Remembering without a past: Individuals with anterograde memory impairment talk about their lives

MARIA I. MEDVED

University of Manitoba, Canada

Abstract
This paper describes the linguistic resources people with anterograde amnesia draw on in conversational narratives. Because of their problems in recollecting post-morbid memories, it is particularly challenging for such individuals to refer to personal experiences. Seven patients with anterograde memory impairments due to neurotrauma were interviewed one year post-event. Among other topics, they were asked to talk about their new lives and selves, which was expected to be a precarious affair given that they did not have many or any autobiographical memories. Microanalyses of their narratives identified three readily available linguistic resources that participants used to facilitate their storytelling. These were categorized as “memory importation” (transplanting a past memory into the present), “memory appropriation” (taking another’s memory as one’s own), and “memory compensation” (searching for memories). It is argued that although these resources were not always efficiently used by participants and their use often violated conversational expectations, these linguistic techniques provided a helpful means to sustain the production of personal narratives, even in the absence of autobiographical memory.

Keywords: Amnesia, autobiographical memory, conversation, narrative, neurotrauma

Introduction
With most illnesses or disabilities, our brain remains intact and we can depend on it to perform all basic neurocognitive processes essential for our conscious life. Many such processes involve recollecting autobiographical memories. Among others, this recollecting allows us to know what has happened to us since we were injured or fell ill. After a serious neurotrauma (regardless of etiology), however, individuals often can no longer rely on their brains to reliably fulfill such a task. This is the predicament I will examine in this article.

To illustrate this situation, let me begin by presenting the case of a woman I met in a hospital. Our interaction was by no means unique, and in fact, I see it as typical of my encounters with many patients. Ms. L had had an accident that damaged a region of her brain—the medial temporal area—essential for memory recollection. As a consequence, she was left with an anterograde memory impairment, that is, she had difficulty remembering post-morbid events. She was unable to recall, for example, whether she went on vacation last summer, had an argument with a friend or what had recently made her
happy, angry or sad. At the same time, however, she seemed to recall some events about the past—bits and pieces—as if there were some islands of memory left intact (Medved & Hirst, 2006).

Asked to provide background information during a clinical history interview, Ms. L was unable to say with much certainty what had happened to her since her neurotrauma, although she was able to describe events occurring prior to her neurotrauma. Even replying to a question such as “How have you been doing lately?” was problematic. There were simply no or only very few memories to draw on for an answer. There appeared to be no other experience than that of the very present.

Nevertheless, Ms. L, as most people with neurotrauma, struggled to formulate an autobiographical narrative to tell the interviewer. At certain points individuals such as Ms. L have little concrete to say, while at other points their stories appear awkward in that they seem confabulatory, scripted, or repetitive. Often these limitations are so salient that it is difficult to conceive of such accounts as stories at all. In fact, it appears more plausible to view their utterances as evidence of pathognomonic or decreased neuropsychological functioning, in other words, as an expression of their brain damage or disorder.

When viewed in this way, clinical assessment of the individual’s faulty neurocognitive functioning seems a reasonable way to proceed. Typically, this would involve measuring the extent of the memory impairment and any other cognitive impairments. However, while it is important to quantify a person’s cognitive deficits, the problem with formal assessment is that it is often conducted in isolation, that is, it is decontextualized from personal, familial, and other social experiences in order to measure “pure” cognitive functioning. The danger of this approach, as pointed out prominently by Luria (1979), is that it tends to reduce living reality to abstract schemas. What gets lost is how individuals try to cope or adapt to their memory loss.

To return to the case example, we can find all of these problems and misgivings in the formal assessment of Ms. L’s memory. The assessment revealed that her memory capacities fell in the severely impaired range. Although this information was helpful as it indicated areas of daily life where she might have particular difficulty, it was limited in that it did not indicate how she might deal with her lack of autobiographical memories when trying to reflect on her life. It also did not indicate how she might deal with her reduced number of autobiographical memories in a real-life social environment, such as during a conversation or, for that matter, clinical history interview. These are complicated psychological and social issues, and the question is how can we deal with them in a more satisfying clinical manner? I want to argue that a narrative approach offers a promising avenue to investigate these issues.

One reason I believe narrative provides an efficient means to explore such complex issues resulting from reduced memory capacity is because it is, in fact, through narrative that people deal with their present and past life experiences. As Bruner (2001) and many other researchers have pointed out, by giving form and structure to even disconnected experiences and memories, narrative offers a space for self-reflection and self-construction. By examining personal narratives, we have access to how people are attempting to make sense of their selves and worlds. Studying narrative also provides a nuanced means to examine intersubjectivity. Many of our interactions with others take place in the form of conversational narratives, covering the entire range of everyday social life (Edwards, 1997; Norrick, 2000; Ochs & Capps, 2002). In all of this, narrative is crucial for a large variety of psychological and social functions; thus, not surprisingly, any change affecting narrative competence has the potential to alter the success of these functions. Since self-narratives, in particular, draw, organize, and interpret autobiographical memories—in fact, both are
intimately intertwined (Fivush & Haden, 2003)—this leads to the question how do people construct their narratives when such essential memories are lacking.

There are two main strategies used among researchers who investigate illness narratives. One focuses on the cognitive dimension, conceiving of narrative as essential to the ability to remember, organize, and understand complex verbal information. More specifically, studies using this approach might ask individuals to repeat a story that has been read to them or generate a story about a picture scene. Typically, these narratives are then coded for incoherence, repetition, thematic and detail-oriented information, and so forth. The limitation of this strategy is that it neglects or even excludes the contextual dimensions of narrative, that is, the psychological and social embeddedness of every narrative event.

The second strategy attempts to capture this embeddedness by emphasizing those dimensions of narrative discourse that are essential to how people cope with their illness or disability. In contrast to studies examining cognitive functions (and dysfunctions), studies that explore such issues use conversation-analytical, discursive, or narrative methodologies. These studies explore topics ranging from cultural influences on illness (Kleinman, 1988), phenomenological experiences of disability (Holt & Slade, 2003), narratives of hope (Smith & Sparkes, 2005) to identity construction in people with chronic illness (Frank, 1995). As a consequence, the many different ways people cope with illnesses and disabilities have become subject to differentiated narrative analyses.

This, however, we cannot say for illnesses and disabilities caused by neurological impairments, which have gotten much less attention. The few studies that have used narrative methods to investigate such disabilities have been limited to people whose cognitive capacity is gradually deteriorating, such as with dementia (e.g., Sabat, 2001) or individuals with intellectual developmental delays (e.g., Croft, 1999; Medved & Brockmeier, 2004). What is missing in the literature is research on narratives from individuals who have been abruptly left with cognitive impairments. This is exactly what I shall examine in this study.

Using narrative analysis, I will describe the linguistic devices and resources people with anterograde memory impairments draw on in their conversational narratives. The individuals selected for this study were explicitly invited to discuss events that took place since their brain damage, which had occurred approximately one year prior to the interview.

The participants’ memory impairments were due to various neurological lesions and etiologies. These individuals suffered from diencephalon, medial temporal lobe, or frontal lobe lesions as a result of a traumatic brain injury, cerebral vascular accident, anoxia, or abscess. Lesions to the diencephalon specifically impair memory performance because, along with the medial temporal lobes, the diencephalon mediates the encoding of new experiences for later recollection (see Squire, 1995, for further details). Lesions to the frontal lobe impair memory performance because the frontal lobe is involved in the regulation of retrieval strategies needed to access explicit memory (Conway, Pleydell-Pearce, & Whitecross, 2001).

In conducting this study, I attempted to capture Luria’s idea of “living reality” by embedding personal and social experiences as much as possible into my research design. I conducted the interviews, for example, in participants’ homes so I could observe the participants in their natural environment. Also, the interviews were conducted in a way that tried to capture the flow of a natural conversation, although more pointed questions were asked than might be typical in a regular conversation. Lastly, my research team and I have followed these participants for almost a year, which allowed us to develop an ongoing relationship with both the participants and their families.
Method

Sample

Just prior to their discharge from a neurorehabilitation unit, about 2–3 months post-event, inpatients were approached about their willingness to participate in a study exploring how people cope with brain injuries. Of the 9 patients whose cognitive deficits were primarily restricted to memory, 8 agreed to participate. One of these patients was not available at the time of the interviews, thus the final sample consisted of 4 women and 3 men.

These 7 participants had an anterograde memory impairment that was identified by a standardized neuropsychological assessment. Their brain lesions resulted in at least moderate memory impairment and their memory quotient (based on the Wechsler Memory Scale-III) had to be at minimum 20 points lower than their intelligence quotient (IQ based on the Wechsler Adult Intelligence Scale-III). Although the participants were considered amnestic, most of them were not “dense amnestics” (as often depicted in Hollywood movies) because they retained some memory and learning capability. For this reason, they are called memory impaired rather than amnestic. In terms of retrograde amnesia, none them demonstrated major indicators of it. Other cognitive domains such as attention, executive functioning, intellectual ability, and speech and language ability were assessed as intact or only mildly impaired.

Traumatic brain injury (TBI), cerebral vascular accident (CVA), anoxia or abscess was the cause of the participants’ neurotraumata. In Table I, the etiology and major neurological lesion site for each participant is shown. All identifying details have been altered to protect participants’ anonymity and confidentiality.

Data collection

In addition to accessing the neuropsychological and medical reports of the participants, I drew on informal observations of them in their home environment over time and casual conversations with other family members. The primary source of data is transcripts based on interviews conducted with the participants 1 year after their neurotrauma. All interviews took place in the participant’s home and were conducted in private. Each participant was interviewed twice, the interviews separated by 1 week, with each interview ranging from 30 to 55 minutes. All interviews were audiotaped and fully transcribed at a later date (see Appendix A for transcription conventions). A broad interview guide was used to elicit autobiographical narratives that primarily focused on the events occurring and subjective experiences of the participants since their neurotrauma.

Table I. Participant profile using pseudonyms.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Etiology</th>
<th>Primary lesion site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. E</td>
<td>46</td>
<td>CVA</td>
<td>Right frontal</td>
</tr>
<tr>
<td>Ms. P</td>
<td>56</td>
<td>TBI</td>
<td>Right frontal</td>
</tr>
<tr>
<td>Mrs. A</td>
<td>64</td>
<td>CVA</td>
<td>Diencephalon</td>
</tr>
<tr>
<td>Mr. M</td>
<td>27</td>
<td>TBI</td>
<td>Diencephalon</td>
</tr>
<tr>
<td>Mrs. K</td>
<td>47</td>
<td>Anoxia</td>
<td>Bilateral medial temporal</td>
</tr>
<tr>
<td>Mr. W</td>
<td>76</td>
<td>Anoxia</td>
<td>Bilateral medial temporal</td>
</tr>
<tr>
<td>Mrs. C</td>
<td>51</td>
<td>Abscess</td>
<td>Left fronto-medial temporal</td>
</tr>
</tbody>
</table>

CVA, cerebral vascular accident; TBI, traumatic brain injury.
During the interviews, I attempted to balance the need to include more interviewer prompting than might be usual when interviewing a person without neurological lesions (Paterson & Scott-Findlay, 2002). In particular, I wanted to adapt the pace of the interview to allow the participants the time necessary to inhabit the conversational space. I also remained mindful that responses of participants that seemed superficial during interviewing could reflect, as Gregory (1998) pointed out, the person’s unfamiliarity with their new neurological state after their brain injury.

Data analysis

Following an ideographic approach, each interview was separately analyzed. Each transcript was examined according to narrative and conversation analysis methods. This included, in the first phase, examining the structure of the transcribed texts, and then, in a series of stages, progressed to investigating more detailed narrative forms, stylistic features, and discursive strategies. Preliminary interpretations were then reanalyzed and again checked in the transcribed material. The results from each participant were cumulatively compared with the results from the other participants. This analytical procedure was carried out in a circular process of modifications and redefinitions.

Validity of the results was judged in terms of its applicability for describing similar experiences in other situations, connection with theory and other studies, and usefulness in terms of theory and practice (Fischer, 2006). Internal validity and reliability was achieved by using a number of criteria. These included reflective listening during the interview to check interpretations (Stiles, 1993), and to ensure internal coherence of the analysis, interpretations were checked to make certain they were warranted by having members of the research team independently review each step of the analysis documentation.

Results

Analysis of the interview transcripts involved examining the linguistic options individuals with memory impairments used when communicating their post-morbid experiences. The results indicate there are three main linguistic resources participants draw on to articulate their experiences. I categorized these resources as “memory importation,” “memory appropriation,” and “memory compensation.” The analysis also shows that the individual participants appeared to rely on only one of them.

Memory importation

One strategy that three of the participants relied on involves extending or transplanting an autobiographical memory of a pre-morbid event and presenting it as if it took place post-morbidly. In such a scenario, the temporal binding of the memory is loosened so that the mnemonic episode can be shifted. I use the word, “importation” because it captures the way in which participants stretch or move events embedded in their autobiographical memories closer to the present. The memories are always relocated from the time before to the time after the neurotrauma.

Participants had two ways to accomplish this importation. One involves extending the temporal framework of a memory by altering the verb tense used to describe the events. The other involves inserting a memory into a narrative sequence in which it appears plausible but to which it originally did not belong. In temporally coherent stories,
experiences and events are typically situated in the same general temporal space unless otherwise marked.

The following excerpt from Mrs. E demonstrates how she imported memories by altering the tenses of her verbs.

**Example A**

E: We've [Mrs. E and her husband Bob] been together 14 years and I'M the strong, organized one. I always used to do it all. Bob used to ask me about everything except for his work and what he does. I work at least 12 hours a day at least. I *am* responsible for <home, cleaning, laundry, everything, bills, groceries> (. ) our daughter...  
I: You still do all this?  
E: Well(:,), I have slowed down.  

In mentioning how she has been responsible for most domestic activities during the past 14 years of her marriage, Ms. E uses a blend of self-descriptive observations and generalized recollections. Generalized recollections are those that are based on the amalgamation of similar events that happen over time (Singer & Salovey, 1993). For Mrs. E, the verb tense she uses indicates her generalized memory ("I *used* to do it all") is temporally located in the past, and within the context of the interview, it appears to be the past before her brain lesion. Mrs. E then puts forward another generalized recollection. What is different about this recollection is that it is suddenly articulated in the present tense ("I *work,* "I *am* responsible"). Her performance of these duties may have started before her neurotrauma but the present tense verb insinuates she continues to perform them in the contemporary present. In other words, her carrying out of these domestic duties is imported, or stretched, from before to after her neurotrauma. In reality, though, Mrs. E has been unable to perform her usual chores since her stroke. The interviewer, knowing this, is led to question the veracity of her memory.

Another participant, Mr. M, also uses memory importation by altering the verb tense of a generalized memory. Below, he describes how he relies on all-nighters to get things done.

**Example B**

M: Before my accident, I was in university and I pulled all-nighters. (. ) A friend and I always did it together. We take turns keeping each other awake and making pots of coffee. (laughs.) I pull all-nighters all the time.  
I: Wow, you *still* pull all-nighters.  
M: Can’t really remember. (4) I always do so.  

Mr. M begins by situating his generalized memory of pulling all-nighters as something that took place before his neurotrauma. He does this explicitly by using the temporal adverb "before my accident," and more generally, by articulating his recollection in the past tense ("I *pulled* all-nighters"). His narrative then abruptly shifts to the time frame of the contemporary present. This shift is marked by the use of the present verb tense (e.g., "we *take turns,*" "I *pull* all-nighters"). This verb usage gives the impression that even after his neurotrauma Mr. M continues to stay up the entire night to meet deadlines. Given the social context of his present life, this surprises the interviewer who then seeks to clarify if this indeed is the case.
Mrs. K makes use of “narrative context” to import her memories. By narrative context I am specifically referring to the temporal context in which experiences and events in a story are expected to be made coherent. To import memories using context, an event from the past is inserted into a present-oriented narrative, which then makes it appear as if the event is also occurring in the present. As will become evident shortly, this method is used with memories that are relatively isolatable in time (as opposed to amalgamated memories). In example C, Mrs. K demonstrates how context works to import memories.

**Example C**

I: How long had you been working there before your brain injury?
K: For about 2 years. I would like to move though. It’s not challenging enough. I got a call from another company. I spoke to the lady at HR (human resources). We set up an interview.
I: You set up an interview?
K: YEAH, I know the job well.
I: You have an interview? Now?
K: (3) No not now.

Mrs. K, discontented with her work, mentions a specific memory—speaking to a woman about setting up an interview. In the context of the narrative, the interviewer is led to understand Mrs. K as saying she recently received an interview invitation. This is because expressions such as “would like to move” and “it’s not challenging enough,” using a subjective and present tense verb respectively, refer to Mrs. K’s current perceptions and thus situate the narrative in the time frame of the recent present. Thus, by embedding the event in present-oriented discourse, the memory is moved forward in time. In response to the unexpected news of the interview, the researcher asks when it is about to happen, although in fact, this telephone call occurred prior to Mrs. K’s brain damage.

Memory appropriation

The second linguistic resource that individuals told their post-morbid stories with is what I call memory appropriation: It consists of presenting another person’s memory as one’s own. When someone appropriates an mnemonic episode from another person, it does not involve the act of re-experiencing or, to use Tulving’s (1985) term, autonoetic awareness while remembering. Memory appropriation does involve, however, taking someone’s memory, transforming it, and then adding it to one’s own set of autobiographical stories. This transformation is accomplished by narrating the event from a first person perspective rather than a third person perspective so the “memory” can be presented as one’s own.

In the following example, Mrs. P uses the strategy of memory appropriation to tell a story about how she traveled all the way to Kansas for a wedding, only to miss it because her sister drove into a ditch.

**Example D**

P: As far as I can remember I took a plane on my own to get to Kansas. My sister picked me up at the airport. Then after flying and getting there, I missed it because our car got STUCK in a puddle because of the dirt roads. My sister drove into a big ditch.
I: STUCK IN A DITCH. (laughs.) Did you push the car out?
P: Noo. I can’t remember who. (3) Maybe my sister?
I: You can’t remember?
P: I can’t remember the trip at all.
I: Then how do you know you went?
P: Because my sister said, you went to Kansas and this is what happened.

What becomes evident is that Ms. P is not really recollecting her visit in the traditional sense of an autobiographical memory even though this “memory” is fleshed out with details. Instead, she is repeating her sister’s recollection (her sister, in fact, narrates this event in similar words). But Ms. P does not simply repeat this memory by telling it from her sister’s perspective, she narrates it from her own perspective, and by doing so, she makes the memory her own. It is only when Ms. P is asked for additional details that she cannot provide beyond her scripted story that her appropriation becomes apparent; otherwise it would have gone unnoticed. In this light, Ms. P’s introduction of her story with “as far as I can remember” could be reinterpreted as to qualify her recollection of her sister’s rendition of the visit rather than her memory of it.

Another example of memory appropriation is from Mrs. C. As illustrated in Example E, as she tells the interviewer about a Christmas mess.

**Example E**

C: We went to my sister’s house for Christmas. There were 14 people. The dog jumped on the tree and it fell over smashing the ornaments. My nephew started crying. (,) We had to spend an hour cleaning up. The dog has never done that before. > We don’t know why. <
I: Were there any family heirlooms broken?
C: Uh, don’t know, don’t think so, couldn’t say.
I: I hope it didn’t hurt anybody.
C: (3) No, I don’t think so.
I: Not sure? Why not?
C: Don’t really remember it. Don’t remember at all. My family knows.

Mrs. C’s account provides a rich description of the Christmas tree falling; she mentions the dog jumping, her nephew crying, the hour-long cleaning and even the exact number of people involved. This richness of detail certainly suggests a vivid memory. However, like Ms P, she is reiterating what others have repeatedly told her about this event, an event her son confirms he has told her numerous times. She does not simply repeat it but personalizes it by using the pronoun “we” and telling the event as if it were a memory told from her personal perspective. If the interviewer had not probed for additional details, which Mrs. C cannot offer, this exchange may have been deemed unremarkable and her memory taken to be of a “genuine” autobiographical flavor.

**Memory compensation**

There is a third register participants used to tell their narratives. I will call this option memory compensation. This option is different from the other two in that it does not involve any kind of “manipulation” of autobiographical memories. In fact, it does not directly involve autobiographical memory at all; instead, the focus here is on “searching” for
memories. Akin to a common rhetorical style, the individual asks questions that include mental and intentional verbs such as “wonder” and “think,” as if to shift the attention of the listener from a possibly expected coherent memory account to an attempt to search for memories, an effort to cobble vague memory pieces together. As we often also find such attempts to remember in normal conversations, this discursive device works as a “normalizer” in an otherwise difficult conversation.

In the following example, Mrs. A talks about her poor memory, but she turns her account into a narrative report about her attempts to figure out what has happened to her now that she has trouble remembering.

EXAMPLE F

A: I can’t remember anything. Why am I forgetting or am I not thinking things through? ( ) Or was it really forgotten? I don’t know.
I: Mmm.
A: I should remember. Is that a symptom? I wonder what happened? You know, that’s what I don’t know. I don’t know if forgetting or asking things twice is a symptom of having an aneurysm or not? Is IT?
I: Depending on the part of the brain affected, it can be.
A: Is it?
I: Yes.
A: Well, there you are? Well, I think, why can’t I remember asking it? What happened to me?
I: What do you tell yourself?
A: Why am I forgetting things? I think I’m not trying hard enough to remember. I don’t know why. >I’m so tired< . . .

In this account, we see Mrs. A struggling to talk about her life since her neurotrauma. Left bereft of most of her autobiographical memories, she actively inquires into the consequences of her brain damage by asking multiple questions (“what happened to me”, “why am I forgetting”, “why can’t I remember”). Her use of various mentally oriented verbs (“I think I’m not trying hard enough”) puts a strong emphasis on her role in figuring out, directing, and defining her story, and thus provides a focal point for her narrative.

When, in another part of the interview, directly asked, Mrs. A is able to state she had a stroke that left her with memory impairments; but now her main concern seems to be finding a more or less coherent story, a story that also tells about her “normal” attempts to compensate for her lost memories.

The following excerpt, example G, from a conversation with Mr. W bears similarity to the one from Mrs. A in example F. Here, Mr. W speculates about his memory and light-headedness.

EXAMPLE G

W: Why can’t I remember asking it, you know. I can’t think of anything else at the moment. Was it you that just took me into the kitchen? I don’t have a problem cooking.
I: No it wasn’t me.
W: I think, why can’t I think things through?
I: So you’ve noticed problems with your memory?
W: I’ve also had a few falls. I do get light-headed. I’m light-headed now. I think I should bring it up with my doctor. I don’t know whether I should be or whether I shouldn’t.

In contrast to Mrs. A, Mr. W is able to provide a generalized memory (“had a few falls”), which he uses as a springboard to engage in a series of questions (“Why can’t I remember, what happened . . .?”) that are remarkably similar to Mrs. A’s. He also uses many verbs that represent psychological processes (“I think, I don’t know”), highlighting his role as protagonist and the center of his narratives. His linguistic repertoire appears designed to demonstrate how he goes about directing his story, trying to search for memories that may give his story more coherence and provide him with a conversational attitude. And like Mrs. A, Mr. W is able to state, and appears to know, what has happened to him. But without any concrete autobiographical memories, this knowledge somehow seems unreal to him. Through all this the listener’s involvement in these interviews is restricted to answering and asking basic questions of Mrs. A and Mr. W.

Discussion

The aim of this paper is to examine the linguistic resources people with anterograde amnesia draw on in their conversational narratives. In order to accomplish this, patients with anterograde memory impairments due to neurotrauma were interviewed one year post-injury. These individuals were asked to talk about their new selves and lives, discussing issues such as what they had done the previous year, how they had been coping since their injuries and so forth. Of particular focus was how these people illustrated the points or ideas they were trying to explain given that they did not have many or any autobiographical memories to help them do so. A microanalytic narrative approach that captured participants’ lived reality was necessarily adopted because research methods such as using a structured coding scheme proved inadequate to explore the often times subtle discursive registers of the participants.

The results indicated that one way people with memory impairment tried to deal with their memory loss was to use particular linguistic resources, which were labeled “memory importation,” “memory appropriation,” and “memory compensation.” These resources are not particularly unique or unusual, they are linguistic options readily available for arranging experiences in a meaningful way for all speakers of the English language. Memory importation, the transplanting or extending of memories from the past to the present frequently happens, for example, when people mention an autobiographical memory that may have happened decades ago, yet tell it as if it reflects their current activities. In even more exceptional circumstances, people typically re-live past traumatic events in an ongoing present, re-experiencing them in several simultaneous time orders. This re-experiencing includes not only sensory flashbacks, but also memories more generally. Brockmeier (2000) points out that people organize their autobiographical memories in many different temporal frames, fusing events from the past, present or future in one order, the order of narrative. Likewise, Conway (2002) argues that memories have different temporal durations, which, I suspect, are constructed and embedded in narrative.

Memory appropriation, consisting of taking on and presenting another person’s memory as one’s own, is also common. This bears resemblance to what happens in social situations of memory talk such as when family members gather to reminisce about their shared past (Edwards & Middleton, 1999). In family conversations, for example, individual members often remember events that mirror the dominant family narrator’s memory of those events,
even if that is not what they originally recollected (Hirst, Manier, & Apetroaia, 1997; Tschuggnall & Welzer, 2001). This is what also was observed in some of the individuals with memory impairment. After hearing a family member’s memory often enough, their own individual “memory,” or narrative telling, tends to reflect it. As Middleton and Edwards (1990) emphasize, recalling and recounting of shared past events is one of those everyday discursive activities that blurs the distinctions between collective and individual remembering.

Lastly, there is the strategy of memory compensation, with questions and intentional verbs organizing a large portion of the discourse. This often repetitive form of discourse is similar to what takes place when people are at a loss to explain what has happened to their lives. In therapy or with partners and close friends, for instance, individuals often ask why their life went so wrong, searching for incidents that might make things clear. One might argue that this mode of discourse does not really represent a linguistic “strategy”, and that the participants are simply filling the space left by the dearth of autobiographical memories with a kind of perservative stream of consciousness (or discourse).

It is true that memory compensation may appear less “sophisticated” than memory importation or appropriation. Closer examination of individuals’ narrative accounts, however, demonstrates a forceful, even if at times desperate attempt to come to grips with the dramatic changes in their lives. These narratives do not just passively follow a tangential stream of consciousness but represent a focused effort to present a story about one’s life after injury. And, what’s more, they explore possibilities that might give meaning to what happened.

Although the individuals in this study were able to draw on common linguistic devices to help them tell their narratives, admittedly, these devices were not always implemented in a typical manner. In most circumstances, even if people import memories, they normally do not maneuver memories quite so liberally; even if people appropriate a memory, they likely remember at least some elements of the reported events; and even if people compensate for lost memories, they do not constantly repeat the same self-centered speculations and questions. Thus participants’ use of the various linguistic options may have led to structural difficulties in their narratives; and in fact, their use may explain some of the difficulties observed in the stories of people with memory impairments when traditional cognitive coding methodologies are used (e.g., Caspari & Parkinson, 2000).

The next stage of research might involve examining the use of linguistic devices in people with different cognitive profiles. Another topic deserving further investigation is the role of these linguistic devices in the relation between self-knowledge and episodic memory. Klein (2004) argues that self-knowledge and episodic memory are dissociable and are located in separate subsystems. It would be interesting to explore whether the linguistic registers outlined in the present study mediate between these two subsystems. In addition, the linguistic devices, particularly memory importation, might mediate between the observed altered sense of being in time and brain damage (see Levine, 2004, for more about the self in time as dependent on a distributed fronto-temporo-parietal system).

A pivotal topic needing further investigation is the role of conversational expectations in the context of brain injury. Participants’ use of the various linguistic strategies violated conversational expectations as indicated by the listener’s responses. Responses on the part of listeners are particularly important because they legitimate or silence aspects of the narrator’s stories (Pasaupthi, 2001). The listener often halted, interrogated, or ignored the narrative when these devices were used, thus insinuating that the narrative might be the result of confusion, confabulation, and the like. This implies that the listener noticed a problem in the stories; that the accounts told in this way were deemed improbable or odd. It
would be interesting to investigate whether family members and friends respond to the linguistic options in a manner similar to the interviewer.

Rather than being due to actual problems in the narrative itself, however, these responses may have been the product of the listener’s discursive engagement, who, as health professionals and family members do, knew the neurological history of the interviewed individuals. The label of brain damaged alerts the listener to look for “symptoms.” This raises the question as to whether a person ignorant of the speaker’s neurological status would attend to the narrative in quite the same way. If naive listeners did not respond to the devices in the same way, it would suggest that “symptoms” in the narrative are not as relevant if one is focused on other aspects of the stories, such as their meaning. These stories might embody, for example, what the person is experiencing or what their life is like (Medved & Brockmeier, in press). The most important issue, thus, might be that these linguistic registers enable the person to tell accounts at all.

In light of narrative meaning-making, one way to view the identified discursive devices is to look at them as a way to cope with absence—in this case, absence of memory. As Goldstein (1995) put it, “symptoms are answers, given by the modified organism, to definite demands: they are attempted solutions” (p. 35). Exploring narratives from people with brain damage, we begin to understand how they deal with their cognitive loss. We can see that one “solution” of individuals lacking autobiographical memories is to use certain linguistic resources to facilitate their accounts even if their use of them makes their conversational narratives look “symptomatic”. This is particularly important to keep in mind in rehabilitation contexts because it helps us to see what it means that a symptom can serve as a “solution.”

Typically, rehabilitation efforts focus on helping people with memory impairments “remember” autobiographical events by encouraging them to use memory books and similar aids. While this is an essential intervention, there also needs to be an awareness by health professionals interacting with these individuals that in trying to adapt to their losses they may use memory strategies such as memory importation, memory appropriation and memory compensation.

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References


Appendix A. Transcription conventions

< > Speed up talk
> < Slow down talk
(2) Pauses in seconds (here: 2 seconds)
(·) Micropause
(:) Prolongation of preceding sound
Underlining Emphasis
CAPITALS Speech that is louder than the surrounding speech
Italics Increase in pitch
[] Transcriber’s comment