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Navigating internal consistencies: a case report on neuropsychological assessment of functional cognitive disorder

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ABSTRACT: Functional Cognitive Disorder (FCD) is a subtype of Functional Neurological Disorder (FND), with diagnostic criteria that have only recently been established in a major disease classification system. Although objective neuropsychological measures are not required for diagnosing FCD, they can provide valuable insights into discrepancies between subjective cognitive complaints, functionality, and objective neuropsychological performance. We present the case of a 51-year-old Malay female with a history of Major Depressive Disorder who developed neurocognitive complaints affecting her occupational and social functioning following the sudden death of her husband. A comprehensive assessment, including neuropsychological testing, brain MRI, and laboratory investigations, was conducted. Neuropsychological evaluation revealed significant impairments across multiple neurocognitive domains. However, the presence of situational and mood-related variability in memory performance, along with an inconsistency between the severity of her objective cognitive impairments and her largely preserved ability to perform instrumental activities of daily living (IADLs), supported a diagnosis of FCD. The diagnosis and management of FCD require a multidisciplinary approach. Clinical neuropsychology plays a crucial role in both diagnosing and understanding FCD by assessing neurocognitive functioning and intrapsychic processes. The use of various psychological instruments can help elucidate the neurocognitive profile of FCD to inform a more comprehensive and individualized management plan.

Keywords: Functional cognitive disorder; Dissociative neurological symptom disorder; Functional neurological disorder; Conversion disorder; Neuropsychological assessment.

1.0 INTRODUCTION

Functional cognitive disorder (FCD) is a type of functional neurological disorder (FND) characterised by one or more neurocognitive impairments in the absence of organic or psychiatric causes. It is a condition that is likely common in clinical practice but underdiagnosed (Ball et al., 2020). Various definitions and terms have been used to describe FCD. For instance, cogniform disorder is used to describe a pattern of excessive cognitive complaints or low neuropsychological test scores that have no evidence of an organic or psychiatric cause or malingering (Delis & Wetter, 2007). Until recently, FCD was not included in major disease classification systems. The 11th revision of ICD (ICD-11) classified FCD as "Dissociative neurological symptom disorder, with cognitive symptoms." In contrast, the latest text revision of the Diagnostic and Statistical Manual of Mental Disorders – DSM-5-TR continues to limit FND to symptoms related to sensory or motor functions (World Health Organisation, 2022; American Psychiatric Association, 2022). Ball and colleagues (2020) described diagnostic criteria for FCD that align with the ICD-11 description (**Table 1**).

Table 1. Diagnostic criteria of FCD

i.	One or more symptoms of impaired cognitive function.
ii.	Clinical evidence of internal inconsistency.
iii.	Symptoms or deficits that are not better explained by another medical or psychiatric disorder.
iv.	Symptoms or deficits that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, or warrant medical evaluation.

Given that the diagnostic criteria for FCD have only recently been established in a major disease classification system, the neuropsychological characteristics of FCD can only be derived primarily from studies of individuals with subjective cognitive complaints, which may include a subset who meet the current diagnostic criteria for FCD. FCD has distinct neuropsychological characteristics compared to neurodegenerative disorders. Individuals with subjective memory impairments but normal objective cognition were more likely to experience attention deficits or word-finding impairments as first symptoms. In contrast, memory impairments and unspecified symptoms were more likely to be the initial symptoms of dementia (Haussman et al., 2018). In studies using objective measures of cognition, FCD participants showed comparable immediate memory impairment but stronger category fluency, delayed memory, recognition memory, and memory retention than those with mild cognitive impairment (Ball et al., 2021; Wakefield et al., 2018). In addition, FCD participants exhibited a neuropsychological profile like that of healthy controls, including normal performance in straightforward attention tests (Wakefield et al., 2018; Schmidtke et al., 2008). Individuals with FCD may have comorbid psychiatric conditions or psychosocial stressors such as depression, anxiety, and interpersonal conflicts, and the cognitive difficulties they experience may exceed what would typically be expected from these comorbid conditions. (McWhirter et al., 2022; Bhome et al., 2019; Schmidtke et al., 2008).

2.0 CASE HISTORY

This case study describes the clinical presentation and multidisciplinary evaluation of a patient seen at the Advanced Memory and Cognitive Clinic, Universiti Sains Malaysia Specialist Hospital. Written informed consent was obtained from the patient for participation in psychological services and for the use of her clinical information in this case report. Her next-of-kin was present during the informed consent process.

Mrs. D is a 51-year-old Malay female with a history of Major Depressive Disorder (MDD). She was referred for evaluation of persistent cognitive disturbances despite effective management of MDD. Following her husband's sudden death in 2018, she experienced depression symptoms and forgetfulness, including incidents of misplacing objects and lapses in recollection. She sought psychiatric evaluation four years later and was given mood stabilisers. While her mood and sleep disturbances improved significantly with pharmacotherapy, her memory issues persisted.

In 2021, she was relieved from her secondary school teaching duties due to significant memory impairments, including forgetting classes, confusion with schedules, getting lost, and repeatedly teaching the same topic. She also reported feeling unsupported by her colleagues, which contributed to emotional distress and underlying resentment.

While she remained independent in basic activities of daily living (ADLs), she required intermittent assistance with some instrumental ADLs, such as managing medications, preparing meals, and handling finances (see Activities of Daily Living Scale in **Table 2**). She could drive to familiar locations without difficulty. Her memory was notably better during pleasurable activities but worsened when she was depressed or irritated.

After the sudden death of Mrs. D's husband, she was the sole breadwinner for herself and three adolescent children. She was saddened by her underperformance at work and worried that she might be asked to take early retirement, which would disqualify her from receiving a full pension to support her family. Mrs. D was not involved in any medicolegal matters.

2.1 Clinical investigation

Mrs. D had no family history of neurodegenerative or psychiatric disorders. A brain magnetic resonance imaging (MRI) performed in 2023 showed foci of hyperintensity in the bilateral frontal regions on T2-weighted imaging, with no evidence of an intracranial space-occupying lesion (see **Figure 1**). Blood tests for autoimmune diseases in 2024 were negative.

A comprehensive neuropsychological assessment in December 2023 identified significant impairments across multiple neurocognitive domains. Following this, Mrs. D underwent seven sessions of Cognitive Behavioural Therapy (CBT) alongside ongoing pharmacotherapy between June and September 2024. This intervention was associated with a reduction in her Beck Depression Inventory (BDI) score from the moderate to the mild range. A follow-up neuropsychological reassessment was carried out in September 2024 after the completion of CBT.

Table 2. Neuropsychological assessment results.

Neuropsychological Test	Initial Test Score	Initial Normative Comparison	Follow-up Score	Follow-up Normative Comparison
	December 2023		September 2024	
Performance-based Test				
Performance Validity Test				
Reliable Digit Span	-	-	7	Below cut-off
RFIT and Recognition Trial	-	-	16	Below cut-off
Attention				
CTMT-II [a]: Trial 1	18	Significantly Impaired	-	-
WAIS-IV [b]: Digit Span Forwards	-	-	1	Significantly Impaired
Memory				
WMS-IV [c]:				
Auditory Memory	47	Significantly Impaired	49	Significantly Impaired
Visual Memory	65	Significantly Impaired	62	Significantly Impaired
Visual Working Memory	67	Significantly Impaired	70	Moderately Impaired
Immediate Memory	63	Significantly Impaired	53	Significantly Impaired
Delayed Memory	44	Significantly Impaired	53	Significantly Impaired
Executive Function				
Delis-Kaplan Tower Test [b]:				
Total Achievement Score	8	Mild Impairment	4	Significantly Impaired
Time-Per-Move-Ratio	9	Average	10	Average
Move Accuracy Ratio	1	Significantly Impaired	1	Significantly Impaired
Rule-Violations-Per-Item Ratio	3	Significantly Impaired	9	Average
Self/Informant-report Questionnaire				
Mood				
Beck Anxiety Inventory – Malay [d, e]	1	Minimal	9	Mild
Beck Depression Inventory – Malay [d]	3	Minimal	2	Minimal
Dissociation				
MID-60	-	-	13	Limited
Activities of Daily Living				
Activities of Daily Living Scale[d]				
Katz Form (ADL) (self-report)	10/10	A higher score indicates greater ability	10/10	A higher score indicates greater ability
Lowton Form (IADL) (self-report)	15/16		15/16	
Katz Form (ADL) (informant-report)	10/10		10/10	
Lowton Form (IADL) (informant report)	12/16		12/16	

[a] T score, [b] scaled score, [c] index score, [d] raw score, [e] Score inconsistent with reports; may reflect memory effects, PVT: performance validity tests, RFIT: Rey 15-item Test, CTMT-II: Comprehensive Trail Making Test-II, WAIS-IV: Wechsler Adult Intelligence Scale-IV, MID-60: Multidimensional Inventory of Dissociation 60-item; ADL: activities of daily living; IADL: instrumental activities of daily living

Table 2. Neuropsychological assessment results (Continued from last page).

Cognitive Domain	Test	Score	
		Initial Assessment	Follow-up
PVT	Reliable Digit Span	-	7
	RFIT and Recognition Trial		16
Attention	CTMT-II [a]: Trial 1	18	-
	WAIS-IV [b]: Digit Span Forwards	-	1
Memory	WMS-IV [c]:		
	Auditory Memory	47	49
	Visual Memory	65	62
	Visual Working Memory	67	70
	Immediate Memory	63	53
	Delayed Memory	44	53
Executive Function	Delis-Kaplan Tower Test [b]:		
	Total Achievement Score	8	4
	Time-Per-Move-Ratio	9	10
	Move Accuracy Ratio	1	1
	Rule-Violations-Per-Item Ratio	3	9
Mood	Beck Depression Inventory-II	6	2
	Beck Anxiety Inventory-II	3	9
Dissociation	MID-60	-	13

[a] T score, [b] scaled score, [c] index score, PVT: performance validity tests, RFIT: Rey 15-item Test, CTMT-II: Comprehensive Trail Making Test-II, WAIS-IV: Weschler Adult Intelligence Scale-IV, MID-60: Multidimensional Inventory of Dissociation 60-item

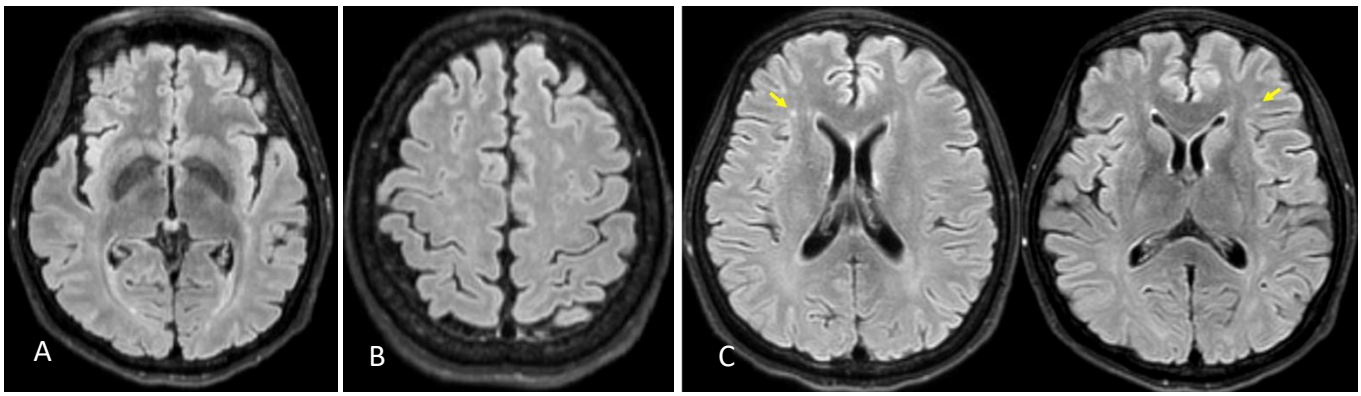

Figure 1. Axial FLAIR MRI brain images at the level of the third ventricle **(A)** and vertex **(B)** demonstrate mild sulcal widening, indicative of mild cerebral atrophy. Image **(C)** shows a few foci of hyperintensity in the bilateral frontal subcortical white matter (arrows).

All neuropsychological assessment tools used were objective, performance-based tests that assessed various neurocognitive functions, with the exceptions of the Beck Depression Inventory, Beck Anxiety Inventory, MID-60, and Activities of Daily Living Scale, which are questionnaires based on subjective reports from the patient or their informants (see **Table 2**).

Two personality tests were administered during the follow-up assessment. Her Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) profile was not valid because of a high score (T score: 80) on the True Response Inconsistency Scale. Rorschach Inkblot Test using the comprehensive scoring system (RCS) suggested that Mrs. D might struggle to process and express emotions, experience stress overload due to low frustration tolerance and limited coping strategies, and pay insufficient attention to herself.

2.2 Outcome

Mrs. D's subjectively reported cognitive difficulties occurred after the sudden death of her husband and were experienced concurrently with grief and depression. Despite a positive response to pharmacotherapy and CBT in terms of mood symptoms, no significant changes were observed in Mrs. D's neurocognitive functioning or her capacity to perform IADLs. She continued to experience intermittent

feelings of resentment and stress, particularly in situations where she perceived a lack of support from others.

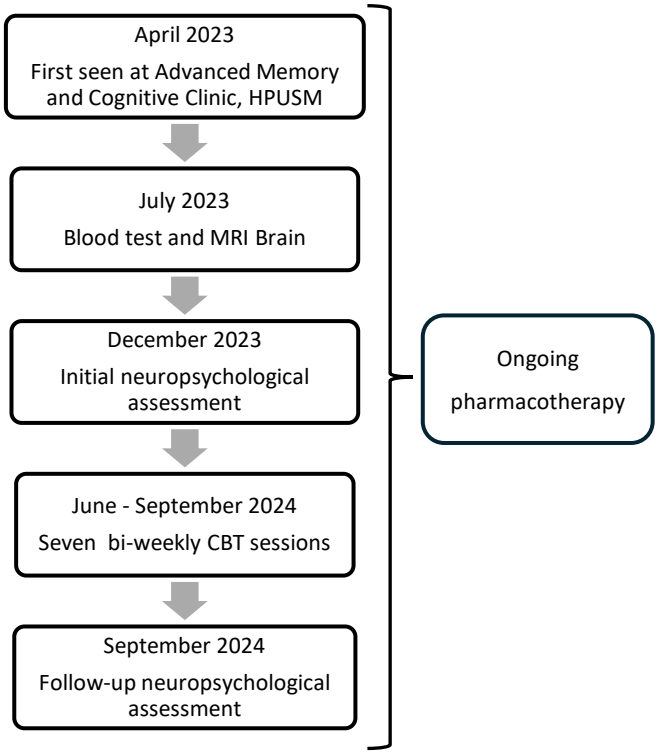

Figure 2. Flow of Investigation.

Clinical investigations suggested that the cognitive impairments aligned with the diagnostic criteria of FCD. Firstly, objective measures of her neurocognition indicated that she had significant deficits in attention, memory, and executive functions. Secondly, a notable inconsistency was observed between the severity of her objective neurocognitive impairments and her preserved ability to perform instrumental ADLs, such as driving. In addition, her memory function varied with her mood and situational context. Thirdly, no neuroimaging abnormalities, medical conditions, or psychiatric disorders were identified that could adequately account for the extent of her neuropsychological impairments. Lastly, these cognitive difficulties caused significant distress and impairments in her daily functioning.

Given the presence of context-dependent emotional distress, potential difficulties in emotional processing and expression, persistent cognitive complaints, and objective evidence of cognitive impairment, Mrs. D would likely benefit from continued psychological support. Psychotherapeutic approaches such as psychodynamic therapy, schema-focused therapy, or neuropsychological interventions tailored to FND (Van der Hulst, 2023) may be appropriate to address underlying emotional conflicts, cognitive-emotional interactions, and functional impairments.

3.0 DISCUSSION

FCD shares overlapping clinical presentations with various medical and psychiatric disorders, including neurodegenerative disorders, pathological fear of cognitive lapses, and malingering. (Kemp et al., 2022). Although neuropsychological testing is not required for diagnosing FCD, it can provide valuable insights into internal inconsistency (Kemp et al., 2022). In this case report, internal inconsistency was established by comparing objective cognitive findings with self- or informant-reported daily functioning, behavioural observations, and established neurocognitive models.

Empirical studies have shown that individuals with FCD often perform similarly to healthy controls on cognitive tasks (Wakefield et al., 2018). However, this report shows persistent extremely low cognitive performance in both initial and follow-up assessments. Similarly, a comparable case report documented significant below-average performance in the domains of attention and memory, which improved significantly after non-pharmacological interventions (Godena et al., 2023). Such severe cognitive symptoms are possible, but they tend to occur in isolated cases (Kemp et al., 2022).

Given the history of MDD in this case report, it is important to consider whether depressive pseudodementia better accounts for the cognitive impairments. Individuals with MDD may have cognitive impairments that may persist after remission in MDD (Rhee et al., 2024; Semkovska et al., 2019). The cognitive impairments in individuals with MDD in remission are generally modest in magnitude except for pronounced deficits in inhibitory control (Bora et al., 2013). In contrast, this case report presents profound deficits across all cognitive domains, including inhibitory control, even after improvement in depressive symptoms. This pattern suggests that factors beyond MDD may be contributing to cognitive impairment. Notably, the presence of MDD does not exclude a diagnosis of FCD, and their comorbidity may perpetuate each other's symptoms (Bhome et al., 2019).

Validity assessment is a crucial component of neuropsychological assessment to ensure the accuracy of conclusions regarding cognitive functioning (Heilbronner et al., 2009). Consistent with prior studies,

this case report highlights failures in performance validity tests (PVTs) (Godena et al., 2023; McWhirter et al., 2022). Although symptom validity tests (SVTs) on the MMPI-2-RF in this case report were uninterpretable due to fixed response patterns, FCD has been associated with overreporting of symptoms on the MMPI-2-RF (Ball et al., 2021). Experts have opined that single or multiple failures in PVT or symptom validity test (SVT) are common in feigning, exaggeration, and malingering but rare in FCD (Kemp et al., 2022). However, such should not be automatically interpreted as evidence of intentional suboptimal effort. One plausible explanation is that excessive effort to perform well in neuropsychological tests may, counterintuitively, result in poorer performance (McWhirter et al., 2022). In this report, excessive effort to perform well might have been driven by the desire to prevent early retirement and loss of full pension. Regardless of the causes, the neuropsychological test data of this case should be interpreted with caution, as they do not accurately reflect Mrs. D's cognitive abilities. However, it does not exclude FCD (Schroeder & Martin, 2022; Sweet et al., 2021).

FCD is associated with greater emotional or internalising dysfunction, somatic and cognitive complaints, as well as a tendency to experience a wide range of negative emotional experiences on the MMPI-2RF (Ball et al., 2021). Although the MMPI-2-RF data of this case report are invalid, RCS suggested challenges in processing and expressing emotions, low frustration tolerance, and limited coping strategies. These findings are consistent with the view that the onset and maintenance of FND involve dysregulation of the top-down and bottom-up emotional processing contributed by psychosocial stressors (Pick et al., 2019). In this case, difficulties in processing unpleasant emotional experiences following the sudden death of Mrs. D and the subsequent period of adjustment might have caused cognitive impairments.

Mrs. D received CBT that primarily engages top-down mechanisms of change by consciously manipulating the contents and processes of thinking (Ruggiero et al., 2018). Although CBT may alleviate MDD symptoms, its effectiveness in regulating bottom-up emotion processing dysfunction that perpetuates FCD is limited and may even be counterproductive (Frederickson et al., 2018). This conceptualisation highlights the need to integrate broader psychotherapeutic models into FCD assessment and treatment. In addition to CBT, approaches that focus on bottom-up mechanisms, such as psychodynamic therapy and schema therapy, may offer additional benefit (Yakin & Arntz, 2023; Russell et al., 2022). Psychological assessment instruments, such as the Schema Mode Inventory (Young et al., 2007) and psychodynamic conflict scales (Simmonds et al., 2015) can complement symptom severity scales and neuropsychological tests by offering insights into the underlying psychological processes of FCD and comorbid psychiatric conditions. Projective tests, such as the Rorschach Inkblot Test, are useful for subtly assessing personality and neuropsychological profiles (Minassian & Perry, 2004). For example, the Rorschach Inkblot Test is useful in identifying personality strengths and weaknesses in FND and providing insights into neurocognitive deficits (Luca et al., 2024; Carmela et al., 2020).

One main limitation of this case study is the lack of a consistent set of assessment tools employed for both pre- and post-intervention evaluations. In this case, different tools were used for some cognitive domains at each evaluation, limiting the comparability of results and weakening the strength of conclusions regarding changes in cognitive functioning over time. For future evaluation, it is recommended to use the same neuropsychological instruments at each assessment point to enable direct comparison and a more robust interpretation of outcomes.

4.0 CONCLUSIONS

This case report highlights both the variability and similarities between the neuropsychological profile of this case and findings from existing studies and case reports. Given the relatively recent establishment of FCD diagnostic criteria in ICD-11, there are limited studies of well-defined cases of FCD. Many published neuropsychological profiles of FCD are based on various operational definitions and related neurological or psychiatric disorders. Thus, these profiles should not be used as diagnostic markers (Cabreira et al., 2023).

As demonstrated in this case report, diagnosing and managing FCD requires the integration of neurology, psychiatry, and clinical neuropsychology. Specifically, clinical neuropsychology, as a subspecialty of clinical psychology, can contribute to diagnosing and understanding FCD by assessing both neurocognitive functioning and intrapsychic processes using various psychological instruments, and subsequently providing psychological interventions informed by a more comprehensive conceptualisation of FCD.

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