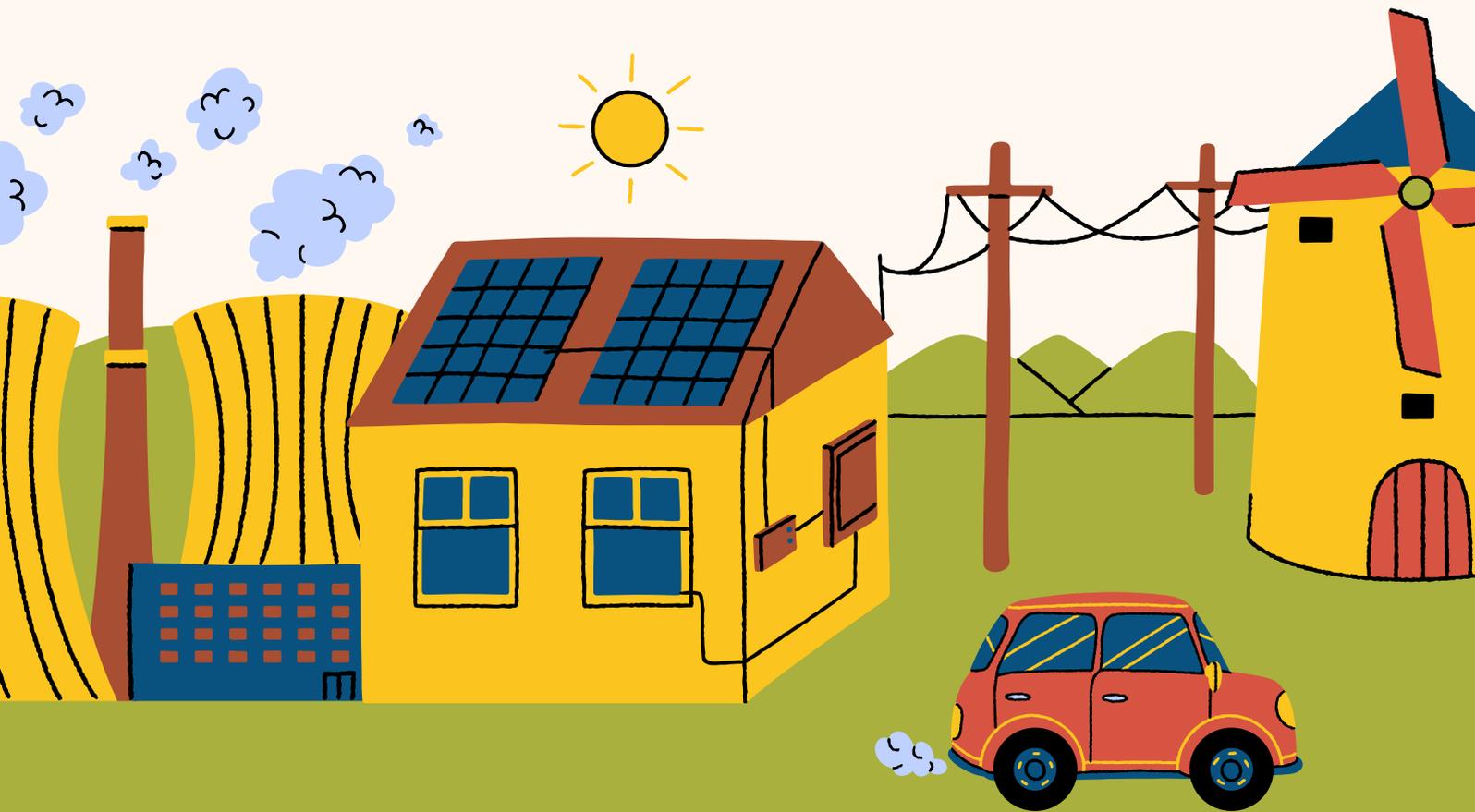


Dr Ben Marram

# THE FRONTAL LOBE PARADOX FIELD GUIDE



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# THANKS

*This guide would not have been possible without the seminal writing of Sam Gilbert and Melanie George (2018).*

*With thanks to the clinicians, researchers and colleagues who reviewed early drafts of this document and for their heartfelt contributions.*

*Thanks to those living with neurological conditions and families for reviewing this content and for their bravery and patience in helping us understand this complex area.*

*For my boys - Caleb and Reuben - stay curious; carry the fire.*

*"Coming together is a beginning. Keeping together is progress. Working together is success"*

*Henry Ford*



# ABOUT THE AUTHOR

*Dr Ben Marram is a Consultant Clinical Neuropsychologist who works with adults and families affected by acquired brain injury and other neurological conditions.*

*His experience of the Frontal Lobe Paradox (FLP) is directly from his clinical experience and supervision of other professional groups navigating this complex clinical issue. He has seen first hand the catastrophic outcomes that a misunderstanding of the paradox creates. He hopes that this publication is an easy and accessible guide to raise awareness of the FLP and to reduce negative outcomes for survivors and their families.*



# WHAT'S INSIDE:

## Introduction

What is the Frontal Lobe Paradox?

Why it matters...



## Chapters

Nurses - *The paradox at the bedside*

Social Workers - *The paradox in plans and paperwork*

Support Workers - *The paradox in daily life*

Physiotherapists - *The paradox in movement*

Occupational Therapists - *The paradox in everyday occupation*

Psychologists - *The paradox in conversation*

People living with neurological conditions - *The paradox in understanding*

Families - *The paradox in connection*



## Closing thoughts

Controversies and debates

The paradox across settings



# CHAPTER 1

## What is the frontal lobe paradox?

What is the Frontal Lobe Paradox?  
Why it matters...

## What is the frontal lobe paradox?

The frontal lobe paradox describes a mismatch between what someone can say and what they can do.

A person may:

- Appear cognitively intact in conversation
- Demonstrate insight, reasoning, and understanding
- Agree with plans, advice, or goals

...but struggle to:

- Initiate action
- Sustain effort
- Sequence tasks
- Apply decisions in real-world settings

This is not a contradiction.

It is not deliberate.

And it is not uncommon following brain injury, neurological illness, or frontal-executive impairment.



# Why it catches professionals out

Modern professional practice relies heavily on:

- Conversation
- Explanation
- Verbal agreement
- Written plans

When someone presents well verbally, it is understandable to assume that action will follow.

When it doesn't, frustration often creeps in:

- "They know what to do."
- "They agreed to this."
- "They've been told."

Over time, this can lead to mislabelling:

- Non-compliant
- Resistant
- Unmotivated
- Manipulative

The paradox invites a different explanation.



## Is there an area of the brain that can be injured which causes this?

The frontal lobe paradox is not tied to one single spot, but most commonly involves specific frontal-subcortical control networks, especially when they are disconnected rather than destroyed.

### What areas?

#### *Dorsolateral Prefrontal Cortex (DLPFC)*

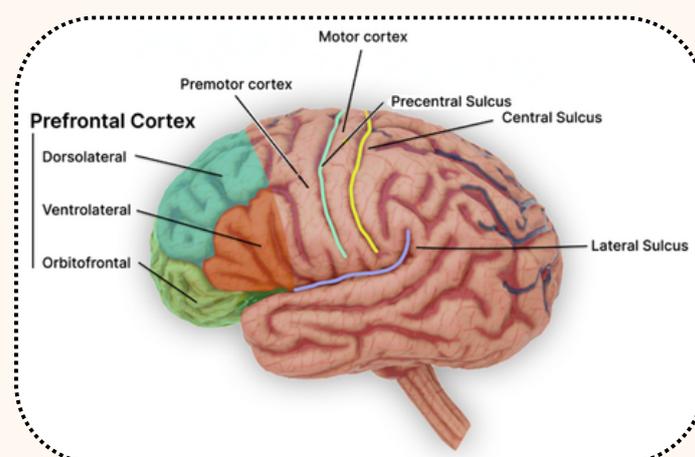
- Key for planning, working memory, organisation, and goal-directed behaviour
- People may understand what to do but fail to initiate or sustain it
- Classic “knows but doesn’t do” presentation

#### *Orbitofrontal Cortex (OFC)*

- Regulates social judgement, inhibition, and emotional decision-making
- Damage/disconnection → impulsivity, tactlessness, poor real-world judgement
- Often appears fine in structured assessments

#### *Ventromedial / Medial Prefrontal Cortex*

- Motivation, emotional weighting, insight, and self-monitoring
- Linked to apathy, emotional blunting, reduced drive
- Patients may verbally endorse goals but not act on them



## Why does this cause the paradox?

In clinical environments or in test situations, executive **knowledge** remains; the person can say what they would do, how they would do it, what they would need...they tend to rely on a template of knowledge for the task.

This is usually coupled with preserved or strong verbal skills; *it seems entirely plausible.*

However, executive **control** in real life is impacted. The person knows what they would do, but not how to do it in the moment.

**STRUCTURE + PROMPTS** = the person does well

**UNSTRUCTURED REAL-WORLD SITUATIONS** = difficulties

The frontal lobe paradox arises when prefrontal systems for insight and reasoning remain intact, but networks required to translate intention into action are disrupted.



## Why is it so important that we understand this phenomena?

Where there is a discrepancy between what someone says they will do and what they *actually* do or can do, this has implications for:

- Risk assessment and understanding of risk, particularly when discharged from hospital or when living in the community
- Mental Capacity decisions - understanding the person's ability to make decisions at the time the decision is required, otherwise known as the 'material time'
- Planning ongoing rehabilitation and support in the community, or ensuring provision for ongoing support if the issue is chronic and enduring
- The increased risk on relationship breakdown after acquired brain injury



# CHAPTER 2



## FLP in Nursing

The paradox at the bedside...

**Key Focus** - *Task completion on ward, adherence, insight vs action, ward-based judgements*

### Key themes:

- “they understand...so why won’t they...”
- Verbal insight (telling you what they will do) does not mean follow through
- Fatigue, distraction, emotional load amplify the paradox

### Where you might spot it:

- Medication refusal despite verbal agreement
- Missed hygiene, nutrition or mobilisation despite clear explanations
- “Yes, I will” followed by inaction

### Common misinterpretations:

- Non-compliance
- “Manipulative”
- “Choosing not to engage”



### What helps:

- Breaking tasks into structured steps that are then prompted by an external factor e.g., verbal prompt, environmental prompt
- Reducing reliance on verbal agreements
- Using routines
- Being guided by what the person says *and* does to guide care plans

***If you are providing constant reminders with no action, despite verbally agreeing...the problem isn't motivation - it's executive load***

# CHAPTER 3

## FLP in Social Work



The paradox in plans and paperwork...

**Key Focus** - *Capacity, risk, self-neglect, safeguarding, least-restrictive options*

### Key themes:

- Articulate patients / clients who can't sustain safe behaviour
- Capacity that *fluctuates* between conversation and context
- Risk emerging *after* apparently sound decision-making

### Where you might spot it:

- Evidence of well-reasoned explanations of choices that **repeatedly** lead to harm
- Care plans agreed / co-constructed but not enacted
- "Unwise decisions" that look more like impaired execution e.g., gambling consistent with pre-injury frequency, but with *significantly* higher spending

### Common errors:

- Over weighting of verbal responses in mental capacity assessments
- Assuming that insight e.g., into challenges, guarantees follow through with behaviour
- Escalating restriction on movement or liberty, when well-informed support would suffice

### What helps:

- Asking "can they carry this out?" and not just "can they explain it?"
- Asking "what happens between what they say they will do and what they then do?"

***Mental capacity is not just about thinking - it's about doing***

# CHAPTER 4



## FLP in Support Work and Rehabilitation Assistance

The paradox in daily life...

**Key Focus** - *Everyday functioning, routines, prompts, frustration in care delivery*

### Key themes:

- The person understands the plan or task, including the “rules”, but can’t apply them
- **Repeated** support for tasks that the person appears capable of
- Relationship strain from repeated prompting and a lack of learning over time

### Where you might spot it:

- Getting “stuck” in tasks that the person felt confident with
- Abandoned tasks where progress was not being made
- Emotional shutdown when emotionally overwhelmed

### Why does it feel so hard?:

- Support workers can be told the person is “high functioning”, but their functional performance is much worse than had been expected
- There can be a pressure to reduce support earlier than is needed
- Support workers can feel “blamed” for a lack of progress

### What helps:

- Doing *with* the person, not *for* the person
- Support with routine and structure
- Clear note keeping - identifying discrepancies - and escalating concerns to relevant professionals

***If support is removed too soon, failure looks like choice...***

# CHAPTER 5



## FLP in Physiotherapy

The paradox in movement...

**Key Focus** - *Carry over, initiation, consistency, functional gains vs clinical performance*

### Key themes:

- Excellent performance in sessions, poor carry-over at home
- Exercise plans understood and agreed but not initiated
- Inconsistent engagement despite verbal reassurance of motivation for sessions

### Where you might spot it:

- "They did that perfectly yesterday"
- Home exercise programmes not followed, despite clear agreement and motivation
- Variability in performance day-to-day

### Misreadings?:

- "They're not trying"
- "They're just deconditioned"
- "They're anxious"



### What helps:

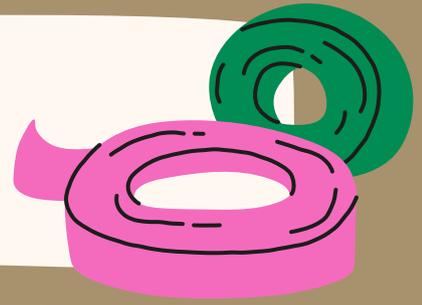
- Rethinking rehab - fewer exercises, more repetition
- Linking movement to routine, not instruction
- Cue-based initiation rather than memory based plans e.g., 'do X exercise when in the living room' - place visual prompt there

***Physical rehabilitation fails when it relies on memory, planning and self-initiation***

# CHAPTER 6

## FLP in Occupational Therapy

The paradox in everyday occupation



**Key Focus** - *observation of performance; not verbal description, what needs to be provided (e.g., external prompting) for occupation to occur*

### Key themes:

- Performance improves in highly structured tasks, with prompting
- Person does not always recognise their difficulties in occupation

### Where you might spot it:

- A person accurately describes how to complete a task but cannot initiate it
- Functional assessments go well, but skills do not carry over
- Tasks are abandoned part-way through
- Independence deteriorates when structure or prompting is reduced
- Performance varies significantly across settings or times of day

### Common misinterpretations:

- Lack of motivation
- Anxiety or avoidance
- Learned dependence
- "They can do it when they want to"

### What helps:

- Externalise executive function
- Visual schedules and checklists
- Environmental cues and object placement
- Clear task start and end points



Design routines, not instructions

- Link tasks to time, place, and habit
- Reduce reliance on memory and self-initiation

Grade independence carefully

- Focus on consistency, not best performance
- Observe performance over time and context

Build in cognitive pacing

- Recognise the impact of fatigue
- Expect variability rather than linear progress

### **Language to use (and avoid)**

Avoid:

- “They’re capable but choosing not to”

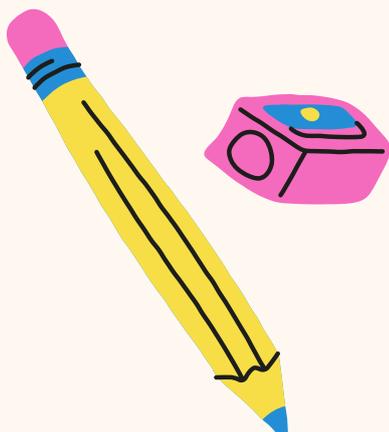
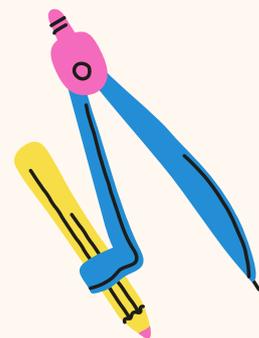
Use:

- “They require external structure to perform this task consistently”

This language:

- Reduces blame
- Improves MDT understanding
- Strengthens OT recommendations

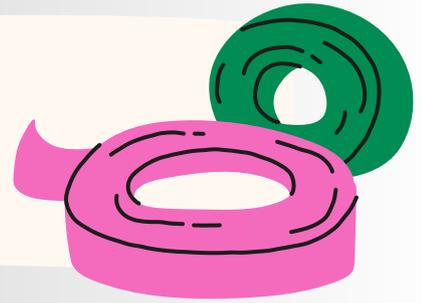
***If occupational performance collapses when structure is removed, the difficulty lies in executive scaffolding – not insight or effort.***



# CHAPTER 7

## FLP in Psychology, Neuropsychology and Psychotherapy

The paradox in conversation, self-report and assessment



**Key Focus** - *insight, self-report, low behavioural change*

### Key themes:

- The person talks insightfully about their difficulties
- They may score within normal limits on many cognitive tests
- Sessions are reflective, articulate and emotionally engaged, yet meaningful change fails to generalise

### Where you might spot it:

- High verbal insight, low behavioural change
- Excellent reflection about emotions, but poor regulation in vivo
- Clear articulation of goals without follow-through
- Agreement with therapeutic strategies that are never enacted

### Common traps:

- Over-valuing insight - insight becomes mistaken for capacity or control
- Assuming therapy = learning - understanding a concept does not mean it can be applied under pressure
- Responsibility drift - the client is expected to self-manage strategies they cannot reliably initiate or sustain
- Formulation inflation - ever more complex psychological explanations compensate for a lack of behavioural traction

### What helps:

Traditional formulations may unintentionally over-attribute:

- motivation
- agency

- intentionality
- emotional regulation capacity

An FLP-informed formulation asks different questions:

- Can this person initiate strategies without prompting?
- Can they hold goals in mind when emotionally activated?
- Can they generalise learning across settings?
- Is behaviour being mistaken for choice rather than capacity?

### ***Adapting therapy for FLP***

Externalising executive function:

- written plans
- visual prompts
- environmental cues

Reducing reliance on insight:

- Less “what do you think?”
- More “what happened just before...?”
- Focus on sequences, triggers and consequences



### ***Working with emotion and risk***

People with FLP may describe emotions accurately but fail to regulate those emotions when activated.

They understand risk conceptually but not operationally.

For example, safety plans that rely on self-initiation may fail. Emotional regulation strategies may work only when externally cued. Decisions or “choice” may fluctuate with fatigue, stress and/or arousal.

***The frontal lobe paradox is not an invitation to do less therapy - it's about doing therapy with a comprehensive appreciation of the BIO in biopsychosocial formulation.***

# CHAPTER 8

## Understanding your frontal lobe paradox

The paradox in understanding

### Why this chapter exists

You may have been told things like:

- “But you understand it.”
- “You explained that really clearly.”
- “You sound fine.”
- “Why didn’t you just do it?”

You may have asked yourself the same questions.

This chapter is here to explain something many people with brain injury experience – and often blame themselves for – called the frontal lobe paradox.

### What the frontal lobe paradox feels like

The frontal lobe paradox is when:

- You know what you need to do
- You agree with the plan
- You want to do it

...but your brain doesn’t reliably turn that knowledge into action.

### You might experience:

- Getting stuck starting tasks
- Losing track partway through
- Feeling overwhelmed by “simple” things
- Doing well one day and not the next
- Feeling exhausted just trying to get going



This can be deeply frustrating — especially when other people think understanding should be enough.

### **Where you might notice it most**

You may recognise the paradox when:

- You can explain something clearly but can't carry it out later
- You agree to plans but don't follow through
- Tasks feel harder at home than when someone is with you
- Fatigue makes everything suddenly collapse
- You feel capable — but unreliable

These experiences are common after brain injury, especially when the frontal parts of the brain are affected.

### **What this is not**

The frontal lobe paradox is not:

- Laziness
- Lack of effort
- Not caring
- "Using your injury as an excuse"



And it is not a personal failing.

Your brain may be working harder than it ever did — just to do everyday things.

### **What's actually going on**

Some parts of the brain help with:

- Starting things
- Planning steps
- Staying focused
- Keeping going
- Switching between tasks

After brain injury, these processes may not work automatically anymore.

Talking and explaining often use different brain systems than doing things in real life.

That's why you might sound fine — but still struggle.

### **What helps in real life**

Many people find it helps to:

- Reduce the number of steps in a task
- Use reminders, prompts, or checklists
- Do things at the same time each day
- Have someone start the task with you
- Rest before you feel exhausted, not after

Needing support does not mean you are incapable.

It means your brain works better with structure.

### **Language that matters**

If you hear (or tell yourself):

- "I should be able to do this."
- "I'm useless if I can't even manage that."
- "Other people think I'm just not trying."

Try replacing it with:

- "My brain needs support to turn plans into action."
- "This is about how my brain works — not my effort."
- "Structure helps me succeed."

Words shape how we treat ourselves.

***If you can explain it but can't do it, the problem isn't motivation — it's how your brain gets started and keeps going.***



# CHAPTER 9

## Supporting Families to Understand the FLP

The paradox in connection



### Why this chapter exists

If you are supporting someone with a brain injury, you may find yourself thinking:

- “They know what they’re supposed to do.”
- “They explained it perfectly yesterday.”
- “Why won’t they just get started?”
- “Are they doing this on purpose?”

You are not a bad person for having these thoughts.

The frontal lobe paradox can be confusing, exhausting, and emotionally draining for families. This section is here to help you understand what’s really happening – and how to support without burning out.

### What the frontal lobe paradox can look like at home

You may notice the paradox when your family member:

- Agrees to plans but doesn’t follow through
- Starts tasks and doesn’t finish them
- Needs repeated reminders for everyday things
- Manages well when someone is with them, but struggles alone
- Has “good days” followed by sudden collapses

This can feel inconsistent – even unfair – especially when they can clearly explain what needs to be done.

### Why this is so hard for families

At home, effort and intention matter deeply.

When someone sounds capable but doesn't act, it can feel like:

- They're not listening
- They don't care
- You're being taken for granted

Over time, this can lead to:

- Frustration
- Resentment
- Guilt for feeling frustrated
- Relationship strain

None of this means you're failing.

### **What this is not**

The frontal lobe paradox is not:

- Laziness
- Lack of respect
- "Switching it on when they want to"
- A sign they don't care

Brain injury can affect the systems that help people start, organise, and carry out actions – even when they fully understand them.

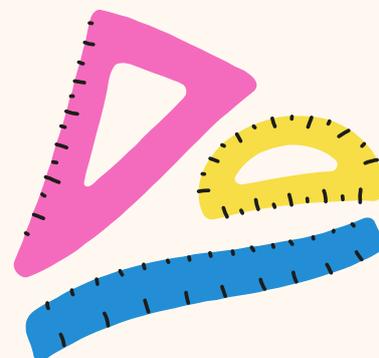
### **What's actually happening**

After brain injury, some parts of the brain that manage:

- Getting started
- Keeping track of steps
- Staying focused
- Managing overwhelm

...may not work automatically anymore.

Talking and explaining are often easier than doing.



This is why your family member may:

- Sound capable
- Mean what they say
- Still not manage the task

## **What helps families in practice**

Reduce reliance on reminders and arguments

- Repeating instructions often increases stress for everyone

Use structure, not persuasion

- Routines
- Visual prompts
- Doing tasks together to get started

Focus on the environment

- Fewer distractions
- Clear places for things
- Simple, predictable routines

Notice patterns

- Fatigue, time of day, stress, and noise all matter

Share the load

- Supporting executive function is tiring
- You need support too

## **Language that protects relationships**

Instead of:

- "You know how to do this."

Try:

- "Let's start this together."

Instead of:

- "Why won't you just do it?"

Try:

- "What would make this easier right now?"



Small changes in language can reduce conflict and protect connection.

# CLOSING POINTS



# CONTROVERSIES AND DEBATES



## Working toward evidencing the FLP

There is much discussion in legal frameworks and in clinical environments about the utility and meaning of frontal lobe paradox as a label. The aim of this guide is not to explore each of these in detail, but more frame the discussions as questions to lead to further reflection and clinical research into what is observed clinically. Here are some of the common questions related to the issue:

- Is it really a paradox, or just a misunderstanding of executive function more generally? The paradox may be conceptual – but the difficulty is real.
- Is FLP just poor assessment practice? Is the problem the person, or the way we test them?
- Where does motivation fit in? Distinguishing “won’t” from “can’t” is rarely simple
- Do we risk excusing harmful behaviour? Although understanding FLP informs how support and safeguards are designed
- FLP complicates legal and ethical frameworks that rely on verbal reasoning and stated understanding
  - Capacity assessments may overestimate real-world ability
  - Fluctuating capacity challenges binary judgements
- Overlap with mental health and personality; can FLP overlap too heavily with depression, anxiety, personality change and trauma?
- Risk of diagnostic labelling – FLP should describe a *pattern*, not a diagnosis

# FLP ACROSS SETTINGS



## Why the Frontal Lobe Padox Changes Shape

### A core principle

The frontal lobe paradox becomes more visible as structure decreases and executive demand increases.

### In hospital and inpatient settings

#### What it often looks like

- Good engagement on ward rounds
- Clear understanding of risks and plans
- Tasks completed with prompts or routine

#### Why FLP can be missed

- High external structure
- Regular cues and reminders
- Predictable routines
- Staff-initiated activity

#### Risk

- Overestimating independence
- Assuming performance will generalise after discharge

## **In rehabilitation settings**

### **What it often looks like**

- Strong performance in therapy sessions
- Poor carry-over between sessions
- Variable progress day to day

### **Why FLP starts to emerge**

- Less continuous structure
- Increasing expectation of self-initiation
- Fatigue from therapy intensity

### **Risk**

- Interpreting poor carry-over as lack of motivation
- Advancing goals too quickly

## **In the community**

### **What it often looks like**

- Missed appointments
- Poor adherence to routines or medication
- Self-neglect or safety risks
- Inconsistent engagement

### **Why FLP becomes clearer**

- Fewer prompts
- Competing demands
- Real-world distractions
- Reliance on memory and planning

### **Risk**

- Labelling difficulties as “non-compliance”
- Withdrawing support too early



## At home

### What it often looks like

- Doing better when someone is present
- Tasks not started or left unfinished
- Conflict around reminders and expectations

### Why families feel the strain

- No formal structure
- Emotional load
- Continuous executive demand

### Risk

- Relationship breakdown
- Families being seen as “over-supportive”
- Survivor internalising blame

## In formal assessments

### What it often looks like

- Fluent conversation
- Clear explanations
- Good insight demonstrated verbally

### Why FLP is often hidden

- Artificial structure
- One-to-one support
- Reduced environmental complexity

### Risk

- Over-reliance on verbal performance
- Misalignment between assessment findings and lived experience



## Why teams disagree across settings

Different professionals often see different versions of the same person.

- Hospital teams see competence
- Community teams see risk
- Families see inconsistency
- Survivors feel misunderstood

These differences are not contradictions.

They are context effects.

## What helps across settings

Share context, not just conclusions

- Describe where and when difficulties appear

Weight real-world performance

- Especially in low-structure environments

Anticipate the drop in function

- When moving from structured to unstructured settings

Plan transitions carefully

- Discharge, step-down, and service withdrawal are high-risk moments

## Language to support shared understanding

Instead of:

- "They were independent on the ward."

Try:

- "They managed well with high external structure and prompting."

Instead of:

- "They deteriorated at home."

Try:

- "Executive demands increased beyond available support."



# RESOURCES



## Where can I read more?

- George, M.S., & Gilbert, S. (2018). Mental Capacity Act (2005) assessments: why everyone needs to know about the frontal lobe paradox. *The Neuropsychologist*, 5, 59 – 66.
- <https://www.headway.org.uk/about-brain-injury/further-information/research/health-and-social-care/frontal-lobe-paradox-and-the-mental-capacity-act/>



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