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PSYCHOGERIATRIC NOTE

How the UK describes functional memory symptoms

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Functional neurological symptoms are thought to be caused by dysfunction in cognitive processing, which leads to physical symptoms without underlying brain pathology. These functional symptoms are commonly seen in neurology and psychiatric clinics, and examples include non-epileptic attacks and functional tremor. Some memory complaints may also be recognized as a functional symptom.[1] The 2015 Royal College of Psychiatrists audit found UK memory clinics assessed, on average, 30.9% more patients in 2014 than in 2013.[2] This has been associated with an increase in the number of people referred to memory clinics without neurodegenerative conditions.[3] Patients who seek help for concerns about memory represent a heterogeneous cohort, but in many cases, they do not have dementia.[1] Functional memory complaints are included in this non-neurodegenerative group. As functional memory symptoms appear to be increasing in UK memory clinics, we surveyed neurologists and psychiatrists working in these settings.

An email survey was sent to 55 neurologists running memory clinics in the UK using the Association of British Neurologists Specialist Interest Group in Cognition on 22 July 2013. A similar online survey, with additional questions about the treatment of functional neurological symptoms, was distributed to the Royal College of Psychiatrists Old Age Faculty mailing list on 23 April 2015. The list represents 1583 consultant old age psychiatrists working in the UK in a variety of settings, including 222 memory assessment services. Both neurologists and psychiatrists were given 3 months to respond.

Eleven (of 55) neurology-led memory clinics and 33 psychiatrists responded. Data from psychiatrists represented 32 memory clinics or memory services within older adult community mental health teams. The mean estimated prevalence of dementia was 50.6% in people attending the neurology-led memory clinics and 69.0% in the psychiatry-led clinics. All of the neurology-led survey respondents and nearly two-thirds (65.6%) of the psychiatry respondents recognized functional

Table 1 Terms used to describe functional memory disorders in UK memory clinics

Terms used to describe functional memory disorders		
Functional memory disorder	Subjective memory impairment	Suboptimal cognitive performance
Attentional cognitive complaints	Normal cognitive ageing	Cognitive impairment secondary to complex psychological processes
Attentional amnestic disorder	Worried well	Memory impairment of uncertain aetiology
Stress-related	Hypochondriasis	Memory problems, no dementia
Subjective memory complaints	Normal	Concentration difficulty
Age-related forgetfulness	Subjective memory problems	

These terms vary dramatically. Some try to normalize the symptoms whereas others try to explain the cause.

memory symptoms, which are defined as: 'a patient presenting with a memory complaint, but no evidence of organic dementia or major psychiatric illness on neuropsychological or radiological investigation'.

Although the majority of doctors recognized functional memory disorders (FMD) as a condition they see, there was no consensus on terminology used to describe this syndrome. Table 1 shows the terms used.

Of the psychiatrists surveyed, 73.1% discharged patients with FMD to primary care. Of those who treated patients with FMD, there was no agreement on what was appropriate. Treatments included doing nothing, reassurance, psychology assessment, community mental health team referral, or commencement of selective serotonin reuptake inhibitors.

The lack of agreement on terminology may affect treatment. Giving patients a clear label for a condition can help understanding and facilitate access to peer support. Current terms used to describe FMD vary dramatically, with some seeking to normalize the symptoms and others trying to explain the cause.

It is likely that more than one type of FMD exists.[1] However, multiple diagnostic categories may not demonstrate clinical utility. Comparing FMD to non-epileptic attacks illustrates that a label is important, and how symptoms are described and explained can affect patient engagement with therapy. A questionnaire study found 'functional' was more acceptable to patients than terms such as 'pseudoseizures' and 'symptoms in the mind'.[4]

As diagnostic memory clinics are primarily concerned with the diagnosis and treatment of dementia, it may not be appropriate or feasible for FMD to be managed in this setting, and most patients will be discharged to primary care. Treatment for FMD is not well understood, although psychological interventions and group therapies have been tried.[5] Research diagnostic criteria have been proposed, and a preliminary follow-up found that FMD was a stable but chronic disorder with low risk of developing dementia.[6]

This survey has limitations, in particular the poor response rate. Future surveys should collect data from general practitioners. Cognitive complaints are a common reason for attending primary care. It is not known whether general practitioners recognize FMD and refer patients with concerns about dementia to memory clinics, or whether there is a lack of alternate appropriate services. It may be possible to diagnose FMD in primary care. One potential technique is conversation analysis, which has been used in the assessment of memory complaints and has revealed distinct profiles that could be employed to distinguish FMD from dementia.[7]

In summary, in the UK, there is currently no uniform terminology used in memory clinics to describe FMD. The early diagnosis of disorders causing dementia and then distinguishing them from issues related to normal ageing is difficult. Improving awareness of FMD in both primary and secondary care is important, as is the development of terminology that is acceptable to both clinicians and patients. This is the first step to facilitating research into the diagnosis, prognosis, and possible treatments.

ACKNOWLEDGMENTS

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REFERENCES

1 Stone J, Pal S, Blackburn D, Reuber M, Thekkumpurath P, Carson A. Functional (psychogenic) cognitive disorders: a perspective from the neurology clinic. *J Alzheimers Dis* 2015; **48** (Suppl 1): s5–s17.

2 Hodge S, Hailey E. *Second English National Memory Clinics Audit Report*. London: Royal College of Pyschiatrists, 2015. [Cited DD MM YYY.] Available from URL: http://www.rcpsych.ac.uk/pdf/English%20National%20Memory%20Clinics%20Audit%20Report%202014.pdf
3 Larner AJ. Impact of the National Dementia Strategy in a neurology-led memory clinic: 5-year data. *Clin Med* 2014; **14**: 216.
4 Stone J, Campbell K, Sharma S, Carson A, Warlow CP, Sharpe M. What should we call pseudoseizures? The patient's perspective. *Seizure* 2003; **12**: 568–572.
5 Metternich B, Schmidtke K, Dykierek P, Hüll M. A pilot group therapy for functional memory disorder. *Psychother Psychosom* 2008; **77**: 259–260.
6 Schmidtke K, Pohlmann S, Metternich B. The syndrome of functional memory disorder: definition, etiology, and natural course. *Am J Geriatr Psychiatry* 2008; **16**: 981–988.
7 Elsey C, Drew P, Jones D *et al.* Towards diagnostic conversational profiles of patients presenting with dementia or functional memory disorders to memory clinics. *Patient Educ Couns* 2015; **98**: 1071–1077.

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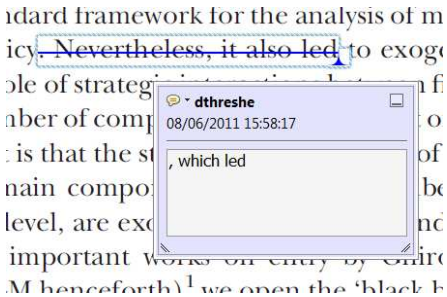

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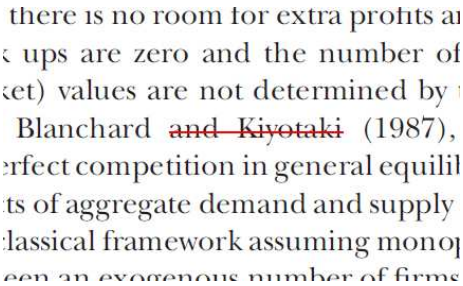

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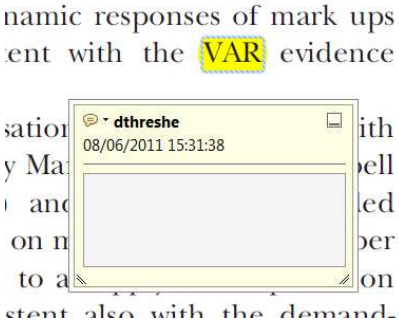

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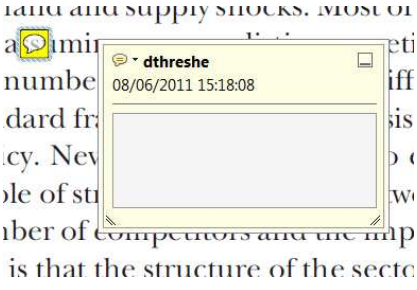

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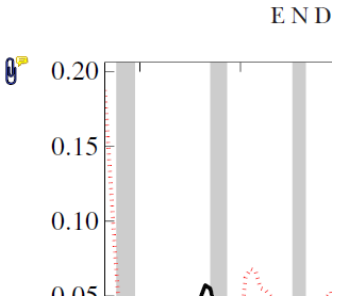

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