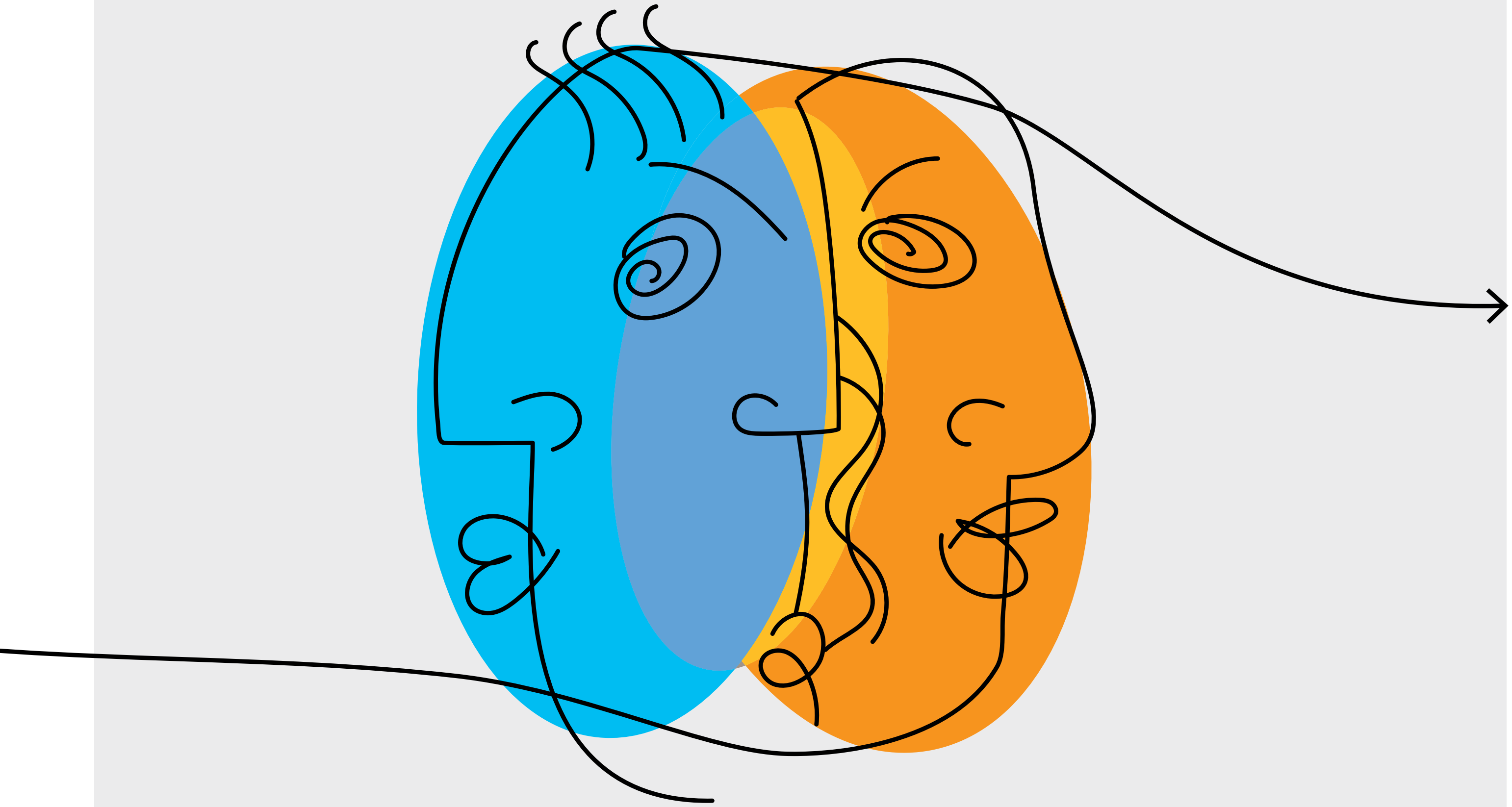
CHAPTER 4

SEX AND GENDER DIFFERENCES IN DEMENTIA

There are many distinctions in dementia that matter when it comes to sex and gender.



> Both sex and gender can shape a person's dementia experience, from prior to onset, through treatment and beyond. There are sex and gender differences in the number of individuals affected by dementia, the risk factors for developing the condition, how symptoms are expressed, and the needs for care and caregiving.
>
> When seeking to understand why these differences occur, it is important to acknowledge that both biological and social factors play a strong role. Researchers have come to recognize that both sex and gender are important characteristics to consider when examining dementia outcomes and care needs.

Definitions of sex and gender used by Statistics Canada as of 2021

"Gender refers to an individual's personal and social identity as a man, woman or non-binary person (a person who is not exclusively a man or a woman). Gender includes the following concepts: gender identity, which refers to the gender that a person feels internally and individually; gender expression, which refers to the way a person presents their gender, regardless of their gender identity, through body language, aesthetic choices or accessories (e.g., clothes, hairstyle and makeup), which may have traditionally been associated with a specific gender. A person's gender may differ from their sex at birth, and from what is indicated on their current identification or legal documents such as their birth certificate, passport or driver's licence. A person's gender may change over time. Some people may not identify with a specific gender" (Statistics Canada, 2021a).

"Sex at birth refers to sex assigned at birth. Sex at birth is typically assigned based on a person's reproductive system and other physical characteristics. Sex at birth may also be understood as the sex recorded at a person's birth, for example, what was recorded on their birth certificate" (Statistics Canada, 2021b).

This chapter and the data in it reflect the fact that there are slightly different terms of reference for sex and gender, even at the national level, and that research and language continues to evolve to better reflect the realities and lived experience related to gender and sex.

Given this context, in this chapter we will outline some of the sex and gender differences in dementia. This will be followed by some of the findings related to sex at birth from the Landmark Study (no gender data was available for those study analyses).

Why do sex at birth differences in dementia rates exist?

Across many high-income countries, females outnumber males in dementia diagnoses at a rate approximately two to one (Niu et al., 2017; Rajan et al., 2021; Yoshitake et al., 1995).

This difference in dementia numbers between the sexes is often attributed to difference in life expectancy. In Canada, on average, females live four years longer than males—83.9 years versus 79.8 years according to Statistics Canada (Bushnik et al., 2018). And since age is the strongest risk factor for dementia in general, the lifetime risk of dementia is then greater for females. However, there is much more to the story of sex differences in dementia than just differences in lifespan.

While it is known that women across high-income countries experience more dementia than men, it is less clear whether women are at higher risk of developing dementia after accounting for differences in longevity. Some studies have found that women are at greater risk after accounting for life expectancy; other studies have found no such difference between the sexes (Mielke et al., 2022).

For example, research studies in the United States have repeatedly found no difference in the risk of onset of dementia (Bachman et al., 1993; Edland et al., 2002), whereas European reports have found women to be at a higher risk (Fratiglioni et al., 1997; Andersen et al., 1999).

These mixed results indicate that there are important differences between study populations and geographic locations that may be influenced by sex and gender (Andrew & Tierney, 2018). Based upon the many known differences between the sexes in terms of both biology and their engagements with the social, political and economic determinants of health, we believe that it is critical for dementia research that sex and gender differences be studied in much more depth.

Females have risk factors for dementia beyond longevity

Sex differences in dementia risk factors may help to explain why so many more females develop dementia in late life.

If you look at the scientific literature on dementia, sex differences can be found in many areas:

- genetic risk factors (APOE e4 confers greater risk in females; Altmann et al., 2014)
- rates of depression (more common in females; Kessler et al., 1993)
- levels of frailty—"frailty" is a term used by medical experts to describe a state of increased vulnerability to stressors (females report higher levels of frailty; Hubbard, 2015)
- prevalence of cardiometabolic risk factors (females experienced greater risk for all-cause dementia; Blanken & Nation, 2020)
- sleep apnea (more common in males; Bixler et al., 2001)

There are also sex-specific risk factors for dementia in females, including high blood pressure during pregnancy (preeclampsia; Fields et al., 2017), menopause (Galea et al., 2017), and bilateral oophorectomy (removal of both ovaries and both fallopian tubes) prior to age 48 without hormone replacement (Rocca et al., 2014).

A sex-specific risk factor for dementia in males is cumulative androgen deprivation therapy for prostate cancer (Jayadevappa et al., 2019) which is associated with higher risk of developing dementia.

Gender roles and experiences impact risk of dementia

Risk factors can also be related to social constructions of gender roles and differences across genders.

From low education (women have historically faced systemic inequities in access to education; Hasselgren et al., 2020) to reduced occupational opportunities (Qiu et al., 2003), many studies have identified dementia risk factors that align with restrictions around gender expectations, discrimination and roles.

Conceptions of gender- and sex-related risk factors are also growing and changing as sexism and bias within the research field itself is being confronted. For instance, at one point in time, traumatic brain injury was believed to be a risk factor for dementia primarily for men due to an assumed higher likelihood of being involved in physical altercations, accidents, military service and contact sports.

However, some women researchers and the Pink Concussions group summits (begun in 2016) have more recently found that women are exposed to more traumatic brain injury risk via intimate partner violence than men (Haag et al., 2022; Valera et al., 2021; Pink Concussions, n.d.-a).

They have also highlighted earlier data from the American Medical Society for Sports Medicine (2012) showing that in sports with similar rules, female athletes sustain more concussions than their male counterparts; in addition, several studies show that female athletes experience or report a higher number and severity of symptoms, as well as a longer duration of recovery than male athletes (Pink Concussions, n.d.-b).

Thus, it's possible a different source and level of the risk related to traumatic brain injury—and in turn, dementia—is connected to gendered experiences in different ways than previously thought.

In another example, depression in later life (over the age of 65) is a known risk factor for dementia. Recently, research focusing on younger women has suggested that experiences of gender discrimination and sexism are linked to higher rates of depression (Vigod & Rochon, 2020; Stepanikova et al., 2020; Young Women's Trust, 2019). More research is needed on older age groups in this respect.

Likewise, a recent World Health Organization review of men's health issues in the European region (2018) highlighted a few reasons depression may be underreported and underdiagnosed in men—reasons partly related to ideas and restrictions in roles of masculinity: "Analysis of coping mechanisms show that men (more than women) tend to cope with their problems and dilemmas by taking refuge in addictions or ignoring needs for treatment. Consequently, depression symptoms in men often remain undiagnosed" (Emslie & Hunt, 2009).

And clearly, again, more research is needed about the intersections of sexism, ageism, age, sexuality, class, culture and ethnicity (among others) in regard to even this one major dementia risk factor—depression—to better understand the complex ways gender and gender discrimination or roles can influence it, and the consequent dementia risk.

In Canada, a process called Sex- and Gender-Based Analysis Plus (SGBA+) has been promoted by federal health research funding bodies (Government of Canada, 2023). SGBA+ aims to ensure that researchers closely consider factors in their projects related to sex and gender, as well as factors related to race, ethnicity, religion, age, and mental or physical disability, so that the results are impactful to all people living in Canada and relevant to the diversity of the population.

Box 5. Some characteristics where sex and gender differences can impact dementia risk

DIFFERENCES THAT CAN IMPACT DEMENTIA RISK

SEX DIFFERENCES	GENDER DIFFERENCES
+ Stress response	+ Experiences of stress
+ Brain structure	+ Education
+ Inflammation and metabolism	+ Occupation
+ Pregnancy	+ Diet and physical activity
+ Menopause	+ Smoking
+ Frailty	+ Alcohol use
+ Genetics and epigenetics	+ Social isolation
+ Prostate cancer	+ Gender-based discrimination
+ Obstructive sleep apnea	+ Traumatic brain injury
+ Hormones	

Why is this breakdown important? There are still many more important sex and gender differences that need to be better understood in the dementia sphere. The mechanisms, pathways and risk factors for dementia differ across sexes and genders—and they merit further investigation, as these differences may have consequences for future treatments and for fully understanding how dementia develops in humans.

The clinical presentation of dementia can differ across sex and gender

Each individual experiences dementia in their own way. However, when we examine the clinical presentation of dementia by sex and gender, we can find patterns that indicate differences in how dementia presents in terms of its progression, changes in behaviour, responses to treatments, and even in the diagnosis of the condition itself (refer to Box 6).

Box 6. Some of the clinical aspects of dementia where sex and gender differences have been found to occur

CLINICAL ASPECT	DETAILS
Rate of progression	✚ Risk of mild cognitive impairment is generally higher in males (Brodaty et al., 2013; Roberts et al., 2012). ✚ Some studies suggest women progress faster or get a later diagnosis when compared to men (Sinforiani et al., 2010; Laws et al., 2016).
Changes in mood, personality and behaviour	✚ Females experience a broader range of changes in mood, personality, and behaviour in relation to their dementia (Tao et al., 2018). ✚ Males can experience more severe apathy, whereas females can have more depressive symptoms, psychotic symptoms, delusions, and aberrant motor behaviour relative to males (Eikelboom et al., 2022).
Response to treatment	✚ Research subjects for intervention studies have historically been primarily male, ignoring important sex and gender differences in dementia. ✚ Sex and gender differences may influence both responses to treatment and the decision to provide certain treatments (Ambrosino et al., 2020). ✚ Prevention and treatment may require a different approach depending on one's sex (Mielke et al., 2014). ✚ Frailty, on average, is higher in females, and higher levels of frailty can impact disease management decisions and ability to tolerate some treatments (Siebert et al., 2021).
Diagnosis	✚ Sex and gender differences are seen in preclinical signs of dementia (impairment in memory and instrumental activities of daily living; Pérès et al., 2011; Cherbuin et al., 2015). ✚ Diagnosis relies on functional decline, and gendered differences in function after retirement can make it easier to notice a change in women (traditionally doing more work in the home) versus in men (if they focused function on working life and have limited functional expectations after retirement; Andrew et al., 2018).

People's identities often can be consumed by a dementia diagnosis

When it comes to the experiences of people living with dementia, sex and gender are often not discussed. Gender neutral terms are often used, such as "person living with dementia" and "family caregiver." Policies and programs often do not consider gender or sex, despite the many differences that can be found in dementia.

Research that includes sex and gender has found that the lived experiences of women and men can differ on health outcomes, social interactions, and service use (Bartlett et al., 2018), among other areas. Again, more research is warranted on the experiences of non-binary people in this respect.

A 2023 study sought to better understand how gender affected women's dementia experiences (Wiersma et al., 2023). The women interviewed for this study discussed caregiver roles, perceptions of gender differences, the impact of dementia on families, and women's strength and resilience. Wiersma and colleagues emphasize the importance of developing our understanding of diversity and gendered experiences for those diagnosed with dementia. These authors conclude that people's identities can often be consumed by a dementia diagnosis and may weaken the important roles that women value in their lives.

Women and men have unique caregiving challenges

People living with advancing dementia often rely on a family member or friend to provide support and ongoing care. More than half of dementia care partners are women. Refer to Chapter 2 in the first Landmark Study report for a more detailed description of caregiving for people living with dementia (Alzheimer Society of Canada, 2022).

Men and women have unique challenges and needs when caring for people living with dementia. However, there has been little exploration of the sex and gender differences of care partners for people living with dementia. Caregiving is often described from a woman's perspective, and women are more likely to take on caring roles than men (Sharma et al., 2016). The few studies that have focused on gender and sex differences in caregiving have focused on challenges of caring and coping strategies (Bartlett et al., 2018). Few studies have addressed the unique challenges non-binary people experience around caregiving (for more on this, refer to the following section).

One recent systematic review highlighted evidence of sex and gender differences in caregiving stress, the mental health of care partners (depression, psychological distress, guilt), and the physical health status of care partners (comorbidities, sleep, inflammation). Females were reported to experience greater caregiving challenges and depression compared to their male equivalents. However, the authors also reported that when studies accounted for other characteristics of the caregiver, findings on sex differences were less conclusive (Xiong et al., 2020). This conclusion underscores the importance of recognizing intersectionality and the need to consider the interconnected nature of social identity characteristics (including gender, class, and race) in dementia research. Refer to Chapter 3, page 54, for more information on intersectionality.

Some other insights into intersectionality in dementia caregiving can be found in research by Dr. Danielle Alcock, member of Chippewas of Rama First Nation. Her 2019 doctoral research examined Indigenous female caregivers' experiences of caring for a family member with dementia. She found, among other insights, that "the gendered caregiving role needs to be examined to create financial supports and programs that contextualize that women are predominantly the caregivers for loved ones with [Alzheimer's disease and other dementias] and this is applicable in Indigenous communities where women are providing care with minimal to no resources."

Cultural, health, family and gender experiences can also create different kinds of challenges linked to gendered caregiving. A Chinese study about the experiences of male dementia caregivers found that sons who provided support to a parent living with dementia experienced more challenges when that parent had reduced functioning and apathy (Tsai et al., 2022). This same study also found that father and son caregivers experienced stress differently depending on the symptoms that were being expressed by the person living with dementia.

In this, as in other dementia realities, there is no one, single, universal experience—intersectionality and diversity of experience must be honoured both in future research and support planning.

Dementia research about non-binary and trans people is growing

There is a lot of necessary work to do to better understand sex and gender differences in dementia and dementia care. In this chapter we've highlighted a few of the many issues, and we want to acknowledge that dementia research at large hasn't yet begun to address the challenges and experiences that may face intersex, non-binary and trans people who develop dementia.

Some of the limited research that has looked at dementia risk factors in non-binary and trans people shows that they experience health disparities and additional psychosocial stressors that increase risk of cognitive impairment in later life (Cicero et al., 2021; Lambrou et al., 2021).

Dementia care concerns for trans and non-binary people also have some distinctive aspects. As David, a non-binary person living with dementia, puts it in a recent European report, "[Health and social care professionals need to] start by acknowledging the absolute failure of the healthcare system to adequately train healthcare providers in delivering holistic, integrated care to older queer folk that does not erase their sexual and gender identity. The 'we treat everyone the same' model is bullshit" (Alzheimer Europe, 2022).

Elsewhere in the report, David adds, "I am VERY concerned about not only homophobia/transphobia in eldercare, but also heteronormativity that is pervasive and is every bit as harmful. I want care services that acknowledge my sexual and gender identity as a central component, not as some sort of afterthought, or worse, totally ignored."

In Canada, some positive strides have been made to expand research and improve health-care training. In November 2022, Egale Canada and the National Institute on Ageing launched the National Resource Centre on 2SLGBTQI Aging. This centre supports and aggregates resources and research related to two-spirit and trans people's experiences of dementia, among other topics. In addition, one February 2023 resource, *Acting in Allyship with 2SLGBTQI People Living with Dementia: Guiding Principles for Healthcare and Social Service Professionals*, urges health providers to call out transphobic comments in their workplaces when they hear them, among other recommendations for making dementia care more inclusive.

More research and tools on this topic are needed. For more about sexuality and dementia in particular, please refer to Chapter 6.

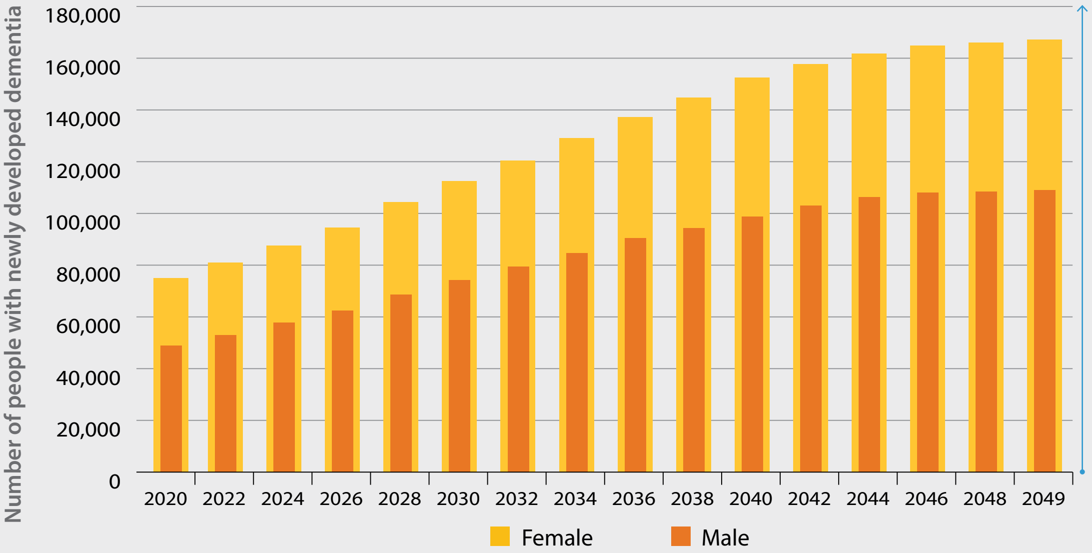
The Landmark Study is based on findings from a simulation model that combined data from the 2016 Statistics Canada Census and findings from the literature to estimate the impact of dementia in Canada over the next 30 years.

The results portrayed in this section only focus on differences in sex (female and male) as we were not able to incorporate differences in gender into the model due to limitations in the available data.

More females than males by almost a two-to-one ratio

The number of females who will be diagnosed with dementia is projected to exceed males by almost a two-to-one ratio. In 2020, an estimated 61.8% of persons living with dementia in Canada were female. By 2028, if current trends prevail, over 100,000 women will be diagnosed with dementia each year in Canada (refer to Figure 10 below).

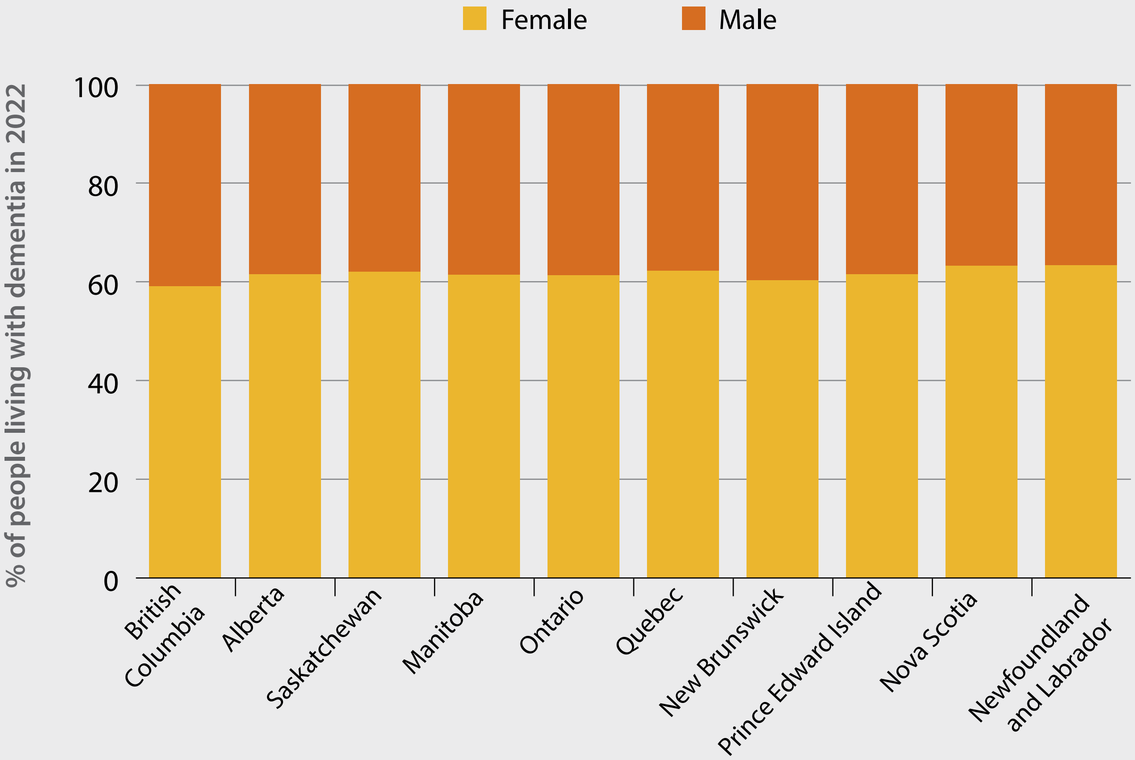
Figure 10. **Annual number of people with newly developed dementia by sex, 2020 to 2049**



Note that this figure and the model's overall analyses do not account for individuals who are born intersex. Statistics Canada does not currently collect information on intersex people for reasons related to the small size of the intersex population and challenges in identifying intersex people. Further, data on dementia outcomes for those born intersex is lacking. Approximately 1.7% of the population is born with intersex traits. While this may seem like a small percentage, from a national perspective, this is over 500,000 individuals (United Nations Free and Equal, n.d.).

This pattern of differences between the sexes is consistent across all provinces of Canada, with only small variations that are dependent on the makeup of the province's population (refer to Figure 11). Canada isn't alone in this trend. When we look at dementia rates from the United States (Alzheimer's Association, 2023) and Europe (Niu et al., 2017), females also experience dementia more often than males by a rate of almost two to one.

Figure 11. Number of people living with dementia in 2022 by sex and province



The one population in Canada where this pattern might not hold true is in Indigenous people. While much work is still needed to fully understand dementia in the First Nations, Inuit, and Métis communities of Canada, one study by Jacklin and colleagues (2013) indicated that Indigenous males may have a higher risk relative to Indigenous females. This finding is consistent with what has been found in First Nations people of British Columbia (British Columbia Provincial Health Officer, 2009) and in Indigenous people in Australia (Smith et al., 2008).

When looking at the projections over the next three decades, **we can expect the sex difference to widen slightly from 61.3% females in 2020 to 62.8% in 2050.**

Based on current trends, **by 2050 over 1,000,000 females** living in Canada will have dementia.

Table 3. Number of people living with dementia (all ages) by sex at start of each decade (2020–2050)

YEAR	FEMALE	MALE	TOTAL	FEMALE %
2020	366,400	230,900	597,300	61.3%
2030	610,900	379,700	990,600	61.7%
2040	900,700	541,100	1,441,700	62.5%
2050	1,075,300	637,100	1,712,400	62.8%
INCREASE FROM 2020 TO 2050	**708,900**	**406,200**	**1,115,100**	**1.5%**

Table 4. Number of people with newly developed dementia (all ages) by sex at start of each decade (2020–2049)

YEAR	FEMALE	MALE	TOTAL	FEMALE %
2020	74,900	48,800	123,800	60.5%
2030	112,600	74,200	186,800	60.3%
2040	152,400	98,700	251,100	60.7%
2049	167,200	109,000	276,300	60.5%
INCREASE FROM 2020 TO 2049	**92,300**	**60,200**	**152,500**	**0.0%**

Table 4 above highlights the expected number of new cases each year at the start of the next three decades. By 2030, over 100,000 females will develop dementia each year, whereas new diagnoses for males will surpass 75,000 new cases each year after 2030.

In addition to females experiencing dementia at much higher overall numbers compared to males in Canada, there are several important differences found between the sexes in relation to dementia. This includes differences across a wide range of key factors, including underlying biology (e.g., hormones, brain structure), prevalence of risk factors (e.g., education, heart disease), pathology (e.g., brain atrophy), and even in the clinical expression of dementia after accounting for neuropathology. Sex is a fundamental characteristic to be considered in studying all aspects of dementia—from the development of pathology within the brain to diagnosis to dementia care.

It is important to note that while many more females are projected to develop a dementia, **males are still greatly affected in large numbers.**

By 2040, over 500,000 males will be living with dementia in Canada.

Breakdown by sex for dementia care partners in Canada

The Landmark Study model can also be used to examine the sex of care partners for people living with dementia. Refer to the first report of the Landmark Study for more details on the projections for care partners in Canada. Similar to the above findings, we were not able to include gender in these estimates.

Table 5 breaks down these care partner numbers by sex and demonstrates that greater than half of all care partners for people living with dementia are female. Females also provide a greater share in the number of hours of care provided (Table 6). However, males will see a greater percentage growth in number of care hours from 2020 to 2050 (199% for males vs. 189% for females).

Table 5. Number of care partners for people living with dementia (by sex) at start of each decade (2020–2050)

YEAR	FEMALE	MALE	TOTAL	FEMALE %
2020	189,400	160,200	349,600	54.2%
2030	315,800	269,700	585,500	53.9%
2040	456,400	394,900	851,300	53.6%
2050	538,800	467,100	1,005,800	53.6%
% INCREASE FROM 2020 TO 2050	**192%**	**184%**	**188%**	

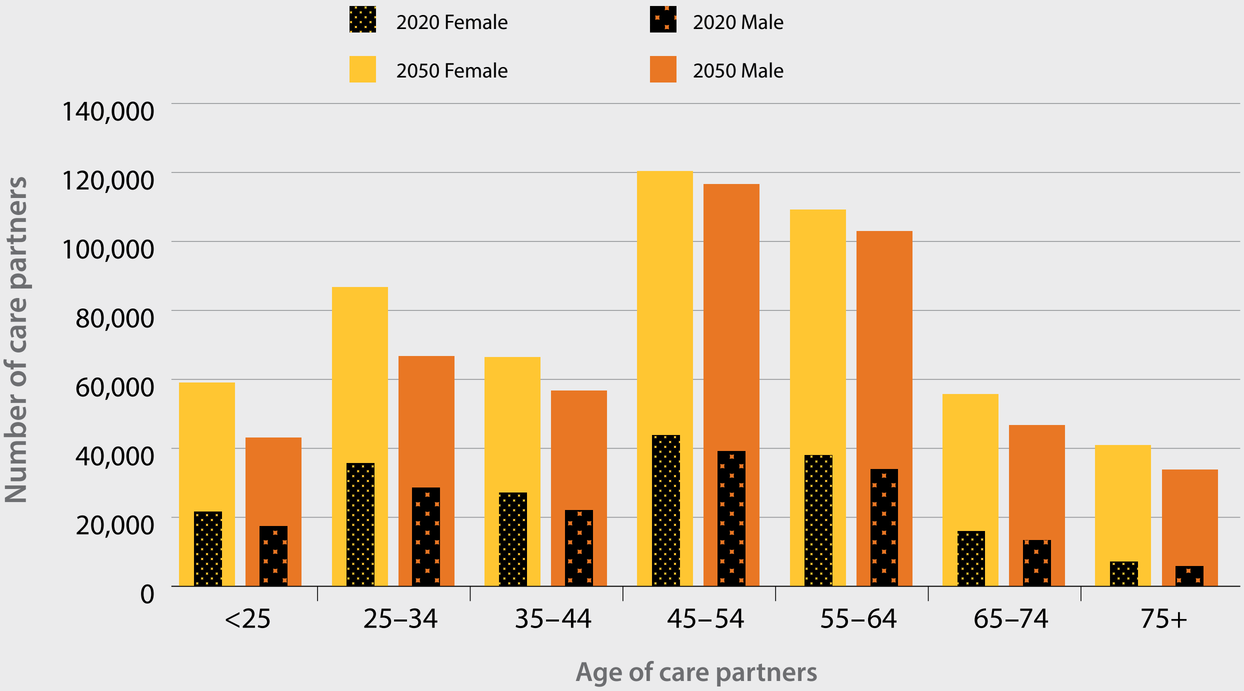
Table 6. Number of hours of dementia care per week provided by care partners (by sex) at start of each decade (2020–2050)

YEAR	FEMALE	MALE	TOTAL	FEMALE %
2020	5,357,800	3,730,500	9,088,300	59.0%
2030	9,021,300	6,366,300	15,387,700	58.6%
2040	13,102,800	9,394,400	22,497,300	58.2%
2050	15,496,200	11,151,400	26,647,600	58.2%
% INCREASE FROM 2020 TO 2050	**189%**	**199%**	**193%**	

Further differences are found between the sexes in the challenges and support needs for dementia care partners. Sex is a fundamental characteristic to be considered in studying all aspects of dementia—from the development of pathology within the brain to diagnosis to dementia care.

When we look at the Landmark Study estimates for care partners by age and sex, we see some of the greatest differences between the sexes in age groups under the age of 45. This may be driven by the adult daughters of people living with dementia taking on care responsibilities for their aging parents at a higher rate than adult sons.

Figure 12. Breakdown of care partners by age and sex, 2020 and 2050



We need to develop our understanding of diversity and gendered experiences for those diagnosed with dementia—and for those involved in dementia caregiving, too.

FACES OF DEMENTIA
TYLER'S STORY

Tyler Redublo is a caregiver for his grandmother Alicia, who lives with dementia. Here, he shares some perspectives on dementia caregiving as a teenage boy and finding community in his 20s around these experiences.

"I'VE been a caregiver—more specifically a young caregiver—for my grandmother Alicia for almost 10 years now. My role as a caregiver started at 15 years old when I was still in high school. My grandmother's name is Alicia, but my siblings and I called her "Mum," and she was an extremely important part of our family. She was the primary person to pick my siblings and I up from school or to wait at the bus stop for us so that we could walk home together. She also cooked delicious Filipino food for our entire family and was an avid baker.

One of the first symptoms of dementia that we noticed was when Mum started misplacing things. On one occasion, I remember opening the oven to see if dinner had been prepared, and instead I was surprised to find couch cushions inside. It became clear that something was wrong. Another time, Mum was cooking a chicken recipe she had made for years, that she had perfected—I remember biting into it and it was raw, which was the first time that ever happened.

Story continues on next page

Photo: Courtesy of Tyler Redublo and family.

> **"For me, a challenging part of caregiving, especially in high school, was going home and not knowing what sides of Mum I would see that day, or what sort of situations I would face. To cope with these feelings, I tried to keep myself as busy as possible."**

In terms of my caregiving role, a lot of it involved supporting Mum and my own mother, Judy, who is her primary caregiver. In particular, Mum went to day programs offered by the Alzheimer Society. So, before I left for school, I was helping her to take medications, eat, get dressed, and walk her to the bus. After I came home from school, my siblings and I also made sure that she got back home safely.

Over time, we also learned to use de-escalation strategies when Mum became upset. One difficult situation we were often faced with was when Mum thought that our family members were stealing money from her. She would ask me, "Tyler, where did you put my bank card?" And I'd respond saying, "Mum, actually, it's at the bank right now because we're getting a new card for you." Instead of reacting emotionally, doing this helped keep her to stay calm and reassured.

For me, a challenging part of caregiving, especially in high school, was going home and not knowing what sides of Mum I would see that day, or what sort of situations I would face. The uncertainty and progressive decline of Mum's condition made me feel stressed, sad, angry and isolated. Because of these feelings, I was often uncomfortable to go home, knowing that it would be more difficult to study or focus on work.

In addition, to cope with these feelings, I tried to keep myself as busy as possible. For example, I joined sports teams, did extracurricular activities, and had a part-time job. In a way, those things were like a temporary escape from caregiving, and they helped me tremendously.

My caregiving role also changed my social life, which sometimes created barriers between me and my peers. Throughout high school, especially in the early stages of Mum's condition, I didn't want to share my caregiving experiences with anyone outside of my family. A lot of this was due to stigma, and feeling like people could not relate to me and my experiences.

But then, in the last year of high school, I finally built up the courage to tell two of my best friends about Mum and my family's situation.

I remember the moment very vividly; it was a summer night and we were sitting in a parking lot together. I told them that my grandmother was living with Alzheimer's and that I was providing care to her, and it felt really liberating—like a huge weight was lifted off my body. However, it was also an important bonding moment for us because they revealed that they were also providing care for their grandparents who were living with dementia as well! It made me realize that dementia affects tons of other people, beyond my own family.

After high school, I went on to university, which is when I started to embrace the young caregiver role more, and I was more open and accepting of it. For example, when people asked me to hang out, sometimes I would tell them, "Sorry, I can't, I'm helping my family with my grandma tonight."

Something I would share with other young caregivers, or caregivers in general, is to try and connect with people who are able to listen and understand. You don't have to carry the responsibilities by yourself if you don't want to! So, try your best to stay connected. Also, while caring for another person, it can be very easy to neglect your own needs. Self-care is a really important aspect of providing good, consistent care, so make sure to be patient and caring to yourself as well!

What I have found rewarding about caregiving was seeing little glimpses of Mum's true self. When we would play a song that she knew and she would start singing along, for example. These moments bring up a lot of happy, positive memories and feelings.

If I could provide advice to my past self, I would tell him to be honest and open about his experiences. Also, I would tell him to consider connecting with other people that are like you— young caregivers, who will have useful advice, and similar experiences to relate to."

> **"Something I would share with other young caregivers, or caregivers in general, is to try and connect with people who are able to listen and understand. You don't have to carry the responsibilities by yourself if you don't want to! So, try your best to stay connected."**