Definition

Frontotemporal Dementia (FTD) is an umbrella term under which there are a variety of different types. This is not another name for Alzheimer’s disease. These types of dementia affect the frontal and/or temporal lobes of the brain. Some of the different clinical forms of FTD are:

- Behaviour Variant FTD
- Primary Progressive Aphasia – non-fluent type (speaks hesitantly and labored)
- Primary Progressive Aphasia – semantic type (unable to understand/formulate words into a sentence)
- Motor Movement Disorders

Characteristics

True FTD typically begins when someone is in their fifties or sixties, although some cases have been as young as 21 or as old as 85 years. It is important to remember that unlike patients with Alzheimer’s disease (AD), patients with FTD may not have as significant memory problems.

The type of FTD is determined based on:

- Inappropriate social conduct (dis-inhibition)
- Apathy (which may be labeled by staff or family as depression)
- Ritualistic/repetitive behaviour (perseveration)
- Loss of attention to personal hygiene
- Difficulties with language
- Executive dysfunctioning (inability to set goals or easily follow a plan of action; poor insight and judgement)
- Weakness/motor neuron diseases (limb weakness, prone to falls)
- Hyperorality (mouthing of objects, particularly sweets)

A person may have a primary diagnosis of another type of dementia like Vascular Dementia and still have frontal lobe problems. This may be a result of mini-strokes in the frontal lobe area. It is also possible that they may have had a traumatic brain injury or lesion in that area of the brain.
Creating a behavioural care plan

The following key points should be addressed in a care plan:

1) Structured routine and individual care

Patients like rules and structure in their day-to-day activities. Planning and setting goals is hard for them. It is helpful to clearly write out the patient’s routine in their care plan. Consider:

- What time do they get up in the morning?
- What time do they like to go to bed?
- What do they like/not like to eat?
- What activities do they enjoy/not enjoy?

Ask the patient’s family about what the routine was at home. Try to duplicate this. Make sure all staff follow the same routine for the patient. If changes need to be made, tell the patient prior to the disruption. For example, if you want to change the sheets on at patient’s bed let the patient know that you want to do this first. Ask the patient’s permission or ask the patient to help you.

It is also important not to move or rearrange any personal belongings in the patient’s room without their permission. If you do have to move items (for cleaning), be sure to put the items back exactly where they were. Remember that the patient’s memory may be good despite their behaviour.

These patients also need guidance for personal care. Often, patient’s let their personal care go and do not recognize it. Allow the patient to perform their own care if they are able or leave them a visual cue (towel and face cloth) to do it.

2) Recognition of common behaviours

Overstimulation

Provide one-on-one time, or “quiet time”, where you both can participate in an activity together. Too much stimulation can be distressing. Try to avoid activities that involve loud music, too much noise, or too many people. Avoid all sources caffeine - even decaff tea has caffeine!

Repetition

Often patients with frontal lobe dysfunction exhibit repetitive behavior. For example, may repeatedly make the same comment, or perform the same action over and over.

Hyperorality

Often patients with frontal lobe dysfunction like to eat especially sweets. They may sneak many sweets before you know it!

3) Identify triggers for angry outbursts and disinhibition
It is very difficult for these patients to maintain socially accepted behaviour. Remember, behaviour is related to brain dysfunction and should not be seen as a personal attack on you as a caregiver. Use a calm approach, reassuring the patient that you value what they are saying.

During an outburst, give them space, letting them know that you will return in a specific period of time. Do not argue with the patient or tell them to stop. Responding with language like “Stop that!” only serves to escalate frustrations on both sides. Trying to reason may also aggravate the situation. Do not force the patient to do something they don't want to do.

Note what triggers the behaviour and include this in the care plan.

If the patient becomes fixated on something disruptive, try to redirect to an activity that they enjoy. Use a type of music the patient enjoys as a means of decreasing irritability. You can also try discussing a topic of interest to them (learned in Life Story) to redirect their focus.

In the case of disinhibition, try to redirect the patient from saying something before it turns inappropriate or sexual. You may have to use humour. Allow them to do their own personal care if they are able to because sometimes the caregiver doing the care is the trigger for the behavior. Remember that this patient group does not realize when their language and behaviour is not the social norm. Sometimes, an SSRI medication such as Sertraline/Citalopram may help with dis-inhibition.

4) Clear communication techniques

These patients require a concrete conversation approach. If you need to leave the patient for a period of time, tell them precisely when you will return. Instead of saying “I'll be back later,” try “I'll be back in 20 minutes” and be sure you do exactly that. This patient group tends to focus on their own needs more so than the needs of others.

5) Learn about what works and share with other care providers

Get to know the patient outside of regular physical care time by learning about who they are as an individual. Ask questions about their life story. Use humour to ease tension. Think of their behaviour as a way to express an unmet need.

Brainstorm as a group! Share with others what you’ve learned about behavioural triggers. For example, if you know that a patient does not enjoy eating with others and prefers to sit in a specific chair, adjust your care and the care environment to their preferences.

Make the patient feel noticed and important by reassuring that you are there to help. Being mindful of body language and tone of voice will help you to be proactive and enable you to intervene before the situation escalates.
Maintain their self-esteem. Thank patients often for their help. Tell the patient that you like their company. Avoid “words that wither their self-esteem.” (e.g. “Stop that!”, or, “That’s inappropriate!”

References
