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

Introduction

When patients in the UK have memory concerns, they might talk to their general practitioner (GP) who may refer them on to a specialist service such as a memory clinic for further testing and possible diagnosis (Stone et al. 2015). Most patients attending memory clinics fall into one of a modest number of broad diagnostic categories. Most commonly, cognitive problems are caused by one of several different progressive neurological disorders (ND) associated with functional and structural brain changes, but, especially 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). Dementia is diagnosed when impairment in cognition 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). The diagnostic criteria for Alzheimer's disease have been updated and now are divided in biological markers of AD pathology (amyloid and tau) and allow researcher to diagnose prodromal and pre-clinical AD based on them (Dubois et al). However these criteria are subject to debate especially in terms of prodromal diagnosis based on a biological substrate may distract from other potential treatable or reversible causes of memory impairment (Blackburn et al 2014).

Patients with functional memory disorder (FMD) complain about memory failures although, unlike patients with dementia or MCI, their performance in objective tests of memory and attention does not differ from that of 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 these disorders as characterised by symptoms or deficits not better explained by another medical or mental disorder, but causing clinically significant patient distress or impairment in social, occupational, or other important areas of functioning or warranting medical evaluation. However, 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 were proposed by Schmidtke and colleagues, who characterised 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), which 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 the self-reports from FMD patients and the outcome of the medical assessment.

By analysing how patients with FMD construct 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 a neurologist, 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 in making the diagnosis of FMD at an earlier stage in the diagnostic process, as well as providing 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’ through the interactional resources available to them. In contrast to patients with other types of memory loss, those with FMD typically have subjective concerns about ‘every day’ or normal forgetting, However, in order to gain the neurologist’s acceptance of their problems as medically significant, patients face the challenge of presenting their cognitive failings as exceptional and medically distinct from normal performance fluctuations. We investigate the ways in which patients build their case for aid 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 & Robinson, 2006, p. 58). Thus, our task in this paper is to examine how features of talk are presented as non-typical forgetting.

Data and methods

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) (Hepburn 2004; Jefferson 2004a), enabling detailed analysis of interactions (Hepburn and Bolden 2014). This study was approved by the NHS Research Ethics Committee (NRES Committee Yorkshire and The Humber - South Yorkshire).

All participants had received written information about the study at least 48 hours prior to their appointment, and were encouraged to discuss the information sent to them with anyone they wanted to bring along to the clinic visit. On the day of the visit, they had the opportunity to speak to a member of the research team prior to their appointment. 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 transcripts were pseudo-anonymized of participants' identifiers in any subsequent outputs. 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 (ACE) , followed by detailed neuropsychological examination and an MRI scan (Reuber et al., 2018, Elsey et al. 2015). 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 the neurologist based on face-to-face assessment or suspected in patients scoring >15 on the depression screening scale (PHQ9, see Reuber et al. 2018 for more information on patient selection).

Method

This study adopts conversation analysis (CA) as the approach to analysis, 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; Stivers et al. 2013). CA is increasingly used in the study of medical interaction (Drew, Chatwin, and Collins 2001; Heritage et al. 2006; Maynard and Heritage 2005). The present study places focus on features of talk that are formulated within accounts of patient experience (see Drew 2006). How do patients present their lapses, and how are they accountable as memory problems? Our primary analytic concern is not what patients may or may not forget, but the ways in which these descriptions of memory loss are formulated as problems within the co-participant's interactional domain. All patients bar one reported here (034) were alone during the consultation. Consultations approximately lasted one hour. During a consultation, the neurologist moves through the initial history-taking phase, in which a range of open 'Wh' questions are asked (for example, 'how can I help?', 'what problems have you been experiencing?' or 'why have you come?'), before progressing to a standardised general cognitive screen- (the Addenbrooke's Cognitive Examination-ACE). The focus of this analysis is 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 devices patients commonly use when accounting for their memory problems.

Analysis

When patients attempt to convey the seriousness of their memory lapses they may volunteer an account of their experience. Alternatively, they are prompted by neurologists' questions, illustrated by the following commonly designed information requests.

1. Formulation + follow-up [045]

01 Neu: Mcht .hh u:m (.) and you've given me a few
02 examples there um (0.5) with (>tryin'n'to'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 [001a]

01 Neu: Mcht .hhh and'e- so how is- this impacting yer
02 job.

3. New topic [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.

Patients respond by describing their memory experiences in their everyday lives, but do so in ways that indicate they have a problem, such that aid may be offered. In essence, patients design their talk to be accountable as memory deficiencies they are experiencing, whereby there are interactional consequences for co-participants (Haugh 2013). When patients present their concerns to neurologists, they are designed to be understood as legitimate anxieties. We analyse three of the more prominent interactional practices that FMD patients draw on when characterising day-to-day 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 in some way, 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 – that is, 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 representations which they consider ‘normal’.

In Extract 1, the patient’s partner is represented as having a normal memory, contrasted to his own. This example begins at the opening of the consultation, and starts with the patient giving an account of his memory concern. Notably, while the patient is attending a memory clinic in a hospital, he has not specially been prompted to talk about cognitive problems (cf. Extract 3).

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 Pat: .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, un (.) °I can’t° remember that
10 happening,

This first example demonstrates how the patient (P) presents his memory concern “>an I< thought (.) .hh ↑wl I can’t remember that, un (.) °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 P and his partner have equal epistemic access to these events as shared memories (Buchanan and Middleton 1995; Heritage 2012). However, P exhibits that he has a

concern by presenting his partner's memory ability as the standard. Put another way, the partner's reminiscing as a normal, regular activity is contrasted to P's inability to reminisce because a particular 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 Pat: .hhh u:m (0.3) mcht .hh becau:se #uh uh# something
02 quite shocking had happened to me I'd- mb <been a
03 great traveller .hh in my life and I love
04 travelling.
05 (.)
06 Pat: .hH A:nd I'd booked to see a friend in Germany,
07 .hh a:nd got to the airport'nd was going to
08 collect my ticket at the desk- .HH (.) an I'd
09 booked for the wrong day.
10 (0.8)
11 Pat: °I'd booked the ticket for the wrong day.°

Just before this fragment, N has asked what problems P has been having with her memory.

The first contrastive element of P's response is demonstrated with "I'd- mb <been a great <traveller .hh in my life and I love travelling." (lines 2-3). By presenting herself as an experienced traveller, P invokes someone familiar with the practicalities of organising transport, getting to destinations and such like – essentially, the normal tasks that experienced travellers undertake. P then presents the everyday activities done as a traveller, such as

booking the flight and going to airport (lines 6-7). The second contrastive element is described with P “going to collect my ticket at the desk- .HH (.) an I’d booked for the wrong day.” (lines 7-9). P’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 Pat: 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 Pat: To: (0.2) n:ot being able to remember (.) the
 11 simplest of things now.
 12 (.)
 13 Pat: .Hh (.) It’s (.) mainly names that I can’t (0.2)
 14 can’t get my head around
 15 (0.4)
 16 Pat: .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, the patient demonstrates his previously good memory ability with “I’ve gone from “sort’ve .h probably a year ago (to) havin a (.) .hh a really good IQ.” (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 the extreme case “simplest”. Thus, P’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 how metaphors are used to convey emotional concepts that are difficult to articulate (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 and in ways which can be understood by recipients (Lakoff & Johnson, 1980).

The important point to note about the examples above, 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. Thus, memory problems are depicted as clear deviations from normal everyday experience – in this way, demonstrating that past recollections of memory loss are designed to be treated as credible by their neurologist.

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 & 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 Pat: U:m (1.0) it's more noticeable uh:m (0.6) >wl=it's<
02 noticeable every day, .hH an:d but it's um: (0.9)
03 mcht (.) family.
04 (0.3)
05 Pat: Ng fact when family 'ave sort of (0.3) <commented.
06 (0.5)
07 Pat: °Um° at first it was >a bit of a< (.) a joke.
08 (0.5)
09 Pat: Uh:m (1.0) but (1.1) I think it's really because of
10 the amount of information I have to (0.4)
11 retain.
12 (2.7)
13 Neu: >Sh'you have to <retain lots of (0.3) [information.
14 Pat: [Yeah.

After reporting frequent ‘noticings’ (lines 1-2) (Schegloff 1998), P reports the TPO with “Ng fact when family ’ave sort of (0.3) <commented.” (line 5). The design of this reported observation is notable in that by operationalising ‘fact’, the TPO representation is 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 P’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 joke.” (line 7) seemingly goes further in characterising a casual, unproblematic TPO. However, P’s subsequent turn - “Uh:m (1.0) but (1.1) I think it’s really because of the amount of information I have to (0.4) retain.” (lines 9-11) – 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 P – as one that has developed over time. In this way, P 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 Pat: .hH U:m(.) <and coz the boys if w’go out out for
02 a beer.
03 (.)
04 Pat: .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 Pat: .h uh >Because I< mixed the drink up.
09 (.)
10 Pat: .hh An:d it gets to the point where (.) people do
11 actually ‘ave pass comments (.) <Jokingly.
12 (.)
13 Pat: .hh that um I’ve made a mistake “don’t ask him to
14 do that he’ll forget it.”
15 (.)
16 Pat: .hh Mcht .h (.) An they all laugh.
17 (0.4)
18 Pat: But t’me: (.) I cover it.
19 (0.5)
20 Neu: Y[eah.
21 Pat: [I- it hurts.

P presents his memory problem “I can go to the bar an’ come back with something (0.2) completely different to what somebody asked for.” (lines 4-6), characterised as a general occurrence by the modal ‘can’ (Edwards 2006). Notable also is the extreme case formulation ‘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 illustrated in the previous example, 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), P 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 P 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 P’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 Pat: <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 Pat: .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 Pat: .HH <And it's made an effect thut (.) .hh they treat
13 me differently now.

P reports the TPO “<I think people have noticed at wor-“ (line 1), although hedged with ‘I think’. An account of this noticing is provided with “I were fir:st .HH (.) °bad with ma memory° .HH i- people used to laugh at me >it used to be a bit of a< jo(h)ke” (lines 2-4). As with the two prior extracts, note how P 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, P 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 & 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 P’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”.

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 (Cosser 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.¹ - However, our focus here is how laughter and jocularity in these accounts are produced in talk (Clift 2013) – for instance, illustrating how TPOs are

¹ Literature has previously examined in terms of the social and (negative) moral functions of humour and ridicule (Billig 2005; Mulkay 1988).

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 with voices of the self and others, 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 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 drawn upon whilst 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 Pat: 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 Pat: .hh And we'd send appointment cards out to `em.
10 (.)
11 Pat: .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 Pat: .hh (.) An I couldn't think.
 16 (0.8)
 17 Pat: Of the word appointment car(h)d.

P is reporting 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), P 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 P'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 “right I will send you (.) a” (lines 12-13) reports the memory lapse as experienced by P, 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) . P'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 Pat: Mcht .hh Yeah there >was a< patch kind've um:
 04 (0.8)

05 Pat: 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 Pat: 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 the audible inbreath ‘.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. P 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, P'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 Pat: #I# I 'ave (.) >I mean a< work for m'self I have
 02 guys workin for me.
 03 (.)
 04 Pat: .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 Pat: 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 Pat: >'N they say "well y-< you told us to."
 13 (.)
 14 Pat: And I can't remember sayin that.
 15 (0.4)
 16 Neu: °Mm (hm mm) °

In the final example, P reports the course of action with “And then >when I< go out’n check what they’re doin” (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 P will say as he is usually says it, displaying a dispositional stance for these types of situations (Edwards 1997). P describes the responsive DRS with “>n they say well y-< you told us to.” (line 12). Again, P represents 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, P 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. In this way, 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 a 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 previous 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 an 'accurate' account of speaker 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).

This paper does have some limitations. We do not have access to the biological markers of AD (amyloid and tau). However we have conducted longitudinal follow-up of our patients with FMD (described in Reuber et al 2018). Furthermore Schmidtke et al followed up patients with FMD and found it was a static condition with the majority remaining

symptomatic but stable, a small percentage improved and one patient diagnosed with early AD (Schmidtke et al 2007). The aim of this paper is not to suggest that a diagnosis can be based on CA features only. However these features, plus machine learning approaches to accurately measure semantic features, pauses and acoustic features may in the future provide a low cost stratification tool that if repeated can detect progression and change that prompts further evaluation.

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.² 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. Notably, these extracts are predominantly near the start of consultations, with patients often responding to Wh-questions or other open formatted questions by neurologists (see Schegloff and Lerner 2009). Early volunteering of memory concerns highlights anxiety issues associated with the problem – likewise, patients with panic attacks who talk about their anxieties early in interactions with doctors (as opposed to patients who experience panic in epileptic seizures, who only do so much later in doctor-patient encounters) (Schöndienst and Reuber 2008).

² 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).

The most current published version of the Diagnostic Statistical Manual (DSM-5) has recently changed the diagnostic criteria for the mental disorder previously labelled 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 does 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. This may alleviate pressure on specialist memory services which have recently been faced with a 600% increase in referrals between 2009 and 2014 (Blackburn et al. 2014). We demonstrate that the accounts patients' with FMD give of their cognitive problems are characterised by efforts to present their problem as as 'doctorable', and thus, worthy of medical attention (Heritage & Robinson, 2006). In the context of memory complaints these efforts inadvertently undermine the patient's interactional project and allow the doctor to recognise that the patients cognitive concerns are due to FMD as opposed to a progressive neurodegenerative disorder.

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