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Patients' accounts of memory lapses in interactions between neurologists and patients with functional memory disorders.

Abstract

One of the most commonly made diagnoses in secondary care memory services is functional memory disorder (FMD). FMD is non-progressive and characterised by persistent worries about memory failures without objective evidence of cognitive impairment. This study explores how patients with FMD present their memory concerns. Utilizing video recordings of consultations between patients and neurologists in a memory clinic, we show that FMD patients account for their memory deficits as significant disruptions to their daily lives. Resonating with research which identified a dissonance between self-reports of memory functioning by FMD patients and the outcome of neuropsychological assessments, we demonstrate that, in giving a detailed account of their perceived memory problems, patients provide objective conversational evidence of their cognitive and memory capacity, implicitly undermining the claim of an objective problem. Using conversation analysis, we examine three of the more prominent interactional practices FMD patients draw on when attempting to communicate memory deficits to the doctor – they are (i) contrasts with a standard of 'normal'; (ii) third-party observations; and (iii) direct reported speech. These interactional features are recurrent devices for displaying memory concerns as legitimate problems, embedded within patients' accounts of their day-to-day lives.

Keywords: Conversation analysis (CA), Dementia/Alzheimer's, Mental health and illness

Introduction

When patients in the UK have memory concerns, they might talk to their general practitioner (GP) who could refer them on to a specialist service such as a memory clinic for further testing and possible diagnosis. Most patients attending memory clinics fall into one of a modest number of broad diagnostic categories. Typically, cognitive problems are caused by one of several different progressive neurological disorders (ND) associated with functional and structural brain changes. However, in memory clinics for younger patients, up to 50% of patients will ultimately be diagnosed with a functional memory disorder (FMD). FMD is a condition in which subjective memory complaints are not associated with any identifiable anatomical or physiological abnormalities of the brain, and are not expected to progress (Blackburn et al. 2014; Schmidtke, Pohlmann, and Metternich 2008). Dementia is diagnosed when cognitive impairment is sufficiently severe to affect a person's normal level of functioning (the commonest causes of dementia due to ND are Alzheimer's Disease (AD), but also Cortical Lewy-Body Disease, cerebrovascular dementia or frontotemporal dementia). When cognitive impairment is less severe, but thought likely to progress to dementia due to ND, patients may be labelled as having mild cognitive impairment (MCI) (Petersen 2005).

Patients with FMD complain about memory failures. However, unlike patients with dementia or MCI, their performance in objective tests of memory and attention do not differ from healthy controls (Wakefield et al. 2017). FMD is a cognitive presentation of Functional Neurological Symptom (Conversion) Disorder. The latest version of the Diagnostic Statistical Manual (DSM-5) describes this disorder as characterised by symptoms or deficits *not* better explained by another medical or mental disorder. Yet, the DSM-5 also states that FMD causes clinically significant patient distress or impairment in areas of social, occupational, or other important functioning, warranting medical evaluation. The DSM-5 (as with the previous DSM-IV-TR) clearly distinguishes these disorders from scenarios in which symptoms are feigned or consciously produced. The most widely adopted diagnostic criteria for FMD are proposed by Schmidtke and colleagues, who characterise patients as having "an acquired medical and psychological condition with significant failure of memory and concentration that occurs in daily living, is unrelated to organic factors, and is assumed to be caused by distress and psychological dysfunction" (Schmidtke, Pohlmann, and Metternich 2008 p. 982). This definition specifically excludes those who experience cognitive problems in the context of depression (a scenario sometimes labelled as "depressive pseudo-dementia") (Kiloh 1961).

In recent years there has been a marked increase in GP visits, and referrals to specialist services, due in part to Government initiatives such as the National Dementia Strategy (NDS) – a scheme that promotes the benefits of visiting specialist services to identify care needs, provides access to medication capable of ameliorating some of the symptoms of dementia temporarily, and assists in helping to moderate the loss of patients' quality of life (Blackburn et al. 2014). Previous research using conversation analysis (CA) in memory clinic encounters has identified several important differences between the ways in which patients with ND, and patients with FMD, communicate with doctors in the memory clinic. For example, when asked who is most worried about their memory, FMD patients commonly report themselves as having the concern. In comparison, patients with ND tend to state that others, such as family members, are most worried. FMD patients also tend to give fuller, more detailed accounts of particular memory lapses, whereas people with ND are often unable to think of a specific examples of cognitive failures, or only described their memory problems in vague terms (Elsey et al. 2015; Jones et al. 2015; Reuber et al. 2018). Paradoxically then, it is those patients that tend to display *less* concern in how they account for their memory problems, who are more likely to develop (and receive a diagnosis of) ND. In contrast, those patients who typically display *most* concern are more often diagnosed with (non-progressive) FMD. Consequently, there is a *dissonance* between FMD patients' self-reports and the outcome of the medical assessment.

By analysing how patients with FMD characterise and maintain their accounts of memory failures, this article focuses on the practices FMD patients use to describe memory loss, as they attempt to convince the doctor of their problem, and the severity. What do patients report as significant *for them* when they first describe their memory concerns to neurologists, and how do they display these features interactionally? The identification of commonly formulated features across cases will not only give a greater understanding of how FMD is experienced and characterised, but may assist healthcare professionals identifying FMD at an earlier stage in the diagnostic process. Early FMD diagnosis also enables provision of appropriate treatment, including education about 'normal' memory lapses and reassurance about the likely absence of brain pathology. This aspect of the present study is part of an on-going programme of research designed to explore whether patients' communication behaviour in their interactions with experts in the memory clinic can help with the clinical differentiation between ND and FMD (Elsey et al. 2015; Jones et al. 2015; Mirheidari, Blackburn, Walker, Reuber, and Christensen 2017).

However, this study will also explore another issue. Whilst the memory problems of patients with ND correlate with objective abnormalities on examination or investigation, and may therefore be considered 'medically explained', and whilst patients with depression have a widely accepted psychiatric condition providing a medically valid explanation for their memory problems, the subjective memory concerns of patients with FMD remain 'medically *unexplained'*. The present study is motivated by the question of *how* patients with FMD characterise memory failures that may *not* be 'medically explained'. In contrast to patients with other types of memory loss, those with FMD typically report subjective concerns about every day or 'normal' forgetting. However, for FMD patients to convince neurologists that their problems are medically significant, they face the challenge of presenting their cognitive deficiencies as exceptional and medically distinct from normal performance fluctuations, through the interactional resources available to them. And so, we investigate the ways in which patients build their case for aid in these consultations, as “worthy of medical attention, worthy of evaluation as a potentially significant medical condition, worthy of counselling and, where necessary, medical treatment” – essentially, as ‘doctorable’ (Heritage and Robinson 2006 p. 58). Thus, our task in this article is to examine how FMD patients account for their memory concerns by presenting them as 'non-typical' memory lapses.

Data and method

Data and ethical considerations

The data consists of seventeen video recordings of initial consultations between neurologists and patients who had been referred by their GP to a neurology-led memory clinic, and ultimately received diagnoses of FMD (see Reuber et al. 2018). Data were recorded at the Royal Hallamshire Hospital, Sheffield as part of ongoing research study, aiming to identify interactional features capable of helping with the differential diagnosis of FMD and ND (Elsey et al. 2015; Jones et al. 2015). Routine outpatient encounters were captured in a young onset dementia service, and involved interactions between patients and three consultant neurologists, as well as different neurology trainees. The recordings were transcribed in line with the conventions used in conversation analysis (CA), enabling detailed analysis of interactions (Jefferson 2004a). This study was approved by the NHS Research Ethics Committee (NRES Committee Yorkshire and The Humber - South Yorkshire).

All participants received written information about the study at least 48 hours prior to their appointment and were encouraged to discuss the information with their companions for the clinic visit. Prior to their appointment on the day of the visit, participants had the opportunity to speak to a member of the research team. Participants gave written informed consent, having been told that they could withdraw from the study at any time. Patients who lacked capacity (i.e., were not deemed able to make informed decision about study participation themselves) were not recruited into the study. Confidentiality was assured, and any identifying information (e.g., participants' names and addresses) in transcripts and other materials was pseudo-anonymized. A clinical diagnosis of FMD was achieved through a multidisciplinary assessment process, including history taking, a standardised general cognitive screen (the Addenbrooke's Cognitive Examination or ACE), followed by detailed neuropsychological examination and an MRI scan (Elsey et al. 2015; Reuber et al. 2018). In keeping with the diagnostic criteria for FMD proposed by Schmidtke et al. (2008), patients thought to have 'active depression' were excluded from the FMD group. Active depression was either diagnosed by neurologists based on face-to-face assessments, or suspected in patients scoring >15 on the depression screening scale (PHQ9).[1]

Method

We use conversation analysis (CA) to examine the data, which typically approaches the study of talk by focusing on action, turn design, and how one speaker's turn builds on that of another (Sacks 1992; Sacks, Schegloff, and Jefferson 1974). CA is increasingly used in the study of medical interaction (e.g., Drew, Chatwin, and Collins 2001; Heritage, Elliott, Stivers, Richardson, and Mangione-Smith 2010; Maynard and Heritage 2005; Stivers et al. 2017). The present study focuses on features of interaction that are formulated within *accounts* of patient experience (Drew 2006). We investigate the ways in which patients characterise their lapses, and how these descriptions are accountable as memory problems. Our primary analytic concern is not what patients may or may not forget, but the ways in

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[1] See Reuber et al. (2018) for more information on patient selection.

which these accounts of memory loss are formulated *as problems*, in the context of patient-neurologist encounters. All patients bar one reported here (034) were alone during the consultation. Consultations approximately lasted one hour. During typical consultations, neurologists move through the initial history-taking phase, in which a range of open ‘Wh’ questions are asked (e.g., ‘how can I help?’, ‘what problems have you been experiencing?’ or ‘why have you come?’), before progressing to a standardised general cognitive screen (ACE). The focus of this analysis in on the opening phase, where patients are given the interactional space to describe their experiences of memory loss. In the analysis below, we show three interactional practices that patients commonly use when accounting for their memory problems.

Analysis

When patients attempt to convey the seriousness of their memory lapses, they sometimes volunteer accounts of their experiences. Alternatively, they are prompted by neurologists’ questions, illustrated by the following commonly designed prompts.

1. Formulation and follow-up

```
01  Neu:   Mcht .hh u:m (.) And you’ve given me a few
02         examples there um (0.5) with >tryin’ t’ f’get<
03         people’s names remember my name,
04         (0.4)
05  Neu:   Um are there any other examples you can give
06         me,
```

2. Upshot

```
01  Neu:   Mcht .hHH And e- so how is- this impacting yer
02         job.
```

3. New topic

```
01  Neu:   Can ↑you tell me (.) what problems you’ve been
02         having (.) with your memory and what your
```

03   expectations are from clinic today.

Patients respond by describing memory experiences from their day-to-day lives – but do so in ways that demonstrate they have a problem, so that aid may be offered. In this way, patients characterise their talk to be accountable as memory deficiencies they are experiencing, whereby there are 'interactional consequences' – essentially, their concerns are *designed to be understood* as legitimate anxieties by neurologists (see Haugh 2013). We analyse three of the more prominent interactional practices that FMD patients draw on when characterising everyday events to communicate their memory deficits: contrasts with a standard of 'normal', third-party observations, and direct reported speech.

1. Contrasts with a standard of 'normal'

When FMD patients account for their memory lapses, they often demonstrate their shortcomings by comparing their memory to a benchmark they consider 'normal'. When describing someone or something as odd or irregular, very often it is not enough only to describe a particular action as peculiar - the abnormal action is explicitly constructed in contrast to what is routine and normal (Smith 1978). In designing talk this way, actions can be treated as *accountable* – representations of the world can be formulated as usual, normal or regular, in contrast to what is unusual, abnormal and irregular, in terms of disrupting life's 'ordinariness' (Sacks 1984). The following examples illustrate how patients distinguish their memory loss from characterisations which they display as 'normal'.

In Extract 1, the patient's partner is represented as having a normal memory, contrasted to his own. This example begins at the start of the consultation and begins with the patient giving an account of his memory concern.

Extract 1: 011a

01 Neu: >So I'm< Doctor Johnson.=I'm the (0.7) registrar

02 in neurology, (0.3) >d'you wanna< tell me: (0.9)
03 um why you've come today and what expectations
04 you have about the clinic.
05 Pat1: .hh ↑Well Hh one of the reasons was because uh I
06 have a partner (0.8) a:nd he was sorta
07 reminiscing about (0.4) times past li- holidays
08 and things we've had >an I< thought (.) .hh ↑wl I
09 can't remember that, 'n (.) °I can't° remember that
10 happening,

This first example demonstrates how the patient (P1) presents his memory concern ">an I< thought (.) .hh ↑wl I can't remember that, 'n (.) °I can't° remember that happening," (lines 8-10) to the neurologist (N) in contrast to his partner's normal memory "he was sorta reminiscing about (0.4) times past li- holidays and things we've had" (lines 6-8). As mutual experiences, both P1 and his partner have equal epistemic access to these events as shared memories (Heritage 2012). However, P1 exhibits that he has a concern by presenting his partner's memory ability as the standard – essentially, displaying the partner's reminiscing as a normal, regular activity contrasted to P1's inability to reminisce because a past event has been forgotten. Note also the turn-initial "↑Well" (line 5), which indicates to N that the following account may be an "extended narrative" of the problem (Heritage 2015 p. 92) – a point underpinned by "one", projecting that more reasons for the call are to follow.

In Extract 2, the comparative device represented as the norm is the patient's past ability relating to daily tasks.

Extract 2: 072

01 Neu: Can ↑you tell me (.) what problems you've been
02 having (.) with your memory and what your
03 expectations are from clinic today.
((Attendance details omitted for brevity))
04 Pat2: .hhh u:m (0.3) mcht .hh becau:se #uh uh# something
05 quite shocking had happened to me I'd- mb <been a
06 great traveller .hh in my life and I love

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07          travelling.
08          (.)
09  Pat2:   .hH A:nd I'd booked to see a friend in Germany,
10          .hh a:nd got to the airport'nd was going to
11          collect my ticket at the desk- .HH (.) an I'd
12          booked for the wrong day.
13          (0.8)
14  Pat2:   °I'd booked the ticket for the wrong day.°
```

The first contrastive element of P2's response is demonstrated with "I'd- mb <been a great <traveller .hh in my life" (lines 5-6). By presenting herself as an experienced traveller, P2 characterises someone familiar with the practicalities of organising transport, getting to destinations and such like – essentially, the *normal* tasks that experienced travellers undertake. P2 then presents the everyday activities done as a traveller, such as booking the flight and going to airport (lines 9-10). The second contrastive element is described (lines 10-12). P2's displayed awareness that she made an error booking travel tickets is thus the irregular contrast to the normal standard of what she expectantly does as a competent traveller – booking tickets for the correct day of travel. This type of X/Y contrastive device - "At first I thought X" (the mundane thing) "when I realised Y" (the extraordinary thing) - is often used in marking out both the normalness of one activity in order to account for something else as irregular (Jefferson 2004b).

The next example highlights how a past/present contrastive device is used by a patient when attempting to convey his memory as a concern.

Extract 3: 054

```
01  Neu:    So (0.5) mcht thanks f'coming in today, (.) >an I
02          think< my first question to you is (.) um to say
03          .hh what problems have you notice of any with
04          your memory an' what your expectations of coming
05          (.) to this clinic.
06  Pat3:   Mcht .hh ahm (1.5) .h I- I s:: (0.4) >(I mean)<
07          I've I've gone from sort've .h probably a year ago
```

```
08          (to) havin a (.) .hh a really good IQ.
09          (0.7)
10   Pat3:  To: (0.2) n:ot being able to remember (.) the
11          simplest of things now.
12          (.)
13   Pat3:  .Hh (.) It's (.) mainly names that I can't (0.2)
14          can't get my head around
15          (0.4)
16   Pat3:  .Hh: Not names of people but names of: like
17          plants an' things.
```

Extract 3 illustrates how points in time are used as a resource when accounting for a memory lapse. First, P3 demonstrates his previously good memory ability (lines 7-8). Note the rhetorically emphasised "really good IQ" which appears inversely contrasted to the second element "n:ot being able to remember (.) the simplest of things now." (lines 10-11), underlined with "simplest". Thus, P3's current inability to remember what is cognitively undemanding is in many ways an extreme opposite of the past really good IQ. Further, there is a spatial aspect to this account which appears reminiscent of work on metaphorical expression (Drew 2006). The metaphorically conceptualised term "I've gone from" prefaces the contrast between past (having a really good IQ) and present (not being able to remember the simplest of things). Thus, metaphors can be resources for displaying concepts which may be problematic to communicate, in ways which can be understood by recipients (Lakoff and Johnson 1980).

A significant point to note about the examples in this section, is that patients' descriptions of their memory problems are *not* presented in isolation. In recalling past events, patients frame their memory deficits within a range of everyday activities, relationships, and experiences. By using contrastive formulations such as these, patients demonstrate what is regular or normal day-to-day life, compared to what is irregular or abnormal. And so, memory problems are depicted as clear deviations from normal everyday experience, demonstrating that past recollections of memory loss are designed to be treated as credible by neurologists.

2. Third-party observations

Another practice drawn on by patients to demonstrate they have a memory concern is to report comments about their memory made by third-parties. In characterising their memory as deficient, patients observably measure their difficulties against some normal or normative judgement by others. While not present in these consultations, the inclusion of a third party (forming a triadic ‘three-person association’) in the presentation of memory concerns may have consequences for the interaction where previously a dyadic (two person) association operated (Simmel 1950). By working to justify their reason for visiting, patients are tasked with presenting their medical problems as ‘doctorable’, in the sense that their concerns are valid (Heritage and Robinson 2006). In this way, a third-party observation (TPO) may present a more compelling case, in terms of supporting patients’ memory concerns as *legitimate* medical issues.

The first example in this section demonstrates how family remarks are presented by patients in accounting for their memory as problematic.

Extract 4: 001

```
01  Neu:   An:d uh (.) can you tell me a bit more about that?
           ((Attendance details omitted for brevity))
02  Pat4:  U:m (1.0) it’s more noticeable uh:m (0.6) >wl=it’s<
03         noticeable every day, .hH an:d but it’s um: (0.9)
04         mcht (.) family.
05         (0.3)
06  Pat4:  In fact when family ‘ave sort of (0.3) <commented.
07         (0.5)
08  Pat4:  °Um° at first it was >a bit of a< (.) a joke.
09         (0.5)
10  Pat4:  Uh:m (1.0) but (1.1) I think it’s really because of
```

```
11          the amount of information I have to (0.4)
12          retain.
13          (2.7)
14  Neu:    >Sh'you have to <retain lots of (0.3) [information.
15  Pat4:                                         [Yeah.
```

Extract 4 begins with a follow-up question from N (the first being “how can I help?”), in response to P4 indicating she is here for her memory appointment. After reporting frequent ‘noticings’ (lines 1-2) (Schegloff 1998), P4 describes the TPO with “In fact when family ’ave sort of (0.3) <commented.” (line 6). The design of this reported observation is notable in that by operationalising ‘fact’, the TPO displays something difficult to counter. Yet, the hedged ‘sort of’ and informal ‘commented’ appear to reduce the rhetorical impact of the TPO - the implication being that P4’s report is authentic and the TPO was said in passing rather than raised as a specific memory concern. Indeed, “°um° at first it was >a bit of a< (.) a jo**k**e.” (line 8) seemingly goes further in characterising a casual, unproblematic TPO. However, P4’s subsequent turn (lines 10-12) marks out the prior TPO as objectively noticeable, by the way in which jokiness is contrasted to things C has to remember. Further, referencing the jocularity of others in the form ‘at first’, implies a change since then, and thus, is significant for showing the ‘noticings’ of others as a serious memory concern for P4 – as one that has developed over time. In this way, P4 can be seen as characterising *prior* observations of others in contrast with her *present* reality.

The next extract illustrates how a social engagement with friends is drawn on when constructing memory as a concern.

Extract 5: 045

```
01  Pat5:   .hH U:m(.) <and coz the boys if w'go out out for
02          a beer.
03          (.)
04  Pat5:   .hh I can go to the bar an' come back with
05          something (0.2) completely different to what
```

```
06          somebody asked for.
07          (.)
08  Pat5:   .h uh >Because I< mixed the drink up.
09          (.)
10  Pat5:   .hh An:d it gets to the point where (.) people do
11          actually ‘ave pass comments (.) <Jokingly.
12          (.)
13  Pat5:   .hh that um I’ve made a mistake “don’t ask him to
14          do that he’ll forget it.”
15          (.)
16  Pat5:   .hh Mcht .h (.) An they all laugh.
17          (0.4)
18  Pat5:   But t’me: (.) I cover it.
19          (0.5)
20  Neu:    Y[eah.
21  Pat5:    [I-  it hurts.
```

Extract 5 starts just after the start of an account, in response to N’s opening question - “What problems you’ve been having with your memory and what expectations you have from coming to the clinic today?” P5 presents his memory problem (lines 4-6), characterised as a general occurrence by the modal ‘can’ (Edwards 2006). Notable also is the extreme case formulation (ECF) ‘completely’- a practice sometimes used to defend against some state-of-affairs being countered or challenged when making a claim (Edwards 2000; Pomerantz 1986). The TPO is then reported with “.hh an:**d** it gets to the point where (.) people do actually ‘ave pass comments (.) <Jokingly.” (lines 10-11). As with the previous extract, a spatial metaphor is used (here, with “gets to the point”) - again, as a way of indicating that things have got worse over time (Drew 2006). Further, by reporting that his friends comment “Jokingly.” (line 11) and “they all laugh” (line 16), P5 observably characterises the TPO as something amusing to his friends, contrasted to his own reported feelings on the matter (“I cover it” at line 18 and “it hurts” at line 21). Contrasting his feelings to the TPO allows P5 to project an emotional state as authentic in the face of potential humiliation by others. Emotion

metaphors such as ‘I cover it’ and ‘it hurts’ can be specifically selected to perform particular functions in talk, such as displaying P5’s memory loss as a genuine problem (Edwards 1997).

The next example shows how work colleagues’ observations are formulated when patients characterise their memory as deficient.

Extract 6: 010

```
01  Pat6:  <I think people have noticed at wor- an y- when
02         I were fir:st .HH (.) °bad with ma memory° .HH i-
03         people used to laugh at me >it used to be a bit
04         of a< jo(h)ke <julie’s ng said summut wrong again
05         yer know.
06         (.)
07  Pat6:  .hHH u:m(.) But now it’s irritating and no:w .HH
08         I think people (0.3) well (I know) this °managers
09         s:lagged me off behind me back to all of the
10         tea:m that I work in,°
11         (.)
12  Pat6:  .HH <And it’s made an effect thut (.) .hh they treat
13         me differently now.
```

Extract 6 begins just after the start of the patient’s account, in response to N’s initiating question “who’s more concerned about your memory, is it yourself or family and friends?” P6 reports the TPO “<I think people have noticed at wor-“ (line 1), although hedged with ‘I think’. An account of this noticing is provided (lines 2-4). As with the two prior extracts, note how P6 invokes a previous point in time by using a spatial metaphor – in this case, when she was first bad with her memory. By describing her problem in this way, P6 observably marks out her concern as one that has endured over of period of time – thereby, projecting her problem as something ‘doctorable’, and thus worthy of medical attention (Heritage and Robinson 2006). As with previous examples in this section, others are reported making jocular observations – people laugh, it’s ‘a bit of a joke’. Note the contrastive elements of P6’s account, as she reports how others view her memory problems, compared with her

emotional reality with “but now. it’s irritating” (line 7), in which the present ‘now’ is neatly embedded and emphasised in contrast to the prior “I were fir:st” (line 2).

Aside from the recurrent use of spatial metaphors, an important point to make about the extracts in this section is the jocularity assigned to others’ observations. Considered in psychological terms, humour has been regarded as a means of allaying anxiety in others (Freud 1950), or something interactionally designed through the reinterpretation of personal experience, into an event that can be mutually shared (Coser 1959). In everyday discourse, laughter commonly indicates mutual displays of alignment, such as laughing together at a joke (Glenn and Holt 2013; Jefferson 1979). However, in the examples above, laughter or jokiness is not reportedly shared by patients, implying that patients are potentially being laughed at, rather than with.[2] However, our focus here is how laughter and jocularity in these accounts are produced in talk (Clift 2013) – for instance, illustrating how TPOs are designed as a generalised phenomenon (‘they’, ‘people’, and ‘family’). Significantly, jokiness is observably used as a contrastive element, set against patients’ realities. A comparison can be drawn with how the seriousness of complaints are objectively enhanced, with contrasts to jocular expression (Edwards 2005).

3. Direct reported speech

A third practice identified in the talk of FMD patients when displaying the seriousness of their memory lapses, is by quoting the talk of themselves and others through direct reported speech (DRS). In characterising what is said through DRS, provides for an authenticity in talk’s production, in so far as patients are *doing the voice of* (Clift and Holt 2006). However, the quotation of talk verbatim is highly improbable in the course of reporting content (Bartlett

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[2] For an examination of the social and (negative) moral functions of humour and ridicule, see Billig (2005) and Mulkay (1988).

1932; Volosinov 1971). Thus, when speakers describe speech in talk, considerations should be made in terms of the formulation of dialogue rather the reporting of it (Tannen 1989). Consequently, DRS can be utilised as a way of enhancing the rhetorical impact of some claim or account (Wooffitt 1992).

The first example in this section demonstrates how DRS in the workplace is characterised when reporting memory issues.

Extract 7: 036

```
01  Neu:   Uhm (1.2) when: hh can you give me an example >of
02         the< last time your memory let you s- let you
03         down.
04         (0.5)
05  Pat7:  Mcht .hhh (0.3) #I m- u:m# hh I was on the
06         telephone (0.6) mcht makin an appointment
07         f'someone at wor:k.
08         (.)
09  Pat7:  .hh And we'd send appointment cards out to 'em.
10         (.)
11  Pat7:  .hh And I'd picked the appointment card up
12         <n a said to the (.) customer .hh "right I will
13         send you (.) a,"
14         (.)
15  Pat7:  .hh (.) An I couldn't think.
16         (0.8)
17  Pat7:  Of the word appointment car(h)d.
```

In this example, P7 reports an incident at work relating to arranging a customer appointment (lines 5-7). After a brief clarification of the appointment card's function (line 9), P7 continues with "and I'd picked the appointment card up" (line 11), in so doing indexing the significance of the card within the telling of the DRS "<n a said to the (.) customer .hh "right I will send you (.) **a**"" (lines 12-13). A common feature in the corpus is how the DRS is prefaced – here with 'and I said'. This introductory component of P7's account acts to frame the reported talk by a proceeding speech verb plus a name or a pronoun. Prefaces play a central role in how

reported speech is ‘footed’ as a recognisable device for recipients in separating what is reported from what is not (Holt 2006). The DRS itself reports the memory lapse as experienced by P7, as what has been omitted is the component reportedly forgotten. Note how the *designedly incomplete* turn is abandoned after the emphasised ‘a’, marking out the turn’s deficiency (see Stokoe 2010) . P7’s “.hh (.) an I couldn’t think.” (line 15) attends to her memory concern as an event she was the recipient of – it wasn’t that she wouldn’t, but she couldn’t think. The increment “Of the word appointment car(h)d .HH” (line 17) neatly underlines what has been omitted.

The next case demonstrates how others’ talk is reported when patients describe memory lapses at social functions.

Extract 8: 002

```
01  Neu:   An c’n you give me: an example the last time your
02         memory let you s- let you down.
03  Pat8:  Mcht .hh Yeah there >was a< p↑atch kind’ve um:.
04         (0.8)
05  Pat8:  Mcht .hh (>It must<) be: kind of about three °or°
06         four months ago, (0.6) I: (1.0) I missed a dinner
07         date with some friends they’d cooked me dinner
08         °and everything an then phoned me up g-° sayin
09         .hh “where are you.”
10         (0.3)
11  Pat8:  Mcht .hh uhm: Fortune’ly they’re old friends so
12         they und(h)st(h)ood bu-(.)t (.) that’s not good
13         really,
```

In Extract 8, there is an introductory component which aids the DRS footing (here, prefaced with the action) “an then phoned me up g-° sayin” (line 8) followed by the DRS itself “.hh where are you.” (line 9). Unlike the last extract, there is no single speaker whose talk is reported. However, in terms of framing what is reported here and in the last extract, there are distinct similarities. Note P8’s audible inbreathe ‘.hh’ here and in Extract 7 (line 12). As there doesn't appear to be a distinct prosodic shift in reported talk as is common in such cases (Couper-Kuhlen 2006), the audible inbreath could further contribute to the marking out of what is said and what is reported as said. P8 closes her account with "fortune'ly they're old friends so they und(h)st(h)ood" (line 11-12), which indicates that although this account reports a single event, P8's memory lapses may be a recurrent problem.

The final extract illustrates how self-talk is reported, and how work colleagues respond when patients report memory problems.

Extract 9: 034

```
01  Pat9:  #I# I 'ave (.) >I mean a< work for m'self I have
02         guys workin for me.
03         (.)
04  Pat9:  .hh And it's quite frustrating because (0.5)  #I#
05         I'll say: (0.3) obviously said something to
06         them at w- at some stage.
07         (0.7)
08  Pat9:  And then >when I< go out'n check what they're
09         doin I'll say "why you doin that."
10         (0.4)
11  Neu:   °Hm°
12  Pat9:  >'N they say "well y-< you told us to."
13         (.)
14  Pat9:  And I can't remember sayin that.
15         (0.4)
16  Neu:   °Mm(hm mm)°
```

Extract 9 starts midway through an account P9, in response to N's "would you like to describe the problem now with which you are seeing me today?" P9 reports the course of action (lines 8-9) followed by the DRS "I'll say "why you doin that."" (line 9), initiated by the introductory component "I'll say". Notably, this component seems generally formulated, as opposed to 'I said' - it is something P9 *will* say as he is usually says it, displaying a dispositional stance for these types of situations (Edwards 1997). P9 describes the responsive

DRS (line 12), characterising the DRS in generalised terms with the component “they say”. Note the turn initial ‘well’, indicating something potentially non-straightforward may be uttered next. Further, both self and others’ talk is reported as a question directly followed by a response. The sequential representation of this event reflects everyday turns-at-talk in that first-pair part inquiries are generally followed by second-pair part responses (Schegloff 2007). By characterising his memory concern through a responsive DRS device, P9 may be attempting to convey the authenticity of an interaction by reporting the completeness of it.

A significant feature of Extract 9 relates to how the patient reports self and others’ talk in generalised or normative terms (‘I’ll say’ and ‘they say’). However, as DRS is reported verbatim, an interesting paradox is revealed. As noted earlier, it is highly unlikely that others’ talk is quoted accurately (Volosinov 1971). Thus, by normatively foregrounding DRS (that is, by indicating that forthcoming reported talk is not just reference to *one* occasion, but is generalised to *multiple* occasions), patients can be seen as interactionally enhancing the rhetorical impact of DRS. And so, it is not what patients or others may or may not have previously said, but *how* accounts of their memories are formulated as authentic depictions of everyday life.

Discussion

This paper describes the conversational methods that patients with FMD use when describing their subjective memory impairment (SMI) to specialists in a memory clinic. There is a considerable amount of literature on the medical significance of SMI as a categorical feature. For instance it has been shown that older adults with SMI are at increased risk of developing dementia (Jessen, Amariglio, et al. 2014). In younger adults, SMI was found to be more closely associated with anxiety and depression than a higher risk of AD (Paradise, Glozier, et al. 2011). One study specified that SMI associated with 'no concern' was not associated with an increased risk of developing AD, whereas self-reported impairment associated with 'concern' predicted a higher risk of developing AD (Jessen, Wolfsgruber, et al. 2014). However, whereas these studies simply differentiated between patients on the basis of whether SMI was present or not, the present study focuses on *how* patients with SMI identify and communicate their concerns to a doctor. This topic has previously received less attention, especially in patients subsequently diagnosed with FMD.

We have presented three interactional practices FMD patients commonly use when characterising their memory concerns to a doctor. These practices are observably designed to convince the doctor of the seriousness of their memory problem. The demonstration of difficulties with factual, day-to-day experiences provides objective evidence of patients' subjective concerns. First, *contrasts with a standard of 'normal'* are devices drawn on to demonstrate patients' memory lapses as irregular and abnormal compared to a benchmark they consider regular and normal memory – whether others' or their own memory. Second, patients report *TPOs* to emphasise their memory difficulties, relative to the (jocular) judgements of others. By indexing others' observations, patients present a more compelling, and thus 'doctorable' case for aid, in terms of validating their own memory concerns – a point underpinned by the contrastive use of past/present spatial metaphors. Third, patients quote the talk of themselves and others through *direct reported speech*, allowing for the re-characterisation of past events as 'accurate' accounts of speakers' utterances.

These FMD patients construct accounts in ways that sustain realities of memory loss, which are not reflected in their objective neuropsychological tests. This is not to say that they are feigning a memory problem or seeking medical attention without cause. However, there is a dissonance between patients' *displays* of serious memory problems, and the *reality* that they do not have any objectively demonstrable current cognitive impairment, or progressive degenerative condition (Pollner and McDonald-Wikler 1985; Wakefield et al. 2017). When talking about their memory concerns, patients depict the disruption to their daily lives, but do so by embedding their concerns within ordinary routines and activities – yet, troubles are presented as something endured or managed (Heritage and Robinson 2006). In this sense, there is a tension between attending to the trouble, reporting *business-as-usual* in these consultations (Jefferson 1988), and the conversational competence with which these accounts are delivered. FMD patients in our corpus appear attentive to the notion that their concerns should be described appropriately, and by depicting past events, *good reasons* should be communicated to the medical practitioner in order to validate the visit (Halkowski 2006).

The notion that patients seek to describe their problems to doctors is not necessarily a surprising revelation. However, it is the ways in which memory concerns are presented *as problematic* that are significant for this and future research.[3] The practices identified here may be beneficial to the ongoing programme designed to explore whether patients' interactional profiles can impact on the clinical differentiation between degenerative and non-degenerative memory conditions. Many, if not all, FMD patients' accounts of their memory deficits could be considered as the kinds of lapses that regularly occur in the course of everyday life. However, patients do interactional work to represent their lapses as irregular and abnormal, in the face of what may be considered as usual or regular forgetting.

The most current published version of the Diagnostic Statistical Manual (DSM-5) has recently changed the diagnostic criteria for the mental disorder previously labelled

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[3] However, it should be noted that in the absence of equivalent observations from ND patients commenting on the specificity of the observations made or on their differential diagnostic value is unwise. There are some features of talk about memory problems which could be sought out in future studies of interactions with ND patients and which may then contribute to the diagnostic process. It may be that patients with ND have a smaller need to objectify their memory problems. It is also likely that the form of their accounts of memory failings would be more consistent with the content of these accounts (the narratives may be incomplete and characterised by memory gaps).

Conversion Disorder and now also called Functional Neurological Symptom Disorder (FNSD). Unlike the previous edition (DSM-IV-TR), the DSM-5 does not require diagnosticians to identify conflicts or other stressors which could be associated with the symptoms. Instead, neurological criteria such as evidence of incompatibility between the symptom and recognised neurological or medical conditions have been given greater diagnostic significance. When patients with FMD attempt to 'objectify' their cognitive problems by providing detailed recollections of memory failings, including TPOs and DRS, they show the sort of inconsistency between their symptoms and objective signs of cognitive failings, demonstrating that they meet one of the key diagnostic criteria of FNSD/FMD. The nature of their accounts do not mean that their memory failings are not real or not causing distress, but it does make it unlikely that they have underlying neurodegenerative pathology causing the memory problems.

The identification of patients’ intact communicative and cognitive competence in the presence of complaints about memory dysfunction is similar to the inconsistencies between symptoms and clinical signs which are used diagnostically and therapeutically in the context of other functional symptoms (Stone 2014). For instance, the Hoover test (causing an involuntary activation of muscles failing to carry out willed actions) is used to show patients how their paralysed leg can be made to work and therefore recover, potentially reducing patients’ fears of permanent paralysis. Similarly, clinicians may alleviate patients’ anxiety about incipient dementia by noticing the conversational practices described here, and feeding back to patients *how* the detail with which they are able to describe their cognitive problems reflects a good/normal level of cognitive functioning. This observation can be the starting point of a further explanation of functional symptoms.

The observation of the typical conversational means of presenting symptoms in FMD may allow clinicians an earlier and more certain diagnosis of this condition. We demonstrate that the accounts FMD patients give of their cognitive problems are characterised by efforts to present their concerns as ‘doctorable’, and thus, worthy of medical attention (Heritage and Robinson 2006). In the context of memory complaints, these efforts inadvertently undermine the patient’s interactional project, and allow the doctor to recognise that patients’ cognitive concerns are due to FMD, as opposed to a progressive neurodegenerative disorder.

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