the actors around them. Thus, for Pierre, complicity is expressed through "the grandchildren", whereas for Julienne, it is experienced with his "daughter-in-law". Furthermore, for Ondomo and Mekwa, the circumstances and actors are not related to the grandchildren. Ondomo expresses his complexity only when he is "happy", whereas Mekwa does so with the person who takes care of him. He claims to be in complicity: "with the person who looks after him". While complicity exists in Cecile and Susan, it is experienced differently. And Cecile qualifies his attitude by saying "we evaluate over time". From the point of view of "meaning", we can say that for our participants, every statement is taken into consideration to account for its coherence or incoherence.

5.5.3.3. Looking out for others

The quality of attention we give to the person in front of us helps to build the relationship of trust that is the fundamental pillar of the work of liberation and reconstruction in support. This rare, unprecedented, focused and uninterrupted listening to the person expressing themselves is reinforced by their gaze and non-verbal communication. Observation shows that all our participants pay attention to others. But the analysis distinguishes the nature of the actor concerned by the attention. Cecile, for example, is talking about his wife. He specifies: "I'm attached to my wife" and Susan to "his relative". Only Pierre pays attention to his children. She said: "I'm asking for my children". Paying attention to others is always a different, specific kind of attention, different from the one we paid a few minutes earlier to an animal, a car, a screen, another individual, or why not the same person (Citton, 2014). Indeed, the testimonies show that from vigilance to danger to consideration for others, there are many ways of being attentive to others, and not all attentions are equal...

5.5.3.4. Confidence

Everyday conversations are among the phenomena often neglected by the social sciences, not only because of their 'minor' nature - defined as imprecise, vague and elusive - but also because of their allegedly poor explanatory capacity in determining other social dynamics, processes and behaviours under study. It is through interaction and everyday conversations that we enter into relationships, define our relationships and reflect on our relationships. These everyday conversations, at first sight volatile phenomena, are spaces of sociability where the complex processes of constructing and structuring both valued models of love and models considered unsuitable are articulated and put to the test. Our results show that all our participants have the power to confide in each other through at least one channel. While Cecile and Ondomo only admit to doing so, as Cecile states, "I do it", for the other cases, the power to confide is always directed towards a close third party. Pierre, for example, can confide in his "daughter", while case 3 can confide in "the person he is close to". Only Mekwa and Julienne openly declared that they could confide in family members. Mekwa confided in "his children" and Julienne in "his son".

We can see here that while caring for others is the rarest and the purest form of generosity, a significant part of our daily exchanges and interactions is devoted to the question of love and relationships. In fact, it's through daily interaction and conversation that we enter into relationships, talk about our relationships, discuss other people's situations, and so on.

5.5.3.5. Making a suggestion

While everyday conversations have had a certain golden age in sociology and linguistics following the work of Sacks (1995) , today they are rarely studied in terms of their themes (Traverso, 1996) , their modalities and above all from the angle of their reception (following in the footsteps of Jauss, 1978 ; Hall, 1980 ; Boullier, 2003) . Nevertheless, their analysis has already been considered essential for understanding the interplay of social normativity involved in the fine fabric of the subjective construction of reality (Berger and

Luckmann, 1986; Schütz, 1987) facilitating interrelations. In this logic, suggestion, like listening, is a norm of socialisation. Thus, for Cecile, the possibility of making suggestions is only possible "when there is a family gathering", whereas for Pierre, this possibility exists "during a traditional meal". For Mekwa, suggestions are made according to his mood. He said that he could make suggestions "as he wished". Only Susan and Julienne did not recognise this power in their experience of their illness.

5.5.3.6. Giving your opinion

The universe of emotional norms (De Courville-Nicol, 2011, p. 12), which everyday conversations reveal, is not a space of simple cohesion but also the place where it is possible to have a very rich qualitative and aesthetic experience which modulates love relationships, situates them in mobilising atmospheres and frames the elective logic of relationships Martuccelli, (2010, p. 24) . This shows us that everyday life is a register of experience in which it is possible to observe the concrete interplay of overarching phenomena. Analysis of the verbatim reports shows that for our participants, the relationship with others is synergistic and reciprocal, with everyone able to give their opinion in a given life situation. However, the frequencies are divergent: for Cecile, it's "from time to time", whereas for Susan she wants to, but doesn't say how often. Furthermore, the data show that Mekwa gives her opinion "on her farm", whereas Julienne gives her opinion "on what she wants". We come to think that, through the accounts of our participants, we are witnessing the formidable interweaving of concrete, every day, personal, contingent issues, specific to individual lives, and issues affecting the collective categories of equality, freedom, the division of social labour and gender. This is what Giddens (2006, p. 19) means when he speaks of "everyday social experiments" to refer to the concrete issues and interactions in which we struggle in everyday life.

5.5.4. SOCIAL SUPPORT

Social support can be understood as an interpersonal transaction involving one or more of the following dimensions: (1) emotional interest (love, friendship, empathy), (2) instrumental or material assistance (goods or services), (3) information (concerning the environment) or (4) esteem (information concerning self-esteem). In this brief, we have retained the first three forms of social support.

5.5.4.1. Types and nature of aid

The people identified in each person's social network play various roles in their lives. They generally offer support. For example: parents give advice and listen; friends do activities with each other; the teacher or employer encourages; the sports team lets you have fun; the teacher teaches you things and the doctor treats you when you're ill. Analysis of the data shows that all the participants in our study know the nature of the help and where it comes from. This was the case for Cecile and Pierre, who said they received help from their "children".

5.5.4.2. Emotional

Emotional support involves the expression of empathy, the idea of "caring", reassurance and trust, and enables the expression of emotion and emotional release. It consists of expressing to someone the positive effects that we feel towards them (friendship, love, comfort, sympathy), and brings them feelings of reassurance, protection or comfort. On analysis, the results of the verbatim reports show that, with the exception of Cecile where "the illness blocked everything", all the other 5 participants in our study received emotional support. For Pierre, Susan, Mekwa and Julienne, this support was empathic and characterised by "crying". So, for these participants, the emotional component is the 'heart' of the support. In addition, we could postulate here that the satisfaction felt by the recipient of the support is the most relevant indicator of the adequacy of the support behaviours to the expectations and needs of this same recipient.

5.5.4.3. Instrumental/material assistance

Instrumental support implies the possibility of material help, for example, financial assistance or help with everyday tasks. It involves actual assistance such as the loan or donation of money or material goods, or services rendered at difficult times. It also characterises help in the form of time or work. Only Ondomo stated that he received no material assistance from anyone and felt abandoned, whereas Mekwa received none from his family. On the other hand, all the other cases acknowledged receiving instrumental support. While case 1 receives it solely from his children "my children only", this seems to be the situation for Susan and Julienne. This was the position adopted by Susan when he said he received this type of support "from my children", and nothing from "my family and friends", he added.

5.5.4.4. Information

Informational support refers to the provision of relevant information designed to help the individual deal with the usual difficulties and usually takes the form of recommendations or advice on how to manage a problem. As such, it involves advice, suggestions, the provision of knowledge about a problem, and proposals for solving a new problem, for example.

Analysed through the verbatim reports, the results show that 2 of our 6 participants do not benefit from this type of support. These were Ondomo and Julienne. On the other hand, if the others do, the frequency is not the same. This was expressed by case 1 when he said "not very often". The need for informational support therefore exists among our participants because, as we can see here, informational support encompasses the decision-making latitude that enables Alzheimer's patients to organise their tasks. Secondly, this support characterises the proposals for improving living conditions and facilitating the exchange of information between the members of the relationship groups. This is what Mekwa is all about when it states "as for the news". Finally, it includes actions to encourage cohesion between the members of these groups.

5.5.4.5. Social support

Not all of an individual's social relationships are useful and/or intended to be useful when they are experiencing difficulties. However, studying social support implies studying the social network, which encompasses the measurement of social integration, the notion of network being determined by the number of links established between the individual and those around him. Social integration is a two-dimensional construct. The first dimension is behavioural and refers to an individual's involvement in social relationships. This form was not identified in any of our participants. The second dimension is cognitive and relates to a sense of community and identification with a social role. This second dimension of social integration would construct the subjective perception of integration relating to the feeling of belonging, mutual obligation and intimacy. It is this form that is characteristic of Cecile, Susan, Mekwa and Julienne. In fact, for cases 1 and 5, social support in the form of integration is a function of the children - this is what case 1 means when he says: "especially the children" - whereas for Susan and Julienne it is "the medical profession". We can therefore postulate here that identity depends on the social positions or roles occupied by individuals in a social context. In this interactionist approach, the identity constructed by social roles and the feeling of being socially integrated would directly influence the health and well-being of Alzheimer's patients.

5.5.5. QUALITY OF LIFE

Quality of life can be understood as being made up of a number of factors perceived both objectively and subjectively. It is usually the individual himself who defines the value he attributes to the various factors (although he does so within a cultural and social context). In addition to the factors themselves, it is the final balance that is most important (the relationship between desires and reality), i.e. the degree to which a desired physical, psychological and social well-being is achieved in the subjective experience. In this research, emphasis was placed on the notion of life plan and the level achieved in the ongoing pursuit of goals and objectives.

5.5.4.1. Perception of qualityof life components

Quality of life is an assessment criterion that is supposed to be objective, even though it is subject to the most subjective interpretation. Moreover, it is important not to confine oneself to sensation or perception, but also to take account of the reality that perception covers up. For example, the feeling of loneliness cannot be totally separated from the reality of existing social ties. Our results show that three of our participants (Pierre, Ondomo and Julienne) say they do not perceive the components of quality of life. For Pierre, this is due to the fact that he feels pain. He said: "No, because I'm ill, I feel pain". While Pierre was thinking, Susan was "living in pain". According to him, this does not help him to perceive the components of quality of life. Furthermore, the analysis shows that for Cecile it is "simply because I'm ill". These results justify the view that the approach to the health of the Alzheimer population is more a question of health-related 'Quality of Life', rather than an approach to health based on pathologies or disabilities. In this respect, health-related QoL is a multidimensional concept, taking into account the person's subjective perception of their ability to function, their physical symptoms, their emotional well-being and their social functioning.

5.5.4.2. Life satisfaction

The concept of quality of life is centred on the notion of perception, or even "the subject's overall satisfaction with the general meaning he or she gives to well-being" (Kop, 1993) . An individual's quality of life is based on two elements: a general sense of well-being (satisfaction of needs) and performance (actualisation of skills). This is what emerges from our participants' accounts. For Susan, life is not very satisfying: he says "not very satisfying" before expressing a feeling of "regret because of the harm done to people" and then adding, as if to relax, "but today I don't see it any more". Ondomo also shows dissatisfaction with the experience. However, the regrets seem to have diminished because of the relationship and exchanges with her daughter. She said: "but with her daughter's advice, the crying has diminished". These analyses show that the bridge between aspirations and achievements is experienced by the individual in the perspective of time. Their congruence generates a cognitive reaction of satisfaction or an emotional reaction of joy to live. Conversely, their incongruence produces a reaction of dissatisfaction or depression. We can therefore conclude that as far as individuals experience adequate satisfaction of their needs and achieve a certain level of performance in fulfilling their roles, they are adapted to their environment and enjoy a good quality of life.

5.5.4.3. Happiness

That the pursuit of happiness, or the means to achieve it, is a universal end of human nature seems to have been recognised a long time ago. Man knows what he wants: he seeks satisfaction, fulfilment; in a word, he wants to be happy. Many theories are based on the premise that happiness can be reduced to the unlimited satisfaction of pleasures. Happiness implies the unreserved satisfaction of all desires. Analysing the participants' accounts, we can see that Cecile and Pierre are the only ones to declare that they are not happy. For the first, two aspects seem to be holding happiness back. For this participant, happiness is not reducible to the satisfaction of this or that particular need or desire; the occasional satisfaction of a need is not yet happiness. This position seems to be in line with that of Pierre, who feels he can't be happy because of "pain". Thus, happiness is not just the limited satisfaction of a limited need; that is why it is not enough to eat to your hunger, or drink to your thirst, to be happy. This is expressed by Ondomo when he says: "because of the presence of my daughter". We conclude that the state of happiness, by definition, is not the immediate and present consequence of a specific satisfaction of a need or desire, but transcends it; far from depending on a particular satisfaction, happiness is independent of it, because it constitutes the subjective colouring of existence in its totality.

5.5.4.4. Subjective well-being

Feelings of happiness or despair are not the result, or the outcome, of a certain number of lived experiences whose additive sum would secondarily produce these subjective states, but they absolutely precede any lived experience, which can, in turn, only be affected by a certain affective colouring because it is integrated into a pre-existing totality, which is none other than the being of the person himself. From this perspective, subjective quality of life takes into account a person's cognitive and emotional perceptions. Cognitive perception emphasises the components of satisfaction with life, while emotional perception focuses on mood and affect. The results of our study point in the same direction. For participants Cecile, Pierre, Ondomo and Julienne, the perception of subjective well-being is negative. For Cecile, it was "because there's a problem somewhere", whereas for Julienne, it was related to the suffering caused by the illness: "I'm suffering". In the same vein, Ondomo said he would rather "die". We can see from these analyses that, contrary to popular belief, mood is not determined by external events, but absolutely precedes them and gives them meaning, since it is by this yardstick that they are assessed. Factors such as self-fulfilment in a job, appreciation of the beauty of nature and the arts, a sense of identification with the community and the feeling of having given maximum effort all come into play. This justifies the position of participants Susan and Mekwa, who are not asking to die like Ondomo, but to live. Participant Susan says "I don't want to die", while Mekwa says "I want to live again". We can see here that the main components of subjective well-being are aspirations, achievements and reactions. A person's aspirations are their feelings or perception of their life, i.e. their goals, values, standards of comparison, desires or life plans. Achievements are defined by what the person currently has, is, possesses or controls, in relation to their life standards.

CHAPTER 6: INTERPRETATION OF RESULTS DISCUSSION AND PERSPECTIVES

It is necessary for social cohesion that is the necessity of families to cater for the elderly once they arrive a certain age and even the community in which they live so that they can develop confidence base on the compassion and the will to help truthfully without ceasing is very difficult. We always say we do not affirm that we do not become useful at certain time in life. But when we are face with health challenges there are reactions of suffering. Worries of the family concern becomes seek how they can have solutions to the problem with this manifestation of the health challenges and its constrain of care, but nothing can make the reality to disappear nor to clear away the experiences of the health challenge which signal changes in to his daily life nor erase the sadness which appears to be sad as a result of degenerative health. This has to do with the quality of life of old age person suffering from Alzheimer at time keeps a certain distance due to (psychological. Physical and social perception), the elderly person conceives a certain distance which is isolation. With our participant we notice a high level of aggressiveness, anorexia, sleep disorder during crises. It is shown that with our participant it is noted that lack of confidence from the patient can lead to depression especially when felt no support is provided. The attachment of the patient is shown when care is being shown either by the medical body or caregivers to establish that equilibrium and this can be done when there is that humanistic care.

6.1 INTERPRETATION OF RESULTS

In this section, we shall interpret the results of study through the theories and the activities associated to the theory of quality of life. The theory of quality of life is based on two elements: 1- The general feeling of well-being (satisfaction of needs) and 2- performance (actualization of skills). This needs are considered taken from Maslow (1943).3- Basic needs(physiological and safety) needs of affiliation , esteem, to autonomy, self-actualization. The environment provides opportunity to satisfy these needs, both materials. 4- (food, shelter. et) and social (friends, spouse, work etc.) to apprehend the contribution to feeling in his life face with health challenges in the hospital , in families and community.

6.1.1 Application of the Reich and Zoutra model (1984) Exploration

This model is based on the belief that quality of life of a person's life is related to the types of events he /she experiences. This model is based on the affective and cognitive impact that event have on quality of life. At the light of this walk of the activity, we are trying to put on the surface the social affection determinant of old age person affected with Alzheimer having participated in our study. In a concrete manner, we shall see the interpretation on the form to education the elderly and the young people on how to live a life that which will not lead them to developing this disease.

6.2.1.1 EVALUATION OF NEEDS OF THE OLD AGE PERSON

The objective intervention, in conformity with values that is prone in adaptation in psychosocial, it had to do with individualization, centred on needs and objective of the person, ideal measurable and limited in time (Caldwell and Wood, 2000).

Evaluation, consist to determine in a person his forces and difficulties in order to recognize his needs and to better manage well his services by offering. Evaluation by psycho-social follow-up aim is to have a large vision or mirror of the person, At the plan of his forces, his ability and his resources, up to the plan of his particular difficulties or his need at the psychological level, residential, social and vocational Fankas and al (1994). The capacity of observation and evaluation of the quality old age person affected with Alzheimer is centred at this level, of the same capacity to create a climate of confidence and mutual openness which favours a better understanding of an old age person

Case of Susan: “the emotion of this participant being very weak and negative, his relationship and quality is a sympathy type and averagely good, his behaviour of obedient to medical rules shows that the patient is worn out of his suffering and the psycho-analysis of the biology of the person that we have in front of us and that, we are giving support action. We take into consideration the psychological dimension, we take into consideration the social dimension, cultural and even anthropological aspects”.

Psycho-social follow-up, is a consecrated activity at social point of view of perception, his orientation and ending. The activity treatment carries psychic component, life satisfaction, happiness, and subjective well-being. It is by its immediate tools which are (cognitive and materialize) and intra-psychic structure (cognitions, emotions, motivations). From intra-psychic structure (language, gestures) with old age person is through interactions. Social affection determinant and quality of life of old age person affected with Alzheimer: his brain, his mood of functioning and its manifestation, also the impairment of the frontal affected (the individual activity) with the old age person, we observe aggressiveness during crises, then is about anxiety.

6.2.2 APPLICATION OF THEORY ON QUALITY OF LIFE TO THE APPREHENSION OF THE TRAUMER OF ALZHEIMER IN GERIATRIC

The situation of caring is a situation mark by the presence of emotions, it is a subjective relation, a relation of aide with old age person is confronted to situation of caring. At the end of a long duration of pain of patient was confronted to treatment when arrive at the end of efforts feels a profound sentiment, elderly people need to make effort to control their emotions. Neurodegenerative could lead to the fact that emotions grow and lead to conflict or opposition, in this contradiction of the situation of health emerges a perturbation in caregiving and observation condition, this sentiment that put the caregivers through what is more profound in him and expresses depression.

The psychoanalysis approach of quality of life conduct to the elaboration of many theories. The Ecological model Bubolz and al (1980) is a model of quality of life which is associated with adjustment between the individual’s needs and resources. Of social affection is perceived in terms of relationship with others. This conception brings us to the explanation of consequences of feelings, change in mood to old age person psychosocial follow-up in the situation of support action.

6.2.2.2. QUALITY OF LIFE AND SOCIAL SUPPORT

Across reading of quality of life and social support means looking at the human condition and, in particular, at the ontological fragility of human being. Indeed, man is the only being born without the means to satisfy his need. Thus all humans are dependent on each other, FIAT (2006) pointed out “we owe our humanity to others”

6.3. DISCUSSIONS

In the present section we shall continue to present the results of the various theories of quality of life and support action theory all deals with humanity, affection, relationship, positive vision of life. To an extend man owe humanity to others”. This is to say no matter the health challenges one may experience there will always be people to cater for that is why in our study we visited homes that cater for vulnerable people, this is to say man is not an island to live alone’ When an individual has a strong relationship with others he will overcome difficult moment in life because people will show him love in hard moment and that we go along to improve his perception of life.

- Close affective relationship contributes to the improvement of quality of life

- The importance of living together in the construction of projects contribute to the improvement of quality of life of elderly people with Alzheimer disease
- Social support helps to improve the quality of life of elderly people with Alzheimer
- This are factors that will help boost the elderly person’s life if these strategies are put in place, they will live a life of satisfaction no matter their state of health.

6.3.1. PROXIMITY AND DISTANCE

The relationship with the old age person is a relation dotted with a heavy emotional charges. A care of distance, it is a difficult concept to explain. But we are saying that distance with them and still show love that is our attitude in mood of action. It is an attitude we need to adapt toward the ageing implication observe in situation of support action. Notwithstanding a great implication may trap the care giver that will be emerge with affectivity and will be difficult to withdraw” gives a vacuum” after a day of work.

A tool that certain number of humanity needs to know: the respect of the other, the identity, the confidence, etc., are indispensable so that a help relationship is efficient in his entity. Let’s mention that, in this help relationship which is supposed to be based on principle of communication of caring, the risk is to be affected “the intimate confidence with the other and the proximity lead to a closeness in a manner of being in the link that binds you”

The distance that we are making mention in this context, is about the affective distance that will have some negative emotions. It implies then to accept self and the well-being of the old age person do not belong to care givers, but to themselves. It implies that when there are crises or health challenges it is not the caregiver who suffers. So help relationship establish a thanks to verbal communication and non-verbal communication. It is based on confidence of the old age person to his close relationship. The attitude of the caregiver is important: to listen and have empathy, that is having a feeling as being of self. Being closer to the person.

6.3.2. IMPLICATION AND PERSPECTIVES OF THE STUDY

The implication and perspective of the study are many and can be situated in the methodological plan, theoretical and practical.

6.3.3. IMPLICATION OF THE STUDY

Very long time families have taken care of the elderly, without the help from the public services. As well as ageing is a psychological process and not a disease, help and assistance becomes Constance as long as the person losses his equilibrium his softness etc.

The family is the first in whom is being addressed to the old age persons because they have an essential role to play as a sustenance. As the principal social group, the family appears like the best place of refuge and support, as normally the privilege place of solidarity, of welcoming, and affection exchange and material. With the evolution of the society the family have changed and his daily attitude do not live a great place to the old one.

The family do not have time to give, the close one are not available to welcome them, even to visit them while the elderly will even likely want to do more.

6.3.4. THE PESPECTIVES

It is pertinent to know that the emotions of old age people which the fear of developing Alzheimer disease I ageing. The rejection of the old age person in itself is a problem but the image of developing emotional desire as to die. Each day in and out there are emergency of cases of health challenges with the old age person and the pain they are experiencing and the indifference. We need to show competency and humanity in the follow-up.

This research will have as objectives to boost the quality of life of old age person affected with Alzheimer and also project a study on the aspect of overcoming the disease in the early age of life especially during the adolescent age before adulthood and ageing. Study shows that in time to come they shall be a treatment for this disease as science embark on more study hopefully but we need to take good care of ourselves what we eat and drink, our resting period and relaxation should be primordial.

GENERAL CONCLUSION

We had titled our work" Social affection determinants and quality of life to old age person affected with Alzheimer". It was carried out to the angle of special education (mental Handicap or mental disability) our ambition is to ask question Does social affection determinants influences the quality of life of old age person affected with Alzheimer and how they live in their environment with prejudges and stigmatization that prevail. And for that reason, we went for the proximity with ageing, suffering from this disease admitted at the geriatric. In effects, we made a report which shows that prior works representations did not meet the question of social affection determinant, they mention mostly the physical, the mental and social well-being that are being taking care of and did not bring out the determinant that can help boost the life of an old age person affected with Alzheimer to continue to live a good life no matter his state of mental impairment. There are strategies to favor the quality of life of the person.

The fact of being confronted with health challenges having to do with neurodegenerative disease which represent a danger to the person affected. We noticed that this disease affects the person's sentiment, his mood, his emotions, his relationship. The person's quality of life is affected in a profound way as what he use to do before he can't do them again due to the loss of cognitive and functional abilities are lost; it is certain that with this disease they cannot live by themselves because they will have moment of difficulties, they become fragile, they may have mobility and mental health challenges. We see cases of abandoning therefore the need of support action. It is in this context that we pose a research question Does social affection influence the quality of life of old age person affected with Alzheimer? The problem that we pose in this study is the determinants of quality of life of old age person affected with Alzheimer. To state that if these determinants are put in place, it will enhance the life of the person affected with Alzheimer disease in clinical follow-up with the old age person. By learning on psychoanalysis, psychological approaches, our hypothesis "social affection determinants influence the quality of life of old age person affected with Alzheimer". The objective of the study was to boost the quality of life of old age person affected with Alzheimer.

To meet the objective of this study, we used the clinical method. We base our work on an old age and ageing. This method was chosen by his capacity to furnish and analyzed in a phenomenon in their context. We use qualitative data analysis; we use content analysis for the study, we proceeded in three essential steps: the transcription of data, coding, of information and treatment of data. We made the inventory of information and treatment of data harvested and put them in then in the form of writings. Aurebach and Silverstein (2023) qualitative data is presented under the form of text, words, phrase, and expression of language or symbolic information (gesture, tongue of the voice, impressions). Following our criteria of inclusion, we went for 10 participants though we work effectively only with 6. These were old age persons which were all admitted at the geriatric. After the elaboration of an observation scale, which we collected some information on the participant, we had to elaborate an interview guide emphasizing on significance.

The results to which we arrived at allows us to understand that, extreme vulnerability of Alzheimer’s disease patient, takes risks and consequences of their daily exposure to factors, makes their situation complex to understand, very often gives rise to tension. We can see from the results of our participants that, the psycho-affective dimension has everything to do with emotions, to develop skills and committed. Establishing a therapeutic relationship and a climate of trust, enables progress. We can therefore states that as far as individuals experience adequate satisfaction of their needs and achieve a certain level of performance and in fulfilling their roles, they are adapted to their environment and enjoy a good quality of life.

The subjective or psychological consequences of social support in relation to health behaviour, physiological process related to social support, material and information resources models. Explain its possible causes and its disturbances. Reich and Zoutra model (1984) is based on the belief that “quality of person’s life is related to the type of events he /she experiences”. Abbey and Andrew models (1985)” indicate that stress and depression are strongly related to negative perceptions of quality of life”. According to Abbey and Andrew, when individuals try to determine the extent to which they enjoy their lives, they focus on the positive determinant of well-being namely internal control and social support. There are challenges to note during the follow-up of old age person related to their quality of life.

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ANNEXS

REPUBLIQUE DU CAMEROUN
Paix – Travail – Patrie
*****
UNIVERSITE DE YAOUNDE I
*****
FACULTE DES SCIENCES DE L'EDUCATION
*****
DEPARTEMENT D'EDUCATION SPECIALISEE

REPUBLIC OF CAMEROON
Peace – Work – Fatherland
*****
THE UNIVERSITY OF YAOUNDE I
*****
THE FACULTY OF EDUCATION
*****
DEPARTMENT OF SPECIALIZED EDUCATION

The Dean

N° 1P /23/UYI/FSE/VDSSE

RESEARCH AUTHORISATION

I the undersigned, **Professor BELA Cyrille Bienvenu,** Dean of the Faculty of Education, University of Yaoundé I, hereby certify that **FAI Judith RIFOR,** Matricule **21V3624,** is a student in Masters II in the Faculty of Education, Department: ***SPECIALIZED EDUCATION,*** Option: ***MENTAL HANDICAP.***

The concerned is carrying out a research work in view of preparing a Master's Degree, under the supervision of **Pr. AMBANG Zachée.** Her work is titled ***« Social affection determinant and quality of life to old age person affected with Alzheimer ».***

I would be grateful if you provide her with every information that can be helpful in the realization of her research work.

This authorisation is to serve the concerned for whatever purpose it is intented for.

Done in Yaounde, the 0 9 JAN 202

For the Dean, by order

Le Vice-Doyen

GO Etienn
Professeur

REPUBLIQUE DU CAMEROUN
Paix-Travail-Patrie
MINISTERE DE LA SANTE PUBLIQUE
SECRETARIAT GENERAL
DIRECTION DE L'HOPITAL CENTRAL DE YAOUNDE
UNITE ADMINISTRATIVE ET FINANCIERE

REPUBLIC OF CAMEROON
Peace-Work-Fatherland
MINISTRY OF PUBLIC HEALTH
SECRETARIAT GENERAL
DIRECTORATE OF CENTRAL HOSPITAL
ADMINISTRATIVE AND FINANCIAL UNIT

N°2023/014/AR/MINSANTE/SG/DHCY/UAF

Yaoundé, le 30 JAN 2023

AUTORISATION DE RECHERCHE

Je soussigné, **Professeur Pierre Joseph FOUDA**, Directeur de l'Hôpital Central de Yaoundé, accorde une autorisation de recherche, sous la direction du Pr AMBANG Zachée et la codirection du Dr NTSAMA ESSOMBA Marie Josiane à **Mme FAI Judith Rifor**, étudiante Master 2 en Handicap Mental à l'Université de Yaoundé I, sur le thème : « **social affection determinant and quality of life to old age person affected with alzheimer** ».

L'intéressée est tenue au strict respect du règlement intérieur de l'Hôpital Central de Yaoundé et s'engage à déposer un exemplaire dudit mémoire à la Direction dudit hôpital après correction.

En foi de quoi, la présente autorisation lui est délivrée pour servir et valoir ce que de droit. /-

Le Directeur

Le Directeur,

Pierre Joseph FOUDA

Cecile

OBSERVATION SCALE

In this scale, we want to observe elements which have to do with:

1- Social affection determinant
2- Of the quality of life of old age persons
3- Of the Alzheimer disease

I--We shall observe the following elements:

a- Emotions of old age persons
b- Type of relationship and quality
c- Obedient behavior to rules and instructions having to do with the environment of the subject of the same age, their disease in relation with others
d- Re-enforcement of confidence of these persons observed

a-Strong emotions ☑ b- Weak emotions ☐

Type: positive Type: Negative

b-Type of relationship:

Push relationship ☑ Sympathy relationship ☐
Proximity relationship ☐ avoidance relationship ☐
Antipathy relationship ☐

````````````````````````````````

Neutrality relationship ☐
**Quality of relationship:** ☐

Very bad ☐ bad ☐

Good ☐ averagely Good ☐ Very Good ☐

Excellent ☐ others…. ☐

c- **Obedient behaviour to rules and instructions:**

- Obedient to medical personnel’s rules ☑
- Do not obey to medical personnel’s rules ☐
- Obedient to requirement link to intake of medication, at the port of cleanliness, to consumption of medication and of Knowledge ☐
- To games instructions, jokes and of hobbies. ☐
- To requirement having to do with their age, dis-order and compared with different environment. ☐

**d-Re-enforcement of confidence:**

1-Push confidence ☐ 2- very push 3- total confidence
````````````````````````````````

_With the family ☐ ☐

_With the medical structure ☑

_On visitors, Friends/close friends ☐

_ Colleagues ☐

II—Quality of life

b- Do they eat well:

Good ☑ bad ☐ insufficient ☐

Equilibrate ☐ Not equilibrate ☐

b- Do they have other diseases?

Comorbidity opportunist passing

Bedsores ☐ mobility problems ☑ Anorexia ☐

III- Alzheimer disease

Manifestations:

Aggressive behavior ☐ agitation ☐ apathy ☐

Hallucination ☑ Delirium ☐

Anxiety ☐ sleep dis-order ☐

Isolation mourn

Frontal- temporal pains:

Regular ☐ Not regular ☑ very regular ☐

Social affection determinant	**Quality of life to old age person**	**Of Alzheimer disease**	**Frequency (1-10)**	**Numbering (1-20)**	**Percentage (5a 100)**	**Cotation (0 a 100)**	**Observatio**
Social affection determinant	a- Do they ea well	+	7	10	55	55/100	Acceptable
Of the quality of life of old age persons	b-Do they have Other disease	+	8	15	80	80/100	Acceptable
Alzheimer disease	c-manifestation	+	7	12	90	90/100	Not acceptable
	d-isolation	+	9	16	95	95/100	Not acceptable
	e-Of relationship Type	+	5	10	50	50/100	Acceptable
	f- obedient to rules	+	6	12	70	70/100	Not acceptable

Pierre

OBSERVATION SCALE

In this scale, we want to observe elements which have to do with:

1- Social affection determinant
2- Of the quality of life of old age persons
3- Of the Alzheimer disease

I--We shall observe the following elements:

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Type: positive Type: Negative

b-Type of relationship:

Push relationship ☐ Sympathy relationship ☐
Proximity relationship ☑ avoidance relationship ☐
Antipathy relationship ☐

````````````````````````````````````

Neutrality relationship ☐
**Quality of relationship:** ☐

Very bad ☐ bad ☐

Good ☑ averagely Good ☐ Very Good ☐

Excellent ☐ others…. ☐

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````````````````````````````````````

_With the family ☐ ☐

_With the medical structure ☑

_On visitors, Friends/close friends ☐

_ Colleagues ☐

II—Quality of life

a- Do they eat well:

Good ☑ bad ☐ insufficient ☐

Equilibrate ☐ Not equilibrate ☐

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Comorbidity opportunist passing

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Susan

OBSERVATION SCALE

In this scale, we want to observe elements which have to do with:

1- Social affection determinant
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I--We shall observe the following elements:

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a-Strong emotions ☐ b- Weak emotions ☑

Type: positive Type: Negative

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Proximity relationship ☐ avoidance relationship ☐
Antipathy relationship ☐

``````````````````````````````````

Neutrality relationship ☐

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Good ☐ averagely Good ☐ Very Good ☐

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_With the family ✓ ☐ ☐
_With the medical structure ☐
_On visitors, Friends/close friends ☐
_ Colleagues ☐

II—Quality of life

a- Do they eat well:

Good ☐ bad ☐ insufficient ☑
Equilibrate ☐ Not equilibrate ☐

b- Do they have other diseases?

Comorbidity opportunist passing
Bedsores ☐ mobility problems ☐ Anorexia ☑

III- Alzheimer disease

Manifestations:
Aggressive behavior ☐ agitation ☐ apathy ☑
Hallucination ☐ Delirium ☐
Anxiety ☐ sleep dis-order ☐
Isolation mourn ☐
Frontal- temporal pains:
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Ondomo

OBSERVATION SCALE

In this scale, we want to observe elements which have to do with:

1- Social affection determinant
2- Of the quality of life of old age persons
3- Of the Alzheimer disease

I--We shall observe the following elements:

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Type: positive Type: Negative

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_With the family ☑ ☐ ☐
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_ Colleagues ☐

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Equilibrate ☐ Not equilibrate ☐

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Comorbidity opportunist passing
Bedsores ☐ mobility problems ☐ Anorexia ☑

III- Alzheimer disease

Manifestations:
Aggressive behavior ☐ agitation ☐ apathy ☐

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Anxiety ☐ sleep dis-order ☐

Isolation mourn ☐
Frontal- temporal pains:
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Mekwa

OBSERVATION SCALE

In this scale, we want to observe elements which have to do with:

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2- Of the quality of life of old age persons
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Type: positive Type: Negative

b-Type of relationship:

Push relationship ☐ Sympathy relationship ☐
Proximity relationship ☑ avoidance relationship ☐
Antipathy relationship ☐

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Neutrality relationship ☑

Quality of relationship: ☐

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II—Quality of life

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Type: positive Type: Negative

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Push relationship ☐ Sympathy relationship ☐
Proximity relationship ☐ avoidance relationship ☐
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Neutrality relationship ☑

**Quality of relationship:** ☐

Very bad ☐ bad ☐

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II—Quality of life

a- Do they eat well:

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Isolation mourn ☐

Frontal- temporal pains:

Regular ☐ Not regular ☐ very regular ☑

Social affection determinant	**Quality of life to old age person**	**Of Alzheimer disease**	**Frequency (1-10)**	**Numbering (1-20)**	**Percentage (5a 100)**	**Cotation (0 a 100)**	**Observatio**
Social affection determinant	a- Do they ea well	+	9	10	55	55/100	Acceptable
Of the quality of life of old age persons	b-Do they have Other disease	+	8	15	80	80/100	Acceptable
Alzheimer disease	c-manifestation	+	7	12	90	90/100	Not acceptable
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	f- obedient to rules	+	6	12	70	70/100	Not acceptable

INTERVIEW GUIDE

Dear Sir/Madam, We are conducting a study as part of our university research on : "***Determinants of social affection and quality of life in elderly people with Alzheimer's disease".*** Therefore, we kindly ask you to answer this interview guide in all sincerity and we assure you of the confidentiality of the information we will obtain from you, according to the code of ethics of the profession of educational psychologist.

Case of Cecile

0-Sociodemographic information of the participant

Date and place of interview....26 Avril 2023......Nkolfullu..(soa)............................
Time and start............10h:11..
Time and end..............11h:15..
Age of respondent.........75 years..
Region of origin.............Centre (Ewondo)......................................
Education level.............Bachelor’s Degree.................................
Profession.....................Teacher......................................
During this interview I would like to discuss with you certain events related to **the social condition** around your illness. So we will, as far as possible, go through a set of themes that I will propose to you. But in the meantime, tell me a little about yourself and your illness.

Them 0: Brief history of participant......:After my studies, I was recruited at the public service on etude de dossier. I was transfer to the Obala, then to West region at Mefi and to Akonolinga Nion and Foumou..…..
....
....
I would now like us to discuss the themes that I am proposing to you. Each time I will give you the theme and I will invite you to tell me what you think. So, it is a question of you developing your opinions on each of the sub-themes that will be proposed to you after the theme.

Theme 1: Close emotional relationships/positive social-emotional signs

Sub-theme 1: Gestures of tenderness
........Aggressive....(sometimes)..
Sub-theme 2: Solidarity Manifesto
.......Yes (In a global manner people with whom I have worked they usually passes and check on me) ....
Sub-theme 3: Relaxation Manifesto
...Yes(He does that within the compound not out of the compound and if he has to do that out of the compound he need to be accompanied by somebody). ....

Theme 2: Close emotional relationships/negative social-emotional signs

Sub-theme 1: Disapprove
....Yes (approuved...)..

Sub-theme 2: Tension Manifesto
.... Yes.(. at times impatient..).....................
Sub-theme 3: Manifesto of antagonism
..........Yes..

Theme 3: The importance of living together in building projects

Sub-theme 1: Engaging with each other to share everyday life
......No...
Sub-theme 2: Complicity
.....Yes (it evaluated with time) ....
Sub-theme 3: Attention to the other
....
......Yes ....
....
Sub-theme 4: Confidence
..............Yes..
Sub-theme 5: Making a suggestion
..........Yes..
Sub-theme 6: Providing an opinion
.............Yes..
Sub-theme 7: Providing information
............Yes..
Sub-theme 8: Requesting information
...........Yes ..(yes the mother was here on her return to the village , He call to find out if she travel safely)..
Sub-theme 9: Asking for an opinion
..............Yes..
Subtheme 10: Request a suggestion
................Yes ..(he is asking to go do his consultation)...

Theme 4: Social support

Sub-theme 1: Types and nature of support
..........Yes..
Sub-theme 2: Emotional
...............No (the disease has turn down everything) ....
Sub-theme 3: Instrumental/Material Assistance
....................Yes...
Sub-theme 4: Informational
..........Yes not long ago ....
Sub-theme 5: Social support
.............Yes..

Theme 5: Quality of life

Sub-theme 1: Perception of the components of the QoL
.............Yes..

Sub-theme 2: Life satisfaction
............Yes...

Sub-theme 3: Happiness
....
.......No (problem at the level of manner, at the level of frontal, he doesn't see well)..
Sub-theme 4: Subjective well-being

.... Negative (Because there is problem somewhere). ....

Thank you for your collaboration

INTERVIEW GUIDE

Dear Sir/Madam, We are conducting a study as part of our university research on : "***Determinants of social affection and quality of life in elderly people with Alzheimer's disease".*** Therefore, we kindly ask you to answer this interview guide in all sincerity and we assure you of the confidentiality of the information we will obtain from you, according to the code of ethics of the profession of educational psychologist.

Case of Pierre

0-Sociodemographic information of the participant

Date and place of interview........24 April 2023 Central hospital..............................
Time and start............9h:45..
Time and end..............10:30..
Age of respondent.........84 years..
Region of origin.............Centre (Ewondo)......................................
Education level............./................................
Profession.....................Housewife.....................................

During this interview I would like to discuss with you certain events related to **the social condition** around your illness. So we will, as far as possible, go through a set of themes that I will propose to you. But in the meantime, tell me a little about yourself and your illness.

Them 0: Brief history of participant......: The loss of the sister, after two weeks, she began with delirum…..
....

I would now like us to discuss the themes that I am proposing to you. Each time I will give you the theme and I will invite you to tell me what you think. So, it is a question of you developing your opinions on each of the sub-themes that will be proposed to you after the theme.

Theme 1: Close emotional relationships/positive social-emotional signs
Sub-theme 1: Gestures of tenderness
........Aggressive...
Sub-theme 2: Solidarity Manifesto
.......Yes ....
Sub-theme 3: Relaxation Manifesto
.......................No (because she has glaucoma). ....
Theme 2: Close emotional relationships/negative social-emotional signs
Sub-theme 1: Disapprove
....Yes (disapprove. At times when food is given to her she says those people she is seeing have already eating the food and she pours it.)...........................
Sub-theme 2: Tension Manifesto
.....Yes...
Sub-theme 3: Manifesto of antagonism
.........Yes...

Theme 3: The importance of living together in building projects

Sub-theme 1: Engaging with each other to share everyday life

......Yes (At times she gives her ideas). ....

Sub-theme 2: Complicity

.....Yes (when she is happy)...

Sub-theme 3: Attention to the other

......Yes ....

Sub-theme 4: Confidence

.............Yes.(I'm the only daughter she is attach to). ....

Sub-theme 5: Making a suggestion

..........Yes..(when we have a family meeting)...

Sub-theme 6: Providing an opinion

............Yes..

Sub-theme 7: Providing information

...................No...

Sub-theme 8: Requesting information

...........Yes ..(yes the mother was here on her return to the village , He call to find out if she travel safely)...

Sub-theme 9: Asking for an opinion

.............Yes...

Subtheme 10: Request a suggestion

................Yes..

Theme 4: Social support

Sub-theme 1: Types and nature of support

..........Yes.(just her children)...

Sub-theme 2: Emotional

...............No (She cries most of the time) ....

Sub-theme 3: Instrumental/Material Assistance

....................No..(abandonne)..

Sub-theme 4: Informational

..........No..

Sub-theme 5: Social support

............Yes.(follow-up by the geriatrics) ....

Theme 5: Quality of life

Sub-theme 1: Perception of the components of the QoL

.............No (thoughtful)..

Sub-theme 2: Life satisfaction

............No (but with much advise by her daughter, crying has reduced)....................................

Sub-theme 3: Happiness

.......Yes since my daughter is there..

Sub-theme 4: Subjective well-being

.... Negative (the patient keep saying she prefers to die.). ....

Thank you for your collaboration

INTERVIEW GUIDE

Dear Sir/Madam, We are conducting a study as part of our university research on : "***Determinants of social affection and quality of life in elderly people with Alzheimer's disease".*** Therefore, we kindly ask you to answer this interview guide in all sincerity and we assure you of the confidentiality of the information we will obtain from you, according to the code of ethics of the profession of educational psychologist.

Case of Susan

0-Sociodemographic information of the participant

Date and place of interview....26 April 2023 Central hospital..............................
Time and start............11:05..
Time and end..............11h:35..
Age of respondent.........92 years..
Region of origin.............Centre (Bafia)......................................
Education level................O/L.............................
Profession.....................Director of Nursery school......................................
During this interview I would like to discuss with you certain events related to **the social condition** around your illness. So we will, as far as possible, go through a set of themes that I will propose to you. But in the meantime, tell me a little about yourself and your illness.

Them 0: Brief history of participant
......:The Illness began two weeks with a problem of forgetfulness...…....................
....
I would now like us to discuss the themes that I am proposing to you. Each time I will give you the theme and I will invite you to tell me what you think. So, it is a question of you developing your opinions on each of the sub-themes that will be proposed to you after the theme.

Theme 1: Close emotional relationships/positive social-emotional signs
Sub-theme 1: Gestures of tenderness
........Aggressive...
Sub-theme 2: Solidarity Manifesto
.......Yes ....
Sub-theme 3: Relaxation Manifesto
............No...
Theme 2: Close emotional relationships/negative social-emotional signs
Sub-theme 1: Disapprove
....Yes (disapprouved...)..
Sub-theme 2: Tension Manifesto
.....Yes...
Sub-theme 3: Manifesto of antagonism
..........Yes...

Theme 3: The importance of living together in building projects

Sub-theme 1: Engaging with each other to share everyday life

......Yes...

Sub-theme 2: Complicity

....Yes...

Sub-theme 3: Attention to the other

......Yes ....

Sub-theme 4: Confidence

.............Yes..

Sub-theme 5: Making a suggestion

..........No...

Sub-theme 6: Providing an opinion

............Yes...

Sub-theme 7: Providing information

............No...

Sub-theme 8: Requesting information

...........Yes ... (she always asks of her other children) ....

Sub-theme 9: Asking for an opinion

.............Yes..

Subtheme 10: Request a suggestion

................Yes..(because she asks what she desire).................................

Theme 4: Social support

Sub-theme 1: Types and nature of support

..........Yes. (just us her children) ....

Sub-theme 2: Emotional

...............Yes (When she is alone she cries) ....

Sub-theme 3: Instrumental/Material Assistance

....................Yes.(her children , her surrounding no)..

Sub-theme 4: Informational

..........Yes not long ago ....

Sub-theme 5: Social support

............Yes...

Theme 5: Quality of life

Sub-theme 1: Perception of the components of the QoL

.............positive (she takes all her medication)...

Sub-theme 2: Life satisfaction

...........No (not satisfying, regret of the good she did and today she is not seeing them anymore)...

Sub-theme 3: Happiness

.......Yes...

Sub-theme 4: Subjective well-being

.... Positive (she doesn't want to die now. It is what she tells us). ....

Thank you for your collaboration

INTERVIEW GUIDE

Dear Sir/Madam, We are conducting a study as part of our university research on : "***Determinants of social affection and quality of life in elderly people with Alzheimer's disease".*** Therefore, we kindly ask you to answer this interview guide in all sincerity and we assure you of the confidentiality of the information we will obtain from you, according to the code of ethics of the profession of educational psychologist.

Case of Ondomo

0-Sociodemographic information of the participant

Date and place of interview.....3 May 2023 Central hospital..............................
Time and start............3: 25.......................................
Time and end..............3: 46.......................................
Age of respondent.........90 years.......................................
Region of origin.............West (Tonga).....................................
Education level............/................................
Profession....................House wife...................................

During this interview I would like to discuss with you certain events related to **the social condition** around your illness. So we will, as far as possible, go through a set of themes that I will propose to you. But in the meantime, tell me a little about yourself and your illness.

Them 0: Brief history of participant

......: A very sad event, her daughter was stapped in front of her face) ..….........................
....

I would now like us to discuss the themes that I am proposing to you. Each time I will give you the theme and I will invite you to tell me what you think. So, it is a question of you developing your opinions on each of the sub-themes that will be proposed to you after the theme.

Theme 1: Close emotional relationships/positive social-emotional signs

Sub-theme 1: Gestures of tenderness

........Aggressive...

Sub-theme 2: Solidarity Manifesto

.......Yes..

Sub-theme 3: Relaxation Manifesto

...No (just in the house)..

Theme 2: Close emotional relationships/negative social-emotional signs

Sub-theme 1: Disapprove

.... Disapprove...

Sub-theme 2: Tension Manifesto

.....Yes...

Sub-theme 3: Manifesto of antagonism

..........Yes...

Theme 3: The importance of living together in building projects

Sub-theme 1: Engaging with each other to share everyday life

......Yes..

Sub-theme 2: Complicity

.....Yes (it evaluated with time).......................................

Sub-theme 3: Attention to the other

......Yes ....

Sub-theme 4: Confidence

.............Yes..

Sub-theme 5: Making a suggestion

..........Yes...

Sub-theme 6: Providing an opinion

............Yes...

Sub-theme 7: Providing information

...........Yes..

Sub-theme 8: Requesting information

...........Yes ..(yes the mother was here on her return to the village , He call to find out if she travel safely)..

Sub-theme 9: Asking for an opinion

.............Yes..

Subtheme 10: Request a suggestion

....

................Yes ...(he is asking to go do his consultation)..................................

Theme 4: Social support

Sub-theme 1: Types and nature of support

..........Yes..(only her children)..

Sub-theme 2: Emotional

.............Yes (she is thoughtful and cires) ....

Sub-theme 3: Instrumental/Material Assistance

....................No...

Sub-theme 4: Informational

..........Yes not long ago

Sub-theme 5: Social support

............Yes...

Theme 5: Quality of life

Sub-theme 1: Perception of the components of the QoL

...........No(because she had a painful life style)...

Sub-theme 2: Life satisfaction

...........No(her first son died couple with with a painful life style.).........................

Sub-theme 3: Happiness

.......No ....

Sub-theme 4: Subjective well-being

.... Negative (seeing her life experience). ....

Thank you for your collaboration

INTERVIEW GUIDE

Dear Sir/Madam, We are conducting a study as part of our university research on : "***Determinants of social affection and quality of life in elderly people with Alzheimer's disease*". ** Therefore, we kindly ask you to answer this interview guide in all sincerity and we assure you of the confidentiality of the information we will obtain from you, according to the code of ethics of the profession of educational psychologist.

Case of Mekwa

0-Sociodemographic information of the participant

Date and place of interview.....3 May 2023 Central hospital.............................
Time and start............4 :05.......................................
Time and end..............4: 50.......................................
Age of respondent.........85 years.......................................
Region of origin.............Centre (Eton).....................................
Education level.............A/L plus two..............................
Profession..................Agent of ...development....................................

During this interview I would like to discuss with you certain events related to **the social condition** around your illness. So we will, as far as possible, go through a set of themes that I will propose to you. But in the meantime, tell me a little about yourself and your illness.

Them 0: Brief history of participant...
.....Orphan of mother at the age of 6 years and of father at the age of 16 years . He struggle to become a responsible man in the society).....................................
....

I would now like us to discuss the themes that I am proposing to you. Each time I will give you the theme and I will invite you to tell me what you think. So, it is a question of you developing your opinions on each of the sub-themes that will be proposed to you after the theme.

Theme 1: Close emotional relationships/positive social-emotional signs
Sub-theme 1: Gestures of tenderness
........Yes...
Sub-theme 2: Solidarity Manifesto
. Yes..
Sub-theme 3: Relaxation Manifesto
.........Yes..
Theme 2: Close emotional relationships/negative social-emotional signs
Sub-theme 1: Disapprove
...Disapprove..
Sub-theme 2: Tension Manifesto
.....Yes..(. at times..)...
Sub-theme 3: Manifesto of antagonism
..........Yes...

Theme 3: The importance of living together in building projects

Sub-theme 1: Engaging with each other to share everyday life

......Yes...

Sub-theme 2: Complicity

.....Yes...

Sub-theme 3: Attention to the other

......Yes ....

Sub-theme 4: Confidence

.............Yes....(to us the children)...

Sub-theme 5: Making a suggestion

..........Yes...

Sub-theme 6: Providing an opinion

.............Yes..

Sub-theme 7: Providing information

............Yes...

Sub-theme 8: Requesting information

...........Yes ....

Sub-theme 9: Asking for an opinion

.............Yes..

Subtheme 10: Request a suggestion

................Yes ....

Theme 4: Social support

Sub-theme 1: Types and nature of support

..........Yes..(medical care and some social workers)...............................

Sub-theme 2: Emotional

...............No (He cries most of the times) ....

Sub-theme 3: Instrumental/Material Assistance

....................Yes..(by his children)..

Sub-theme 4: Informational

..........Yes (about politics and Biya)

Sub-theme 5: Social support

.............Yes..

Theme 5: Quality of life

Sub-theme 1: Perception of the components of the QoL

.............Yes..

Sub-theme 2: Life satisfaction

............Yes...

Sub-theme 3: Happiness

.......Yes (due to the fact that the children are doing their best to provide his needs) ....

Sub-theme 4: Subjective well-being

.... Positive (He says he wants to live again). ....

Thank you for your collaboration

INTERVIEW GUIDE

Dear Sir/Madam, We are conducting a study as part of our university research on : "***Determinants of social affection and quality of life in elderly people with Alzheimer's disease".*** Therefore, we kindly ask you to answer this interview guide in all sincerity and we assure you of the confidentiality of the information we will obtain from you, according to the code of ethics of the profession of educational psychologist.

Case of Julienne

0-Sociodemographic information of the participant

Date and place of interview.........3 May 2023 Central Hospital..............................
Time and start............3:10.......................................
Time and end.............3.: 25.......................................
Age of respondent.........88 years.......................................
Region of origin.............Centre (Ewondo).....................................
Education level.............ENS................................
Profession.....................Teacher.....................................
During this interview I would like to discuss with you certain events related to **the social condition** around your illness. So we will, as far as possible, go through a set of themes that I will propose to you. But in the meantime, tell me a little about yourself and your illness.

Them 0: Brief history of participant.
.....:The first time she time ,she began by talking to alone as she loss her son and since then she cries and isolate herself…..
....
I would now like us to discuss the themes that I am proposing to you. Each time I will give you the theme and I will invite you to tell me what you think. So, it is a question of you developing your opinions on each of the sub-themes that will be proposed to you after the theme.

Theme 1: Close emotional relationships/positive social-emotional signs
Sub-theme 1: Gestures of tenderness
........Aggressive...
Sub-theme 2: Solidarity Manifesto
.......Yes ....
Sub-theme 3: Relaxation Manifesto
...Yes(around his house not outside. And if he want to go out he is accompanied) ....
Theme 2: Close emotional relationships/negative social-emotional signs

Sub-theme 1: Disapprove
...Disapprove..
Sub-theme 2: Tension Manifesto
.............Yes..
Sub-theme 3: Manifesto of antagonism
.........Yes...

Theme 3: The importance of living together in building projects

Sub-theme 1: Engaging with each other to share everyday life
......Yes...
Sub-theme 2: Complicity
.....Yes ....
Sub-theme 3: Attention to the other
......Yes ....
Sub-theme 4: Confidence
.............Yes...
Sub-theme 5: Making a suggestion
..........No...
Sub-theme 6: Providing an opinion
............Yes...
Sub-theme 7: Providing information
...........Yes...
Sub-theme 8: Requesting information
...........Yes ....
Sub-theme 9: Asking for an opinion
.............No...
Subtheme 10: Request a suggestion
................Yes ....

Theme 4: Social support

Sub-theme 1: Types and nature of support
..........No (only the children)...
Sub-theme 2: Emotional
.............Yes (cries most of the time ....)...
Sub-theme 3: Instrumental/Material Assistance
...................No...
Sub-theme 4: Informational
..........No...
Sub-theme 5: Social support
............Yes...

Theme 5: Quality of life

Sub-theme 1: Perception of the components of the QoL
............No (because she can't do her activities again)...
Sub-theme 2: Life satisfaction
..........No(..Not satisfied ..)...
Sub-theme 3: Happiness
.......No (because she hallucinating)...
Sub-theme 4: Subjective well-being
.... Negative (Because there is problem in my head and my health).

Thank you for your collaboration

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