

## *Editorial*

# **Antidementia Drugs: Are They Effective in Improving Quality of Life for Elderly Persons With Dementia?**

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During an epidemiological survey conducted in Tokyo in 1988 by the Department of Psychiatry, Tokyo Metropolitan Institute of Gerontology, I met two demented elderly women in the course of interviewing city residents.

The first woman, G., was 74 years old. When I visited her, she was almost bedridden as a result of right hemiplegia and she was lying on an unclean mattress on a floor of straw mats (at that time, elderly Japanese people did not often sleep in Western-style beds). G. was mildly demented, and her 78-year-old husband was her primary caregiver. She required his help with getting dressed, eating, and bathing, and with excretion. G. had two sons and two daughters. Her daughters lived within 5 minutes' walking distance, and every day the older daughter delivered lunch and the younger daughter delivered dinner. G.'s sons visited their parents at night, two or three times a week.

When I visited the household, I spoke with G.'s husband and younger daughter. They told me that G. and her husband received no welfare services from the ward office, and that their only income was from their pensions. When G. got a cold, her husband put her on his bicycle to take her to a nearby general practitioner; neither they nor their children had a car. Their economic status was quite low, even taking into account that the Japanese economy was generally weak at that time, and their physical environment reflected their poverty. However, I was impressed by G.'s husband's appreciation of his children's help and by his warm attitude toward his wife. He and his wife seemed entirely satisfied with their lives, and their facial expressions showed no depressive signs.

The second person I met was a 78-year-old woman, H. She was mildly demented, and her mobility was restricted due to rheumatoid arthritis. She was also hypochondriacal. She had two sons and a daughter, and was living with her older son's family in the house her late husband had built. The other two children lived outside Tokyo. When I visited her, I was scrutinized by a television camera at an electric gate. It took me 2 minutes to drive from the gate to the entrance of the

house. H.'s large room was air-conditioned, and she spoke to me from her electric bed. Her primary caregiver was a hired aide. Obviously, H.'s economic status was high and her physical environment luxurious. I talked to both H. and her aide. H. said that her daughter-in-law, a homemaker, did not participate in her care at all, and that her son, who worked at a trading company, had almost no time to spend with her or with any other member of the family. For approximately three fourths of my interview with H., she complained about her son and her daughter-in-law.

These cases represent two extremes. However, I felt that G.'s situation was the more desirable of the two, even though the environment she lived in was far poorer and she was much less able to participate in activities of daily living (ADLs). Although no information on the self-esteem or life satisfaction of either woman was available, G.'s quality of life seemed better than H.'s. One of the major differences in the factors affecting quality of life for the two women seemed to be the kinds of relationships they had with their families. Thus, it seems reasonable to imagine that these interpersonal relationships played a major role in the two women's quality of life.

According to a recent report by Lawton (1994), quality of life is composed of the same components for people with dementing illness as for other people. The components of better quality of life for people with Alzheimer's disease (AD) include competent cognitive functioning, the ability to perform ADLs and to engage in meaningful social behavior and use of time, and a favorable balance of emotions (more positive than negative). Theoretically, it would seem reasonable to include these variables in an assessment of quality of life for elderly people with dementia. However, cognitive functioning and the ability to perform ADLs and instrumental ADLs (IADLs) all decline irreversibly over a long-term course. Knapp and colleagues (1994) found an overall improvement in quality of life for patients who were randomized to receive antidementia drug treatment for 30 weeks and whose abilities were measured by the Progressive Deterioration Scale (DeJong et al., 1989). They found improvement in scores on items addressing cognition, ADLs, IADLs, and the appropriateness of social behavior. However, no results have yet been reported over a long-term period, such as more than a year; thus, it has not yet been confirmed whether cognition, ADLs, and IADLs should be included as valid components in the assessment of quality of life for the demented elderly.

If one accepts the concept that behavioral competence is a major domain of quality of life for the demented elderly, behavioral assessment—including a behavior-observation approach—would seem useful. Behavioral symptoms of AD patients are not always due to the disease process and may be influenced by family and social relations (Homma et al., 1994). This finding may suggest that nonpharmacological approaches can be used as interventions for behavioral symptoms. Also, behavioral disturbances are one of the major predictive factors of caregiving burden for family members (Grafstrom et al., 1994; Hinchliffe et al., 1992; Jerrom et al., 1993). A few results have been reported indicating that the patient's behavioral symptoms can be ameliorated by reducing the family's caregiving burden (Hinchliffe et al., 1992), and it seems logical to hypothesize

that the family's caregiving attitude could cause or influence some behavioral symptoms in dementia, or vice versa.

So far, there have been no results indicating that treatment with antidementia drugs is successful in reducing behavioral symptoms manifested by AD patients. It is not yet certain that quality of life for people with dementia will positively correlate with that for the family. At least in Japan, some families caring for demented elderly relatives prefer that the relatives be in a bedridden state, thinking it is easier to care for a demented older person who is bedridden than one who is active. Such attitudes probably result in some general practitioners prescribing inappropriate doses of major tranquilizers. In such cases, it seems that quality of life for the family negatively correlates with quality of life for the elderly person. However, in my clinical experience, a positive correlation between the patient's and family's quality of life has been seen in some cases in which the patients were free from marked behavioral disturbances and the families had adequate social resources. There is no doubt that this positive correlation will be a goal for the demented elderly cared for in the community. So, is it possible to improve quality of life for the demented elderly, as well as for their family members, by treating the patients with antidementia drugs? Even if antidementia drugs could slow the progression of the disease course, prolonging the progression is not always related to improvement in the patient's quality of life. Although conservative pharmacotherapy—including neuroleptics, antidepressants, sleep inducers, and replacement therapy with cholinergic agents—should remain the basis for treatment of behavioral symptoms, nonpharmacological management combined with pharmacologic treatment will be the best approach for improving the quality of life of the patient and the family. Recently, Teri and colleagues (1995) reported results from their longitudinal study showing that agitation was significantly related to increased rates of cognitive decline. This finding supports the idea that treatment of AD patients' behavioral symptoms is valid.

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