Institute of Translation and Interpreting

When words are data: translation of a qualitative research article

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Abstract

This dissertation takes the form of a translation and commentary. It presents a 5,000-word translation of the Introduction, Methods and Results sections of a qualitative research article published in the official journal of the French College of Obstetricians and Gynaecologists. The article uses semi-structured interviews to explore care seeking for gynaecological problems in women with a history of sexual abuse. The source text presents an interesting translation challenge as it combines the highly conventional medical research article genre with first person, transcribed oral testimony from the participants, whose words make up the data analysed in the study. Although research articles have been widely studied in both Translation Studies and related fields, there is little research specifically on texts originating from a qualitative paradigm. Therefore, this translation and commentary has been undertaken as an exploratory case study in this under-researched area. The commentary discusses three particular challenges: linguistic, cultural and ethical. The translation solutions adopted are discussed and critically evaluated. The discussion focuses particularly on the use of ontological narrative theory when translating the women's words. The effectiveness of a dual domesticating and foreignizing translation strategy for the two different types of text is also explored. The commentary argues that a balanced approach is needed in order to produce a target text which conveys the women's words authentically but is also comprehensible and so able to meet the translation brief. The importance of ethical decision-making throughout the text is also identified. Further research is recommended, ideally involving the qualitative research discourse community who have hitherto expressed concern at overly domesticating translation practices potentially impacting on the integrity of their research.

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Abbreviations

B.T.	Back Translation
S.L.	Source Language
S.T.	Source Text
T.L.	Target Language
T.S.	Translation Studies
T.T.	Target Text

CHAPTER ONE: INTRODUCTION

1.1 Context and rationale

This dissertation explores the process of translating 5,000-words of a 5,800-word research article (Iraola et al., 2023) which uses qualitative methods (semi-structured interviews) to explore the impact of sexual abuse on women's care seeking behaviour for gynaecological problems. The source text (S.T) is published in the official journal of the French College of Obstetricians and Gynaecologists and is edited by, and targeted at, doctors working in those medical specialties (Elsevier, 2023).

The S.T includes lengthy quotes from interviews with the participants: these form the data on which the S.T. producers base their analysis and argumentation. This offers an interesting contrast to the formal register and structure of the remaining text, which conforms to the highly conventional research article genre (Swales, 2004).

Translation Studies (T.S) scholars have explored many issues relating to this type of text (Olohan, 2015), but there is little in the literature addressing the challenges posed by texts which describe research of a qualitative nature. At the same time, producers of qualitative research articles have identified translation, process and product, as problematic (Abfalter et al., 2021) and have tentatively sought solutions in T.S. theory (e.g. Santos et al., 2015). These are the two reasons why this topic has been identified as warranting further investigation.

Using the S.T. as a single-case study, the dissertation describes and analyses the application of pertinent T.S. theory, in particular that of ontological narrative (Baker, 2006), to the translation of qualitative research. The description and analysis take the form of a commentary, a well-established method of enquiry in translation process research (Williams & Chesterman, 2002; Saldanha & O'Brien, 2014).

1.2 Literature review

A systematic search of relevant databases was undertaken and strategies such as forward/backward citation tracing were used to obtain as comprehensive overview of the literature as possible.

1.2.1 The research article

The research article has been described as "the prime vehicle for scholarly communication" (Van Bonn & Swales, 2007, p. 94). It has been widely studied in the field of linguistics, with a particular focus on genre characteristics (Swales, 2004) and metadiscourse features (Hyland & Tse, 2004; Pearson & Abdollahzadeh, 2023). Metadiscourse, or the linguistic means by which the writer guides the reader through the text and signals their attitude to the material, is known to vary between academic disciplines and languages (Swales, 2004). For example, hedging is more prevalent in research articles written in English compared to those written in Chinese (Huang & Li, 2023) and French (Vold, 2006). Cao and Hu (2014) also identified variation according to the epistemological assumptions underpinning the research itself: qualitative research articles use fewer impersonal and passive structures, compared to those texts based on a positivist paradigm.

1.2.2 Translating research articles

Empirical studies in the T.S. literature have examined the impact of genre and metadiscourse variation in the translation of research articles and/or their component structures (Pezzini, 2003; Vold, 2006; Olohan, 2015; Huang & Li, 2023). The translator needs to be aware of these variations so that they can convey the S.T producer's intentions appropriately in the target text (T.T) (Montalt & González-Davies, 2014). Without such an awareness, there is a risk of distorting research findings (Martikainen, 2018). No empirical studies were identified on the translation of qualitative research articles.

The research article is discussed in practice-focused texts in the fields of medical (Montalt & González-Davies, 2014) and technical translation (Olohan, 2015; Scarpa, 2020). These texts describe a range of macro and micro strategies, and their theoretical underpinnings, for use during the translation process. Nord's functional model (Nord, 2018) is considered to be the most appropriate equivalence framework for medical translation, including the research article (Montalt & González-Davies, 2014; Popineau, 2016). Target culture genre norms are the determining factor in shaping a macro-level translation strategy, to the extent that the T.T "…should read like an original text, that is, the readers should not be aware that they are reading a translation." (Montalt & González-Davies, 2014, p. 156). None of these practice-focused texts address the challenges of translating research articles based on qualitative research methods.

1.2.3 Translation in the qualitative research discourse community

The producers of qualitative research texts find the highly domesticating approach to translation described above as problematic (Ruitenberg et al., 2016). This is particularly the case when the research is based on interviews, since words are data: "Often data (quotes) are presented as if the participant was fluent in the target (English) language, which is not always (almost never!) the case," (Helmich et al., 2017, p. 131). Inauthentic sounding participant voices potentially undermine the validity of the whole research (Ruitenberg et al., 2016). For this reason, Santos et al. (2015) hypothesize that a more foreignizing approach might be needed in the *Results* section of the T.T.

1.2.4 Domesticating and foreignizing

The terms domesticating and foreignizing are associated with Venuti (1994). A domesticated translation is one which favours fluency and readability in English. Conversely, a foreignized translation aims to deviate from T.L norms in order to signal that the text derives from a non-Anglophone culture. Other T.S scholars prefer the terms T.L oriented and S.L oriented to describe these approaches to translation (e.g. Pedersen, 2005). Both sets of terms are used interchangeably throughout this dissertation.

1.2.5 Ontological narrative translation

Venuti (in Laaksonen & Koskinen, 2020) emphasised that the choice between domesticating and foreignizing strategies is very much an ethical one. Baker (2006) also highlights the ethical nature of decision-making in translation with a particular focus on conveying the authentic voice of those who have experienced conflict or trauma. The translation of personal stories (or ontological narrative in her typology) presents a number of challenges; in particular, Baker (2006) argues that domesticating strategies risk distorting and diminishing the survivor's voice.

The ethical nature of translation decisions is illustrated most profoundly in the translation of Holocaust testimony. Ensuring that the voice of the survivor is preserved and communicated in the T.T is an ethical imperative for the translator working with these texts (Glowacka, 2012; Deane-Cox, 2013). Bosseaux (2020) explores similar themes in her study on subtitling documentaries (language pair French/English) which address the issue of men's violence towards women. She highlights a lack of research in ontological narrative translation

and subtitling, arguing for the development of guidelines and strategies to ensure that, "…the voices of women are transmitted in the most ethical way." (p. 89). These scholars, drawing on Hatim & Mason (1990), argue that the translator should aim to achieve pragmatic equivalence; that is, the T.T should communicate the illocutionary force of the S.T (Glowacka, 2012; Deane-Cox, 2013; Bosseaux, 2020).

1.3 Research questions

No studies were found within the T.S. literature specifically on the translation of qualitative research articles. Scholars and practitioners in the field of medical translation generally advocate strategies which conform to target culture norms. However, producers of these texts, and T.S. scholars, argue that personal narratives of trauma require S.T. oriented translation strategies. This dissertation aims to explore the process of translating a piece of qualitative research by posing the following questions:

- What are the linguistic, cultural and ethical challenges in the translation of a qualitative research article on a sensitive medical topic?
- What strategies are used to overcome these challenges?

1.4 Hypothesis

Theoretical approaches developed in the field of T.S, particularly that of ontological narrative, are helpful in addressing the translation challenges posed by a qualitative research article on a sensitive medical topic.

1.5 Methodology

This dissertation uses the S.T. as a single-case study to analyse and describe the process of translating qualitative research. As a method of enquiry, it is considered appropriate when exploring an under-researched topic (Susam-Sarajeva, 2009). The data for analysis is at the micro-level (challenges and strategies within a single text) (Munday, 2016). The results – description and analysis of the process – are presented in a commentary, which is a commonly used tool in translation process research (Williams & Chesterman, 2002).

1.6 Translation brief

Context is essential in case-study research (Susam-Sarajeva, 2009), and so a hypothetical translation brief was created:

A UK-based clinical researcher is doing a narrative synthesis on the experience of sexual violence and women's use of gynaecology and other health services. A literature search has identified the S.T as potentially highly relevant to the study via key-terms in its English language abstract. The researcher has therefore asked for a translation of the whole paper so that they can determine whether it meets the criteria for inclusion in the narrative synthesis. If it does, it is possible that the researcher may include direct citations from the T.T in their own study, which they hope to publish in a peer-reviewed journal. However, the T.T as a whole is not intended to be published.

1.7 Source text summary

The S.T. includes the introduction, methods and results sections of 5,800-word research article. The introduction and methods are typical of the genre: the introduction follows the usual moves of identifying and occupying a niche, as described by Swales (2004). The methods section can be classified as an informative text, using Reiss's typology, (in Munday, 2016), as it outlines the procedures relating to participant recruitment, interviewing and data analysis. In the results section, 34 quotes taken from interview transcripts are presented, accompanied by researcher-authored comments.

1.8 Overall translation strategy

Based on the findings of the literature review, the S.T. was divided into two sections: a T.L oriented translation strategy was adopted for the researcher-authored sections of the S.T. and a source language-oriented strategy was adopted for the participant quotes.

For the researcher-authored sections, target culture textual norms were adopted e.g. reporting of statistics, use of punctuation. The Vancouver referencing system was also retained, as this T.T. is not for publication and so does not have to conform to any particular author guidelines which might necessitate changing the referencing style. Although the intended function of the T.T is slightly different to that of the S.T., it does need to conform to

the conventions of scientific/medical writing in the T.L. in order to be considered acceptable by the T.T. reader.

It was decided to treat each participant quote as an individual "microtext" (Baker, 2006) but to translate all the quotes together and then re-insert them into their place within the whole text. This was to manage the cognitive demands of using two very different overall translation strategies. Conservative and foreignizing procedures were used wherever possible in order to retain the authentic original voice of the participant.

CHAPTER 2: TRANSLATION WITH SOURCE TEXT

N.B: Table 1 referred to on p. 13 is located at the end of the text, pp. 35/36.

Recours au soin gynécologique chez les femmes rapportant des violences sexuelles : étude qualitative

Healthcare seeking for gynaecological symptoms in women with a history of sexual abuse: a qualitative study.

Introduction	**Introduction**
En France, la Haute Autorité de Santé recommande une fréquence annuelle de consultation gynécologique en matière de contraception [1], de dépistage individuel du cancer du sein après 25 ans [2], de dépistage des infections sexuellement transmissibles avant 25 ans [3] et des deux premiers dépistages du cancer du col de l'utérus avant 30 ans [4]. Hormis ces indications, la consultation gynécologique annuelle semble davantage relever d'une habitude partagée que d'une recommandation professionnelle validée. Les recommandations sont plus précises aux États-Unis et ont évolué ces dernières années : en 2012, une visite gynécologique annuelle était recommandée [5]; depuis 2018, un suivi qualifié de régulier est préconisé avec un intervalle entre deux consultations pouvant différer en fonction des besoins des femmes [6] ; l'examen pelvien n'est en revanche plus recommandé systématiquement chaque année [7-10].	In France, the National Authority for Health recommends an annual consultation with a gynaecologist for contraceptive advice [1], individual breast cancer screening for those over 25 [2], sexually transmitted disease screening for those under 25 [3] and for the initial two cervical cancer screening tests for those under 30 [4]. Apart from these recommendations, the annual gynaecology consultation seems to be based more on common practice than on expert professional advice. Guidelines in the United States are more detailed and have evolved over recent years: in 2012, an annual consultation with a gynaecologist was recommended [5]; since 2018, the advice has been for regular consultations, with the frequency of follow-up variable according to a woman's needs [6]. An annual pelvic examination is however no longer routinely recommended [7-10].

Les antécédents de violences sexuelles et leurs conséquences physiques et psychologiques peuvent constituer des déterminants du recours ou de non-recours au soin. Certaines études ont montré des différences de recours au soin gynécologique entre les femmes présentant des antécédents de violences et celles qui n'en avaient pas. Ces différences étaient inconstantes. Ainsi, certaines méta-analyses et revues systématiques ont confirmé l'association entre les violences subies dans l'enfance ou à l'âge adulte et le développement de symptômes et pathologies gynécologiques comme les douleurs pelviennes, les dysménorrhées, le vaginisme et la dyspareunie [11-14].	A history of sexual abuse, and its physical and psychological effects, can be determinants of healthcare seeking behaviour. Some studies have shown differences in gynaecology care seeking between women with a history of sexual abuse and those without. These differences are not consistent. Thus, a number of meta-analyses and systematic reviews [11-14] have identified an association between abuse experienced as a child or adult and the development of gynaecological symptoms and disorders, including pelvic pain, dysmenorrhea, vaginismus and dyspareunia.
Cette forte pathogénicité pourrait entrainer un recours accru au suivi gynécologique. De fait, une étude cas-témoins menée aux Pays-Bas auprès de 100 femmes consultant en médecine générale rapportait des consultations plus fréquentes pour un motif gynécologique chez les femmes exposées à des violences conjugales physiques, psychologiques ou sexuelles que chez celles qui ne l'étaient pas [OR = 3,0 IC95 % = 1,3–6,8] [15].	This marked pathogenicity may result in more frequent healthcare seeking. For example, a case-control study of 100 women conducted in the Netherlands reported that gynaecological symptoms were more frequently identified as the reason for consulting a general practitioner by women who had experienced physical, psychological or sexual abuse than by those who had not [OR = 3.0, 95% CI = 1.3-6.8] [15].
Par ailleurs, les femmes présentant des antécédents de violences ressentaient l'examen pelvien réalisé au cours d'une	Conversely, women with an abuse history experience greater discomfort during the pelvic examination, conducted within a

consultation gynécologique de manière plus inconfortable que celles n'en présentant pas [16-22]. Cet inconfort pourrait entrainer un moindre recours au suivi gynécologique. De fait, deux études menées, l'une aux États-Unis auprès de 1480 femmes consultant pour un motif contraceptif, l'autre en Turquie auprès de 210 parturientes, mettaient en évidence un recours qualifié de suboptimal [OR = 2,2 IC95 % = 1,2–4,3] [23], des consultations évitées [OR = 0,4 IC95 % = 0,2–0,8] [23] ou un recours retardé dans un contexte d'évitement de l'examen pelvien [OR = 3,10 IC95 % = 1,4–6,9] [24] chez les femmes présentant des violences conjugales ou sexuelles.	gynaecology consultation, than those without such a history. [16-22]. This discomfort may result in less frequent care seeking. For example, two studies – one conducted in the United States amongst 1480 women seeking contraceptive advice and the other conducted in Turkey amongst 210 parturients – described suboptimal care seeking [OR = 2.2, 95% CI = 1.2-4.3] [23], missed appointments [OR = 0.4, 95% CI = 0.2-0.8] [23] or delays in seeking care in order to avoid pelvic examination [OR=3.10, 95% CI = 1.4-6.9] [24] in those who had experienced domestic abuse or sexual violence.
Les hypothèses contraires d'un moindre recours et d'un recours accru n'ont jamais été prises en compte dans la même étude, tant en France que dans d'autres pays. L'objectif de cette étude était de caractériser le recours au suivi gynécologique et d'en chercher les facteurs associés chez des femmes présentant des antécédents de violences sexuelles.	The opposing hypotheses of reduced and increased frequency in healthcare seeking have never been considered within the same study, either inside or outside France. The present study aims to describe gynaecology care seeking behaviour in women with a history of sexual abuse and to identify the factors associated with it.
Méthodes Entre le 15 octobre 2021 et le 1er mars 2022, 25 entretiens semi-structurés ont été menés auprès de femmes présentant	**Methods** 25 semi-structured interviews were conducted between 15/10/21 and 1/3/22

des antécédents de violences sexuelles dans l'enfance ou à l'âge adulte. Les participantes ont été recrutées par l'intermédiaire d'une annonce publiée sur le site internet du Collectif Féministe Contre le Viol. Cette association créée en 1985 propose une permanence téléphonique nationale, anonyme et gratuite, dénommée 'Viols Femmes Informations' qui vise à apporter une écoute, une orientation juridique, sociale, psychologique ou médicale aux personnes victimes de violences sexuelles. L'étude a reçu un avis favorable du comité d'éthique de l'université de Paris (avis N°2021-82, 12 octobre 2021). Les entretiens individuels menés par l'une d'entre nous (EI), d'une durée moyenne de 90 minutes, ont été réalisés en présence ou par téléconférence selon le choix de la personne interrogée. Trois thématiques étaient abordées : la santé gynécologique, le suivi gynécologique et les violences subies. À partir de leur enregistrement (logiciel TEAMS), les entretiens, retranscrits de manière anonyme, ont été analysés (logiciel NVIVO) de manière individuelle, puis de manière croisée par les trois auteurs afin de limiter la subjectivité relative à l'interprétation des données.	with women who reported experiencing sexual abuse either as a child or adult. Participants were recruited via an advert posted on the website of the Feminist Collective Against Rape *(Collectif Feministe Contre le Viol).* This organisation, founded in 1985, offers a free and anonymous national telephone helpline, 'Rape Women Information,' *(Viols Femmes Informations)*. Its aim is to provide victims of sexual abuse with the opportunity to talk, as well as information on legal, social, psychological or medical help available. Ethical approval for the study was obtained from the University of Paris Ethics Committee (ref no: 2021-82, 12/10/2021). Individual interviews were conducted either online or in person, according to participant preference, by one of the author's (E.I.) and lasted on average 90 minutes. Three topics were addressed: gynaecological health, gynaecology care and abuse experienced. The interview recordings (on TEAMS) were transcribed and anonymised before being analysed using NVIVO software. Analysis was conducted on an individual basis initially, and then, in order to minimise subjectivity in data interpretation, by the three authors jointly.

Résultats	**Results**
Caractéristiques des personnes interrogées et des violences déclarées	*Participant characteristics and features of abuse disclosed*
Les femmes interrogées, âgées de 20 à 60 ans, présentaient pour la plupart une bonne insertion professionnelle et un niveau d'études élevé. Elles avaient le plus souvent connaissance des préconisations et recommandations de bonne pratique en matière de prévention et de dépistage en gynécologie.	The participants, aged from 20 to 60, were well-educated and typically from professional backgrounds. In most cases, they were aware of best practice guidelines and recommendations regarding preventive gynaecology care and screening.
Les violences déclarées pouvaient avoir été isolées ou récurrentes pendant l'enfance, à l'adolescence et à l'âge adulte. Les violences avaient parfois une dimension familiale, voire transgénérationnelle. Les violences avaient été commises par un auteur appartenant le plus souvent au cercle familial ou de leurs connaissances.	The abuse disclosed may have been an isolated incident or part of a repeated pattern in childhood, adolescence and adulthood. There was sometimes a familial, indeed intergenerational, aspect to the abuse. In most cases, the abuser was a family member or a person known to the family.
Dans le cadre d'une relation de couple, la coercition contraceptive ou procréative était citée comme une forme de violence conjugale. Elle se traduisait par une contrainte entravant la décision des femmes interrogées, quel que soit le mode de contraception adopté et le choix de la poursuite de la grossesse ou du recours à une interruption volontaire de grossesse.	In the context of an intimate relationship, contraceptive or reproductive coercion was cited as a form of domestic abuse. This involved interfering in participants' contraceptive use, regardless of method chosen, and controlling the decision to continue or terminate a pregnancy.
Alors que la description des violences dans l'enfance était parfois imprécise, celles	Although the description of childhood abuse was sometimes vague, detailed accounts

subies dans l'adolescence ou à l'âge adulte étaient décrites de manière circonstanciée. Les trajectoires de santé des personnes interrogées comportaient de nombreux symptômes gynécologiques – douleurs pelviennes, dyspareunie, dysménorrhées, vulvodynie, métrorragies ou ménométrorragies, troubles du cycle, infections – et psychiques : troubles anxieux et dépressifs, troubles du comportement alimentaire, conduites addictives, idéations et comportements suicidaires, survenus à la suite des violences.	were given of abuse experienced in adolescence and adulthood. Participants' healthcare journeys featured a number of abuse-related symptoms, both gynaecological (pelvic pain, dyspareunia, dysmenorrhoea, vulvodynia, metrorrhagia or menometrorrhagia, menstrual disorders, infections) and psychiatric (anxiety and depressive disorders, eating disorders, addictions, suicidal ideation and behaviour).
Les femmes interrogées rapportaient également des conséquences des violences sur leur vie affective ou sexuelle telles qu'une asexualité ou une hypersexualité subie, un trouble du désir et du plaisir, des dyspareunies, une sexualité associée à une image dégradée d'elle-même, anxiogène, ou un changement de pratiques sexuelles pour atténuer le risque ressenti dans une relation hétérosexuelle. Le terme 'sang', et les adjectifs qui en dérivent, évoqués de manière récurrente dans les différents entretiens, représentait un marqueur commun de la brutalité des violences dans le couple et de l'importance de leurs conséquences sur la santé gynécologique.	Participants reported that an abuse history also had an impact on their emotional or sexual functioning. Effects included hyposexuality or hypersexuality, disorders of libido and arousal, and dyspareunia. The women described their own sexuality as a source of anxiety, linked to low self-esteem, or they reported changing their sexual behaviour to minimise the risks associated with a heterosexual relationship. The word "blood," and adjectives derived from it, were mentioned repeatedly in several different interviews, suggesting that violence was a common feature of intimate partner abuse and highlighting the significance of its impact on gynaecological health.

« Quand j'avais mes règles et j'avais des règles hémorragiques très abondantes, surtout avec le fibrome, il rentrait, j'étais pleine de sang. Et il me disait 'On n'a rien à se cacher'. J'étais sa chose ». *(Fanny, 40 ans, ingénieure cadre).* *Recours au soin gynécologique* Des références relatives à trois niveaux de recours au soin gynécologique ont été mises en évidence : le non-recours ou les périodes de moindre recours au soin gynécologique, le recours régulier, et le recours accru. Certains facteurs, se rapportant aux caractéristiques des violences et aux perceptions en matière de santé gynécologique, étaient liés par les femmes interrogées au niveau de recours au soin (**Tableau 1**). *Facteurs associés au moindre recours en gynécologie* L'évitement de l'examen gynécologique était décrit comme le principal motif d'un moindre recours. L'examen était perçu comme contraignant, subi, intrusif voire violent, dans un corps négligé, considéré comme cassé ou anormal. Il était associé directement aux souvenirs des violences. Les termes utilisés étaient	*"When I was on my period and I used to have very heavy periods, very heavy flow, especially with the fibroids, he would stick it in me, I'd be covered in blood. And he used to say to me, 'We've got nothing to hide from each other.' I was his thing."* *(Fanny, 40 senior engineer).* *Gynaecology care seeking* Three levels of gynaecology care seeking behaviour were identified: absent or periods of infrequent care seeking, routine care seeking and frequent care seeking. The level of care seeking was associated with a number of factors relating to participants' perceptions of gynaecological health and the abuse they had experienced (**Table 1**). *Factors associated with infrequent care seeking* The main reason given for infrequent care seeking was to avoid being examined. Gynaecological examination was perceived as stressful, intrusive, even abusive: something to be endured by an uncared-for body, regarded as broken or abnormal. It was linked directly to memories of abuse, with similar terms being

semblables pour décrire l'examen pelvien et pour décrire les violences. *« Quand on a violé notre intimité, c'est un combat d'aller en gynéco ».* *(Inès, 20 ans, étudiante en sociologie).* *« La dernière fois, c'était en 2009, depuis je n'ai plus reconsulté. Je ne fais plus de dépistage non plus. On se sent tellement de la viande que c'est insupportable ».* *(Linda, 60 ans, psychiatre).* *« Moi, j'ai toujours l'impression d'être transformée en morceau de viande qui doit surtout fermer sa bouche, ne rien dire. Et obéir. Mais je ne suis pas là pour ça. J'essaye de prendre sur moi. Mais… ».* *(Perrine, 49 ans, docteure en microbiologie).* *« Je suis dans le déni complet de mon appareil gynécologique. Je joue l'autruche. Je ne fais pas de frottis. Je n'ai absolument aucun suivi gynécologique. Et je ne supporte pas d'en avoir. Si je devais en avoir un, j'y penserais des semaines avant, il faudrait que fasse un énorme effort pour prendre rendez-vous […] En fait, à un moment donné, il m'est apparu l'envie de ne*	used to describe both the pelvic exam and abuse experienced. *"When you've had your intimacy violated, it's an ordeal to go and see a gynae doctor."* *(Inès, 20, sociology student).* *"The last time, it was in 2009, since then I've not had any more appointments. I don't do screening tests anymore either. You feel so like a piece of meat that it's intolerable."* *(Linda, 60, psychiatrist).* *"I always feel like I've been turned into a piece of meat that ought to first and foremost keep its mouth shut, say nothing. And do as it's told. But I'm not here for that. I try to just get on with it. But…"* *(Perrine, 49, medical microbiologist).* *"I'm in total denial about my reproductive system. I'm like an ostrich. I don't go for smears. I have absolutely no gynaecology follow-up. And I couldn't stand having it. If I had to have it, I would be thinking about it for weeks in advance, it would be a huge effort for me to make an appointment […] In fact, it came to the point, I had the urge to stop abusing my body in any way whatever.*

plus violenter mon corps de quelque manière que ce soit. *Et même si, au final, c'est pour son bien. Mon corps a suffisamment souffert, je dis stop […] quand je pense consultation gynécologique, je commence à visualiser le moment où je vais avoir les jambes surélevées. Même si ce n'est rien du tout. C'est notamment… le bec de canard… C'est l'introduction de cet objet, l'écartement et tout ça. On est rentré en force pendant des années, donc l'idée que ça puisse se reproduire et même si c'est médical…Ça me stresse ce moment, ce bec de canard ».* *(Laura, 38 ans, formatrice dans l'insertion sociale).* Au-delà de l'examen pelvien, les femmes interrogées percevaient des analogies entre les violences et la santé sexuelle, génésique et périnatale. *« Je suis partie mettre un stérilet. Le lendemain du viol, j'ai pris rendez-vous pour une pose de stérilet. Moi, je n'en voulais pas de ce stérilet. Mais il fallait que je me protège. Parce que je ne voulais vraiment pas retomber enceinte. Ce qu'il me restait comme dignité, c'était mon utérus ».* *(Estelle, 31 ans, professeur de danse).*	*And even if, in the end, it's for your own good. My body has suffered enough, I say stop […] when I think about seeing a gynaecologist, I start to visualise the point when I'm going to have my legs up. Even though it's nothing at all. It's particularly…the speculum, the 'duck's beak.'…. It's this object being put inside you, the leg-spreading and all that. You've been forcibly penetrated for years, so the idea that this might happen again and even though it's medical…That moment stresses me out, that 'duck's beak.'"* *(Laura, 38, career's adviser).* Aside from the pelvic exam, participants perceived connections between abuse and sexual, reproductive and perinatal health. *"I went to get a coil put in. The day after the rape, I made an appointment for a coil fitting. I didn't want this coil. But I had to protect myself. Because I really didn't want to fall pregnant again. What was left of my dignity, it was my uterus."* *(Estelle, 31, dance teacher).*

« Viols qui ont duré comme ça presque tous les soirs. Pendant environ 3 ans. Entre-temps, j'ai eu mon petit garçon mais mon fils n'a pas été conçu dans un viol. Cette fois-là, non ». *(Laura, 38 ans, formatrice dans l'insertion sociale).*	*"Rapes which went on like that nearly every night. For about 3 years. In between, I had my little boy but my son wasn't conceived through rape. That time, no."* *(Laura, 38, career's adviser).*
« Je rêvais aussi un peu d'un accouchement magique, ou le couple est soudé. Là, pas du tout. Il était juste de l'autre côté, pour voir le sang, pour voir la déchirure, pour voir la béance du vagin. Je n'ai que ce souvenir-là de sa présence ». *(Isabelle, 47 ans, infirmière).*	*"I also used to dream a bit about a fairy-tale birth, where the couple are really close. But, not at all. He was just at the other end, to see the blood, to see the tear, to see my gaping vagina. I only have that memory of him being there."* *(Isabelle, 47, nurse).*
« Il y avait un truc qui m'était insupportable, c'était de m'imaginer sur une table d'accouchement avec les pieds dans les étriers. Je vivais ça comme une scène de torture ». *(Linda, 60 ans, psychiatre).*	*"There was one thing that was intolerable for me, it was imagining myself on a delivery table with my feet in stirrups. I experienced that like a scene of torture."* *(Linda, 60, psychiatrist).*
« J'avais peur, j'étais super angoissée… pour ma fille en fait. Et je me rappelle d'un épisode ou j'étais en bas, dans le salon, et son père l'a changée en haut. J'ai entendu pleurer… Et je suis partie en courant… en trombe. Et j'avais peur. Et je sais pourquoi j'avais peur…. [Sanglots] J'avais peur qu'il lui fasse du mal. [Sanglots] ». *(Ericka, 42 ans, gestionnaire ministère).*	*"I used to be scared, I would be super anxious…for my daughter, really. And I remember one time when I was downstairs, in the lounge, and her father was changing her upstairs. I heard crying…And I ran out of there…. like a shot. And I was scared. And I know why I was scared…[sobs]. I was scared that he was doing something bad to her. [sobs]."* *(Ericka, 42, department manager).*

Dans l'objectif de pallier les conséquences de l'évitement de l'examen pelvien, des stratégies de contournement étaient mises en place. Afin de réduire les symptômes gynécologiques gênants ou de répondre à leur besoin contraceptif, les femmes interrogées privilégiaient parfois le recours à un professionnel n'appartenant pas au champ de la gynécologie (médecine générale, dermatologie, infectiologie), recouraient à une automédication ou à un suivi en dehors d'un cadre médical, sollicitaient la délivrance d'une contraception en utilisant une prescription caduque, ou formulaient expressément une demande gynécologique à la fin d'une consultation dont le motif principal n'était pas gynécologique, répondre de manière erronée ou éludée à l'interrogatoire médical pour ne pas risquer une prescription d'examens complémentaires considérés comme intrusifs.	Workaround strategies were used to mitigate the consequences of avoiding pelvic examination. In order to alleviate symptoms, or to get their contraceptive needs met, participants sometimes opted to see a professional from outside the field of gynaecology (general medicine, dermatology, infectious diseases), to self-medicate or to seek help beyond a healthcare setting. Other strategies included using an invalid prescription for contraceptives, deliberately raising a gynaecology-related concern at the end of an appointment whose main purpose was not gynaecological, or responding to doctors' questions in an inaccurate or evasive manner in order to avoid being referred for further tests deemed to be intrusive.
« Et par exemple, pour la prescription de pilule, ça se passait comment ? *Chez le généraliste. J'y allais pour autre chose. Et je lui demandais dans les deux dernières minutes, une prescription de contraception. Peut-être qu'il me prescrivait un bilan sanguin pour voir si tout allait bien… Mais sans examen gynéco, ça c'est sûr… ».*	*"So, for example, getting a prescription for the pill, how did that go?* *At the general practitioners. I would go there for something else. And in the last couple of minutes, I would ask him for a prescription for contraception. Maybe he would ask for some blood tests to see if everything was okay…But without doing a gynae exam, that's for sure…"*

(Alexia, 39 ans, étudiante infirmière). *« Mais la fois d'après le généraliste a voulu que je refasse une échographie de contrôle. Je n'ai pas été faire l'échographie… Et j'ai juste arrêté de me plaindre….* *Avec des douleurs toujours présentes ?* *Oui ».* *(Justine, 36 ans, responsable d'un établissement médico-social).* *« Quand elle m'a demandé si « ça se passe bien dans mon couple ? ». « Oui, oui ». Evidemment, que je ne lui ai pas dit « Non, ça se passe mal ». Sinon, elle n'aurait jamais posé [le DIU]. Elle m'avait aussi préconisé d'utiliser des capotes en plus du stérilet, ce qui n'était pas du tout pour me rassurer. Je me souviens très bien de la question « Est-ce que ça se passe bien dans votre couple ? » : je me suis dit « Eh ben, non, d'ailleurs, c'est pour ça que je suis là ». Ça, je ne lui ai évidemment pas dit. Je ne pouvais pas lui dire sinon je n'aurais pas été protégée. Et sachant que j'avais la pression de mon ex. Enfin, je n'ai pas du tout eu une relation de confiance avec elle ».* *(Estelle, 31 ans, professeur de danse).*	*(Alexia, 39, student nurse).* *"But the time after the general practitioner wanted me to have another ultrasound. I hadn't been for an ultrasound…And I just stopped complaining.* *While you were still experiencing pain?* *Yes."* *(Justine, 36, care home manager).* *"When she asked if 'everything was going okay in my relationship?' 'Yes, yes.' Obviously, I didn't say to her, 'No, it's going badly.' Otherwise, she wouldn't have put it in [the IUD]. She also advised using condoms as well as the coil, which did nothing at all to reassure me. I remember the question very well, 'Is everything going okay in your relationship?' I said to myself, 'Well, no, actually, that's why I'm here.' Obviously, I didn't say that to her. I couldn't tell her otherwise I wouldn't have been protected. And knowing that I was being pressurised by my ex. Basically, I didn't have a trusting relationship with her at all."* *(Estelle, 31, dance teacher).*

L'évitement du suivi gynécologique pouvait être également associé au fait de ne pas se sentir prête à révéler les violences et penser devoir le faire, dans ce contexte précis du soin, bien qu'elles soulignent toutefois un bénéfice à aborder les violences en consultation et parfois un regret que ce sujet soit insuffisamment évoqué.	Participants' avoidance of gynaecology follow-up might also be associated with feeling unready to disclose abuse, but thinking that they would have to do so in this particular healthcare context. At the same time, the women stressed the advantages of broaching the subject of abuse during appointments and sometimes expressed regret that this did not happen often enough.
Les personnes interrogées affirmaient le caractère indicible des violences. Dans le contexte de soin gynécologique, lorsqu'elles surmontaient cette indicibilité, elles étaient susceptibles d'être confrontées à l'incrédulité et l'incompréhension des professionnels. Les violences révélées pouvaient ainsi être perçues comme banalisées, éludées ou provoquer de la gêne chez les professionnels, même lorsque les symptômes gynécologiques et psychiques étaient bruyants. Les symptômes gynécologiques et psychiques ne semblaient d'ailleurs pas minorés chez les femmes décrivant un parcours de soin gynécologique marqué par un moindre recours par rapport à celles ayant un fort recours au soin.	The women stressed how difficult it was to put their experience of abuse into words. When they were able to overcome this in a gynaecology setting, professionals often responded with disbelief and a lack of understanding. This could then lead participants to believe their experience of abuse was being ignored or trivialised and their disclosure an inconvenience for the professionals, even when presenting with significant gynaecological and psychological symptoms. Moreover, women with infrequent healthcare seeking did not appear to have fewer gynaecological and psychological symptoms compared to those who frequently sought care.
Pour certaines femmes, les sentiments d'incompréhension, de désintérêt et	The lack of interest shown, and the feelings of being misunderstood and

d'incrédulité prédominaient, confortant le silence et accentuant le moindre recours gynécologique. La banalisation des symptômes gynécologiques par les professionnels semblait raviver le sentiment de ne pas être crû et conforter le fait de taire les violences, d'autant plus si la symptomatologie gynécologique était intense et qu'elle était directement attribuée par la femme aux violences subies.	disbelieved, affected some women in particular, strengthening their silence and reinforcing reduced care seeking. Professionals' trivialisation of symptoms tended to exacerbate the feeling of not being believed and was further silencing. This was particularly the case if gynaecological symptoms were severe and the woman attributed them directly to the abuse they had experienced.
« J'ai parlé des violences sexuelles à mon médecin traitant, il a un peu rigolé en disant [elle lève les yeux au ciel] 'Bon, bon.' Avec lui, je n'ai pas employé le mot viol mais je lui disais que mon compagnon me faisait pression pour avoir des relations avec lui ». *(Laura, 38 ans, formatrice dans l'insertion sociale).*	*"I spoke to my general practitioner about the sexual abuse, he laughed a bit saying [she rolls her eyes] 'Okay, okay.' With him, I didn't use the word rape but I told him that my partner would pressurise me to have sex."* *(Laura, 38, careers adviser).*
La honte et la culpabilité liées aux violences, à leurs conséquences gynécologiques et au moindre recours médical s'alimentaient mutuellement. La culpabilité naissait de la honte d'avoir une santé altérée ou de ne pas avoir évoqué les violences. Cette culpabilité était renforcée par la honte et la culpabilité inhérentes aux violences sexuelles, alors même qu'elles estimaient que le fait de parler des violences	The shame and guilt associated with a history of abuse, the impact of that abuse on gynaecological health, and infrequent care seeking behaviour were all mutually reinforcing. Guilt arose from the shame of having poor health or from not having disclosed abuse. This was then reinforced by the shame and guilt intrinsic to the experience of being sexually abused. At the same time, participants also believed that talking to a healthcare professional

à un professionnel de santé aurait pu contribuer à diminuer le sentiment de honte. *« Dans les faits, je n'ai jamais… [prononciation accentuée] JAMAIS consulté en gynécologie, j'ai 39 ans et je n'ai jamais fait d'examen gynéco… Donc, je cumule le fait que je n'ai pas pris soin de ma santé et que ce n'est pas bien… Et la honte de ne pas l'avoir fait… Et de culpabiliser de ne pas voir fait, de ne pas avoir été… Et que c'est trop tard… Et voilà… Donc en presque 40 ans, je ne suis jamais allée chez le gynéco… ».* *(Alexia, 39 ans, étudiante infirmière).* *« Il n'y a que peu de temps que j'en parle, avant j'avais trop honte. Si j'ai développé autant de maladies physiques et psychologiques, c'est que j'avais trop honte. Et trop de culpabilité. […] Mais si j'avais parlé plus tôt, si j'avais été honnête, sincère ou authentique, certainement, je n'en serais pas là. J'ai honte et je culpabilise de parler aussi tard. Ça aurait été plus courageux si j'avais pu parler avant. J'ai peut-être rencontré des gens qui auraient pu m'aider et je n'ai pas vu ».* *(Caroline, 49 ans, sans activité).* Les situations médicales perçues comme des situations de violence étaient	about abuse could have helped reduce feelings of shame. *"As a matter of fact, I've never….[emphasis] NEVER seen a gynaecologist, I'm 39 years old and I've never had a gynae exam…So, I'm stuck with the fact that I haven't taken care of my health and that's not okay…And the shame of not having done it…And feeling guilty for not having it done, not having been…and it's too late…And there you go…So in nearly 40 years, I've never been to see a gynae doctor."* *(Alexia, 39, student nurse).* *"It's only recently that I've been talking about it, I was too ashamed before. If I've developed so many physical and psychological illnesses, it's because I was too ashamed. And too guilty. […]. But if I'd spoken up earlier, if I'd been honest, sincere or truthful, I definitely wouldn't be here. I'm ashamed and feel guilty for speaking up so late. It would have been braver if I'd been able to speak up earlier. I might've met people who could've helped me and I didn't see it."* *(Caroline, 49, not in employment).* Clinical encounters perceived as abusive were liable to reinforce infrequent

susceptibles de renforcer le moindre recours aux soins. Lors d'une reprise des soins en gynécologie ou dans d'autres spécialités médicales, des gestes vécus comme intrusifs étaient pratiqués. Certaines situations de soin étaient décrites comme profondément déshumanisantes alors qu'elles étaient perçues comme banalisées par les professionnels de santé. Elles évoquaient des paroles déplacées ou absentes, des gestes mécaniques, une intimité bafouée, sans prise en compte des violences déjà subies. Le récit de ces situations de soin était proche de leur propre récit des violences.	care seeking behaviour. Procedures conducted whilst engaging with gynaecology or other specialist medical services were sometimes experienced as intrusive. Some clinical encounters were described as profoundly dehumanising yet seemingly trivialised by healthcare professionals. Participants reported that their abuse history was not taken into account and described inappropriate comments or lack of verbal response, inattentive care, and disrespect for their dignity and privacy. The narratives surrounding these clinical interactions resembled the women's own abuse narratives.
« Avant de me toucher, il m'a dit 'je regarde' et a mis son spéculum… Je m'y attendais pas du tout en fait. Et là, je suis sortie de là, je ne savais plus où j'habitais. Ça m'a cramé le cerveau ». (Charlène, 42 ans, éditrice).	*"Before touching me, he said, 'I'll take a look' and put in his speculum…I really wasn't expecting it at all. And then, when I left there, I didn't even know where I was. That messed my head up." (Charlène, 42, publisher).*
« Je n'ai pas pris conscience sur le coup. Je me suis sentie abusée, là, c'était clair. J'ai eu plusieurs rendez-vous avec ce gynéco. Il me disait de me déshabiller, de me mettre sur le fauteuil et il n'avait pas ses gants. Et il me caressait les cuisses. Moi, je ne sais pas… Je ne m'en rendais pas compte. Je ne peux pas accepter ça… La fois de trop, c'est qu'il m'a ausculté pour	*"I didn't realise straight away. I felt that I'd been abused, that was definite. I had several appointments with this gynae doctor. He would tell me to get undressed; to get up on the couch and he wouldn't have his gloves on. And he used to stroke my thighs. I don't know…I didn't realise. I can't take it…The last straw was when he touched me when examining me. Really, he*

regarder. En fait, il devait juste regarder, il ne devait pas… Il ne m'avait pas prévenue ou quoi que ce soit… *Et il a mis ses doigts à l'intérieur de moi. Sans rien me dire, sans me dire pourquoi. Je ne vois pas pourquoi il est parti regarder à l'intérieur sans me prévenir. Il m'avait dit que peut-être dans plusieurs séances, il allait faire quelque chose à l'intérieur… mais pas cette fois-là. Il ne m'a dit pas dit ce qu'il allait faire et j'ai ressenti… c'était humiliant… Quand je me suis rhabillée, j'ai eu un frisson de dégout [Pleurs]. Et c'est là, que le corps, il se rappelle et il nous dit attention ».* *(Inès, 20 ans, étudiante en sociologie).*	*should've just looked, he shouldn't…He hadn't warned me or anything…* *And he put his fingers inside me. Without saying anything to me, without telling me why. I don't see why he went looking inside without warning me. He'd said that maybe in a few sessions time, he was going to do something internal…but not that time. He didn't tell me what he was going to do and I felt…it was humiliating…When I'd got dressed again, I shivered in disgust [cries]. And that, that's the body warning you and telling you to pay attention."* *(Inès, 20, sociology student).*
Facteurs associés au suivi régulier en gynécologie La volonté de correspondre à la norme expliquait le besoin de normaliser le recours au suivi gynécologique en minorant des symptômes attribués aux violences, afin que leur santé et leur suivi soient similaires à ceux des femmes n'ayant jamais subi de violences. Parfois, une résignation face aux violences permettait d'expliquer une apparente acceptation de l'examen pelvien. *« Je veux être normale. Donc ça doit se faire. C'est naturel. Tout le monde le fait. Et que je dois aussi y passer. Bien que*	*Factors associated with routine care seeking* The desire to emulate conventional behaviour led participants to normalise care seeking by minimising abuse-related symptoms so that their health and care would resemble those of women without a history of abuse. On occasion, a sense of resignation in response to abuse explained an apparent acceptance of the pelvic examination. *"I want to be normal. So, it has to be done. It's natural. Everyone does it. And so, I have to go through it as well. Even though*

dans le fond, je me dis que je mens à moi-même. Je ne serai jamais comme tout le monde. Mais j'ai envie de réagir, de faire, d'avoir le même traitement que tout le monde ». *(Ericka, 42 ans, gestionnaire ministère).* *« En fait, mon vagin était une telle autoroute que bon… une fois de plus… C'était pareil… Ecarter les jambes pour quelque chose de désagréable faisait partie de mon quotidien. Que ce soit pour mon ex-conjoint ou pour mon frottis, c'était pareil ».* *(Sarah, 36 ans, enseignante-chercheuse).* L'amnésie traumatique et les troubles dissociatifs consécutifs aux violences sexuelles semblaient participer à rendre plus tolérable l'examen gynécologique. *« Je subissais les différents examens et me disant 'il faut le faire'. Comme un dédoublement. Après mes accouchements, lors du suivi gynécologique, il fallait que les professionnels fassent leur travail. Je subissais. J'avais encore la chance de pouvoir me dissocier. Et maintenant, je ne supporte plus ce jeu-là, je n'arrive plus à me dissocier ».* *(Linda, 60 ans, psychiatre).*	*deep down, I tell myself that I'm lying to myself. I'll never be like everyone else. But I want to react, to do, to have the same treatment as everyone else."* *(Ericka, 42, department manager).* *"Actually, my vagina saw such a lot of traffic that, fine…one more time…It was the same…Spreading my legs for something unpleasant was part of my everyday life. Whether it was for my ex-partner or for my smear, it was the same."* *(Sarah, 36, teacher/researcher).* Traumatic amnesia and dissociative disorder secondary to sexual abuse seemingly made gynaecological examination more tolerable. *"I went through the various tests telling myself, 'You have to do it.' Like a splitting in two. After giving birth, at gynae follow-up, the professionals had to do their work. I put up with it. I was lucky to be able to dissociate. And now, I can't handle that game anymore, I'm not able to dissociate anymore."* *(Linda, 60, psychiatrist).*

« On peut avoir un examen gynéco en étant complètement dissociée de son corps… sans rien en bas… peu importe ce qu'il s'y passe, ça ira ». *(Sarah, 36 ans, enseignante-chercheuse).*	*"You can have a gynae exam while being completely dissociated from your body…with nothing down there…doesn't matter what's going on, it'll be okay."* *(Sarah, 36, lecturer/researcher).*
Une ou plusieurs expériences de soin gynécologique ou psychique perçues positivement incitaient à adopter un suivi régulier. La capacité à se projeter dans des projets personnels ou familiaux et le vécu d'une santé sexuelle satisfaisante étaient associés à l'effectivité d'un suivi gynécologique. Des stratégies étaient aussi déployées pour faciliter le recours médical comme une préparation à l'examen pelvien, par exemple.	One or more positively perceived episodes of either gynaecological or psychological care motivated routine care seeking. The ability to pursue personal or family goals, and a satisfying sex life, were also associated with effective use of gynaecology services. In addition, strategies were employed to assist in seeking medical care; for example, preparing for the pelvic exam.
« Après je me suis entrainée, oui, c'est très bizarre [Rires]. De manière à ce que ça puisse se passer dans de meilleures circonstances ». *Vous vous êtes entrainée, c'est-à-dire ?* *« Clairement, je me suis mis des doigts [Rires]. Et même avec ça, le premier coup, le toucher vaginal et le spéculum ont été très compliqués et très douloureux ».* *(Céline, 34 ans, médecin-pompier).*	*"After that I trained myself, yes, it's really weird [laughs]. So that it could happen under the best conditions."* *"You trained yourself, what do you mean?"* *"I put my fingers inside, obviously [laughs]. And even with that, the first time, the vaginal exam and the speculum were very difficult and very painful."* *(Céline, 34, emergency medic).*
L'adhésion au suivi obstétrical faisait parfois exception dans les parcours marqués par le moindre suivi	For those who sought help for gynaecological symptoms infrequently, an exception was often made during pregnancy,

gynécologique. Malgré la présence de peurs et de résurgences relatives à l'accouchement et la maternité, l'adhésion au suivi obstétrical primait sur toutes les raisons qui motivaient l'évitement du suivi gynécologique. Pendant cette période, elles adhéraient volontiers au suivi médical avec une motivation liée davantage à la promotion de la santé de l'enfant à naitre qu'à leur propre santé. Ce constat se vérifiait lorsque le désir de grossesse ou de maternité était présent, mais aussi lorsqu'il ne l'était pas. *« Je n'avais jamais eu de consultation gynéco avant la grossesse car l'examen gynéco me faisait peur. Pendant la grossesse, je me suis rendue de manière attentive à toutes les consultations, les prises de sang, les examens etc, comme un peu la bonne élève que j'avais été [Rires]. Même les examens gynécologiques pendant la grossesse avaient un sens. Comment vous dire ? C'était une sorte de parenthèse ».* *(Julie, 32 ans, administratrice civile).* *« Je pense qu'à ce moment-là, je n'étais plus qu'un ventre avec un bébé que l'on attendait. J'étais tellement centrée sur mon désir de maternité. J'étais à ce moment-là régulièrement suivie, sans que ça soit gênant. Clairement, à ce moment-là, le désir de maternité était plus fort. Aujourd'hui, étant confrontée au fait que je*	childbirth and in the postnatal period. Despite feeling fearful and experiencing triggers related to giving birth and becoming a mother, compliance with obstetric intervention overrode all the factors which drove avoidance of gynaecology care. During this period, the women engaged readily with services, motivated more by a wish to care for their unborn baby than to attend to their own health needs. This was found to be the case whether or not the woman wanted to become pregnant or have children. *"I'd never had a gynae appointment before becoming pregnant, because the gynae exam scared me. When I was pregnant, I was careful to go to all my appointments, the blood tests, the examinations etc. a bit like the star pupil I used to be [laughs]. Even gynae exams during pregnancy made sense. How can I explain it to you? It was a sort of time-out."* *(Julie, 32, administrative officer).* *"I think at that point, I was nothing but a belly expecting a baby. I was so focused on wanting to become a mother. At that point I was being monitored regularly, without it being a problem. Obviously, at that point, wanting to become a mother was stronger. Today, faced with the fact that I have to go there for myself, and not for a*

doive y aller pour moi, et pas pour un bébé que nous voudrions avoir, j'ai du mal quand même ». *(Line, 49 ans, psychologue).*	*baby that we'd like to have, I find it hard still."* *(Line, 49, psychologist).*
La présence de symptômes gynécologiques pouvait favoriser l'adhésion à des soins gynécologiques chez une partie des personnes interrogées et, à l'inverse, le recours préventif était perçu comme peu incitatif. La peur d'une maladie gynécologique suffisait, chez certaines, à dépasser la peur de l'examen clinique et à entamer ou à reprendre un suivi gynécologique, mais ce n'était pas une motivation suffisante pour toutes.	The presence of gynaecological symptoms might encourage some participants to engage with treatment; conversely, there seemed to be little motivation to seek care for preventive purposes. For some women, the fear of illness was enough to overcome the fear of being examined and to initiate or resume engagement with gynaecology care. However, this was not sufficient motivation for every participant.
« Et puis culpabiliser, ça ne marche pas 'Vous avez un cancer, vous allez mourir'. Ça ne fonctionne pas sur les fumeurs. Je ne vois pas pourquoi ça fonctionnerait sur une femme violentée ». *(Céline, 34 ans, médecin-pompier).*	*"And then shaming people, that doesn't work, 'You've got cancer, you're going to die.' That doesn't work on smokers. I don't see why it would work on a woman who's been abused."* *(Céline, 34, emergency medic).*
Facteurs associés au recours multiple au suivi gynécologique	*Factors associated with frequent gynaecology care seeking*
Les parcours de soin en gynécologie pouvaient être marqués par le recours à un nombre important de professionnels et de consultations pour des plaintes identiques ou proches. Les femmes	Consultation with a number of different professionals for similar or identical complaints might typify some gynaecology care journeys. Participants expected professionals to recognise that

interrogées attendaient que les professionnels identifient spontanément les violences subies, sans qu'elles aient elles-mêmes à les nommer, d'autant plus lorsque ces professionnels constataient des symptômes attribués aux violences. Des diagnostics médicaux considérés comme imprécis et incomplets suscitaient l'insatisfaction et le rejet. Le sentiment d'incompréhension et d'incrédulité à l'égard de professionnels indifférents ou évitants pouvait aussi inciter à des soins gynécologiques et psychiques multiples.	they had experienced abuse spontaneously, without them having to name it. This was particularly the case when abuse-related symptoms were observed by these professionals. Non-specific and inadequate medical diagnoses evoked feelings of dissatisfaction and rejection. Incomprehension and disbelief towards indifferent or avoidant professionals could also lead to repeated gynaecology and psychology consultations.
« J'allais parfois aux urgences. Parce que j'avais mal. Parce que je saignais du sang. Je sais que je saignais du sang. Vous apportez aux urgences votre tube de pipi avec du sang et on vous dit 'mais c'est parce que vous avez vos règles'. Non, je n'avais pas mes règles. Je saigne du sang. Si j'avais mis ce tube à côté d'un tube de sang, on n'aurait pas vu la différence entre l'urine et le sang. Et là, ils l'ont envoyé au laboratoire et encore une fois, un côté très frustrant. Et là, vous vous dites…mais ils n'ont rien compris [Pleurs]… J'avais des infections urinaires et des infections urinaires mais personne ne m'a posé la question (des violences) ». *(Isabelle, 47 ans, infirmière).*	*"I sometimes used to go to the Emergency Department. Because I was in pain. Because I was bleeding. I know I was bleeding. You take your tube of pee with blood in it to the E.D and they say to you, 'but it's because you're on your period.' No, I wasn't on my period. I was bleeding. If I'd put that tube next to a tube of blood, you wouldn't have been able to tell the difference between the urine and the blood. And then, they sent it to the lab yet again, very frustrating. And then they say to you…but they haven't understood anything [cries]. I used to get urine infection after urine infection but no one asked me the question (about abuse)."* *(Isabelle, 47, nurse).*

« La gynécologue que j'ai vu en août 2020, elle m'a demandé à quel âge j'avais eu mon premier rapport et quel type de rapport. C'était complètement en décalage par rapport à ce que j'avais vécu. J'en suis venue à lui dire que je n'avais jamais eu de rapport. Jamais eu de rapport. C'était uniquement des viols…[Pause] ». *(Mélissa, 21 ans, étudiante en ergothérapie).*	*"The gynaecologist who I saw in August 2020 asked me how old I was when I had my first relationship and what type of relationship. It was totally at odds with what I'd experienced. I ended up telling her that I'd never had a relationship. Never had a relationship. It was nothing but rape…[pause]."* *(Mélissa, 21, occupational therapy student).*
Le sentiment de ne pas être crue et comprise lors de la révélation des violences ou lors de l'expression de symptômes gynécologiques ou psychiques attribués à ces violences renforçait la multiplicité des recours au soin lorsqu'elles décrivaient les trajectoires qui amenaient au diagnostic de l'endométriose et du vaginisme. La difficulté d'établir une relation de confiance avec un professionnel était dans ces situations particulièrement présente.	For women pursuing a diagnosis of endometriosis and vaginismus, high frequency care seeking was reinforced by the feeling of not being believed and understood when they disclosed abuse or when their abuse-related gynaecological or psychological symptoms became apparent. In these cases, establishing a trusting relationship with a healthcare professional was particularly difficult.
« Je connais très bien mon corps. Je sais quand il y a la moindre anomalie, et il y en a toujours une. À chaque fois [Rires]. J'ai besoin de quelqu'un qui connaisse ma pathologie, l'endométriose, et en même temps qui soit très à l'écoute. À l'écoute de moi. C'est important pour moi d'être comprise et d'être crue. D'où le fait d'avoir changé autant de praticiens ». *(Charlotte, 26 ans, étudiante en publicité).*	*"I know my body very well. I know when there's the slightest thing wrong, and there's always something. Every time [laughs]. I need someone who knows about my condition, endometriosis, and at the same time who is very good at listening. Listening to me. It's important for me to be understood and believed. Which is why I've changed doctors so much."* *(Charlotte, 26, marketing student).*

Certaines femmes interrogées témoignaient de leur volonté de réussir à être examinée, en faisant référence directement à une possible pénétration, coûte que coûte et sans autre intérêt que d'atteindre cet objectif.	Some women expressed a wish to be examined successfully, referring directly to being able to achieve penetration, no matter the cost and with no aim other than reaching this goal.
« Mais c'est vrai qu'on m'avait dit, que même si je ne voulais pas de sexualité, c'était important d'arriver à la pénétration. Parce que ça pose problème pour les examens gynécologiques, par exemple. Juste dans ce cadre-là, parce que sinon je n'envisage pas de sexualité ». *(Mélissa, 21 ans, étudiante en ergothérapie).*	*"But it's true, I was told that even if I didn't want to have sex, it was important to be able to manage being penetrated. Because it presents a problem for gynae exams, for instance. Just in that context, because apart from that I don't see myself having a sex life."* *(Mélissa, 21, occupational therapy student).*
« Parfois, j'ai l'impression que le spéculum, il cachait là où j'avais mal.	*"Sometimes, I think the speculum hid the place where I felt pain.*
Vous pourriez m'expliquer, quand vous dites le spéculum cachait là où j'avais mal ?'	*Could you explain to me, when you say the speculum hid the place where I felt pain?*
J'ai mal sur les parois qui referment le vagin [elle mime]. À partir du moment où le spéculum est dedans, il regarde dedans, sauf qu'il ne regarde pas là où j'ai mal […]. Parce que quand on est examinée 20 fois par an, quand on tout essayé comme crème, ovule, quand on a tout essayé comme contraception, et qu'on a toujours plein de douleurs c'est peut-être qu'il y a un problème ».	*I get pain in the walls which close my vagina [she mimes]. As soon as the speculum is inside, he looks inside, except he doesn't look where I've got pain […] Because when you've been examined 20 times a year, when you've tried all the creams, pessaries, when you've tried all types of contraception, and you're still in a lot of pain, maybe it's because there's a problem."*

(Emma, 23 ans, étudiante sciences-po).	*(Emma, 23, politics student).*
Moindre recours et recours accru, des parcours inconstants Les parcours de soin individuel, modulés par des facteurs liés aux violences et à la santé gynécologique, se caractérisaient souvent par une alternance entre des périodes de moindre recours, de recours régulier et de recours accru. Ainsi, lorsque les femmes interrogées vivaient une expérience de soin gynécologique satisfaisante, lorsqu'elles avaient une vie affective et sexuelle satisfaisante, elles pouvaient être incitées à un recours régulier. À l'inverse, le fait d'être exposée à des situations de soins anxiogènes, perçues comme traumatiques, pouvaient les dissuader de poursuivre un suivi gynécologique et initier une période de non-recours.	*Infrequent and frequent care seeking: variable pathways.* Individual gynaecology care journeys were often characterised by alternating periods of infrequent, routine and frequent care seeking behaviour, shaped by abuse-related factors and health status. Thus, when participants experienced satisfactory care and/or had satisfying relationships and sex lives, they could be encouraged to engage with services regularly. Conversely, exposure to anxiety-provoking clinical encounters, perceived as traumatic, could discourage them from pursuing gynaecology care and trigger a period of non-engagement.
« Il y a eu UN [diction accentuée] gynéco. Il m'avait fait raconter mon histoire ; il m'avait écouté il était hyper-bienveillant, hyper-attentif, il m'a réconforté. Et il m'a dit 'si vous avez besoin - je peux vous examiner mais je peux aussi juste regarder sans toucher'. Là, je voulais quand même vérifier que tout allait bien donc je lui ai demandé de regarder très rapidement, tranquillement. Il m'a dit que tout allait bien et j'ai trouvé ça incroyable.	*"There was ONE [emphasis] gynae doctor. He got me to tell my story; he listened to me, he was really kind, really attentive, he reassured me. And he said to me, 'if you need it – I can examine you but I can also just look without touching.' At that point, I wanted to just check that everything was okay so I asked him to take a look very quickly, gently. He told me everything was okay and I found that incredible. When he asked why I'd come, he asked me to talk*

Quand il m'a demandé pourquoi j'étais venue, là il m'a demandé de raconter ; je voyais qu'il était vraiment affecté par ce que je racontais. *Je lui ai raconté le viol, je lui ai raconté le vaginisme, toutes les recherches que j'avais faites, toute la galère quoi…Il a tout écouté. Il a eu de la peine pour moi et ça m'a fait tellement du bien et après il m'a dit, je me rappelle plus exactement bien, mais [Rires] 'Vous êtes tellement courageuse, autant de mauvaises expériences. C'est incroyable que vous ayez eu autant de mauvaises expériences médicales, on va essayer de tout faire pour vous. Bravo d'être venue! ». (Victoire, 27 ans, artiste-peintre).* *« Ce premier rendez-vous, je devais avoir… 15 ans. Je voulais avoir des réponses et je ne les ai pas eues. Depuis, c'est vrai que j'ai du mal. Après, j'ai revu une autre gynéco qui m'a fait très mal, donc après je n'y suis jamais retournée. En fait, pendant la consultation, je ne sais pas comment ça s'appelle ? pour ouvrir... le… [elle mime le spéculum] …elle m'a mis ce truc, elle ne m'a pas prévenue. Ça me faisait mal. Ça me bloquait au niveau du ventre. Je le lui ai dit. Et elle m'a dit 'C'est normal'. Sans plus de précaution que ça. Vu que je suis quelqu'un de stressée, ça m'a encore plus bloquée. Et, je me suis dit, non*	*about it, I could see that he was really affected by what I was telling him.* *I told him about the rape, I told him about the vaginismus, all the research that I'd done, the whole nightmare…He listened to everything. He felt sorry for me and that did me so much good and afterwards he told me, I can't quite remember exactly anymore, but [laughs], 'You're so brave, so many bad experiences. It's incredible that you've had so many bad medical experiences, we're going to try and do everything we can for you. Well done for coming!" (Victoire, 27, artist/painter).* *"This first appointment, I must've been…15 years old. I wanted answers and I didn't get them. Since then, it's true I've found it hard. Then, I saw another gynae doctor who really hurt me, so after that I never went back there. In fact, during the appointment, I don't know what it's called? To open…the... [she mimes the speculum] …she put this thing inside me, she hadn't warned me. It hurt me. It was jammed right up to my womb. I told her so. And she said to me, 'That's normal.' With no more care than that. Considering that I'm someone who gets stressed, that has made me even more tense. And, I said to myself, no I don't*

je n'ai pas confiance. Et je n'y suis jamais plus retournée ». *(Coralie, 38 ans, enseignante).*	*trust her. And I never went back there again."* *(Coralie, 38, teacher).*
« En plus, elle a souhaité m'examiner moi, j'étais en panique. De base, les seuls examens gynéco que j'avais eus, c'était après les abus sexuels. C'était une source de stress pour moi. J'avais très peur. Je tremblais. Et quand elle a vu ça, elle n'a pas cherché plus loin. Et j'aurai aimé qu'elle le fasse. Vu les douleurs qu'il y avait et qu'il y a encore. Elle m'a aussi dirigée vers une collègue qui était soi-disant thérapeute spécialiste des victimes de violences sexuelles. Alors que pas du tout. Je suis partie la voir en août 2020 et c'était pire que mieux. Après ça, je ne voulais plus du tout consulter de gynécologue. Je ne voulais plus. J'ai attendu ». *(Mélissa, 21 ans, étudiante en ergothérapie).*	*"Also, she wanted to examine me, I was panicking. Basically, the only gynae exams that I'd had were after being sexually abused. It was really stressful for me. I was very scared. I was shaking. And when she saw that, she didn't go any further. And I would have liked her to. Considering the pain that I was in and that I've still got. She also signposted me to a colleague who was supposedly a therapist specialising in victims of sexual abuse. Not at all though. I went to see her in August 2020 and it was worse not better. After that, I didn't want to see a gynaecologist anymore. I didn't want to anymore. I've waited."* *(Mélissa, 21, occupational therapy student).*

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Tableau 1. Niveau de recours au suivi gynécologique selon les caractéristiques des violences et les perceptions relatives à la santé gynécologique.

	Moindre recours	Recours Régulier	Recours multiple
Percevoir favorablement un suivi gynécologique ou psychologique		x	
Se projeter dans une vie affective/Décrire une santé sexuelle satisfaisante		x	
Eprouver une peur de la maladie gynécologique		x	
Etre enceinte		x	
Revendiquer d'être normale comme les non-victimes		x	
Se détacher de son corps lors de l'examen pelvien		x	
Eviter l'examen pelvien	x		
Adopter des stratégies de contournement de l'examen pelvien	x		
Supporter des violences indicibles	x		
Percevoir la violence dans les actes de soin	x		
Ressentir de la honte et de la culpabilité liées aux violences et à leurs conséquences gynécologiques	x		
Être exposée à l'incompréhension et à l'incrédulité des professionnels au moment d'exprimer les violences et leurs conséquences gynécologiques	x		x
Présenter des symptômes gynécologiques et psychiques accrus	x		x
Rechercher un diagnostic des violences et de leurs conséquences gynécologiques			x
Réussir à pouvoir être pénétrée…à tout prix			x

Table 1: Level of care seeking according to abuse experienced and perceptions of gynaecological health.

	Infrequent	Routine	Frequent
Favourable perception of gynaecology or psychology follow-up		x	
Engagement in relationships/satisfying sex life		x	
Fear of gynaecological disorders		x	
Pregnancy		x	
Wish to be "normal" like non-victims		x	
Bodily dissociation during pelvic exam		x	
Avoidance of pelvic exam	x		
Use of strategies to circumvent pelvic exam	x		
Unable to verbalise abuse experienced	x		
Perception of health care procedures as abusive.	x		
Feelings of guilt and shame in relation to abuse and associated impact on gynaecological health.	x		
Exposure to disbelief/incomprehension of professionals when speaking about abuse and its impact on health.	x		x
Significant gynaecological and psychological symptomatology.	x		x
Pursuit of diagnosis connected to abuse and its health impact.			x
Ability to achieve penetration…at all costs.			x

CHAPTER 3: COMMENTARY - LINGUISTIC CHALLENGES

3.1 Introduction

This case study made two *a priori* assumptions. Firstly, that the S.T could be treated as two separate texts, each with its own overall translation strategy – one essentially domesticating (for the researcher-authored sections of text) and the other foreignizing (for the participant quotes). Secondly, that ethical challenges would principally emerge in the translation of participant quotes. The commentary describes how these two assumptions were called into question as the translation process unfolded. It will highlight the use of foreignizing elements in the research-authored sections of the text, and the need for some domestication to aid comprehension in the sections which include participant quotes. It will also identify ethical challenges which arose throughout the text, largely in relation to the S.T.'s sensitive subject matter.

The commentary is divided into three chapters, addressing each of the three potential challenges identified in the research questions: linguistic, cultural and ethical. This structure has been adopted for clarity but these are not discrete categories and there are significant areas of overlap.

This first chapter will discuss the challenges encountered, and the strategies used to address them, during the translation process in relation to: creating the pattern of research English, medical and healthcare terminology and the language used to describe sexual abuse.

3.2 Creating the pattern of research English

3.2.1 Challenges encountered

Research English is a pattern formed from a combination of lexicogrammatical features such as nominalisation, one clause sentences and lexical density (Halliday, 2004). The overall translation strategy was to recreate this pattern in the researcher-authored sections of text so that the T.T. would read as if it were not a translation. This meant adopting the syntax, structures and vocabulary characteristic of research or scientific English, which tends to favour clarity and concision (Montalt & González-Davies, 2014). Research articles in the source language (S.L) differ in their rhetorical and linguistic structures; for example, longer sentences and use of the passive voice is more common (Van Bonn & Swales, 2007). These differences are evident in the S.T.; in particular, there are a number of long, multiple-clause

sentences. Significant manipulation of the S.T. was, therefore, required in order to create a text which might credibly have been written in the T.L.

3.2.2 Strategies used

The strategies used to address this challenge included splitting or sometimes merging sentences, transposing nouns to verbs, or other parts of speech, and modulation. These are commonly used procedures when translating any text in this language pair (Hervey & Higgins, 2002; Popineau, 2016). More specific to recreating the pattern of research English was the adoption of a structure which is not available in the S.L, but is commonly used in medical/research/science discourse in the T.L. – the compound adjective formed from a noun and past participle (Maniez, 2013). It is used in the T.T. mostly to describe a causative relationship in a more concise way than the S.T; e.g. *abuse-related symptoms/ des symptômes attribués aux violences* (p.12). On occasion, metadiscourse markers have been inserted to assist the reader in navigating the text. This is justified on the basis that the target culture tends to place the responsibility for understanding a text on the writer, not the reader (Swales & Feak, 2012), in contrast to the source culture (Dahl, 2004). Finally, care was taken to select lexical items, especially verbs, which are typically used in T.L. empirical research discourse; e.g. *describe, report, conduct etc* (Bloch, 2010).

The last sentence of the *Methods* section (p.10) illustrates a number of these syntactical, structural and linguistic challenges and their solutions:

ST: À partir de leur enregistrement (logiciel TEAMS), les entretiens, retranscrits de manière anonyme, ont été analysés (logiciel NVIVO) de manière individuelle, puis de manière croisée par les trois auteurs afin de limiter la subjectivité relative à l'interprétation des données.

T.T: The interview recordings (on TEAMS) were transcribed and anonymised before being analysed using NVIVO software. Analysis was conducted on an individual basis initially, and then, in order to minimise subjectivity in data interpretation, by the three authors jointly.

B.T.: From their recording (software TEAMS), the interviews, transcribed in an anonymous manner, were analysed (software NVIVO) in an individual manner, then in a manner crossed by the three authors in order to limit subjectivity relative to the interpretation of data.

The T.T. splits a lengthy sentence which has five clauses and two parentheses into two, each of which describes a single step in the research process (transcription, analysis). This involves transposition from a compound passive verb construction (*ont été analysés)* to a noun (*analysis*) and modulation (*interview* and *recordings* are brought together to create the subject of the first sentence). This creates much greater clarity. The nominalisation of *analysis* then requires the insertion of an appropriate verb, in this case *conducted*. Finally, the metadiscourse marker *initially* is inserted to aid the reader in following the researchers' methodology.

3.2.3 Challenges specific to qualitative research

Some translation challenges were identified which seem to be specific to the qualitative research article. For example, during the translation process it became apparent that the researcher-authored passages of the *Results* section were more discursive than the *Introduction* and *Methods* sections. The linguistic and rhetorical structures used in research articles are known to vary according to the paradigm on which the research is based (Cao & Hu, 2014). In qualitative interview research, knowledge is constructed between the researchers and the participants (Bowling, 2011), which may explain this more reflective style and the more explicit presence of the S.T. authors in this section.

In these reflective passages, the overall domesticating strategy was adapted slightly to allow the voice of the researchers to emerge. This is illustrated in the following example (p.13):

S.T: L'examen était perçu comme contraignant, subi, intrusif voire violent, dans un corps négligé, considéré comme cassé ou anormal.

T.T: The examination was perceived as stressful, intrusive, even abusive: something to be endured by an uncared-for body, regarded as broken or abnormal.

B.T: The examination was perceived as constraining, suffered, intrusive indeed abusive, in a neglected body, considered as broken or abnormal.

The T.T. retains the lengthy, multi-clause structure of the S.T., which arguably conveys a sense that the researchers are processing and trying to understand the women's experiences not just reporting their words. In contrast, a translation prioritising clarity and concision only might read as follows:

The examination was perceived as stressful, intrusive and even abusive. Participants described it as something to be endured in a body which they neglected and considered as broken or abnormal.

3.3 Terminology challenges

Terminology poses a challenge when translating any text drawn from a specialist field (Olohan, 2015), and in medical texts in particular (Popineau, 2016**;** Montalt & González-Davies, 2014). The S.T. in this case study uses terms from the fields of medicine and health research.

3.3.1 Medical terminology

Most of the medical terms used in the S.T. are diagnostic categories. As the Greek and Latin etymology of these terms is shared across source and target cultures (Montalt & González-Davies, 2014), equivalents were usually readily identified; e.g. *les dysménorrhées/ dysmenorrhea* (p.8). Both cultures also use the pan-European diagnostic classification system, the I.C.D-11 (World Health Organisation, 2019) so solutions could easily be crosschecked. However, parallel texts indicated a variation in usage between the two cultures, with some terms appearing less common in T.L texts. Generally, the obvious lexical equivalent was retained on the grounds that the target audience would recognise the term, even if they did not use it themselves. One exception to this was the term *asexualité* to describe a disorder of sexual functioning. This usage is offensive in the target culture, which tends to view asexuality as an orientation not a disorder (Jones, 2018). Therefore, based on the ethical principle of doing no harm (Baker, 2018), the ICD-11 term *hyposexuality* was used instead (p.12).

The use of medical terms by the research participants posed more of a challenge. The S.L., in common with other Latin-based languages, lacks a lower register counterpart for technical medical terms (Jiménez-Crespo, 2017). Therefore, it might be expected that when these kinds of terms are used in everyday spontaneous speech, such as the participant interviews, they are most appropriately translated using lower register T.L. terms; for example, *des règles hémorragiques très abondantes/ very heavy periods, very heavy flow* (p.13). However, the S.T indicates that about a third of the participants have a healthcare background. Uniform use of a lower register would potentially obscure this fact. Therefore, technical terms were retained when the participant appeared to be using them in a technical

sense; e.g. when *Linda,* a psychiatrist, describes splitting (*un dédoublement*) and dissociating (*dissocier*) when being physically examined (p. 24).

3.3.2 Health research terminology

The S.T. employs terminology from the broader field of health research. The phenomenon under investigation, *recours au soins*, is referred to repeatedly throughout the text, including in the title, and so it was essential to establish an appropriate translation. The S.T. researchers do not define the term, so it was assumed that it was not being used in a specific, theory-driven manner which might limit the translation options. Dictionaries were of limited use, as is often the case in all types of technical translation (Olohan, 2015), and so parallel texts were consulted. The term *healthcare seeking behaviour* was selected based on its widespread use (e.g. Kanyadan et al., 2023).

Qualitative health research methods have their own lexicon (Bowling, 2011). For example, although the S.T. uses *thématiques* (p.10) to describe the interview schedule, the term *topic* was selected for the T.T. as the more obvious *theme* tends to be used to describe concepts identified during analysis of interview transcripts (Hennink et al., 2020).

3.4 Language used to describe sexual abuse

Men's violence against women is a universal phenomenon but the language used to name and describe it varies widely between cultures (Bosseaux, 2020). The S.T term *violences sexuelles* does have a direct equivalent in the T.L but this tends to be an umbrella term and is usually not applied to children, where the term *sexual abuse* is preferred (IDAS, 2024). As the S.T. discusses abuse experienced in childhood and adulthood, the latter term was chosen. *Violence* also carries connotations of physical acts, rather than the wider range of controlling behaviours referred to in the S.T. In addition to the labels given to this type of abuse, there are a number of other linguistic terms relating to the victim (or survivor?) and their experience (or suffering?) which are contested even within the same language community, including within the Anglosphere (Tipton, 2018; Boyle, 2019). It was decided to retain *victim,* as one of the interviewees uses this term herself. However, the more neutral *experience* (e.g. p.12) was favoured over *suffer* to avoid potentially negative connotations of passivity (Hepworth, 2024).

The representation of gender in the T.T was more problematic. The gender-neutral term *participant* was adopted for *les femmes interrogées/the women questioned;* this choice is

entirely consistent with a domesticating translation strategy since *participant* is the favoured T.L descriptor for interviewees (Hennink et al., 2020). However, when combined with the lack of grammatical gender in the T.L. and the absence of a gender specific third person pronoun, this ran the risk of lessening the presence of women in a text about a gendered crime (Burrell, 2016). In compensation, *the women* was inserted into the text at appropriate points e.g. *Pendant cette période, elles adhéraient…/ During this time, the women engaged*… (p.26).

3.5 Conclusion

This chapter has described how the overall translation strategies – domesticating and foreignizing - identified at the outset were applied, and sometimes modified, in response to the challenges which arose during the translation process. Ethical considerations emerged unexpectedly when making linguistic choices. This occurred not just with individual terms but also in relation to some of the fundamental lexicogrammatical differences between the source and target languages.

CHAPTER 4: COMMENTARY - CULTURAL CHALLENGES

4.1 Introduction

This chapter will discuss the translation challenges, and the strategies used to address them, which can be ascribed to cultural difference. These challenges can be split into two types, drawing on Katan's (2009) iceberg model: surface-level, "culture-bound" terms (p. 79) and below the surface, broader differences in healthcare culture, particularly in relation to women's healthcare.

4.2 Culture-bound terms

Attitudes towards health and illness vary between cultures **(**Albarrán Martín, 2018). Healthcare systems, institutions and practices also vary between cultures (Montalt-Resurrecció & Shuttleworth, 2012). Health-related texts, therefore, are likely to contain references which are culture specific and thus pose a potential translation challenge (Montalt & González-Davies, 2014). There are a number of studies in the T.S. literature which describe procedures for managing culture-bound terms (Katan, 2009). Pedersen (2005) presents a range of options for the translator from retention (S.L. oriented) to substitution or omission (T.L. oriented). It was initially assumed that the overall translation strategy would drive translation choice in this area; i.e. domesticating procedures for culture-bound terms used by the researchers and foreignizing procedures for culture-bound terms used by the participants. However, as the translation progressed, it became clear that the text needed to be considered as a whole when finding solutions for culture-bound terms.

4.2.1 Culture-bound terms used by the researchers

The researchers use three culture-bound terms in the *Introduction* and *Methods* sections of the S.T. They refer to a state healthcare body (*la Haute Autorité de Santé*), a women's organisation (*Collectif Féministe Contre le Viol*) and a telephone helpline (*Viols Femmes Informations*). An official equivalent, if one exists, is generally the first choice when translating culture-bound terms (Pedersen, 2005). The first of these three items has an English language version of its website from which the term *National Authority for Health* was taken. A search of T.L. parallel texts did not find any alternative terms, and so this solution was adopted as a (semi) official equivalent. It can be categorised, according to Pedersen's typology (2005) as a "direct translation" which is shifted towards the T.L. in the use of *National* rather than *High/Haute* to avoid a calque. This translation, and the context of

its use, is sufficient for the T.T. reader to understand that this body probably fulfils a similar function to the National Institute for Health and Care Excellence [N.I.C.E] (N.I.C.E, 2024).

Whilst common domesticating procedures such as generalisation, substitution or omission were considered for the other two items, they were ultimately rejected in favour of the most S.L. oriented strategy for dealing with culture-bound terms (Pedersen, 2005): direct translation retaining the S.L. term in brackets and italicised. This is illustrated in the solution chosen for the women's organisation (p.10).

S.T: Collectif Féministe Contre le Viol

T.T: Feminist Collective Against Rape *(Collectif Feministe Contre le Viol)*

This highly foreignizing approach in a section of the text which is meant to be written as if it is not a translation was justified on the following grounds. Firstly, the S.T. authors have written in detail about the women's organisation, probably because it is an essential part of their recruitment strategy. The use of a general term or a T.L. substitute would have obscured this part of the researchers' message. Secondly, the T.T. is not for publication so there is no requirement to adhere to author guidelines or journal policies which might require a more domesticating approach (Montalt & González-Davies, 2014). Thirdly, although the text was divided into two in terms of overall strategy and, for practical reasons, during the translation process, it nevertheless forms one whole text. Drawing attention to "foreignness" in the researcher-authored section forms a bridge to the participants' section, signalling to the T.T reader than the women in this study are not T.L. speakers. Baker (2006) describes this kind of framing as an ethical choice, designed to accentuate authenticity in ontological narrative translation. Finally, there is an argument for drawing attention to, rather than erasing through generalisation, this grassroots women's organisation. This is in keeping with an interventionist/feminist translation tradition (Ergun, 2020) and congruent with the gendered subject matter of the S.T.

4.4 Culture-bound terms used by participants

The culture-bound nature of some terms used by the research participants only became apparent during the translation process. Most of these terms related to healthcare delivery. The following example illustrates the challenges this presented and the reasoning behind the solution selected:

One participant described seeking urgent medical care repeatedly because of pain (p. 28):

S.T: J'allais parfois aux urgences… Vous apportez aux urgences votre tube de pipi…

T.T: I sometimes used to go to the Emergency Department. You take your tube of pee…to the E.D…

B.T: I went sometimes to urgent care…You take to urgent care your tube of pee…

In the U.K., the term used for urgent care is generally the proper noun *Accident and Emergency* or *A and E*. However, this is culture specific as other Anglophone countries use different terms; for example, Emergency Room (E.R.) is the norm in the U.S (U.S. Embassy, n.d). In order to convey the "foreignness" of the participants, it was decided to use a less culturally marked translation solution, hence *Emergency Department*. A similar solution was sought for *généraliste/general practitioner* (p.17) rather than the more British English specific *G.P*. This term was also used for *médecin traitant* (p.20) as research indicated the role shares some of the functions of a G.P. in the U.K. (Chambers, 2021). These solutions do not readily map onto the typology described by Pedersen (2005) but are consistent with the approach taken with culture-bound terms in the researcher-authored sections of the text; i.e. they attempt to highlight cultural difference in order to enhance authenticity (Baker, 2006).

4.3 Broader differences in healthcare culture

4.3.1 Differences in researcher-authored sections of text

The S.T.'s opening paragraph describes current practice in France with regard to women's healthcare. The T.T. reader will recognise that this differs markedly to women's healthcare delivery in the U.K. In the National Health Service [N.H.S], screening programmes, contraception and sexual health care/advice is generally provided within a non-specialist setting, with access to a gynaecologist only by G.P. referral in order to treat/diagnose a specific problem (Nevi, 2020). An annual, routine visit to a gynaecologist is not a common custom for women in the target culture (N.H.S, 2023). These kinds of differences in (unspoken) assumptions and norms between source and target culture can present a translation challenge. Katan (2009) describes this as a "culture bump" (p. 82) which requires intervention in the form of cultural mediation. Common strategies for dealing with a culture bump include expansion/explanation, replacement and reframing (Liddicoat, 2015).

As the details of most healthcare practices are described in the S.T., expansion/explanation was not considered necessary except in one particular case where the T.T. reader would probably find further context helpful: *des deux premiers dépistages du cancer du col de l'utérus avant 30 ans/ the initial two cervical cancer screening tests for those under 30* (p. 7). In the target culture, screening is every three years from the age of 25 (N.H.S, n.d) whereas the source culture also has two initial screenings, a year apart. It was decided that this information could be supplied in a translator's note, together with a link to the English language website which outlines the cervical cancer screening protocol (Haute Autorité de Santé, 2019).

4.3.2 Differences in participant quotes

Cultural differences in healthcare practice also emerged in participant quotes, notably around the relative norm of visiting a gynaecologist. At a linguistic level, this was expressed by the use of a familiar term *le/la gynéco,* short for *le/la gynecologue/gynaecologist.* There is no lexical equivalent of this in British English, probably because seeing a gynaecologist is not a familiar activity. It was hypothesised that US English might have an equivalent since it shares the norm of routine gynaecologist appointments with the source culture. The term *gyne doctor* (e.g. p. 14) was identified in this way, and has been used in a slightly adapted form (*gynae*) to ensure consistency in spelling throughout the T.T. This solution was further justified by the common usage of *gynae* as a shortened form of gynaecology in the target culture.

4.4 Linguistic or cultural difference?

It was not always possible to categorise a challenge as being definitively either linguistic or cultural: some challenges were both at the same time. This was the case with the adjective *gynécologique*, which is used over forty times in the S.T. In contrast, usage of the direct T.L. equivalent, *gynaecological*, is much less frequent in parallel texts on similar topics (e.g. Ross et al., 2023). It may even not be used at all (e.g. Clark et al, 2014). In part, this can be explained by greater tolerance for denominal adjectives in the S.L. in general and in medical contexts in particular (Maniez, 2009). However, it may also reflect the broader differences in women's healthcare provision referred to above, including the much smaller role of the gynaecologist in the target culture. Irrespective of cause, it was decided to follow the pattern of usage in parallel texts rather than the S.T. and reduce the frequency of *gynaecological* by about 50%. Solutions included transposition to a noun (*la consultation*

gynécologique annuelle/annual gynaecology consultation) (p. 7) or omission: (*Afin de réduire les symptômes gynécologiques/in order to alleviate symptoms*) (p.17).

4.5 Conclusion

This chapter has described the challenges posed by the S.T. in relation to individual culture-bound terms and to deeper, below the surface, cultural differences in women's healthcare practice. At times, decisions were made for ethical reasons even if this meant deviating from the overall translation strategy. The importance of seeing the text as a whole, rather than two discrete parts, also became apparent during the translation process.

CHAPTER 5: COMMENTARY – ETHICAL CHALLENGES

5.1 Introduction

We have already seen some consideration of ethical issues; for example, in relation to the use of outdated medical terminology. However, this chapter focuses primarily on the challenge identified at the outset in this case study: how to convey the words of the participants in an ethical manner.

Based on the literature, a successful translation of the participant quotes needs to do two things. Firstly, it needs to convey the emotional, as well as the referential, content (Baker, 2006). This can be framed in speech act theory as communicating the illocutionary force in order to have a perlocutionary effect on the reader (Glowacka, 2012; Deane-Cox, 2013; Bosseaux, 2020). Secondly, it needs to convey that the words are those of a non-native speaker (Van Nes et al., 2010; Santos et al, 2015; Helmlich et al, 2017).

This chapter focuses on how a S.L. oriented translation strategy was employed to achieve both these aims. It addresses the challenges, and solutions sought, when translating the features involved in communicating emotion or foreignness including: preserving the oral nature of the text, figurative language, register and other textual or grammatical features. It begins with a few remarks on the need to balance authenticity and foreignness with comprehensibility.

5.2 The need for balance

The lack of suitably foreignized parallel texts against which to measure the translation of participant quotes was a major difficulty throughout the translation: how foreign is too foreign? This was in contrast to the researcher-authored sections of the text where the effectiveness of domestication strategies could be compared with T.L. parallel texts. It was assumed initially that limited translator intervention would help create a sense of authenticity and "foreignness." However, it quickly became apparent that some domestication would be needed in order to produce a comprehensible and usable T.T. which would meet the translation brief. This is also an ethical imperative for the translator (Pym, 2012). The overall stance taken, then, was to seek a balance between authenticity, foreignness and comprehensibility: competing priorities of this kind are a feature of ethical decision-making in translation (Baker, 2018).

5.3 Preserving oral features in the text

5.3.1 Spontaneous speech

One way of conveying authenticity was to reflect the mode in which the women's words were originally constructed; i.e. spontaneous speech. This mode of communication is not planned or organised and often characterised by disfluencies and ungrammatical constructions (Brumme & Espunya, 2012). When the subject matter is difficult to put into words, such as personal trauma, these effects can be amplified (Glowackza, 2012). Ontological narratives, therefore, often contain repetitions, ellipses and loose cohesive ties (Baker, 2006). These features can also form part of the illocutionary structure of the text, since speech delivery patterns convey some of the message's emotional content (Hatim & Mason, 1990). Efforts were therefore made to retain them wherever possible, as in this example which contains significant repetition and ellipsis (p. 16):

S.T: Et je suis partie en courant… en trombe. Et j'avais peur. Et je sais pourquoi j'avais peur…

B: T: And I left running…in a torrent. And I had fear. And I know why I had fear.

T.T: And I ran out of there…. like a shot. And I was scared. And I know why I was scared…

Omission of *et/and* (which appears four times in the full quote) would have been semantically possible. However, its retention conveys a sense of urgency, evoking the fear she describes. It also reflects the additive nature of spontaneous story-telling, in contrast with scripted dialogue (Brumme & Espunya, 2012).

At times, loose cohesion and the unplanned nature of speech meant that some quotes were difficult to understand. It is not clear, for example, what *Emma* means when she talks about the speculum hiding where she hurts. The follow-up question by the researchers suggest that the S.T. producers also found it hard to understand. Therefore, the lack of clarity in this case was retained on the grounds that any attempt to make it more comprehensible would be misrepresenting the S.T and the woman.

5.3.2 Use of S.L. speech patterns

Spontaneous speech is also characterised by the use of structures and expressions not usually found in written texts and which differ between the S.L. and the T.L. (Hervey &

Higgins, 2002). Attempts were also made to retain these, such as the subordinate clause beginning with *c'est/it's*, as in this partial quote from *Linda* (p.16):

S.T: Il y avait un truc qui m'était insupportable, c'était de m'imaginer…

T.T.: There was one thing that was intolerable for me, it was imagining myself…

B.T: There was one thing which to me was unbearable, it was to imagine myself…

This could easily have been smoothed out and domesticated by changing the word order and suppressing the subordinate clause: *One thing that was intolerable for me was imagining myself*…. Emulating S.L. structures in this way communicates some of the "otherness" of the S.T. (Venuti, 1994). However, this quote also gives an example of how the mode shift from oral speech to written text may have resulted in some loss of emotional content, since it cannot convey the tone of voice or emphasis placed on *insupportable*. Hervey and Higgins (2002) suggest that this can be overcome by using italics but to do this the translator would need to hear the recordings from which the text has been transcribed.

5.4. Register

Another element in conveying the voices of the women ethically was matching the register used. This has already been discussed in relation to retaining some of the higher register medical terms given the healthcare backgrounds of many of the participants (see section 3.3.4 above). At other times, slightly lower register choices have been made as more appropriate to the mode of spontaneous speech; for example, *anomalie/the slightest thing wrong* (p.29). Similarly, transposition was used (usually from a noun to verb) to reduce the sense of formality that nominalisation often has in the T.L (Hervey & Higgins, 2002); for example, *sa présence/him being there* (p. 16).

Sometimes it was difficult to identify a T.L. equivalent term which matched the register of the S.T. This was the case with some of the language describing sexual acts, such as *il rentrait* (p. 13). Mossop (2017) argues that the T.L., in contrast to the S.L., lacks a neutral register for talking about sex and so the translator's options can often be limited to vulgar, euphemistic or biological terms. The translation options here seemed either too medical/biological (*he would penetrate me*) or too euphemistic (*he would enter me*). The solution chosen (*he would stick it in me*) gives a sense of him being aggressively in control which seems to be what she is communicating here.

5.5 Figurative language

There is significant use of figurative language by the participants. In part, this reflects the extent to which we think and talk in metaphor (Lakoff & Johnson, 2003). It is also a tool by which a victim/survivor can attempt to convey an experience which it may be difficult for others to understand (Bosseaux, 2020).

S.T. oriented translation solutions to idiom and metaphor tend to favour retention of the S.T. image (Newmark, 1995). This was not always possible to achieve, and some degree of domestication was occasionally necessary to create a comprehensible T.T. As is generally the case (Baker, 2018), idioms which shared the same meaning and form in the S.L and the T.L were the most straightforward to translate (*morceau de viande/piece of meat*; *Je joue l'autruche/I'm like an ostrich*).

It was more challenging to find solutions to original images, such as the use of *le bec de canard/duck's beak* to refer to a speculum. Research indicated that this was not a common metaphor in either the S.L. or the T.L: retention without any further intervention would have risked comprehensibility. Therefore, it was decided to retain the image but signal marked usage through inverted commas and add a reference to the object when the image is first used *C'est notamment… le bec de canard/It's particularly…the speculum, the 'duck's beak.'....* (p. 15).

Another solution to original metaphor was to use a slightly different, but related, image (p. 24):

S.T : En fait, mon vagin était une telle autoroute que bon… une fois de plus…

B.T: In fact, my vagina was such a motorway that good…one time more…

T.T: Actually, my vagina saw such a lot of traffic that, fine…one more time…

These are common procedures for managing original metaphor (Baker, 2018).

There was also sometimes a tension between retaining the image and communicating the emotional content behind the image. Here *Charlène* is describing her trauma response after being unexpectedly examined (p. 22):

S.T: Et là, je suis sortie de là, je ne savais plus où j'habitais. Ça m'a cramé le cerveau.

B.T: And then, I left from there, I did not know anymore where I lived. That burnt the brain.

T.T: And then, when I left there, I didn't even know where I was. That messed my head up.

The emotional content of the S.T. has been retained – the sense of being disorientated – but has been communicated by using an idiom likely to be more comprehensible to the T.T. reader (*I didn't know where I was*). Similarly, the image of a burnt or fried brain was omitted as it can have connotations of the effects of drug abuse in the target culture (Gershon, 2022), potentially distorting the emotional impact and thus the authenticity of the message (Bosseaux, 2020).

5.6 Other textual or grammatical features

It was important to be attentive to all elements in the text which conveyed the emotional impact of the experience being related. These could often be quite subtle, such as tense shifts. The participant *Inès*, for example, describes repeated unpleasant experiences at gynaecology appointments (imperfect), and then relates one particular incident which makes her realise exactly what is happening (pluperfect, perfect). However, this narrative is also interspersed with the present tense (*Je ne vois pas pourquoi il est parti regarder à l'intérieur sans me prévenir/I don't see why he went looking inside without warning me)* (p. 23), indicating that this trauma continues to affect her and telling this story is also affecting her in the moment of telling it.

Another subtle example which might easily be overlooked in a domesticating translation is when *Isabelle*, expresses her frustration at the lack of professional curiosity about her symptoms (p.28):

S.T *: J'avais des infections urinaires et des infections urinaires mais personne ne m'a posé la question (des violences)*

B.T: *I had urinary infections and urinary infections but no one put the question (about abuse).*

T.T: *I used to get urine infection after urine infection but no one asked me the question (about abuse).*

A small domesticating shift (*after* instead of *and*) activates a T.L. idiom which conveys the emotional content (sense of frustration) or illocutionary force of the S.T. The

semantically correct *no one questioned me* was avoided in order to communicate an important element in her emotional reaction: she is a nurse and so knows that her repeated presentation at A and E should evoke not just questioning but *the* question – are you safe, are you being abused?

5.7 Conclusion

This chapter has explored strategies used to preserve the authenticity of the women's voices and to convey the emotional force of their experiences. It has described the need to balance this with producing a comprehensible T.T. sufficient to meet the translation brief.

CHAPTER: 6 COMMENTARY - CONCLUSION

This case study has explored the process of translating 5,000 words taken from a qualitative research article on a sensitive medical topic, namely the effects of sexual abuse on healthcare seeking behaviour in women with gynaecological problems. Although the research article genre has been widely examined, the particular challenge presented by texts describing qualitative research findings is under-researched in the T.S. However, studies on the translation of trauma survivors, and ontological narrative translation were identified as relevant when considering how best to communicate the words of the women interviewed in the S.T. The research questions focused on the linguistic, cultural and ethical challenges encountered during the translation, and the solutions found to address them.

A dual translation strategy was adopted based on the literature: T.L. oriented for the researcher-authored sections of the text and S.L. oriented for the participant quotes. Whilst this had some advantages in terms of managing the cognitive demands of translating in two very different ways, it became apparent that the text ultimately had to be treated as a whole. This meant deviation from the dual strategy in order to produce an effective T.T. Foreignization in the researcher-authored sections, for example, was used to frame and signal the "otherness" of the interview participants, and some domestication was used to ensure that their words were comprehensible and delivered with similar force. Unexpectedly, ethical issues arose elsewhere in the text perhaps highlighting the centrality of ethical decision-making in translation.

Ontological narrative translation theory proved to be a helpful lens through which to consider the ethical challenges, and how to overcome them, in translating the participant quotes. However, the lack of suitably foreignized parallel texts against which to measure the translation proved a major difficulty, in contrast with the sections of the T.T. where domestication could be benchmarked against a range of T.L. research articles.

6.1: Limitations

Although the single-case study design is useful for exploring under-researched topics, findings are not generalisable. Some issues arising in this translation originate in the subject matter of the S.T; qualitative research articles on other topics, and from fields other than medicine, may present different challenges and require different solutions. However, the

findings do indicate that the use of ontological narrative theory in the translation of texts which use qualitative research methods warrants further enquiry.

6.2: Further research

The idea for this dissertation was generated by the qualitative research literature which has been discussing the limitations of current translation practice for a number of years. There is clearly scope for some interdisciplinary work to establish the most effective, and ethical, way of translating the words of interview participants. This could include reception studies to evaluate the qualitative research discourse community's response to translations which have used ontological narrative translation as a theoretical underpinning.

Word count: 12,689

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