



Diagnostic and treatment practices for psychogenic nonepileptic and epileptic seizures in Namibia

Anina du Toit *, Chrisma Pretorius

Stellenbosch University, Department of Psychology, Wilcocks Building, Victoria Street, Stellenbosch 7130, South Africa



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ABSTRACT

Purpose: Information about existing healthcare resources for the management of seizures in developing countries is lacking. These countries are often poorly equipped to deal with the immense burden of costs, mortality, stigma, seizure-related disability, and comorbidities presented by seizure disorders. This study aimed to contribute to the goals of the International League Against Epilepsy (ILAE) by investigating the resources available for patients with seizure in Namibia.

Methods: Two separate surveys on the diagnostic and treatment practices for epileptic seizures (ES) and psychogenic nonepileptic seizures (PNES) were administered to private healthcare practitioners (HCPs) in Namibia.

Results: The findings are based on 50 responses from HCPs involved in the management of seizures. The responses indicate that HCPs have less confidence in their ability to manage PNES than ES. Psychological/psychiatric assessments are seldom utilized. Although HCPs engage in face-to-face communication of diagnoses, they seldom refer patients to additional sources of information. Healthcare practitioners follow up patients with ES more regularly than those with PNES. Healthcare practitioners indicated their willingness to collaborate and recognize the role of traditional health practitioners (THPs) in a supportive capacity when it comes to the management of seizures. Financial constraints, limited availability of specialized equipment, and lack of knowledge and awareness regarding seizure disorders among both HCPs and patients were mentioned as major obstacles in accessing healthcare services.

Conclusion: The findings of this study add to the current literature by demonstrating some of the particular characteristics of HCPs from a lower middle-income African country regarding the diagnosis and treatment of PNES and ES.

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1. Introduction

The importance of investigating the diagnostic and treatment practices available for people with seizures cannot be overemphasized. Epilepsy affects the lives of between 65 and 70 million people all over the world, with between 80 and 90% found in developing countries [1,2]. Epilepsy is Sub-Saharan Africa's (SSA) most common, chronic and severe neurological disorder, and the costs, mortality, stigma, seizure-related disability, and comorbidities with which it comes are enormous [3,4]. One of biomedicine's greatest difficulties is successfully diagnosing and classifying seizure disorders. Epileptic seizures (ES) are often misdiagnosed, with false positives reported in up to 30% of patients [5–7]. Misdiagnosis can have grave consequences for patients, including the unwanted side effects of antiepileptic drugs (AEDs) as well as a negative impact on psychosocial functioning [8–10]. Misdiagnosis is often the consequence of a lack of knowledge about other conditions that look like ES, such as psychogenic nonepileptic seizures (PNES),

the over- and misinterpretation of electroencephalography (EEG) results, inefficient healthcare facilities, lack of training and experience among healthcare personnel, incomplete medical history taking, and lack of funds for specialist care [5,9,11,12].

The International League Against Epilepsy (ILAE) defines ES as “a transient occurrence of signs and/or symptoms due to abnormal excessive or synchronous neuronal activity in the brain” [13]. Psychogenic nonepileptic seizures resemble or mimic ES, but they are in fact episodes of altered experience, sensation, and movement, not as a result of abnormal electrical discharges in the brain, but rather underlying psychological stressors [14–16]. Conventionally, symptoms that arise as a result of organic pathology or physiological dysfunction (physical causes) are seen as “medically explained symptoms” (MES) whereas symptoms that are unexplained by organic disease is referred to as “medically unexplained symptoms” (MUS) [17–19]. According to the above two definitions, ES sort into the category of MES and PNES resort under MUS due to the medically unexplained nature of its symptoms, which instead arise as a result of psychological (psychiatric) causes. This distinction between MES and MUS for ES and PNES affects how the two conditions are usually managed by healthcare practitioners (HCPs). Treatment for MES seems relatively straightforward, with

* Corresponding author at: P.O. Box 86120, Eros, Windhoek 9000, Namibia.

E-mail addresses: anina@letstalkpsych.biz (A. du Toit), chrismapretorius@sun.ac.za (C. Pretorius).

pharmacology in the form of AEDs being the preferred choice of action in the case of ES [1,20]. Various forms of psychotherapy are the most preferred and effective treatment for MUS, such as PNES. However, the misdiagnosis of PNES as ES is common, and it often leads to prolonged treatment with AEDs [21–25]. The debate surrounding the controversy of conversion disorders is also indicative of the perceptions described above, and although the psychiatric taxonomy recognizes its validity, many HCPs still consider it contrived and lacking a physical cause [26,27]. What is more, health professionals commonly misinterpreted the psychogenic origin of these seizures as a sign of deliberate fabrication. They then assume a negative attitude, and the patient fails to accept the diagnosis as a result [22].

Some countries are poorly equipped to deal with the immense economic, medical, and social burden that seizures bring, especially those that fall into the World Bank's classification of Low and Lower Middle Income (LMIC) based on gross national income per capita [11]. Sub-Saharan Africa, parts of Asia, Latin America, and the Pacific regions house most of these countries. They often battle with challenges such as inefficient healthcare systems, widespread poverty, and unevenly distributed material resources [11]. In addition, "The few efficient health care facilities that exist in these countries predominantly benefit people who reside in urban areas and those belonging to the economically advantaged section of society, and rarely benefit the poorer sections of the population who live mostly in rural areas" [11]. Namibia is no exception. Secondary and tertiary healthcare is more accessible to the affluent urban population of Namibia than to the rural poor [28].

Namibia has a dual healthcare system — one is public (state), and the other private. More than 60% of the total Namibian population of 2,459,000 rely on public healthcare provided by the Namibian government while 18.65% is covered by private health insurance and the remainder is out-of-pocket [29]. Namibia has 268 doctors and 66 specialists in full-time government employ to serve more than 1,700,000 uninsured Namibians while HCPs in the private sector mainly serve patients with private health insurance [30]. According to the World Health Organization (WHO), Namibia has 0.374 physicians per 1000 people; 12 psychiatric beds per 100,000 people; and 4.78 computerized tomography (CT) units, 0.87 magnetic resonance imaging (MRI) units, and 0.77 electroencephalography (EEG) monitors per 1,000,000 people [29]. No video-EEG (vEEG) monitors, which are known as the gold standard for diagnosing PNES, are available in the country, nor does the country have an epilepsy monitoring unit.

Most of the studies conducted on the diagnosis and treatment of PNES or ES have been performed in developed countries, with developing countries such as Namibia receiving less attention [25,31–33]. No official statistics or diagnostic and treatment guidelines on PNES or epilepsy can be found for Namibia (H. Riphagen, Personal communication, Epilepsy Namibia, 27 June 2016).

Even though epilepsy is the most common neurological condition worldwide, it involves more than just seizures, and patient concerns center on more everyday worries, such as questions about independent living, uncertainties about social and employment situations, and academic challenges [20]. The same is true for PNES, where associated stigma and loss of quality of life are additional consequences of misdiagnoses [34]. Given that it takes an estimated 7.2 years to reach a definitive diagnosis of PNES, seizures are costly, both to the economy and the healthcare infrastructure [35–37].

The successful management of seizures is, therefore, of extreme importance in developing countries with limited access to adequate healthcare infrastructure and manpower. As a result, it is crucial to determine the diagnostic and treatment options available for people with seizures and how the current infrastructure and skills base contend with ES and PNES. At the same time, health-seeking behavior in Africa is a multi-layered process grounded in a kaleidoscopic range of healing styles and treatment preferences [38,39]. It is no different in Namibia where patterns of utilization may include a variety of healthcare modalities and depend on perceived causes or the healthcare

treatment that is available [40–42]. The majority of people in Namibia reside in rural parts of the country with limited access to specialized services and equipment. It is therefore not surprising that people with seizures may seek care from traditional health practitioners (THPs) who are physically more accessible, who provide greater cultural and conceptual understanding, and whose explanatory model for seizures is possibly closer to those of the people they serve. Traditional medicine (TM) is defined by the WHO as "including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness" [43]. There is some cultural variation in traditional healing practices, but there are also many overlaps and shared practices among the various ethnic groups [40,41]. Traditional medicine in Namibia is offered by faith healers, diviners, fortune-tellers, spirit mediums, bone-setters, herbalists, and homeopaths [40]. African healing practices are traditionally transmitted from generation to generation through oral tradition and some form of apprenticeship [44]. As a result, these practices can be inconsistent, non-standardized, and undocumented [45]. African healing practices are also not universal, but rather personal and particular to an individual patient with treatment that focuses on the specific circumstances of the patient and the healer [45]. This is in stark contrast to the biomedical framework, which is based on scientific enquiry and where disease is seen as universal and treatment as similar across all modalities [46]. Most HCPs such as general practitioners (GPs), neurologists, and other specialists are formally trained in biomedicine at tertiary institutions based on the dominant model of disease in Western culture. In contrast, THPs seldom undergo formal training at tertiary institutions and instead rely on knowledge imparted through divination, apprenticeship, and tradition. The differences between the biomedical and traditional healthcare systems and the perception that biomedicine dominates in the field of healthcare often lead to distrust between HCPs and THPs [47,48].

The current study can contribute to the goals of the ILAE and the ILAE PNES Task Force by providing information on the diagnostic techniques and treatment modalities used in Namibia for the management of seizures.

2. Methods

2.1. Study design

This study formed part of a larger study that included a qualitative component. This article reports the findings of the quantitative part of the larger study and quantifies the approaches to the diagnosis and treatment of PNES and ES respectively. Purposeful sampling was used to identify participants from the available HCP pool in Namibia. According to the Ministry of Health and Social Services (MoHSS) Essential Indicators Database 2006–07 as reported in the WHO Regional Office for Africa Country Cooperation Strategy [49], Namibia is served by 557 medical practitioners that include GPs, dentists, psychologists, and pharmacists. Namibia is served by two state-owned and operated psychiatric wards that cater for approximately 200 patients in total. The psychiatric unit in Windhoek employs 4 psychiatrists while the unit in Oshakati, in the far north of the country, is served by one psychiatrist. There are three psychiatrists in private practice in Windhoek. Three neurologists practice in Namibia and render services to both state and private patients. Two of them are situated in Windhoek while the other one practices in Oshakati. Approximately 35 clinical psychologists practice privately in Windhoek and about 15 in other towns across the country. The psychiatric unit in Windhoek employs the services of 3 clinical psychologists.

The MoHSS, the Health Providers Council of Namibia (HPCNA), Namibia Medical Aid Fund Administrators (NAMAF), and other private bodies are tasked with regulating the activities of healthcare

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