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Healthcare Pathways and Access to Care for Patients with Functional Neurological Disorder in Senegal: From Traditional Healers to Neuropsychiatrists—A Cross-Sectional Study

Momar Camara[1,2*], N'godo Marie Inès Constance Kouakou[1], Sokhna Seck[3], Rokhaya Gueye[1], Ndeye Awa der Dieye[1], Ibra Diagne[1], Maïmouna Dieye[1], El Hadji Makhtar Ba[4], Aïda Sylla[3]

[1]Centre Hospitalier National Psychiatrique de Thiaroye, Dakar, Senegal
[2]Faculty of Medicine, Pharmacy and Odontology, Cheikh Anta Diop University, Dakar, Senegal
[3]Centre Hospitalier National Universitaire de Fann, Dakar, Senegal
[4]Centre Hospitalier National d'Enfants Albert Royer, Dakar, Senegal
Email: *momarcamara@yahoo.fr

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Abstract

Background: Functional neurological disorder (FND) is the second most common reason for neurological consultation worldwide. However, healthcare pathways in sub-Saharan Africa remain poorly documented. **Objective:** This study aimed to describe the therapeutic itineraries, diagnostic delays, and quality of diagnostic communication for patients with FND in Senegal. **Methods:** A cross-sectional descriptive study with retrospective and prospective data collection was conducted from January to June 2024 at the Child Psychiatry and Neurology Department of CHNEAR, Dakar, Senegal. All patients diagnosed with FND according to DSM-5 criteria during the study period were included (n = 8, all female). Sociodemographic data, diagnostic delay, healthcare pathways, diagnosis disclosure, and understanding were collected. A comprehension/disclosure (C/D) ratio was calculated as the proportion of patients who understood their diagnosis among those who received it. **Results:** Eight female patients were included (mean age: 27.6 years; range: 13 - 69). Patients presented with polysymptomatic FND; the most frequent symptoms were headaches (87.5%) and muscle cramps (75%), followed by functional seizures, loss of consciousness, and memory disturbances (37.5% each). The mean delay before specialised consultation was 19 months (range: 4 - 60 months). Five types of healthcare resources were identified: word-of-mouth, traditional healers, general practitioners, neurologists, and psychiatrists. The pathways were classified as simple (50%) or complex (50%). Word-of-mouth dominated sim-

ple pathways (75%), whereas complex itineraries systematically involved traditional healers or multiple general practitioners as entry points. The diagnosis was disclosed to 87.5% of the patients and understood by 62.5%, yielding a C/D ratio of 0.71. **Conclusion:** Healthcare pathways for FND in Senegal are characterised by significant diagnostic delays and frequent recourse to traditional healers. The circulation between general practitioners, neurologists, and psychiatrists without effective coordination contributes to therapeutic wandering. Improved training of healthcare professionals and coordinated care pathways are needed to reduce diagnostic delays.

Keywords

Functional Neurological Disorder, Healthcare Pathway, Traditional Healer, Access to Care, Senegal, Africa

1. Introduction

Functional neurological disorder (FND), formerly known as hysteria, conversion disorder, or somatoform disorder, is a clinical entity characterised by motor, sensory, or cognitive neurological symptoms that are incompatible with recognised neurological diseases [1] [2]. Since the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the eleventh revision of the International Classification of Diseases (ICD-11), diagnoses have been based on the identification of positive clinical signs rather than the exclusion of organic pathology [3] [4].

FND is the second most common reason for neurological consultation after headaches, with an estimated incidence of 4 - 12 per 100,000 inhabitants per year [5]. It preferentially affects young women, with a ratio of 3 to 1 [6]. Despite its high frequency, FND remains underdiagnosed and is often unknown to healthcare professionals. European studies have revealed that nearly half of the physicians in training have never received specific teaching on this disorder [7].

Patients with FND face a twofold difficulty: on one hand, the absence of an identifiable organic substrate generates misunderstanding and stigmatization from healthcare providers [8]; on the other hand, cultural representations associating psychiatric symptoms with weakness, spiritual possession, or divine punishment hinder access to specialized care [7] [9]. These obstacles are particularly marked in sub-Saharan Africa, where recourse to traditional healers often constitutes a preliminary step before seeking biomedical consultation [10].

The resulting diagnostic delay and therapeutic wandering have major consequences, including symptom chronification, impaired quality of life, and considerable economic costs related to multiple consultations and repeated complementary examinations [11] [12]. However, data on the healthcare pathways for patients with FND in Africa remain scarce.

This study aimed to describe the therapeutic itineraries and access to care mo-

dalities for patients with FND followed in a specialised department in Dakar, Senegal.

2. Methods

2.1. Study Design and Setting

This was a cross-sectional descriptive study with retrospective and prospective data collection, conducted from January to June 2024, at the Department of Child Psychiatry and Neurology of the Centre Hospitalier National d'Enfants Albert Royer (CHNEAR) in Dakar, Senegal.

CHNEAR is a tertiary-level public health facility (national referral hospital) dedicated to paediatrics in Senegal. The Department of Child Psychiatry and Neurology serves as a referral centre for neuropsychiatric disorders in children and adolescents. Due to the versatility of its medical team's expertise, the department also provides care for adult patients.

A notable feature of this department is the presence of a practitioner with dual training in neurology and psychiatry (neuropsychiatrist), a profile that is currently unique in Senegal. This dual expertise enables an integrated approach to disorders at the interface between neurology and psychiatry, such as FND, without the need for referrals between two separate specialists. Thus, the department serves as a *de facto* referral centre for functional neurological disorders in Senegal.

2.2. Study Sampling

Inclusion criteria:

- Patients who consulted in the department during the study period.
- Diagnosis of functional neurological disorder according to DSM-5 criteria.

Exclusion criteria:

- Incomplete medical records.
- Patient unreachable or refusing to participate.
- Patients with comorbid structural neurological disorders.

All eligible patients during the study period were enrolled. Eight patients met the inclusion criteria and were included in the study.

2.3. Variables Studied

Sociodemographic variables: age, sex, nationality, marital status, education level, occupation, and area of residence.

Clinical variables: FND subtype (functional seizures, functional motor disorder, functional sensory symptoms), symptom duration, and symptom characteristics.

Healthcare pathway variables: delay between symptom onset and first specialised consultation (in months), types of healthcare resources used, classification of pathway as simple (≤2 steps) or complex (>2 steps), and chronological sequence of resources.

Diagnostic communication variables: diagnosis disclosure to patient (yes/no), patient understanding of diagnosis (yes/no), and comprehension/disclosure ratio (C/D). The C/D ratio is a metric proposed by the authors to quantify the quality of diagnostic communication, calculated as the proportion of patients who reported understanding their diagnosis among those who received a formal diagnosis disclosure.

Treatment variables: type of treatment prescribed (pharmacological, psychological, or combined) and outcome at 12 months.

2.4. Data Collection

Data were collected in two phases: 1) retrospective phase involving identification of FND-diagnosed patient records in consultation registers; and 2) prospective phase involving structured interviews of approximately 90 minutes with each patient, using a standardised questionnaire exploring sociodemographic characteristics, symptom history, healthcare pathway, and diagnosis disclosure modalities. The questionnaire is available upon request from the corresponding author.

2.5. Operational Definitions

- **Simple pathway:** pathway comprising a maximum of two steps before specialized consultation.
- **Complex pathway:** pathway comprising more than two steps and/or involving back-and-forth between different types of resources.
- **Word-of-mouth:** referral to the specialized department by a relative or acquaintance, without prior consultation with a healthcare professional.
- **Traditional healer:** traditional healer, marabout, or therapist using non-biomedical methods.

2.6. Statistical Analysis

Data were entered and analysed using SPSS Statistics version 25 and Microsoft Excel 2016. A descriptive analysis was performed to determine frequencies and percentages for qualitative variables and means, standard deviations, medians, and interquartile ranges for quantitative variables. Given the small sample size (n = 8), only descriptive statistics were used. Inferential statistics were not performed as they would lack statistical power and yield unreliable estimates.

2.7. Ethical Considerations

This study was conducted in accordance with the principles of the Declaration of Helsinki (2013 revision). The study protocol was approved by the Head of the Department of Child Psychiatry and Neurology at CHNEAR and the hospital administration. Written informed consent was obtained from each participant or their legal representatives for minors. Participants were informed of the study objectives, procedures, and their right to withdraw at any time without consequences for their care. Anonymity and confidentiality of the data were guaranteed.

3. Results

3.1. Sociodemographic Characteristics

Eight female patients were included in this study. The mean age was 27.6 ± 18.7 years, ranging from 13 to 69 years. The 13 - 20 and 21 - 30 age groups were the most represented. The population was exclusively female and Senegalese. Most patients (n = 6, 75%) were single. The education level was secondary or higher for 87.5% of the participants. Six (75%) patients were students. Semi-urban areas (Dakar suburbs) were the most represented (62.5%) (Table 1).

Table 1. Sociodemographic characteristics of the population (n = 8).

Variable	n	%
Age (years)		
13 - 20	3	37.5
21 - 30	3	37.5
31 - 50	1	12.5
>50	1	12.5
Marital status		
Single	6	75.0
Married	2	25.0
Education level		
Primary	1	12.5
Secondary	3	37.5
Higher education	3	37.5
Other	1	12.5
Occupation		
Student	6	75.0
Employed	1	12.5
Retired	1	12.5
Area of residence		
Urban (Dakar)	3	37.5
Semi-urban (suburbs)	5	62.5

3.2. Clinical Presentation

Patients presented with multiple functional symptoms (Table 2). The most frequent symptoms were headaches (n = 7, 87.5%) and muscle cramps (n = 6, 75%). Functional seizures were observed in 37.5% of patients (n = 3). Motor symptoms included muscle weakness (n = 2, 25%) and cramps (n = 6, 75%). Sensory symptoms included paresthesias (n = 2, 25%), anesthesia (n = 1, 12.5%), and visual disturbances (n = 3, 37.5%). Cognitive and dissociative symptoms were also com-

mon: loss of consciousness (n = 3, 37.5%), memory disturbances (n = 3, 37.5%), and behavioral changes (n = 3, 37.5%). Most patients presented with polysymptomatic FND. All patients had persistent symptoms (duration > 6 months) at the time of consultation, except for one patient with acute onset (<6 months).

Table 2. Functional symptoms in the study population (n = 8).

Symptom	n	%
Headaches	7	87.5
Muscle cramps	6	75.0
Functional seizures	3	37.5
Loss of consciousness	3	37.5
Memory disturbances	3	37.5
Visual disturbances	3	37.5
Behavioral changes	3	37.5
Muscle weakness	2	25.0
Paresthesias	2	25.0
Anesthesia	1	12.5

Note: Most patients presented with multiple symptoms.

3.3. Diagnostic Delay

The mean delay between symptom onset and the first consultation at the specialised department was 19 months (median: 19 months; SD: 20.4; range: 4 - 60 months). Only one patient (12.5%) consulted within the first 6 months (acute episode), while the other seven (87.5%) had a persistent disorder (>6 months) (**Table 3**).

Table 3. Diagnostic delay (in months).

Parameter	Value
Mean	19
Median	19
Standard deviation	20.4
Minimum	4
Maximum	60

3.4. Types of Resources and Healthcare Pathways

Five types of resources were identified before the specialised neuropsychiatric consultation: word-of-mouth (referral by relatives), traditional healers, general practitioners, neurologists, and psychiatrists. Word-of-mouth and traditional healers were the most frequently used resources for seeking help. Two types of pathways were distinguished: simple pathways (n = 4; 50%), comprising a maxi-

mum of two steps, and complex pathways (n = 4; 50%), comprising more than two steps with heterogeneous trajectories (Table 4 and Table 5).

Table 4. Distribution of simple pathways (n = 4).

Pathway	n	%
Word-of-mouth → Neuropsychiatrist	3	75
Neurologist → Neuropsychiatrist	1	25

Table 5. Distribution of complex pathways (n = 4).

Pathway	n	%
GPs (≥2) → Traditional healer → Neuropsychiatrist	1	25
GPs (≥2) → Psychiatrist → Neuropsychiatrist	1	25
Traditional healer → Psychiatrist → Neuropsychiatrist	1	25
Traditional healer → Neurologist → Neuropsychiatrist	1	25

Simple pathways were characterised by word-of-mouth as the mode of access to specialised care. Complex pathways showed great heterogeneity but shared a common entry point through general practitioners or traditional healers. In all complex pathways, a specialist (neurologist or psychiatrist) was consulted before referral to the neuropsychiatry department.

3.5. Diagnosis Disclosure and Understanding

FND diagnosis was disclosed to seven of the eight patients (87.5%). Only one patient, aged 12 years at diagnosis, did not receive the information directly; it was conveyed to the accompanying adult. Among the seven informed patients, five (62.5% of the total sample) reported understanding their diagnosis after an explanation by the neuropsychiatrist. The comprehension/disclosure ratio (C/D) was 0.71 (5/7), indicating that more than two-thirds of the informed patients understood their diagnosis.

3.6. Treatment and Outcome

Pharmacological treatment was prescribed to 75% of the patients (n = 6). The most commonly used therapeutic classes were anxiolytics, selective serotonin reuptake inhibitors (SSRIs), and calcium and magnesium supplementation. Only two patients (25%) received psychological intervention in addition to pharmacological treatment. At the 12-month follow-up, the outcome was favourable (symptom resolution) in 50% of the patients, while the remaining 50% showed symptom persistence without notable improvement.

4. Discussion

4.1. Main Findings

This study describes, for the first time, the therapeutic itineraries of patients with

FND in Senegal. Four major findings emerged: 1) a polysymptomatic clinical presentation dominated by headaches and muscle cramps; 2) significant diagnostic delay with a mean of 19 months; 3) the predominant role of word-of-mouth and traditional healers in healthcare pathways; and 4) a comprehension/disclosure ratio of 0.71, indicating room for improvement in diagnostic communication.

4.2. Polysymptomatic Clinical Profile

Our patients presented with a polysymptomatic FND profile, with most experiencing multiple functional symptoms simultaneously. This finding is consistent with studies showing that persistent FND is often associated with symptom accumulation over time [3] [11]. The high prevalence of headaches (87.5%) in our sample is noteworthy. While headaches are commonly reported in FND populations, they are rarely the dominant symptom in published series from Western countries [5]. This finding may reflect either a specific phenotypic expression of FND in the Senegalese context or a selection bias related to headache being a more "acceptable" complaint that facilitates healthcare-seeking behavior.

The combination of motor symptoms (cramps 75%, weakness 25%, functional seizures 37.5%), sensory symptoms (paresthesias 25%, visual disturbances 37.5%), and cognitive-dissociative symptoms (loss of consciousness 37.5%, memory disturbances 37.5%) illustrates the complexity of FND presentation. This polysymptomatic profile has important implications for healthcare pathways: patients with multiple symptoms are more likely to consult multiple specialists, contributing to diagnostic delay and therapeutic wandering [12] [13]. Furthermore, the diversity of symptoms may reinforce traditional explanatory models that attribute such presentations to spiritual or supernatural causes, as these models can more easily accommodate polysymptomatic presentations than biomedical frameworks that expect organ-specific symptoms [9] [10].

4.3. Diagnostic Delay and Therapeutic Wandering

The mean delay of 19 months observed in our study is consistent with the international literature. Carson *et al.* reported a diagnostic delay ranging from 1 to 7 years in Western countries [3] [13]. This delay reflects the therapeutic wandering characteristic of FND, which is marked by multiple consultations, repeated complementary examinations, and a lack of clear recognition of the disorder. Several factors contribute to this delay in Senegal. On the healthcare provider side, FND remains poorly addressed in the medical curriculum. European studies have shown that 45.5% of residents have never received training on this disorder [14]. On the patient side, cultural representation plays a major role. In Africa, neuropsychiatric symptoms are frequently attributed to supernatural causes, such as spirit possession, curses, and divine punishment [9] [10] [15].

4.4. Role of Traditional Healers

Our study highlights the pivotal role of traditional healers in the FND healthcare

pathway. Their presence was constant in complex itineraries, either as the first entry point or as a secondary resource after the failure of conventional medicine. This recourse can be interpreted in several ways: the search for meaning in the face of "medically unexplained" symptoms, the quest for recognition and validation of suffering, or greater geographical and financial accessibility compared to specialised hospital facilities. It is important to note that traditional healers and general practitioners serve different but sometimes complementary roles in healthcare pathways: while GPs provide initial biomedical assessment, traditional healers often address the cultural and spiritual dimensions of illness that patients may perceive as equally important. These findings call for a rethinking of the role of traditional medicine in healthcare pathways, favouring an integrative approach and bridges to the biomedical system [16].

4.5. Circulation between Specialties

Analysis of complex pathways revealed frequent circulation between neurologists and psychiatrists before arrival at the neuropsychiatry department. This observation illustrates the nosological "no man's land" in which FND is situated at the border between neurology and psychiatry [17]. In contrast to the fragmented care typically experienced by FND patients—who are often referred back and forth between neurologists who find "nothing wrong" and psychiatrists who may not feel equipped to manage neurological symptoms—the integrated neuropsychiatric model at CHNEAR provides a "one-stop" solution. The fact that this department is led by a neuropsychiatrist—a unique profile in Senegal—probably explains why patients find an appropriate response after wandering between neurologists and psychiatrists. This configuration illustrates the value of cross-disciplinary skills in managing disorders at the neuropsychiatric interface. The emergence of specialised multidisciplinary centres dedicated to FND represents a promising avenue for improving care coordination [11].

4.6. Diagnostic Communication

Our study introduces the concept of the "comprehension/disclosure ratio" (C/D) as an indicator of the quality of diagnostic communication. A ratio of 0.71 means that nearly one-third of the informed patients did not understand their diagnosis. This result is consistent with that of O'Neal *et al*., who showed that only 40% of patients with functional seizures understood their diagnosis at the time of disclosure [18]. FND diagnosis disclosure is a therapeutic act that requires time, empathy, and appropriate educational materials.

Several factors may explain this communication gap: 1) the inherent complexity of explaining a disorder defined by what it is not (i.e., not a structural neurological disease); 2) the lack of culturally adapted educational materials in local languages (Wolof, Pulaar); 3) potential interference of cultural beliefs attributing symptoms to supernatural causes; and 4) the stigma associated with psychiatric diagnoses, which may lead patients to reject the explanatory model offered.

4.7. Low Rate of Psychological Intervention

The low rate of psychological intervention (25%) in our sample is noteworthy, given that psychotherapy is considered a first-line treatment for FND [11]. This may reflect limited availability of trained psychotherapists in the Senegalese healthcare system, as well as cultural barriers to seeking psychological care. The finding that 50% of patients had persistent symptoms at 12-month follow-up may be partly attributable to this treatment gap. Future studies should explore barriers to psychological treatment access and develop culturally adapted interventions.

4.8. Strengths and Limitations

Strengths: This is the first study on FND therapeutic itineraries in Senegal, with detailed data collection on healthcare pathways and the introduction of the comprehension/disclosure ratio concept.

Limitations: The small sample size (n = 8) limits the generalisability of our findings and may lead to over-representation of certain pathway types. The exclusively female population may reflect either the known female predominance in FND (3:1 ratio) [6], the clinic's patient demographics during the study period, or a sampling effect due to the small sample size. Recall bias may have affected the retrospective pathway reconstruction. The single-centre design limits external validity. These preliminary results warrant larger multicentre studies to confirm the findings.

5. Conclusion

Healthcare pathways for patients with functional neurological disorders in Senegal are characterised by significant diagnostic delays (mean 19 months), a predominant role of word-of-mouth and traditional healers, and circulation between general practitioners, neurologists, and psychiatrists without effective coordination. The comprehension/disclosure ratio of 0.71 indicates that there is room for improvement in diagnostic communication. These findings highlight the need to strengthen healthcare professional training, develop coordinated care pathways, and integrate cultural dimensions into patient care.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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