Frontal Lobe Paradox: A Practical Guide for Lawyers

Introduction

This practical guide is produced by a multidisciplinary team[1] to assist lawyers working with clients and individuals in situations where the so-called "frontal lobe paradox" (FLP) may be an issue. Its core purposes are to:

1. Alert lawyers as to what the FLP is;

2. How the FLP may manifest itself;

3. Highlight how the FLP impacts on the consideration of capacity for the purposes of the Mental Capacity Act 2005;

4. Arm lawyers to interrogate evidence and evidential gaps in relation to FLP.

The FLP is an acute example of a well-recognised challenge in the context of capacity assessment, namely translating a clinical phenomenon into the language of the Mental Capacity Act 2005. As such, this practical guide may also assist in terms of other situations where it is necessary to undertake capacity assessments which require observation across time and in context.

Wherever possible, we have provided hyperlinks to freely available online sources.

The frontal lobe paradox

The "frontal lobe paradox" (FLP) is a critical consideration in mental capacity assessments after an acquired brain injury (ABI), as it highlights the gap that can arise between an individual's apparently intact performance in structured or interview-based assessments and their significantly impaired functioning in real-world settings (George & Gilbert, 2018; Walsh, 1985). FLP, also described as the knowing–doing dissociation, applies to a subset of individuals who have sustained a frontal lobe injury.

Despite limited empirical evidence, FLP is a well-recognised phenomenon within neurorehabilitation (Newstead et al., 2022) and presents as an observed and observable difference between an individual's stated belief regarding their abilities and what actions they can/will undertake, and what they do undertake.

It is also important to recognise that the reliable identification of the frontal lobe paradox frequently depends upon the quality of the working relationship between assessor and assessed person. In neurorehabilitation contexts, the therapeutic alliance is not merely

[1] The authors and their details are set out at the end of this document.

facilitative but evidential: it creates the psychological conditions in which discrepancies between "knowing" and "doing" can safely emerge and be discussed.

Where FLP manifests, individuals with may present as articulate, polite, and able to give seemingly coherent answers about risks, choices, or consequences, yet be unable to translate this knowledge into safe, consistent behaviour in everyday life. This dissociation means that Mental Capacity or Care Act assessments relying solely on the person's self-report or abstract discussions on how they would manage the identified risks, can lead to an underestimation of their support needs (Moore et al., 2019).

The relational context in which such information is elicited is therefore critical. Where individuals feel scrutinised, judged, or performance-tested, anxiety may temporarily enhance verbal presentation while masking executive dysfunction. A well-established therapeutic alliance reduces performance pressure and increases the likelihood that real-world inconsistencies will surface.

Assessing Decision-Making Capacity

Owen, Freyenhagen and Martin (2017) elucidate important considerations for assessing decision-making capacity in the context of frontal lobe injury, including that *"impulsivity differs not in degree but in kind from the impulsivity of an individual who has the relevant abilities but in particular instances chooses not to exercise them"* (p.17). Their findings highlight deficits in metacognitive awareness; participants with frontal lobe injury were unable to think about their behaviour in real-time, or to stop and reflect before acting on impulse. This emphasises the need to assess whether a person can use and *apply* information dynamically. In other words, do they have online awareness of the presenting risks? Can they control their actions in the moment?

These questions cannot always be answered through a single structured interaction. Executive failures often emerge over time and in low-threat relational contexts. Longitudinal engagement within a therapeutic alliance may therefore be necessary to observe dynamic use and weighing in practice.

A competent assessment should not only outline the relevant risks and consequences associated with the specific decision during direct engagement with the person, but should also draw upon triangulated sources (George and Gilbert, 2018; Cameron, Codling and Nash, 2022). Essentially, the assessment should refer to real-world evidence of situations where the person is exposed to the multi-layered, unpredictable demands of everyday life. It is vital to consider whether the person's self-report aligns with the accounts of others, and whether there have been occasions in which the person has acted contrary to their stated intentions.

Yet, as Whiting (2020) observes, impulsivity and spontaneity are features of neurotypical behaviour and do not, in themselves, render someone incapable of decision-making. On this basis, the assessment must probe more deeply and ask:

- Is the person aware of inconsistencies between what they articulate and what they demonstrate?
- How do they justify behaviours that contradict their expressed wishes?
- Do they offer a rationale that is coherent within their own frame of reference?
- Are they able to connect different components of the decision and weigh the broader implications?

If, even with practical support, the individual cannot formulate a reasoned narrative in terms of their cost-benefit appraisal, or there are repetitive real-world inconsistencies that cannot be plausibly explained, this may justify the conclusion that the person is unable to weigh, use and apply relevant information. It must then be determined whether there is a causal link between the functional inability and the impairment (the causative nexus), following the correct order of the assessment process, as confirmed in *A Local Authority v JB* [2021] UKSC 52.

Below is an anonymised example of a 'causative nexus' analysis which links the inability to make the specific decision directly to the impairment:

> *The support plan identifies that Dylan requires 1:1 practical assistance and neuro-behavioural scaffolding to support his engagement in daily activities, which reduces the risks of injury, deterioration and disinhibition/ retaliation from others. With prompting and assistance, Dylan could understand and retain this information and expressed that he wants ongoing support in place to remain safe and well. However, it was clear from collateral sources that he is unable to use and apply key information related to the presenting risks when faced with 'real-life' situations,*
>
> *For example, Dylan stated that he needs 1:1 support with walking, and he does not try to mobilise independently as he will likely fall. Yet, when reports from care staff and family were discussed with him, which highlight that he frequently attempts to get up unaided, he could not account for this or provide any reasoning. This was a consistent pattern across other support domains. Dylan lacks awareness in critical moments and disengages from support, exposing himself to the risks that he seeks to avoid, therefore requiring urgent and skilled intervention to prevent harm.*
>
> *Deciding on a plan of support is an ongoing, dynamic process, and on balance, Dylan is unable to use and weigh the relevant information over the material time. The consultations and reports from the neuro-clinicians who have worked with Dylan*

> *long-term confirm that Dylan presents with executive dysfunction secondary to acquired brain injury. This results in impulsivity, an inability to process abstract information, and an inability to self-regulate, particularly in high-stimulus environments. Dylan's inability to apply the information dynamically is directly caused by his acquired brain injury. He therefore lacks the capacity to decide on his support plan.*

It is notable that such inconsistencies often only become visible within trusting, sustained professional relationships. In many cases, individuals initially present as coherent and aligned with support plans, with divergences emerging only once anxiety reduces and the relational space feels psychologically safe.

A robust, clinically appropriate and legally defensible evaluation therefore requires the assessor to examine not only what the person *can say* about a decision but also what they can *do* in context, including their ability to initiate, plan, sequence, inhibit responses, manage impulses, and adapt to changing circumstances. Recognising the frontal lobe paradox helps prevent erroneous conclusions of capacity or care needs in individuals who retain intellectual understanding but lack the executive control necessary to use or weigh information in practice, which is essential for ensuring both autonomy and protection under the Mental Capacity Act 2005, and adequate support in relation to the Care Act 2014 (Owen, Freyenhagen, Martin, & David, 2017).

Insight in the Context of Acquired Brain Injury

Denial and loss of insight following ABI are distinct phenomena arising from fundamentally different mechanisms. Loss of insight, often termed *anosognosia*, reflects a neurological impairment in self-awareness caused by damage to brain networks supporting self-monitoring and metacognition—most commonly frontal and parietal systems—resulting in a genuine inability to recognise deficits even when presented with clear evidence (Ownsworth, McFarland, & McD. Young, 2002; Prigatano, 2014). Metacognition is the ability to think about one's own thoughts. As such it enables someone to reflect on their own limitations. A neurological deficit in this area cannot be overcome, even whilst the person is trying but failing to carry out the task they believe they can do.

In contrast, denial is understood as a psychological defence mechanism, whereby the individual unconsciously minimises or rejects deficits to protect against emotional distress, identity disruption, or reduced self-efficacy; awareness is therefore *potentially intact* but defended rather than lost. This distinction is clinically important because anosognosia requires interventions targeting metacognitive awareness, whereas denial responds better to psychotherapeutic approaches aimed at emotional adjustment (Vaillant, 1992). In short, treating anosognosia is very unlikely to change capacity, whereas treating denial may well help someone regain capacity.

Some individuals will experience full anosognosia, a total loss of insight to the extent that those who are perhaps hemiplegic will attempt to stand and walk and will not learn from the painful feedback of falling on each occasion. This is relatively rare in our work and is associated with individuals who have sustained very severe injuries to the brain, likely requiring around-the-clock support.

More confusingly for us in our roles is when an individual has incomplete awareness into the impact of their brain injury. They are aware that they have been involved in a road traffic collision/life changing incident have had an accident and that it has had an impact upon them. In a conversation with a supportive interlocutor, they can note some of their difficulties and even what the functional impact of these are. However, this knowledge does not enable them to act differently, to take on board strategies to compensate for their difficulties and to always utilise them successfully. At best, his knowledge regarding the acquired brain injury is therefore an "intellectual awareness" (Crosson et al., 1989). This knowledge is extrinsically created, and they demonstrate little to no ability to independently apply this knowledge usefully at a later time or in a different setting or context (Toglia, 2018 ; Toglia & Kirk, 2000).

For individuals with only intellectual awareness, learning compensatory strategies and applying them is impacted. Without the independent ability to internalise or generalise strategies to compensate for the brain injury, functioning is impacted. Inadequate levels of support and less structure in the environment will, predictably, lead to a deterioration in their functioning, engagement and participation.

Incomplete insight is significant for functioning and has an impact upon the type of support required by an individual. It should come as no surprise that non-brain injury specialists will have difficulty in assessing and treating these individuals. Needs are likely to be under-estimated unless specialist and third-party information is integrated into assessments.

The development and accurate assessment of insight is also relationally mediated. Individuals may demonstrate greater intellectual awareness when supported by a trusted professional who can scaffold reflection without triggering shame or defensiveness. Conversely, adversarial or overly interrogative approaches may produce superficial or compliance-based responses that overstate functional awareness.

Put more simply perhaps, some people can 'talk the talk' better than they can 'walk the walk'. This is a function of their brain injury. There is a (rapidly) growing body of evidence of harm caused to people with an ABI, owing to a lack of ability to recognise the FLP and issues with reduced insight/awareness (George & Gilbert, 2018; Holloway & Norman, 2022; Moore et al., 2019; A. Norman, 2016). There is increased understanding of how Social Work as a profession is poorly integrated into interdisciplinary teams and has low awareness of the impact of ABI (Flynn, 2016; Linden et al., 2023; Mantell et al., 2018; A Norman et al., 2026).

Insight vs Mental Capacity?

While impaired insight is a recognised feature of brain injury sequelae, the relationship between insight and mental capacity remains a subject of debate. David (2026) argues that the two concepts should not be treated as entirely distinct and highlights the correlations that exist between them. However, in *Warrington Borough Council v Y & Ors* [2023] EWCOP 27 Mr Justice Hayden draws a clear distinction:

> *Executive dysfunction and frontal lobe paradox is… not to be regarded as synonymous with the functional test for mental capacity… Neither is 'insight' to be viewed as equating to or synonymous with capacity* (para 45).

The same issue came under scrutiny in *CT v London Borough of Lambeth & Anor* [2025] EWCOP 6 (T3) where Mrs Justice Theis held that the judge had erred in stating that CT's insight into his mental impairments was relevant information when making decisions on care and residence.

In practice, the clinical concept of insight is frequently interwoven with the legal concept of capacity. While the terms are not synonymous, interactions do exist, particularly for decisions about care or treatment. This may be applicable for individuals with frontal lobe injury, where the person's awareness of their deficits may be essential for making decisions about the support they need (Owen, Freyenhagen and Martin, 2017). However, if the law is to recognise insight as a relevant factor, it must be clearly defined (Allen, 2009) and the nature of interactions and implications for the specific decision must be explained (Curtice and Moltu, 2026).

The difficulty, it seems, is that the Mental Capacity Act 2005 requires a decision-specific assessment of capacity and demands a black-and-white answer. This is often approached as a static, one-off assessment, yet decisions vary in complexity and temporality. Furthermore, acquired brain injury encompasses a multitude of colours, tones and hues. This requires a comprehensive, interdisciplinary approach to capacity assessments grounded in curiosity and professional diligence. Thereby avoiding broad– brush applications, or erroneous and potentially dangerous conclusions.

Within such an approach, the therapeutic alliance serves as the foundation for reliable observation. Capacity, particularly in executive presentations, may fluctuate according to anxiety, perceived threat, and relational trust. An assessment that does not consider these contextual influences risks conflating situational performance with enduring functional ability.

Supported Decision-Making

Promoting autonomy is a core principle of the Mental Capacity Act 2005, whereby the presumption of capacity and the concept of 'unwise decisions' are used as a protective shield to guard a person's autonomy (Coggon and Kong, 2021; Astrachan, Keene and Kim,

2024). Yet elevating personal autonomy so highly that it leads to a failure to protect life and human dignity raises deeply challenging ethical questions, particularly where individuals may be seen as making deliberate decisions, but in reality, their actions, or inactions, are caused by executive impairment (Braye, Orr and Preston-Shoot, 2017).

Therefore, when working with individuals with frontal lobe injury, it is important to recognise how executive dysfunction impacts decision-making, and to provide appropriate, longitudinal support so that the person can participate meaningfully and achieve an outcome aligned with their authentic self. Knox, Douglas and Bigby (2017) illustrate that individuals with ABI require support from those who not only understand the neurocognitive profile but also know the person well, on the basis that social networks can act as a bridge between participation in decision-making and the development of self-concept.

This highlights the value of a therapeutic alliance, which is integral to neurorehabilitation, and provides a foundation for promoting agency and enabling decision-making capacity to the extent achievable. In this context, the alliance operates not only as a vehicle for rehabilitation but as a means of evidencing authentic preference and values. Where trust is established, individuals are more likely to articulate motivations that are not driven solely by anxiety, habit, or environmental dependency. This also speaks to the concept of relational autonomy, which flourishes within supportive contexts, challenging the individualistic model of autonomy (Harding, 2017). Where best interests decisions are required, a therapeutic alliance helps to understand the person and their true motivations. It also helps build the trusting relationships that foster greater independence and well-being.

Final Thoughts

Brain injured clients with reduced insight, difficulties with behavioural control and executive impairment are those that present the biggest challenge, even to specialised services. Research into use of specialist brain injury case management services identifies those individuals with reduced insight and executive impairments are greater users of independent case management (Clark-Wilson et al., 2016). Brain injury case managers are therefore acutely aware of the need to actively support their clients in making decisions, and report that knowing their client and their family well, is crucial for supporting decision-making (Moore et al., 2019). Where an individual is assessed to lack decision-making capacity, the neuro-rehabilitative support model provides the scaffolding that enables the person to lead a more autonomous and dignified life. However, having solely an intellectual awareness of the impact of injury but reduced ability to change one's behaviour is complicating for a mental capacity assessment and often leads to ambiguities and professional disputes. Some individuals struggle to integrate information to create a cogent view of the future, of themselves or of what they require over the longer term, others sound very coherent and plausible. Impaired self-awareness following acquired brain injury

reflects a multidimensional disruption of the systems responsible for metacognition, executive control, and the appraisal of one's own performance. Although individuals may demonstrate intact intellectual awareness, they may lack the emergent and anticipatory capacities required to recognise difficulties as they occur or to foresee their functional consequences.

This dissociation—central to the frontal lobe paradox—means that articulate verbal reasoning in structured assessments often fails to predict safe or adaptive behaviour in everyday contexts. As real-world functioning depends on the ability to detect errors, adjust behaviour, and anticipate demands, assessments must therefore move beyond interview-based impressions. As noted by Mrs Justice Knowles in *DY, Re (Capacity)* [2024] EWCOP 4:

> *[I]t would be beneficial if expert capacity assessors ensured that, as a matter of routine, they cross-checked their conclusions by looking at the wider canvas about how a person functioned and, if possible, by speaking to those who knew the person being assessed well* (para 47).

They must also attend to the relational conditions under which impressions are formed. Executive dysfunction is frequently masked in high-stakes or unfamiliar environments. Observations derived from consistent therapeutic engagement provide a richer and more ecologically valid evidential base than single-encounter assessments alone.

These considerations underpin the practice recommendations that follow, ensuring that conclusions about risk, capacity, and support needs reflect genuine functional ability rather than a superficial veneer of competence.

Guidance for Lawyers

Drawing together the matters together, we suggest that in any situation where the FLP may be in play, lawyers should:

- Scrutinise whether assessments gather behavioural, real-world evidence rather than relying upon abstract understanding or self-reporting.
- Request evidence about real-world performance, not solely interview-based competence. Consider whether the expert has consulted with the treating clinicians to inform their opinion.
- Question experts on their assessments of the differing levels of awareness and their implications for the person's functioning.
- Check whether the expert has direct experience of practicing in neurobehavioural/neurocognitive rehabilitation of people with an acquired brain injury, do they have experience of supporting such clients in the community? If not, what are they basing their expertise upon?

- Ensure that the expert has considered the possibility of FLP in their assessment and upon reviewing all of the behavioural evidence that they have seen.
- Consider whether the assessment was conducted within a relational context sufficient to reduce performance anxiety and allow real-world inconsistencies to emerge.
- Consider whether the insight evidenced is superficial, reflecting intellectual knowledge but not behavioural implementation.

Guidance for Clinical Practice

Just as it is important for lawyers to be able to interrogate and understand clinical evidence, so it is important that clinicians are able to understand the demands of the law in this area. This means that clinicians should:

- Prioritise performance-based and ecologically valid assessment over interview-based reasoning.
- Determine whether impairments lie in intellectual, emergent, or anticipatory awareness, ideally with input from the long-term clinical team.
- Incorporate collateral accounts, behavioural observations, and longitudinal evidence from the clinical team, support team and relatives
- Document discrepancies between stated ability and enacted behaviour clearly and explicitly.
- Discuss identified discrepancies with the person and consider whether their response is coherent/ consistent within their own frame of reference.
- Recognise the therapeutic alliance as an evidential tool in detecting discrepancies between articulated understanding and enacted behaviour.
- Analyse environmental demands, recognising that reduced structure increases functional impairment and that additional support can mask underlying impairments.

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Alex Ruck Keene KC (Hon) and Jim Hirschmann, barristers, supported this work on behalf of the Court of Protection Bar Association.

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