Lost in Translation – some reflections on experience working and teaching in Malawi in 2016

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As I walked in and saw Steve hunched on the low bench I thought "the medical students have got this wrong!" It was my very first morning in Room 6, and they'd told me the story of a man who'd been expansive and agitated, and had come to clinic because he'd got into a drunken fight at the weekend over the loud music he'd been playing til the early hours. Their differentials were mania and schizophrenia. But now, Steve looked really sad.

"Have you asked him about symptoms of depression?" I asked them.

"No."

"Do you know any?"

"Yes," they said.

"My mood is great," whispered Steve in Chichewa, unsmiling. "Full of energy," he said slowly, not moving a muscle. His brother, at the side of the room, grinned. "I like gardening and watching boxing."

"Ask him when he last did those things," I told the medical students. Steve couldn't remember, but his brother piped up, "he hasn't watched a boxing match for years, and we have to look after his land. It'd be a complete mess otherwise. He just sits there doing nothing most of the time, unless he gets drunk."

The figurative light went on in my head. Steve was only in his mid-30s, but I suddenly remembered the medical students saying that he'd had a positive HIV test and hadn't been back to the ARV clinic. Could this be HIV dementia? My Old Age psychiatry placement seemed a long time ago, right at the beginning of core training, but I remembered my consultant describing someone as "looking subcortical." The students and I did a MoCA with Steve and he scored 11. The use of unvalidated cognitive tests in Malawi has an essay to be written about it on its own, but this time it supported the history of cognitive impairment we then got well enough, and Steve had me hooked on Room 6 (the name of the psychiatric clinic at Queen Elizabeth Central Hospital in Blantyre, Malawi). During core training I'd been a reluctant reflector, but at the end of every clinic day in Blantyre I was scribbling til the early hours about the patients I'd seen.

Those notes will form the basis of this essay. This year I spent six months living and working in Blantyre, with the Scotland Malawi Mental Health Education Project (SMMHEP), helping deliver an undergraduate training programme in psychiatry. Then, after coming back to the UK for a couple of months to apply for higher training, I realised going back to Malawi would be far more interesting and useful than taking a holiday, so I returned to help teach another rotation of medical students. I learned a huge amount about managing and delivering a teaching programme from the head of department, Dr Stefan Holzer. Engagement with the medical students was so easy and rewarding because of their infectious enthusiasm for learning. I got a very wide variety of exposure to clinical problems and had to become more flexible to manage these with a different array of resources to what I'd been used to in the UK.

There is so much to write about it's a pity there's a word limit. However, it has at least made me think about how to focus the essay on an aspect of working overseas which might be useful to others. Is there anything particular you notice about the dialogue with Steve? Something important, is that I could only speak to Steve through the medical students. In many of my consultations in Room 6, I could only communicate with the patient through an interpreter of one stripe or another. Sometimes, this was beneficial. The primary purpose of me being in Malawi was education, and when the interpreter was a medical student or a psychiatric nurse, being in that role meant they had no choice but to think carefully about the questions being asked and the answers given. The flip side was that there were frequent occasions when I was sure something was missing and in retrospect I think that was often due to the way questions were being phrased. Between trips to Malawi, I did some locum shifts in Manchester and noticed that indefinable thing when there is just something odd about what someone has just said, and in your native tongue you can roll it around, feel it and explore it and make up your mind whether it might be psychotic or not. I realised that in not sharing a language with a patient I probably missed quite a few of those slightly odd things, and would have been limited in my ability to explore them anyway.

I've always wanted to work in Africa, but my choice of psychiatry - so reliant on language - as a specialty hasn't really helped with this. I'm a monoglot who can hardly do English so in future I have a choice of focussing on a particular place and forcing its language into my stubbornly non-linguistic brain, or thinking about ways to adapt to the challenges. I attempted to do both in Malawi this year, here's how I got on and some other things I learned in trying.

There are lots of languages spoken in Malawi, all of them (to my knowledge) from the Bantu family of languages, which originated in west central Africa and migrated south with the people who spoke them from around 1,000 BC onwards, gradually displacing the resident Khoi-San speakers[1]. In the southern region the main language is Chichewa. Quite a few people from Blantyre (the largest city in the south) are fluent in English and it's perfectly possible to perform a psychiatric assessment with them without using an interpreter. These would be a minority of the total patients seen in the clinic, however.

Interestingly, I began to notice that older people, in general seem to speak better English than younger people, and that their fluency didn't correlate so well with factors that seemed to predict this in younger people, such as socioeconomic status and level of education. Discussing this with medical students and nursing staff, I was told that this reflected the high standards of education in the decades after independence (in 1964), but that teaching resources have since gradually been overwhelmed by the booming population.

There's also an interesting language split amongst the medical students which became apparent to me early on in the year, when, on reviewing videos Dr Holzer had made of the students in clinic for interview skills training, one remarked "my Chichewa is terrible." Later I found out that some students – those who had attended the best private schools and were from the wealthiest families – speak English at home and regard it as their mother tongue. In contrast students from less prestigious private schools, and the minority attending medical school on scholarships, would speak Chichewa with their families and are more comfortable with it than they are with English. Having said that, almost all the students speak flawless English and this is only interesting as a sociological point rather than having any relevance to the course or to clinical practice.

However, something which does cause difficulties is that the students would very often comment on how difficult it is to translate medical and psychiatric terminology into Chichewa. Medicine has undergone a significant part of its development in English speaking countries. As well as this, medical and psychological terms have become fairly deeply integrated into common parlance in European and American countries in the last few decades, in a way that hasn't really happened yet in Malawi where there is more recent and more limited popular understanding of medicine, psychology, and science in general. In English speaking countries, although we should always be aware of the need to use language patients will understand, we probably take for granted the headstart this gives us.

The problem goes further than that, though. When describing my encounter with Steve, I mentioned we did a MoCA to formally assess his cognitive function. At that time, when I first arrived in Malawi, we were using English versions which the student or an interpreter would read and translate the instructions into Chichewa for the patient. Later, one medical student volunteered to translate it into Chichewa and Dr Holzer obtained permission from the publishers for her to do this. She said it very difficult finding adequate Chichewa translations even for words such as "attention" and "abstraction".

By that time, I had spent a number of weeks continuing to see patients in Room 6 after the academic year had finished and both rotations of medical students had been and gone. Sometimes the nursing staff were too busy to see patients with me and I used one or other of the ad hoc translators who floated round Queen's and were paid by the session. Asking about auditory hallucinations can be difficult even when a language is shared with the patient (I have yet to find a way of asking about them with a new patient that I am completely satisfied with, in English). I noticed however that a particular interpreter who was regularly used there would make circular motions around his ears with his fingers whenever I asked "Do you ever hear people speaking when there's no-one around?"

On one occasion with this interpreter I directed a question to a patient, who then had a lengthy dialogue with the interpreter, lasting several minutes, at the end of which the interpreter turned to me and said "No." This was an extreme example of something I realised was happening fairly frequently, which the authors Farooq and Fear, in an article on working with interpreters[2], called "Condensation". I was pointed in the direction of this article by another volunteer who is an experienced consultant psychiatrist in the UK and it made a great difference to how I understood and sought to improve the problems I'd been having in working with interpreters. I won't exhaustively relate the article in this essay but will attempt to summarise the main interpreter errors and the strategies that can be used to try to minimise their impact. I would definitely recommend reading it to anyone planning to work or volunteer in a setting where they will need to use an interpreter.

"Condensation" is in fact only one of the interpreter errors described in the article and refers to the simplification by the interpreter of a patient's response to a question. An obvious problem this will cause is reduction in the clinician's sensitivity to the presence of thought disorder, but it may also cause other points of fact from the patient's story to be missed. It is closely related to "Normalisation" in which the interpreter, in an attempt to make sense of what the patient says to them, imposes their own understanding of the story upon it when conveying it to the clinician.

"Addition" and "Omission" are also errors in the conveying of the patients speech to the clinician and their names explain what they mean. They are most likely to occur when discussing sensitive

personal issues and especially so when the patient is known to the interpreter. The interpreter may be of similar cultural background to the patient and in making these errors may see themselves as protecting the patient from possible indignity.

"Closed/Open Questioning" refers to alteration of the way in which the patient is asked the question posed by the clinician. This can have profound effects on the way the question is answered – as most of us will have found at some point in practice in our own language, we may get different responses from a patient depending on whether the question is closed or open. "Substitution" may relate to either the question asked by the clinician or the response from the patient and refers to the interpreter replacing one concept with another.

"Role Exchange" is perhaps a combination of several of these errors and then some, when the interpreter takes charge of the interview and directs it themselves, asking their own questions. I recognised this on a few occasions while working in Room 6, and I found it surprisingly easy to passively allow it to happen, and how difficult it could be to wrest back control from the interpreter when it did. I think this can be especially hard in a new and unfamiliar setting where one doesn't feel as sure of one's self as one would at home.

The authors of the article also point out some problems which apply more to psychiatry than other branches of medicine, including sensitivity and cultural awareness. The most significant one of these, in my opinion, is the loss of directness of interaction with the patient – which makes it more difficult to comment on "rapport" in the mental state exam. This problem is very nicely described as "like first watching television without sound, then receiving the sound without pictures, and later trying to combine the two."[3]

After reading the article I became more aware of the problems that were cropping up in practice in Room 6, and was able to employ some of the strategies described in it to mitigate them. Many of these are common sense, but harder to remember to practice than to know about. Such things include basics of good communication skills such as speaking slowly and using short sentences, and using English words that I was sure the interpreter knew.

A further important point which I was aware of from reading the article but often found difficult to practice was to always address the patient (refer to them as "you" rather than "he" or "she", and look at them rather than at the interpreter) – I would often find myself making sure I did this at the beginning of the interview but drifting back to addressing the patient in the third person until I realised what I was doing and rectified it. I think that this is significant in relation to the dynamics of the consultation – it ensures that the patient feels they are the focus of the interview, goes some way to building rapport with them (things which may increase their trust in you and therefore the reliability of what they tell you), and also limits the inclination of the interpreter to try to take over as it reinforces their position as a facilitator rather than an interviewer themselves.

A key action to take (which I did with an interpreter who was regularly used in Room 6) is to have a discussion with the interpreter and make it clear what you want from them and from the interview. I explained to him that it was important that I knew when the patient was talking what he termed "nonsense" and that the form of this speech was a significant sign for me. We talked through ways that difficult questions (both about sensitive issues and questions which are difficult to phrase – such as about auditory hallucinations) could be asked in Chichewa (I also had a similar discussion with the

psychiatric nurses in Room 6, and it is part of the interview skills sessions included in the student curriculum). This increased his understanding of the process and in fact marked a sea change in our partnership – after that day I felt the reliability of information increased, and we were better able to discuss how the patient had come across to him. What I will take from that for future practice is the importance of developing a good working relationship with the interpreter (if possible using the same interpreter for the same patient, if they will be seen a number of times), attempting to ensure that they understand as well as possible the nature of a psychiatric interview, the information I am seeking to gain, and the potential pitfalls of such consultations.

There is a lot more to be discussed about language and the use of interpreters (please read the article, it's really interesting!) but I should emphasise that this area was only one of many in which volunteering in Malawi with SMMHEP benefitted me as a practitioner of psychiatry, as an educator and as a whole person. I was constantly challenged (in a good way!) both by the clinical practice in Room 6 and by the students and nurses in my role as clinical and classroom based educator. In this essay I could have focussed on the differences and similarities between how major mental disorders present in Malawi and the UK, the problems that psychiatry as a specialty faces in Malawi and ideas for its development, or how inspiring I found the patients, the staff, the students, the other volunteers, and especially the commitment and resourcefulness of Dr Holzer. I'm looking forward to starting Higher Training next month but am also longing to be doing a clinic in Room 6 again!

But in writing mostly about language and my experience of its use through interpreters in Malawi I hope I have chosen an area other people can gain something from and use either in the UK or if working or volunteering overseas. It is a very interesting area in itself and I hope I have gone some way to conveying that and stimulating other people to reflect on their own experience. Finally if anybody is considering volunteering abroad I would urge them to consider going to Malawi with SMMHEP – I cannot recommend this enough for reasons I hope have come across in this essay!

Word Count – 2,919

References

1. Vansina J. (1995); New Linguistic Evidence and the Bantu Expansion. Journal of African History: 36(2): 173-195
2. Farooq S, Fear C (2003); Working through interpreters. Advances in Psychiatric Treatment: 9 (2) 104-109
3. Kline F et al (1980); The misunderstood Spanish-speaking patient. American Journal of Psychiatry: 137 1530-1533

Declarations

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