Dementia in men: some useful non-pharmacological solutions

June Andrews, Professor and Adviser to the Dementia Services Development Trust, University of Stirling, Scotland

There are almost twice as many women with dementia as men in the UK, so care services tend to be more female-centric to reflect this patient population. Care services and care professionals may therefore need specific training to provide high-quality care for men. In this article the author highlights some aspects of caring for men with dementia that need to be considered.

‘Dementia’ is the term for the symptom cluster that can be caused by several diseases that have differential rates between the sexes. The rate of Alzheimer’s disease is greater in women, both because of higher prevalence and because of higher incidence due to age profiles. Alzheimer’s disease is the commonest cause of dementia and said to be the second leading cause of death for men, though the leading cause for women.¹

This article focuses on the challenging aspects of men’s dementia care. As fewer men in the UK are affected by dementia than women (35% of people living with dementia are male),² and fewer are taken into care, many health and social care workers are inexperienced in managing or advising families on male-specific problems. Furthermore, as the general majority of the care resident population in elderly care are also women this contributes to the

Figure 1. Examples of how to design a bathroom for male dementia patients. Image courtesy of Dementia Enabling Environments³

1. **Toilet seat** – should be a strong contrasting colour so that it can be quickly and easily seen by a person in a hurry, who may have delayed going to the toilet and may be slow to get out of his clothes.
2. **Toilet cubicle wall and hand grab rail** – should be in strong contrasting colours. Rail should be positioned so that the man is not inadvertently cued to support his weight on the toilet roll holder, which would break and cause a fall.
3. **Toilet floor** – should be a strong contrasting colour with the wall, with a well-defined skirting board. Non-slip, un-patterned, non-shiny surfaces are best for flooring.
4. **Urinal** – the provision of a urinal is a strong visual signal that this is a men’s toilet. The large clear flush sign allows the person dignified use.
5. **Hand dryer** – The person with dementia may, or may not, be familiar with the operation of a hand dryer. Written instructions help, especially if they are supplemented by a picture.
6. **Lighting** – should be bright and positioned to avoid glare or shadows. If movement sensor controlled, it must go on as early as possible as the aging eye adjusts slowly to changes in light level.
7. **Handwash basin** – should have classic design taps and be familiar as possible to encourage use. It should contrast with the surroundings in order to be seen, and to cue handwashing.

Image courtesy of Dementia Enabling Environments³
‘feminisation’ of the service design, which has been established with this patient population in mind. Although it was updated early in 2018, the diagnostic and aftercare guidance on dementia available from NICE is still not gender specific.4

**Nonpharmacological responses**

The focus in this article is on nonpharmacological responses to agitated behaviour in male patients with dementia. People with dementia are often elderly and frail and may take numerous medications for unrelated conditions. Antipsychotic medication that works well for behaviour problems in other patients can have undesirable side-effects that are particularly difficult to manage in frail older patients with dementia. Putting aside risk of death, the side-effects increase the burden for carers and care workers because they include sedation, parkinsonism, risk of falls and infections and worsening of symptoms of dementia.

Medication for pain relief would be of more use and should rank higher than psychoactive medication when thinking about how to respond. This is because the agitated behaviour of a patient with dementia is often caused by undetected pain. The patient may be unable to communicate about their pain, and so one might consider whether pain may be the underlying problem.

Non-pharmacological responses are therefore recommended as the first-line approach, and there is accessible practical advice available based on systematic reviews of nondrug responses.5 The main approaches include: reducing stress, adjusting the environment (including light and noise levels), avoiding arguments and ensuring the patient is exercising and maintaining hydration.

The understanding of behaviours associated with dementia is reflected in the evolution of how they have been labelled. Previously, behaviours were called ‘disturbed’, ‘disturbing’, ‘distressed’ and now are referred to as ‘stressed’ behaviour. This transition reflects the increased understanding that the behaviour is a response to people and situations as experienced by men with dementia.

It is vital to reduce stress in order to avoid precipitating the six most problematic issues that might occur when caring for someone with dementia. Research shows that these are:

- agitation or anxiety
- aggression
- depression
- hallucination
- sleeplessness
- ‘wandering’.

These problems may occur alongside, or be caused by, specific behaviours in men, which include continence problems, ‘aggressive behaviour’ and unacceptable sexual behaviours. Education for families and professionals about effective ways to manage these is essential.

**Continence**

Over two-thirds of people with dementia live at home, but incontinence is a significant reason for institutionalisation. Good management of continence makes life easier for carers, but care and support is often inadequate or inappropriate and guidelines are lacking.6

The loss of bladder and bowel control is associated with old age and frailty, as is dementia, but incontinence is not inevitable in dementia and every person with dementia is entitled to the same continence assessment, diagnosis and treatment as any other patient. In the community they should be referred to the continence nurse and/or urology specialist as required. Dementia specialist nurses can also often advise on managing dementia-related problems during these investigations; for example, by helping the patient to relax and comply with examinations and procedures. However, this standard is not always achieved.

Some men with dementia void in the wrong place, apparently unrelated to bladder or bowel control. This might include urinating in a plant pot, wardrobe or corner of the room, or defecating and smearing faeces. This is understandably difficult to manage at home, and in a care setting it can cause the provider to reject the resident. It is often regarded as ‘bad behaviour’ because it appears to be voluntary.7

In such cases patients must have a clinical assessment by a GP to exclude constipation or causes of urgency and frequency that can be treated. A confused man with constipation and itching or irritation around the anus may resort to giving himself a manual evacuation and then have a disposal problem with the result, leading to smearing. Clearing the bowel and improving diet, fluids and exercise may help.

The patient’s assessment is enhanced by also taking a detailed life history. For example, a farmer, gardener or builder who never had toilets at work, even temporary ones, may revert to behaviour established earlier in their life. The patient’s capacity to distinguish between being ‘at home’ or ‘not at home’ may be blurred, causing behaviour more suited to an ‘outside’ environment. If staff and family understand the reason it may reduce the resentment that creates a spiral of stress and anger that will, unfortunately, make the man’s behaviour worse. He would be aware of the resentment, even if he is unable to fathom what he did wrong, and that discomfort will not improve his agitation.

Design is also important. If a man with dementia enters a toilet in what he regards as a public place and there is no urinal, and perhaps some feminised décor such as flowers and pictures, he may assume he is in the ‘Ladies’ and leave without performing.
This is particularly significant in care homes, where the GP may be called to advise. In such cases the patient requires a men's toilet, with a urinal that smells like a ‘Gents’, giving him the cue to use it. The sign on the door should be unequivocal. There should be bright lighting, and strong contrasting colour between the wall and the porcelain (see Figure 1). Evidence-based design advice for domestic or care environments is freely available online, and simple measures such as leaving the bathroom light on at night, or using movement sensors to switch on the toilet light, may reduce inappropriate voiding caused by confusion and urgency.

‘Aggressive’ behaviour
Aggressive behaviour in male patients with dementia is what often causes the most concern and is usually induced by stress. In many cases male dementia patients are confused about a situation, become afraid and respond aggressively in defence. If you understand how a person is experiencing the world, the aggressive response may seem justified.

To illustrate, imagine a stranger leads you into a room and starts to remove your clothes. The room is full of unexpected equipment. You try to resist them but they become more forceful, even calling for more individuals to aid them. This might easily be the subjective experience of a man with dementia who is being bathed by care workers. He may use all his might and attack them because he has no idea what they are doing and he is terrified. A smaller, frailer female with dementia is less likely to overcome her carers, and she may be described as ‘resistant’ while a male patient might be described as ‘aggressive’ or ‘violent’. The resultant effect is someone gets hurt, and it could have been avoided.

Dementia may also reduce a patient’s control of their responses to the irritating behaviour of co-residents. Men with dementia at home, or in care homes, may be physically stronger than their female co-residents. It is serious if older women fight each other, but if a strong man does this the result can be fatal. This is one of the good reasons for segregation of male and female services, but it may be practically impossible.

Reducing aggression has two strands – avoidance and managing it if it occurs. Avoidance requires the same tactics as stress reduction: avoid contradicting the man, but distract him if necessary; avoid using restraint to divert his actions, because this may lead to a struggle; and carefully reduce all ambient noise. Noise needs to be audited because there are many sounds that professional workers and relatives screen out and do not notice that are irritating to a person with dementia. This includes, for example, radio and TV background noises, road noise, people being loud, banging doors and bin lids and crockery. Make opportunities for exercise, as a fatigued man is less likely to have the energy to fight, but make sure rest is available to avoid the person becoming fractious. It all depends on the individual and knowing them well gives a clear indication of what might set them off. For example, one man’s soothing music may drive another to distraction.

When physical aggression occurs do not attempt to restrain the patient unless there is risk of serious or fatal injury. Make sure that people are out of the way and, when calm returns, make a careful analysis of the precipitating factors to avoid for future reference; for example, if a particular care worker regularly gives rise to a patient’s negative feelings. There is little point in chiding a man with dementia to moderate foul language or difficult behaviour as his condition means that he would rarely be responsive to such an approach. Further advice is available about strategies that avoid medication. This is important as medication is likely to have side-effects that make caring more difficult, such as immobility, unsteadiness, and increased confusion or reluctance to comply with activities of daily living.

Sexuality
Sexuality is a complex and emotionally charged area. In early dementia, a man may experience erectile dysfunction (ED), and volunteers are currently being sought for the PASTIS clinical trial to explore whether a drug licensed for ED may also help increase brain perfusion, to delay or prevent the cell damage that causes vascular dementia. In other cases, partners may be stressed by increased unwelcome sexual demands. Prescription of hormonal agents may be indicated after careful assessment by a psychiatrist.

In care settings, fear about sexual predation by men with dementia can arise. If a man enters a woman’s room or bed he may be confused and think it is his room, or that she is his wife, or he may be opportunistic. Dilemmas can arise if she either consents or appears to consent to sexual contact. Staff attitudes about sex and older people, and concern about moral and legal requirements to protect vulnerable adults, creates quandaries – particularly if either party is thought to be legally unable to consent. The demands of the families involved, who may or may not have Power of Attorney for either party, give rise to further complexity.

Disinhibition, a symptom of dementia, can give rise to uncharacteristic behaviour, such as exposing genitalia, inappropriate touching of care staff during care processes or inappropriate sexual talk. One sweeping solution is the gender segregation of services, though this only solves some of the issues. If staff are working with men who behave inappropriately, they can be educated to avoid offence and
ignore inappropriate language because they understand that it is often ‘the illness talking, not the man.’ They can, through their dress and behaviour, minimise the extent to which they add to the confusion about who they are and what their role is.

In mixed-sex residential services, the design of the building can contribute to the reduction of men entering women’s rooms out of confusion. Risk analysis of any behaviour is essential, and the action plan will depend on the specific problem. It is essential that all staff are educated and that communication with families is open and honest, to reduce tensions caused by fear or embarrassment. As a last resort a difficult man may have to move out, temporarily or permanently. Many behaviours in dementia are a temporary phase. In this brief outline, it is vital to recognise the human rights of all involved. Behaviour that is unacceptable occurs across the full spectrum of human sexuality, and staff must have a plan to respond that observes the human rights of patients or residents but also allows staff and other residents to maintain their dignity.

Many older homosexual men have lived for a significant time when expressing their sexuality was illegal, or socially unacceptable, and even if they have celebrated their partnerships or marriages openly in recent years, dementia may cause them to revert to embarrassment or fear. They can sometimes also be exposed to any prejudice expressed by care workers, co-residents or relatives. Awareness of this is vital. Recent publications address this ‘last taboo’ in dementia care.  

**Conclusion**

Being affected by dementia is a tragedy for men, as it is for women, and it is a pity that their care is not always as ‘man-centred’ as it should be because many of the services are ‘feminised’, that is, set up and run with the female-majority recipients in mind. Positive responses to the loss of relationships and a lack of age-appropriate services for men with early onset dementia include football-related community groups and the ‘Men’s Shed’ movement. An environment that focuses on the brand of a football team, or the shared culture of men hanging out and making things, works well. Most carers and care workers are women, so it is vital that men’s services are designed in the best they can be to support everyone involved.

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**References**


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**Key points**

- More women than men present with dementia, and that means services do not always respond sensitively to male needs
- Agitated behaviour of concern in men with dementia is precipitated and made worse by stress, so the knowledge of staff and carers about how to reduce stress is crucial
- Non-pharmacological responses to agitation are crucial. If medication is required consider whether pain relief will help as a first-line treatment in reducing agitation
- Continence issues in men sometimes present as behavioural problems, and bathroom design can help
- Aggressive behaviour is not inevitable but may have serious consequences, so needs to be understood and managed
- Inappropriate sexual behaviour presents practical, ethical and emotional stress to families and careworkers

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