

1-1-2018

Impulsive, Disinhibited Behavior—Dining in a Restaurant

Ronald C. Hamdy
hamdy@etsu.edu

Amber Kinser
East Tennessee State University, kinsera@etsu.edu

Tracey Kendall-Wilson
East Tennessee State University

Audrey Depelteau
East Tennessee State University, depelteau@etsu.edu

Kathleen Whalen
East Tennessee State University, whalenk@etsu.edu

Follow this and additional works at: <https://dc.etsu.edu/etsu-works>

 Part of the [Family, Life Course, and Society Commons](#)

Citation Information

Hamdy, Ronald C.; Kinser, Amber; Kendall-Wilson, Tracey; Depelteau, Audrey; and Whalen, Kathleen. 2018. Impulsive, Disinhibited Behavior—Dining in a Restaurant. *Gerontology and Geriatric Medicine*. Vol.4 <https://doi.org/10.1177/2333721418756994> ISSN: 2333-7214

This Article is brought to you for free and open access by the Faculty Works at Digital Commons @ East Tennessee State University. It has been accepted for inclusion in ETSU Faculty Works by an authorized administrator of Digital Commons @ East Tennessee State University. For more information, please contact digilib@etsu.edu.

Impulsive, Disinhibited Behavior—Dining in a Restaurant

Copyright Statement

© The Author(s) 2018. This document was originally published in *Gerontology and Geriatric Medicine*.

Creative Commons License

Creative

Commons is licensed under a [Creative Commons Attribution-Noncommercial 4.0 License](#)

Attribution-

Noncommercial

4.0

License

Impulsive, Disinhibited Behavior— Dining in a Restaurant

Gerontology & Geriatric Medicine
Volume 4: 1–7
© The Author(s) 2018
Reprints and permissions:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/2333721418756994
journals.sagepub.com/home/ggm



Ronald C. Hamdy, MD¹, Amber Kinser, PhD¹,
Tracey Kendall-Wilson, RN^{1,2}, Audrey Depelteau, PhD¹,
and Kathleen Whalen, BA¹

Abstract

Dining in a restaurant with a loved one who has dementia can be an ordeal, especially if the expectations of the caregiver do not match those of the patient and the restaurant environment is not suitable for patients with dementia. The size of the dining area, lighting, background music or noise, décor of the room, number of customers, variety of the items on the menu, number of plates and cutlery on the table, in addition to flowers, candles, and other decorations on the table are all potent distractors. There are so many stimuli; the patient can be overwhelmed with information overload and not able to focus on the main purpose of the event: have dinner and especially enjoy the other person's company. In this case scenario, we present a 62-year-old man diagnosed with behavioral variant frontotemporal dementia (bvFTD). His daughter "invited" him to have dinner with her at a very fancy restaurant to celebrate her promotion at work. Unfortunately, whereas the evening started very well, it had a catastrophic ending. We discuss what went wrong in the patient/daughter interaction and how the catastrophic ending could have been avoided or averted.

Keywords

caregiving and management, anxiety, Alzheimer's/dementia, cognition, confusional states

Manuscript received: September 8, 2017; **final revision received:** October 20, 2017; **accepted:** December 19, 2017.

Objectives

At the end of this scenario, readers will appreciate the following:

1. The need to select a restaurant suitable for the patient's level of cognitive functioning.
2. The pitfalls to avoid when dining in a restaurant.
3. The preparatory work that needs to be done prior to getting to the restaurant.
4. The need to match the expectations of the caregiver with those of the patient.
5. Hypoglycemia is a major cause of irritability which may strain the dining experience.
6. The characteristic features of behavioral variant frontotemporal dementia (bvFTD).

year ago, he moved with his wife to an assisted living accommodation because they were finding it difficult to cope in their large house. His wife died about 6 months later, and since then, he has been on his own in the assisted living accommodation. He is very popular with the staff and other residents who enjoy his jovial, disinhibited attitude and tendency to flirt with them. They nevertheless have learnt to avoid getting too close to him as he often tries to touch them inappropriately. This has gradually become worse, since he started collecting pornographic material about a month ago.

- Alexa, George's daughter, single, 42 years old, works in a bank. Once a week, she takes her father to the same small local restaurant to have an evening meal. They both enjoy their time together and got to know well the restaurant

Case Presentation

Characters

- George is 62 years old. He retired from Church ministry about 2 years ago after an alleged inappropriate sexual interaction. Subsequently, he was diagnosed with bvFTD. Approximately a

¹East Tennessee State University, Johnson City, TN, USA

²Alzheimer's Tennessee, Knoxville, TN, USA

Corresponding Author:

K. Whalen, Department of Geriatric Medicine, East Tennessee State University, Box 70429, Johnson City, TN 37601, USA.
Email: Whalenk@mail.etsu.edu



owner and most of the diners. Jokingly George is proud to introduce Alexa as his “date.”

Scenario

Tonight is special. Alexa has been promoted at work and wants to celebrate this event with her dad. She was very pleased to see that her dad was fully dressed and ready to leave when she called at the assisted living accommodation. She smiled as he handed her a small bouquet of flowers: It has been his habit to offer her flowers when they went for their weekly dinner outing. “What a relief,” she thought. “I’m so glad I asked the attendants to make sure he is ready to go to dinner.”

She reminded her dad that tonight they are going to a different restaurant, a very upscale one to celebrate her promotion. “I’m really looking forward to this evening. We are not going to our regular diner round the corner. We’ll go to a new one about 30 miles away. It opened about 3 months ago and has a fantastic reputation,” she tells her dad. “You have no idea how much I am looking forward to it,” he replied as he gently patted her shoulder.

Unfortunately, traffic was quite heavy; there was a road diversion, and it took them over an hour to reach the restaurant. George was getting tired and somewhat irritable, but Alexa kept him entertained with news about her promotion and other events.

When they got to the restaurant, the *maître d’* welcomed them warmly and told them that there was a slight delay; their table will not be ready for another 10 to 15 minutes. They can wait in the bar area and have drinks on the house. George orders a gin and tonic. Alexa is somewhat taken back. “Are you sure dad you want a gin and tonic?”

“Absolutely, in fact I’ll have a double gin,” he says as he winks to the bartender. Alexa orders tonic water for herself. They try to have a conversation, but the noise is so loud they can barely hear each other and stop trying to talk. Eventually, about 30 minutes later, the *maître d’* arrives, apologizes for the delay, and takes them to their table.

The main dining area is quite large; it can sit at least 100 people. It is nicely decorated with massive chandeliers hanging from the ceiling complementing smaller ones on the walls. The wooden wall panels are endowed with impressive paintings and very large mirrors. Two violinists are playing in one corner of the room. The *maître d’* shows them to their table—almost in the middle of the dining area—and hands them the menu.

The selection of food is extensive: The menu is 10 pages long: two for starters, six for entrées, and two for dessert. There is also a page listing the chef’s special choices. The menu is nicely decorated with pictures in the background. The waiter joins them a few minutes later, describes the chef’s special choices, and states his own personal recommendations. He leaves the wine list booklet on the table. Alexa returns the wine list, but

George says that he fancies a glass of wine. The waiter hands him back the wine list and every few minutes checks with George and Alexa.

George, however, cannot make up his mind. He thumbs through the menu but is distracted by the surroundings. The waiter keeps coming at a few minutes’ intervals. George cannot decide what to have. His daughter tries to help him decide, but he is distracted by other diners, the chandeliers, and décor of the restaurant. He even gets distracted while looking at the menu: There are so many pictures and photographs in the background. On at least a couple of occasions, he stands up, takes a few steps, and returns to his seat. Alexa has been used to this behavior. Eventually, Alexa tells her dad that she is ordering the beef for him; that is what he usually has at their regular restaurant. George agrees.

About 20 minutes later, the waiter brings the food. George does not eat; he is still too distracted. He keeps looking at the other diners, the ceiling, chandeliers, mirrors, and paintings on the wall and just cannot concentrate on eating his food. Also, on several occasions, he would abruptly stand up, take a few steps as if he was going to leave the dining area, but then return to his seat. Alexa offers to cut the steak for him, but he refuses: “I’m perfectly able to cut my food. Thank you very much!” But he does not.

Alexa has finished all her food; George has yet to take his first bite. She picks his plate, dices the meat, and hands the plate back to her dad. She is pleased to see that at last he takes his first bite. “The food is cold,” he says. Alexa is tempted to say that is because he postponed eating for quite some time, but refrains and instead asks the waiter to warm the food. The waiter obliges, and a few minutes later, the waiter returns with a steaming plate.

George takes a bite: “I don’t like the meat, it’s overcooked and too tough.” Alexa recommends he eat the rest of the food. He now says that he is not hungry. Alexa says, “OK then, let me take you back home.” But he objects: He wants to have a dessert, like the one the diners beside them are having. “It looks delicious,” he says. Once again Alexa obliges and orders the dessert. The waiter brings in the dessert and takes George’s dinner plate. But George objects: “I haven’t finished eating. Put that plate back.” The waiter apologizes and puts the plate back on the table. But George does not eat. He picks at the food, has an occasional spoonful of dessert, but is too occupied looking around him and at the diners.

Alexa is getting more and more irritated. Eventually, she says, “Come on dad, let’s go. It doesn’t look as if you’ll eat tonight.” She stands up and mutters, “It’s a shame you’ve ruined a great evening.” But George did not hear her. Once they are both seated in the car, George says, “Let’s go back, I want my dessert.”

“Well that’s too bad,” Alexa says. “I’ve had it with you. You behaved like a naughty spoiled brat all evening. You’ve been absolutely ridiculous. I can’t believe you behaved so badly. You should be ashamed of yourself.”

“No!” George shouts. “You’re the one who should be ashamed of yourself. Talking like this to your old man. My own daughter! That’s it, I don’t want to have anything more to do with you. Just take me home . . . In fact just drop me here, I’ll find my own way.” He opens the door and tries to get out of the moving car, but the seat belt is on. The door is, however, open and hits the car on the inner lane. Fortunately, no one is injured, but the damage is extensive.

Case Analysis

George is exhibiting many signs of bvFTD: uninhibited behavior with inappropriate sexual content, impulsivity, compulsive behavior, and lack of empathy.

Turning Points: What Went Wrong? Could It Have Been Avoided, Averted, or Defused?

1. Long wait for food: Hypoglycemia probably developed

Irritability and impatience are often the first manifestations of hypoglycemia. Almost 2 hours elapsed between the time Alexa picked her dad from the assisted living accommodation and the food being served: about an hour’s drive to the restaurant, 30 minutes in the bar area waiting for a table, and another 20 to 30 minutes before food was served. By this time, George had probably become sufficiently hypoglycemic to make him irritable.

Could it have been avoided?

Alexa was well organized and quite preemptive: She notified the staff at the assisted living accommodation that she was going to pick up her dad at the given time and he was indeed ready in time. Unfortunately, she did not anticipate the heavy traffic and road diversion on the way to the restaurant and did not anticipate having to wait for such a long time in the bar area and then for the food to be served.

Several strategies could have been adopted to prevent hypoglycemia. Once Alexa realized that because of the traffic it was going to take them much longer than anticipated to reach the restaurant, she could have either changed her plans and gone to another closer restaurant or offered her dad a cookie or a sweet to prevent his blood glucose from falling.

Similarly at the bar, while waiting for a table, she could have asked the waiter to bring them their starters or even just bread and butter or olive oil. A hot sugary decaffeinated coffee or herbal tea with honey also would have been helpful to ensure the blood glucose level does not drop too much. She also could have notified the maître d’ when they first got to the restaurant that she is concerned about her dad’s blood sugar level and needs to give him some food as soon as possible. In all likelihood, the restaurant staff would have accommodated this request.

2. The double gin and tonic George ordered

It must be remembered that George has bvFTD and as such tends to be uninhibited and impulsive. Furthermore, because of his probable hypoglycemia, he is likely to be irritable and impatient. Finally, the double gin and tonic he consumed at the bar while waiting for their table led to further disinhibition.

Could it have been avoided?

Consuming alcoholic drinks is always a sensitive issue that should be avoided. Several strategies are effective. Alexa could have excused herself to go to the ladies and on her way told the barman not to serve her father any alcoholic drink: just the tonic, but not the gin. If she had anticipated this, she could have a written note to this effect that she quietly passes to the barman without her father noticing it. If neither strategy worked, the drink could be “accidentally” knocked over and a fresh—nonalcoholic—one served instead. As much as possible, alcoholic drinks, especially on an empty stomach, should be avoided, particularly in patients with dementia and especially those with bvFTD.

3. A change in the routine

George was used to going to the small local restaurant where he was familiar with the surroundings, the diners, and the waiters. The local restaurant was only a few minutes’ drive away, food was served a few minutes after being ordered, and traditionally, there were only three choices on the menu: beef, chicken, or fish. Tonight, that long-established routine has been shattered: George is taken to a different much larger restaurant about an hour’s drive from home. He finds himself in a totally different and foreign environment, with lots of distractors, and is not able to adjust to these new circumstances. The hypoglycemia and alcohol intake are accentuating his impulsiveness, disinhibition, and irritability.

Could it have been avoided?

As much as possible, it is best not to change routines. Alexa’s wish to go somewhere “special” to celebrate her promotion is commendable, yet because her father has dementia, it would have been much more sensible to “celebrate” in the restaurant he is used to and is familiar with the environment, the owner, and many of the diners. In fact, the “celebration” would have been much more enjoyable as she could have relaxed and not worried about her father’s possible idiosyncratic behavior.

4. Too many distractions competing with the task at hand

There were too many distractors preventing George from focusing on the task at hand: ordering food and then eating his dinner. These distractors included the very large restaurant that could seat over a hundred

diners compared with the small local one, the décor of the restaurant, the chandeliers, mirrors, loud music, other diners (George and his daughter were sitting at a table almost in the middle of the dining area), variety of cutlery, plates, glasses, flowers and candles on the table, in addition to the maître d' and waiters constantly buzzing around them.

Could it have been avoided?

At the time the booking was made, Alexa could have made it clear that she prefers an isolated table, ideally by one of the walls to minimize distractions. George could have been seated facing the wall. The nonessential cutlery and plates also could have been removed as well as some of the decorations on the table. Similarly, if they were seated by a window and there were many distractions outside the window, the shades could have been pulled down to minimize potential distractors.

Alternatively, a less upscale restaurant could have been selected. As mentioned above, it would have been much more appropriate and less traumatizing to celebrate Alexa's promotion in their regular local restaurant.

5. Too many choices available, too many delays serving the food

To choose one item from a 10-page menu booklet is a daunting task, especially if the person has a short attention span and impaired executive functions. Even if memory is not impaired, as is usually the case with bvFTD, too many choices confuse and frustrate patients with dementia. They, therefore should be avoided.

Could it have been avoided?

At the time of booking the table, Alexa could have enquired about the menu and placed the order. Alternatively, she may have checked on the web the menu of that restaurant and placed the order. This has the added advantage of minimizing the wait-time between sitting at the table, selecting, ordering the food, and waiting for it to be served.

6. George's aberrant behavior: bvFTD, hypoglycemia, and alcohol intake

Although the evening started very well, George's aberrant behavior became worse as the evening progressed: He orders a double gin and tonic before eating, demands wine after his daughter rejected it, refuses to eat, then complains the food is too cold, then that it is overcooked and tough, orders dessert, then tells the waiter to leave the main meal plate of food on the table, refuses dessert then, when in the car, asks for the dessert. George's executive functions are impaired because of the underlying bvFTD, worsened by possible hypoglycemia and alcohol consumption.

Could it have been avoided?

George should have been given something to eat long before these symptoms developed. This should have been done as soon as possible, preferably while still in

the car once Alexa realized that it will take them much longer than anticipated to reach their destination. A couple of sweets or a bar of chocolate would have prevented hypoglycemia from developing. But even after the symptoms of irritability and impatience became apparent, it still may have been possible to stem them by consuming a hot (to enhance gastric absorption) sugary (a good source of glucose) drink; alternatively, a carbohydrate-rich starter would have been equally effective.

7. George's outburst in the car

There is no doubt Alexa's behavior and response to various challenges of her father's idiosyncratic, uninhibited behavior are commendable. It is, therefore, no surprise that she could not contain herself toward the end of their stay in the restaurant and subsequently in the car. Notwithstanding, the final episode in the car ended catastrophically and could have had very serious consequences, with her father and possibly herself being severely injured. Luckily, her father's seat belt was fastened and stopped him from getting out of the moving car.

Could it have been avoided?

In addition to ensuring the seat belts are fastened, it is important to ascertain that the doors are locked and that the passenger is not able to unlock the doors. Child-proof locks are recommended whenever transporting patients with dementia to avoid similar episodes from occurring.

Case Discussion

Epidemiology of Frontotemporal Dementia (FTD)

FTD is the third most common type of neurodegenerative dementia, after Alzheimer's disease and dementia with Lewy bodies (Dickerson, 2014). It tends to affect younger age groups more than most other dementias, and after Alzheimer's disease, is the second most common early-onset neurodegenerative dementia (Finger, 2016). Its' highest prevalence is in the 45- to 64-year age group and ranges from 15 to 22 cases per 100,000 (Rabins, Lyketsos, & Steele, 2016). About 10% of the cases occur before the age of 45 years, and about 30% occur in patients over the age of 65 years (Finger, 2016). It, however, has been confirmed by histopathology in patients as young as 21 years (Snowden, Neary, & Mann, 2004) and has been diagnosed in patients in their nineties (Finger, 2016). It also is possible that this prevalence is an underestimate because of the lack of recognition of FTD by nonspecialists (Finger, 2016).

Risk factors include a positive family history: As much as 50% of patients with FTD have a positive family history of the illness. It is transmitted in an autosomal dominant manner, with more than 80% of the cases being caused by mutations in one of the following genes:

tau, progranulin, or C9ORF72. Less common mutations are in the CHMP2B and valosin-containing protein genes (Rabins, Lyketsos, & Steele, 2016).

Very much like other dementias, the diagnosis of FTD is usually made 3 to 4 years after many of the symptoms manifest themselves (Miller & Yoon, 2016). The time lapse between diagnosis and death is usually 4 to 8 years (Miller, 2014).

FTD Subtypes and Clinical Features

Four separate clinical subtypes of FTD are recognized (Finger, 2016; Miller, 2014):

- a. Behavioral Variant Frontotemporal Dementia (bvFTD)
- b. Progressive nonfluent aphasia (PNFA)
- c. Semantic dementia (SD)
- d. FTD associated with motor neuron disease (FTD-MND)

In addition, FTD-related disorders include the following two tau-associated neurodegenerative diseases:

- a. Corticobasal syndrome (CBS)
- b. Progressive supranuclear palsy (PSP)

The term *frontotemporal lobar degeneration* (FTLD) refers to patients with clinical features of FTD and in whom there is positive identification of an FTD-causing mutation or histopathological evidence of FTD.

bvFTD—Presentation/manifestations (Budson & Solomon, 2016)

bvFTD is the most common FTD variant affecting about 60% of the patients with FTD (Miller, 2014). Its main characteristic features include the insidious onset of changes in personality and behavior, which, unlike other dementias occur very early in the disease process, are often the first manifestation of the dementia and frequently have devastating effects on the patients and their loved ones (Miller, 2014). Unfortunately, many patients with bvFTD are misdiagnosed as suffering from some psychiatric disease, being under stress or even suffering the effects of “normal aging” (Miller, 2014).

Changes in behavior are usually due to:

- a. Disinhibition, often in opposition to the habitual lifelong behavior of the individual patient, as manifested by the following:
 - Inappropriate sexual interest, remarks, actions, and behavior including the overt use of pornography.
 - Inappropriate language such as derogatory physical, racial, or gender slurs.

- Impulsivity, including verbal and physical aggression.
- Inappropriate antisocial behaviors, such as belching, passing gas, using profane language, cursing, and urinating in public.
- Lack of concern about and neglect of personal appearance, grooming, and hygiene.
- Urinary and even fecal incontinence.

Patients with FTD are not really incontinent but voluntarily choose to empty their bladder and/or bowels in inappropriate places, sometimes when sitting down because they are not concerned about social norms and/or their appearance.

In other words, whereas patients with bvFTD have control over their urinary and bowel sphincters, patients with other dementias such as Alzheimer’s disease may have no such control. Indeed, whereas many patients with Alzheimer’s disease are embarrassed of being incontinent and may attempt to hide the evidence of their incontinence such as soiled towels, patients with bvFTD are not bothered by their “incontinence” and may not make any attempt to hide it.

- b. Difficulties performing activities requiring the sequencing of events such as washing clothes (first, putting dirty clothes in the washing machine; second, placing the detergent and softener in the right receptacles; third, adjusting the various controls for wash and for rinses . . .); or making coffee (switching on the coffeemaker, adding enough water in the water container, picking the coffee container from the box, introducing the coffee packet in its receptacle, placing the cup under the coffee jet, and then pressing the button to initiate brewing). Patients with bvFTD often miss an essential step such as, for instance, while preparing coffee: forgetting to add water, or placing the coffee container in the coffeemaker. Similarly while using the washing machine, they may forget to add the detergent.
- c. Problems driving

Unlike patients with Alzheimer’s disease who usually lose their way, or get easily distracted, those with FTD tend to have hazardous driving behaviors such as speeding or driving too slowly, changing lanes when it is not safe to do so, driving on the wrong side of the road, turning right at a red traffic-light when such a turn is not allowed, or making U-turns in one-way streets.

- d. Memory problems

The memory impairment seen in patients with bvFTD is different from that seen in other dementias, especially Alzheimer’s disease. Patients with bvFTD have difficulties acquiring new information because they do not pay

attention to the new information that they are asked to remember. If, however, that information is repeated several times, patients with bvFTD are more likely to learn and remember it. Indeed, once that information is learned, it tends to be retained, although it may be difficult to retrieve or access it because of the frontal lobe damage.

In patients with bvFTD, therefore, cues can facilitate access to that information, whereas in patients with Alzheimer's disease, cues are not useful because that information has not been learned in the first instance.

The memory of patients with bvFTD, however, is often distorted with patients confusing and mixing up various details of separate memories.

- e. Apathy and lack of interest in activities the patient used to enjoy. Patients are sometimes erroneously diagnosed as having depression:
 - Emotional indifference, flat or restricted affect, psychomotor retardation
 - Decreased motivation and initiative
 - Lack of interest in activities the patient used to enjoy
 - Decreased concern, reduced empathy toward other people including spouses and caregivers and less fortunate people who have sustained losses
 - Social withdrawal
 - Lack of spontaneous speech
 - Flat or childlike affect
- f. Hyperorality
 - Inappropriate increased intake of food
 - Consumption of food that is rotten and inedible substances
 - Patients may indulge in new habits in contradiction with their previous habits such as starting excessive smoking or alcohol consumption
 - Changes in food preferences
- g. Perseverative, compulsive behaviors
 - Restlessness: The patient abruptly and unexpectedly may stand up during the clinical examination and appear to be ready to leave.
 - Compulsive behavior, including stereotypic repetitious activity or continuing to talk when the interlocutor is trying to end the conversation and suddenly getting up for no reason from one's seat and walking aimlessly.
 - Inappropriate spending and gambling.
 - Repetitive behaviors such as systematically counting/touching various objects, picking scaps of papers.

Clinical Examination and Laboratory Tests

- There are no clinical signs specific to bvFTD, and the clinical examination usually does not reveal any significant clinical finding, except at times

the presence of frontal release signs such as a positive snout, grasp, or palmomental reflex. These, however, are neither specific nor sensitive for bvFTD. It is nevertheless important to conduct a full neurological examination because 10% to 15% of patients with motor neuron disease also have bvFTD. The presence of "mixed clinical signs," that is, lower motor neuron dysfunction (such as wasting and fasciculations), and signs of upper motor neuron dysfunction (such as brisk reflexes and extensor plantar responses) is suggestive of motor neuron disease.

- Laboratory tests: Like other neurodegenerative dementias, there are no laboratory tests to confirm or refute the diagnosis of bvFTD. Genetic testing, however, is becoming more available especially for bvFTD given the frequent positive family history. If motor neuron disease is suspected, nerve conduction studies and electromyograms are recommended.

Neuropsychological Tests

As in FTD memory and visuospatial domains are usually spared, standard cognitive testing may be normal until quite late in the disease process. It, therefore, is recommended to administer tests specifically designed to evaluate executive functions, language, and other cognitive domains associated with FTD. A number of neuropsychological tests are available (Rabins, Lyketsos, & Steele, 2016):

- Clinical Dementia Rating (CDR) assesses the severity of the dementia, but tends to underestimate the severity and impact of bvFTD.
- Dementia Disability Rating (DDR) provides a measurement of disease severity in dementing illnesses.
- Frontal Behavioral Inventory (FBI) evaluates behavioral dysfunction in FTD based on information received from relatives/caregivers who know the patient well.
- Frontotemporal Dementia Rating Scale (FRS) aims at quantifying FTD severity.
- Frontotemporal Lobar Dementia CDR (FTLD-CDR) is an adaptation of CDR which incorporates behavioral and language measurements. It has a better sensitivity for cognitive impairment and interval change in FTD.
- Mini Mental Status Examination (MMSE) is not sensitive enough in patients with FTD.
- Montreal Cognitive Assessment (MoCA) is more sensitive than the MMSE to detect early changes, but tends to become less sensitive in later stages of FTD.
- Neuropsychiatric Inventory (NPI) assesses behavioral dysfunction in FTD based on information obtained from relatives/caregivers who know the patient well.

- Trail-Making Test Part B tests of visual attention and task switching provide information about visual search speed, scanning, processing, and executive functioning.
- Verbal fluency tests test semantic memory.

Special Issues With bvFTD

Given the characteristic impulsive behavioral pattern of patients with bvFTD, particular attention should be given to driving safety and gun access. Patients are also at risk of injuring themselves if they operate power tools. These precautions are the same as those for patients with Alzheimer's disease. In bvFTD, however, there is some urgency as the rate of deterioration tends to be faster and the impact of disinhibition coupled with executive dysfunction may lead to catastrophic situations. It is recommended that a trusted person be given Durable Power of Attorney as soon as possible after the diagnosis is made. This is further discussed in the case study entitled, "Patients With Dementia Are Easy Victims to Predators."

Pharmacological Treatment (Finger, 2016; Boxer et al., 2013)

- a. Trazodone and selective serotonin reuptake inhibitors including fluoxetine, sertraline, paroxetine, fluvoxamine and citalopram are often used to control irritability and agitation as well as behavioral disinhibition, perseverative behavior, and hyperorality in patients with FTD.
- b. Atypical antipsychotics including risperidone, aripiprazole, olanzapine, and quetiapine are often used to control behavioral disinhibition. The challenge is to give a dose large enough to control disinhibition and yet not large enough to interfere with the patient's sensorium and level on consciousness.
- c. A trial of carbidopa/levodopa, titrating up to 25 mg/250 mg 3 times a day, has been recommended as it may help apathy and executive dysfunction.
- d. Acetylcholine esterase inhibitors are not indicated for FTD as they often increase the level of agitation. Notwithstanding as many patients with FTD also have Alzheimer's disease and may benefit from these medications. A 2 to 3 months' trial may be indicated.
- e. Memantine. At the time of preparing this paper, there are no data to support the use of memantine in patients with FTD.

Summary

1. When eating in a restaurant, avoid long waits before being seated and served unless snacks or starters are available.

2. Distractors and crowded and noisy areas should be avoided if possible. When possible, the patient should be seated facing a wall rather than the rest of the diners with the least amount of distractors. Limit the cutlery, decorations, and plates on the table to limit possible choices and reduce distractors and the ensuing confusion.
3. Avoid having to choose from a large menu. Easy distractibility, short attention span, and impaired executive functions make choosing a very difficult task. Selections could be made prior to reaching the restaurant, and orders may be placed before reaching the restaurant to limit the wait-time.
4. If possible, try to establish a routine: same restaurant, same seats, and possibly same food.
5. In a car, before driving, ensure the seat belt is on and the doors locked, preferably with a child-proof lock.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

References

- Boxer, A. L., Knopman, D. S., Kaufer, D. I., Grossman, M., Onyike, C., Graf-Radford, N., . . . Miller, B. L. (2013). Memantine in patients with frontotemporal lobe degeneration: A multicenter randomized, double-blind, placebo-controlled trial. *The Lancet Neurology*, *12*, 149-156.
- Budson, A. E., & Solomon, P. R. (2016). *Memory loss, Alzheimer's disease and dementia* (A practical guide for clinicians). (2nd ed.). Philadelphia, PA: Elsevier.
- Dickerson, B. C. (2014). Frontotemporal dementia. In B. Dickerson & A. Alireza (Eds.), *Dementia comprehensive principles and practice* (pp. 176-198). Oxford, UK: Oxford University Press.
- Finger, E. (2016). Frontotemporal dementias. *Continuum: Lifelong Learning in Neurology*, *22*, 464-489.
- Miller, B. L. (2014). *Contemporary Neurology Series—Frontotemporal dementia*. Oxford, UK: Oxford University Press.
- Miller, B. L., & Yoon, S. J. (2016). Frontotemporal dementia. In M. Husain & J. M. Schott (Eds.), *Oxford textbook of cognitive neurology and dementia* (pp. 391-398). Oxford, UK: Oxford University Press.
- Rabins, P. V., Lyketsos, C. G., & Steele, C. (2016). *Practical dementia care* (3rd ed.). Oxford, UK: Oxford University Press.
- Snowden, J. S., Neary, D., & Mann, D. M. (2004). Autopsy proven sporadic frontotemporal dementia due to microvacuolar-type histology, with onset at 21 years of age. *Journal of Neurology, Neurosurgery, and Psychiatry*, *75*, 1337-1339.