

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

ANALYZING THE DISCOURSE OF GENDER-BASED VIOLENCE VICTIMS IN THE MEDICAL CONSULTATION. REFLECTIONS ON THE TRAINING OF INTERPRETERS

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Abstract

Foreign gender-based violence victims are particularly vulnerable because they do not share the language and the culture of the host country, and this might entail a huge barrier when it comes to access the healthcare system. The discourse they use in the medical consultation presents particular characteristics in the vocabulary, speech acts and other speech patterns. Apart from this, the emotional content and cultural differences might pose important challenges to the interpreters, who, most of the times, lack specific training in this context.

A methodology based on case studies is used to describe the characteristics of medical consultations related to gender-based violence with the ultimate goal of offering suggestions for interpreters performing in this kind of situations. After the analysis of three real conversations a good number of characteristics have been isolated and described. They can be grouped in four main categories: terminology, frequent constructions, emotional impact and coordination of the interaction.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

After our findings we are able to suggest that interpreters should not only be trained in terminology, but they also should be given information about the most common constructions that appear in this kind of conversations, such as the use of reported speech and the formulation of requests. The emotional impact is one of the most frequent and difficult challenges interpreters have to confront. They should be given tools to overcome the impact these situations might have on them and they also need to develop abilities that make it possible for them to recognize the consequences of the emotional impact in the discourse of the participants in the interaction. Last but not least, interpreters have to be aware of the peculiarities related to the coordination of the speakers in this kind of interactions, and should be ready to cooperate with the medical staff in the coordination.

Keywords: Case studies; discourse analysis; gender-based violence; medical conversations; real conversations.

1. INTRODUCTION

Both research and training within the field of public service interpreting has evolved towards a specialization according to settings. Publications, research projects and training proposals about very specific matters such as interpreting in the Emergency Department, in prison settings or, as in this case, gender-violence contexts are proliferating at quite a fast pace.

This piece of work deals with interpreting in gender-based violence contexts, specifically with interpreting for the victims of this kind of violence in the medical setting. Foreign victims are

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

particularly vulnerable because they do not share the language and the culture of the host country, and this might entail a huge barrier when it comes to access the healthcare system (Valero Garcés, Lázaro Gutiérrez & del Pozo Triviño 2015).

The main aim of this paper is to contribute to the exploration of communicative peculiarities in the medical consultation with foreign gender-based violence victims. The use of particular vocabulary and metaphors, the emotional content and cultural differences might pose important challenges to the interpreters, who, most of the times, lack specific training in this context.

In order to explore the main features of medical conversation with foreign gender-based violence victims, a reduced number of conversations will be analyzed following a case study methodology. The challenging aspects for the performance of interpreters will be isolated and described in order to ultimately offer some suggestions for training and performance.

This piece of work will start with an introduction to gender-based violence from a medical point of view through which we will be able to discover its implications for the victims' health and how it is approached by health care providers. A brief and non-exhaustive summary of the research recently carried out about this matter will follow before we deeply deal with the peculiarities of the interpreting

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

in the medical setting and for gender-based violence victims. The methodology of this piece of research revolves around the analysis of case studies, which will be presented before a thorough description of findings is offered. Before concluding, a discussion section will offer some suggestions for interpreters in gender-based violence contexts.

2. GENDER-BASED VIOLENCE: A HEALTH MATTER

As the World Health Organization (2013: 2) claims, “[v]iolence against women is a significant public health problem, as well as a fundamental violation of women’s human rights”. This is because the violence exerted by an intimate partner has reached epidemic proportions and has serious short and long term physical, mental and reproductive health problems both for the victims (or survivors) and their children. These health problems usually lead to high social and economic costs.

Data from the WHO (2013) reveal that around 35 % of women around the world have experienced either intimate partner violence or non-partner sexual violence. Although data are not precise about this, we know that most of the cases correspond to intimate partner violence. In fact,

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

almost 30 % of women around the world have ever experienced violence by their intimate partner and 38 % of all murders of women are committed by intimate partners.

Regarding health outcomes, these victims report higher rates of a good number of conditions. For instance, pregnant women are more likely to have a low-birth-weight baby or an abortion. Victims are also more likely to experience depression or anxiety and, in some regions, they are also more likely to acquire sexually transmitted diseases, such as HIV.

The following diagram shows the pathways and health outcomes of gender-based violence victims:

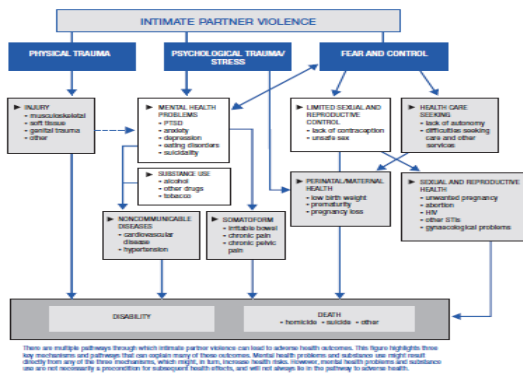


Fig. 1. WHO (2013: 8)

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Regarding foreign women, the WHO indicates that the situations of displacement may aggravate existing forms of violence and give way to additional ones. Foreign gender-based violence victims usually present particular characteristics that exacerbate their vulnerability and isolation, such as a low economic and work status (they are usually dependable from their aggressors), the absence of a social support net (made of relatives and friends), influence from particular cultural aspects, a lack of awareness about their rights and about the different public services they can visit to obtain help, irregular situation in the host country (they can even be threaten by the aggressors with being taken to the police), and so on (Vives Cases et al. 2008, 2009). Of course, one of the main barriers to the access of public services, help and rights is their (scarce) knowledge about the language and the culture of the host country (Valero Garcés, Lázaro Gutiérrez & del Pozo Triviño 2015). In many countries the provision of medical interpreters (when existent) is scarce, intermittent or not adequately supervised, which leads to poor quality and possible negative health outcomes resulting from deficient communication.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

3. RESEARCH INTO PUBLIC SERVICE INTERPRETING IN GENDER-BASED VIOLENCE CONTEXTS

Research on public service interpreting has mainly focused on court (Mikkelson 2000; Hale 2004; Moeketsi 1999; Shlesinger & Pöchhacker 2010) and police interpreting (Ortega & Foulquié 2008), interpreting in hospitals and health-care centers (Angelelli 2004; Bischoff 2006; Pöchhacker & Shlesinger 2007; Lázaro Gutiérrez 2012; Valero Garcés 2014) but there is still very little research dedicated to other done in some more specific settings, such as gender-based violence.

This does not mean that gender-based violence is a forgotten field. In fact, many studies have been carried out about its prevalence and plenty of theoretical descriptions and practical materials such as guides, handbooks and training tools have been developed worldwide (Huelgo, Kaushat, Shah & Shugrue dos Santos 2006; Toledano Buendía, Abril Martí, del Pozo Triviño & Aguilera Ávila 2015; del Pozo Triviño & Álvarez Escobar 2014; Borja Albí & del Pozo Triviño 2015; Costa 2015; Lucero García 2016; Naredo Molero 2015; Travieso Rodríguez 2015). However, not so many pieces of research have exclusively dealt with gender-based violence and translation and interpreting. Apart from some initiatives in the USA and Canada (Toledano Buendía, Abril Martí, del Pozo Triviño

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

& Aguilera Ávila 2015; Abraham 1998), two recent research projects are worth mentioning, the first one being carried out in Australia in 2010-2011 and the second one developed in Spain from 2012 to 2014.

The Project “Breaking through the language barrier: Empowering refugee and immigrant women to combat domestic and family violence through cultural and language training”, was carried out in Australia during 2010 and 2011 under the coordination of Dr Sandra Hale. It was funded by the NSW Department of Premier and Cabinet, Office for Women’s Policy under its 2010 Domestic and Family Violence Grants program.

The main aim of this project was to empower women from a foreign origin by providing them with linguistic, contextual and cultural training so that they could act as linguistic and cultural mediators in interactions with the police, the courts, the health system and community and religious leaders in cases of gender-based violence. Within the specific aims of this project we can find a concern about obtaining information, on the one hand, about the existing provision of language services for “emergent communities” in gender-based violence contexts and, on the other hand, about the needs women of foreign origin.

As part of the project two training actions were executed: a one day course about gender-based

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

violence (“the role of women in the Australian context, women rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the meaning of domestic and family violence, how and when to report domestic and family violence, how to obtain help” (Hale 2011: 9); and a 40-hour course on interpreting (“introduction to interpreting theory, interpreting ethics, interpreting practice, introduction to the language of the law and the language of medicine” (Hale 2011: 9).

The project “Speak out for Support” (SOS-VICS) was carried out from 2012 to 2014 and was co-funded by the EU’s Criminal Justice Programme and the project partners. It explored the communicative needs of foreign, non-Spanish-speaking gender-based violence victims in Spain, analyzed the resources used to bridge communication gaps, and suggested a good number of proposals and practical materials for interpreter training. It was led by the University of Vigo and executed by 9 Spanish universities, and it explored all the areas in which effective communication was needed so that gender-based violence victims could access the different public services provided by the administration, that is, legal, police, social welfare, medical (...) settings.

Thanks to the research actions carried out within this project (mainly through questionnaires and

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

interviews¹) very valuable conclusions were reached concerning the communicative needs of foreign gender-based violence victims and the competences interpreters had to acquire to adequately perform in these contexts (Casado Neira 2015; Pérez Freire & Casado Neira 2015; del Pozo Triviño, Toledano Buendía, Casado Neira & Fernandes del Pozo 2015; Vaamonde Liste 2015; Valero Garcés 2015; Valero Garcés 2016). A good state of the art could also be shaped and all of this constituted a good starting point to initiate actions to improve the situation.

One of the strengths of this project was its ability of using research to create a good number of practical deliverables, amongst which we can find a training website for interpreters, a handbook for interpreters, a manual for agents having to work with interpreters and information leaflets and videos. All of these resources are publicly available at the website of the project: <http://cuautla.uvigo.es/sos-vics/>.

4. INTERPRETING FOR GENDER-BASED VIOLENCE VICTIMS

The WHO (2013) pinpoints the higher risk of experimenting gender-based violence in cases of displacement, and, as it has been mentioned before, foreign gender-based violence victims usually

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

present particular characteristics that make them more vulnerable and isolated (Vives Cases et al. 2008, 2009). Abril Martí (2015) mentions a good number of social, cultural, personal, psychological and emotional risk factors.

For instance, foreign women's social net is usually reduced and very much linked to that of their aggressor, what might make it difficult for them to find support to complain about their situation. On the other hand, the feeling of loss (López 2007; Toledano & Fernández 2012) that immigrants experiment (even leading to the development of the Ulysses Syndrome) aggravates the emotional impact of gender-based violence. Not complaining about gender-based violence at an initial stage will only aggravate both the physical and mental situation of the victim, who will feel more and more lonely and frightened and might even experience feelings of despair, suicidal thoughts or dissociation in all its forms.

A recurrent cause for gender-based violence victims for not complaining about their aggressors is their concern about their financial future, which is more important when they have children. The foreign victims' financial resources are usually more scarce and irregular. Most of them totally depend on their aggressors and have enormous difficulties to find a job due to their administrative

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

situation, their qualifications and the language barrier (Amnesty International 2007; López 2007).

The WHO report (2013) also mentions the cultural issue as a risk factor, in that the tolerance over gender-based violence is higher in particular countries. Many traditional cultures think about the rupture of a marriage as a very serious and undesired event and may put the blame of the failure on the woman, who might have deficiently performed her role of wife and mother (Cala Carrillo 2012).

The lack of knowledge about the institutions, the services and even the rights (Hale 2011) available in the host society also plays an important role and is, most of the times, one of the consequences of their lack of ability to communicate in the language of the host country. Other causes are the differences between the cultural values of origin and host society, the differences in the provision and function of services and institutions dealing with gender-based violence and a lack of awareness, concern and empathy on the part of service providers (Amnesty International 2012; Bodzer 2014).

The language barrier not only has an influence on the access to services and information, but also plays a very important role in how foreign gender-based violence victims present their cases to get help and support. Cala Carrillo (2012) and Abril

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Martí (2015) mention a low proficiency of the language and scarce communicative competence as factors that negatively influence the credibility of foreign victims, making it even more difficult for them to obtain a restraining order. In the healthcare setting similar situations occur when victims are evaluated in the anamnesis phase, a step which is needed not only to discover the case but also to determine the existence of violence in a previous step to issue an injury medical report.

As mentioned in Valero Garcés, Lázaro Gutiérrez & del Pozo Triviño (2015), interpreters performing in a context of gender-based violence must interpret accurately all the questions asked to the victim, paying special attention to the style of the questions, which have been carefully designed by the agents who assist the victim. They must have a good knowledge about the most frequent structures of this kind of interactions (questions, narratives, explanations, and the like), the nature of the encounters, the pragmatic peculiarities of the discourse (metaphors, use of empathy), amongst many other abilities mentioned by Inglis (Iliescu 2001), such as a good usage of syntax, grammar and pragmatics and a deep cultural knowledge (Lázaro Gutiérrez & Sánchez Ramos 2015).

A high linguistic and cultural competence in both languages of the interaction is of utmost importance. Many times the interpreter is the only

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

one in the interaction capable of discovering information regarding emotions, fears and attitudes on the part of the victim, but this will only be possible if he or she possesses an appropriate knowledge of the victim's culture and communication style, which will make him or her able to also render the pragmatic content of the victim's utterances (Lázaro Gutiérrez 2016; Lázaro Gutiérrez & Sánchez Ramos 2015).

Following del Pozo Triviño et al. (2014 a, b), Valero Garcés, Lázaro Gutiérrez & del Pozo Triviño (2015), and Lázaro Gutiérrez & Sánchez Ramos (2014, 2015) interpreters must perfectly know the terminology and frequent expressions in this kind of situations, as well as a thematic knowledge about gender-based violence or a contextual knowledge which includes the way the assistance to the victim is articulated.

5. INTERPRETING IN THE MEDICAL SETTING

It is already widely known that a poor communication in the medical setting prevents healthcare professionals from assisting patients in the most suitable way according to their best competence and ability (Borrell i Carriò 2004; Taibi & Valero Garcés 2004; Kelly & Bancroft 2007). The most useful tool to overcome linguistic

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

and communication barriers is the use of professional interpreters (Lázaro Gutiérrez 2012), but unfortunately, in many countries the provision of medical interpreters is scarce, intermittent and underregulated (Valero Garcés, Lázaro Gutiérrez & del Pozo Triviño 2015; Abril Martí 2015).

Many times it is the patient who has to provide her own interpreter, usually a friend or relative or even someone hired on the patient's income (Valero Garcés 2002 a, b, 2010; Sánchez-Reyes & Martín Casado 2008; Rodríguez Navaza et al. 2009; Rodríguez Navaza 2010; Lázaro Gutiérrez 2012; Jaime Pérez 2014; Illie 2014). Sometimes bilingual professionals (not necessarily clinical staff, but also professionals performing service jobs, such as gardeners or cleaners) help in the communication or some NGOs send volunteers who might not have specific training and qualifications (Morera Montes et al. 2009; Aguilera & Toledano 2013). It might even be the case that the only person available as linguistic bridge is the aggressor (Abril Martí 2015).

The consequences of the intervention of non-professional interpreters have been signalled by many authors (Lázaro Gutiérrez 2014). For instance, they show a tendency to intervene in the communication, and their participation usually changes the content and the course of the interaction (Bührig 2005; Bührig and Meyer 2004;

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Meyer et al. 2010). There seems to be a clear consensus amongst researchers in that the use of non-professional occasional interpreters can lead to inaccuracies, omission of relevant information and role reversal (Flores, 2005; Meeuwesen et al. 2010; Rosenberg et al. 2008). This might be because of many reasons, which include the cultural factor, and it might even be the case that a non-professional interpret sides himself or herself with the aggressor and tries to persuade the patient to act in a particular way (Abril Martí 2015).

Interpreting in the medical setting has its own characteristics within public service interpreting, which makes it different to the interpreting carried out in other domains, such as the legal one. The medical interpreter is usually a member of the interdisciplinary team that assists the patient and, particularly in cases of gender-based violence, has a crucial role in finding out about the patient's condition. Medical interpreters are not just conduits of the information, but also active agents who make use of their linguistic and cultural knowledge to obtain information from the patients and transmit it to other members of the interdisciplinary team, made of clinical and assistential staff (Valero Garcés, Lázaro Gutiérrez & del Pozo Triviño 2015).

The special characteristics of the approach to gender-based violence in the medical setting are

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

usually regulated through protocols and tend to be very clear about the active role agents must have to discover new cases and protect victims. On the other hand, foreign victims, as it has previously been mentioned, have specific characteristics which make them more vulnerable. These two reasons are going to require an extra effort on the part of the medical interpreter to break linguistic and cultural barriers. They must be properly trained in order to face this challenge and perform their role in the most accurate and effective way.

6. CASE STUDIES

In this paper three medical consultations with gender-based violence victims will be analyzed following a case study methodology. The conversations belong to a set of data collected by the FITISPos-UAH Research Group from hospitals and healthcare centers in the central area of Spain. This corpus is continuously growing and started being compiled in 1998.

For this study, a descriptive exploratory analysis of three cases has been carried out. The main aim was to find characteristics particular of the medical consultations with gender-based violence victims in order to offer a set of suggestions for interpreters having to perform in this setting.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

The three cases have been selected because of their adequacy regarding the object of the study and because of their completeness. When dealing with natural data, particularly with medical conversations, it happens more often than not that several parts might be missing because the recorders are activated once the conversation has started or stopped before it has finished. Some other times the sound is sometimes not registered with the required quality, for example, when the interactants move away from the recording device.

Victims of gender-based violence might access the healthcare services from two main ways: the Emergency Department and the General Practitioner consultation. Two of our conversations were audio-recorded in an Emergency Department. In the first one, a Moroccan woman in her twenties speaks to a doctor about a strange trembling disorder in her upper limbs and some injuries that she presents on her skin. The second conversation registers the interaction between a Moroccan woman in her twenties, two doctors and a nurse. Gender-based violence is addressed in a direct way and the victim is questioned about the facts that led to the injuries she presents. In the third conversation the victim is a Spanish woman in her forties who talks to two doctors in the GP consultation. This conversation was video-recorded and the case of gender-based violence and the suffering of the victim appear as a secondary topic,

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

for the consultation was initially about some prescriptions for anxiety.

All the three conversations were carried out in Spanish and there was no interpreter present. Recordings from consultations with gender-based violence victims are very difficult to obtain because they are scarce (when taking into account the many reasons why patients visit consultations) and because the patient usually refuses being recorded. These two factors are even more present when victims are foreign and even more when they do not master the language of the consultation and need the assistance of an interpreter. However, we think that the characteristics of the conversations of our study are similar to other cases and the results of our analysis, which will be presented in the following section, could be extrapolated.

7. PRESENTATION OF RESULTS

The findings will be presented in a qualitative way, as corresponding to a study based on cases, and will be grouped in four main categories: terminology, frequent constructions, emotional impact and coordination of the interaction.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

7.1. Terminology

One of the main features that come to our mind as a hypothesis is the use of particular terminology. In fact, apart from the terms which are common to other medical consultations, we can also find other terms specifically related to violence. In our conversations we found a good number of insults, both to refer to the aggressor and to render insults he addressed to the victim. Other recurrent terms were “dagger” (puñal), “beating” (paliza), “kill” (matar), “pinch” (pellizcar), “burn” (quemadura), “injury” (herida), “prison” (cárcel), amongst others.

Another interesting phenomenon that we could find was the use of euphemisms in order to avoid particular terms related to violence, as we can see in the following examples:

Example 1.

D: ¿alguna vez aparte de eso has tenido malos actos con él?, o sea que te ha pegao, ¿no?, alguna vez [have you ever had bad acts with him?, I mean that he has beaten you, hasn't he? Some time] (Extracted from Conversation 1)

Here we can see, on the one hand, a hesitant and disorganised syntax and word order and a construction which is not common at all in the Spanish language and might even be difficult to

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

understand at the beginning. In fact, the doctor realizes this difficulty and reformulates the question to make it clearer. She is trying to avoid the word “maltreatment”. In the second part of the utterance she finally asks in a clearer way but just when she has finished uttering the question, she tries to minimize it by adding “some time”.

Example 2.

D1: ¿te ha llegado a hacer alguna lesión, eh, importante? [has he ever injured you, em, importantly?]

P: pues casi todos los días [well, almost every day]

D1: pero digo de lesiones importantes, te ha llegado a hacer como de tener que ingresarte por alguna fractura, nada de eso, los golpes quiero decir que si se ven [but I mean important injuries, had he ever injured you and you had to be admitted for a fracture?, no way, the blows I mean, whether they are visible] (Extracted from conversation 2)

The doctor in this fragment doubts before the word “importantly” in his question. He probably was avoiding the term “grave” in Spanish (“serious”). Once the patient has answered he realized he had not been clear enough and completes his utterance with a couple of examples. However, the first one

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

seems too serious for him and negates the question without giving the patient the chance to do it herself, and then reformulates.

7.2. Frequent constructions

Although the focus is usually put first on terminology, there is another aspect which is worth mentioning and is that of the use of particular constructions, such as requests, reported speech or the format of questions. This will be illustrated in the following examples.

Example 3.

P: por favor se lo pido, por la Virgen Santísima [I beg you please, for the sake of Holy Mary] (Extracted from conversation 3)

It is common that the patients utter a good number of requests, sometimes even in despair, as we can see in the previous example. The language of the patients is usually very emphatic, which has an impact both on the words and the tone they use and the requests are usually uttered in the shape of a chain and finally constitute begs.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Example 4.

P: pero no dices nada a mi hermano [but you don't tell my brother] (Extracted from conversation 1)

These requests are usually part of a negotiation, as we can deduce from the previous example. The patient will tell more about what has happened to her as long as the doctor does not tell her brother.

Particularly challenging for the interpreters is the use of the reported speech, which is going to complicate the rendering of the patient's utterances.

Example 5.

P: y me dice que me sacaba un puñal [and he tells me he would take out a dagger] (Extracted from conversation 3)

The use of the reported speech in Spanish in this utterance is very interesting because it is not the formal way of using it. It is rather the form little children use when they imagine stories in their games. It makes the utterance more dynamic but may also create confusion as the verbal tenses are proper of the direct style.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

This reporting is also present in the questions doctors and other members of the staff might utter, as in the following example.

Example 6.

D1: Y tu marido ¿está bebiendo alcohol? [and your husband, is he drinking alcohol?] (Extracted from conversation 3)

In a general medical conversation the doctor's questions are addressed to the patient and focus on the patient. In gender-based violence cases we are going to find a great number of questions that will be addressed to the patient but seek information about the aggressor. Interpreters must pay particular attention to personal pronouns, particularly when translating from Spanish, as the use of subject personal pronouns is not compulsory, the subject of the verb could be easily confused. If we take the sentence “¿está bebiendo alcohol?” as an example, the subject could be either the husband or the patient. The interpreter has to infer the subject from the context.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

7.3. Emotional impact

The situations in which interpreters have to mediate are usually emotionally hard because the victims render their suffering and present injuries both at a physical and an emotional level. Interpreters get in touch with the lowest part of the human nature when they know about the harm and the vexation that patients have undergone. This can be even harder because interpreters have to render the victims' utterances in the first person and this aggravates the emotional impact up to the point that they also feel like victims. Interpreters, then, have to be prepared to confront this kind of situations in which the victims may cry and the doctors might try to comfort them either because they express sadness or because they are frightened, as the following example shows.

Example 7.

D1: pero no pasa nada, ¿eh?, porque aquí estamos para ayudarte, solo para ayudarte y todo lo que tú no quieras que se diga no se va a decir [but it is alright, huh?, because here we are to help you, just to help you and anything that you don't want to tell won't be told] (Extracted from conversation 2)

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Due to feelings of fear and confusion victims may also lie and there might be an environment of distrust from both parts. Let us illustrate this through some examples.

Example 8.

*P: ya no me acuerdo [I no longer remember]
(Extracted from conversation 3)*

Example 9.

*D: ¿no lo recuerdas? [don't you remember?]
(Extracted from conversation 2)*

After living a situation of fear and stress, people tend to forget several details. They might remember them later or might forget those details for good. When victims are questioned about their traumatic episodes, it is quite common that they tell the doctors that they cannot remember particular moments or details of a certain situation. Unfortunately it is also common that mistrust appears when there is a lack of understanding about why crucial details are so easily forgotten. In our conversations we found several examples of doctors manifesting their lack of trust:

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Example 10.

D1: no sé, no... [I don't know, no]

(...)

D2: que venga el lunes y...[she can come back on Monday and...] (Extracted from conversation 2)

Apart from this, there might be other causes of mistrust, like the ones that appear in the following example.

Example 11.

D1: ¿qué tal estás? [how are you?]

P: yo estoy bien pero no puedo estar así [I'm alright but I can't be like this]

(...)

D1: ¿tú crees que es capaz (nombre) de hacerte algo o no? [do you think (name) is capable of hurting you?]

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

P: si luego no me hace na, luego pues ya te digo que luego es un mierda [in the end he does nothing to me, in the end, I tell you, in the end he is a piece of shit] (Extracted from conversation 3)

In the third or our conversations the victim contradicts herself several times. Example 11 shows how she starts saying she feels alright but then manifests that she cannot go on the way things are. After several utterances in which she explains how she suffers maltreatment from her husband and how frightened she is, the doctor asks her explicitly for her fear of being hurt and, surprisingly, she says that he does no harm to her. These constant contradictions are the consequence of the feelings of insecurity and confusion resulting from having lived under the pressure of maltreatment. Unfortunately the credibility of the victim is at stake when she keeps on changing her testimony. For the interpreter this will also result confusing and difficult to render and doctors might think that the source of the contradictions is the interpreter instead of the patient.

Ambiguity and a lack of precision are frequently present, as we can see in the following example.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Example 12.

P: pues de mi familia cuando se van a enterar que he dicho todo [well, my family, when they know that I've told everything]

D1: ¿y qué es todo? A mí no me has dicho nada [what is everything? You didn't tell me anything]

P: es que mi hermano está pegándome y todo [it is that my brother is beating me and everything] (Extracted from conversation 2)

The patient here fails to explain what has happened to her and refers to it as "everything". The doctor insists on asking her about it and she finally utters that her brother is beating her, but that is only one part of the situation, as we can deduce from her use of "everything" once again at the end of the fragment. When interpreters are rendering the patient's utterances, they might want to complete or give more sense to messages which seem incomplete or ambiguous. They should refrain from this and render the utterances as ambiguously as they originally were.

But mistrust is not only present on the part of the medical staff. The following fragment gives us a good example of this.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

Example 13.

P: “pues ayer están discutiendo mis hermanos, los dos, eso sí [well, yesterday my brothers were having an argument, the two of them, just this]

(...)

D: ¿está nerviosa? [are you nervous?]

P: sí [yes]

D: sí pero por algún motivo ya o ya está calmada por esa discusión [yes, but is this because of something or are you already relieved after that argument?]

P: no, estoy calmada ya [no, I’m already relieved]

D: sí, o sea que en teoría ahora no hay motivo aparente para que siga nerviosa [yes, I mean, in theory there is no longer an obvious reason to be nervous]

P: sí [yes]

D: ¿hay motivo? [is there a reason?]

P: no [no]

(...)

P: pero voy a decirte la verdad, estaba discutiendo conmigo mi hermano” [but I’m going to tell you

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

the truth, my brother was having an argument with me] (Extracted from conversation 1)

Example 13 presents some fragments of the same conversation. At the beginning of it the patient does not feel at ease with the doctor and starts rendering her story saying that her brothers were having an argument. Some turns later, after being questioned, the patient manifests being nervous, but the nervousness apparently has nothing to do with the argument. However, some turns later, the patient announces that she is going to tell the truth to the doctor: it is not that her two brothers were having an argument. In fact, one of her brothers (who was exerting violence against her) was having an argument with her. It is quite common on the part of the victims that they cannot easily trust other people. This is a consequence of the victimization they are suffering. It might take some time until they manage to tell their stories.

In order to solve situations of ambiguity and contradictions, doctors tend to use a set of mechanisms which include constant repetitions along the whole conversation and insistence:

Example 14.

D1: ¿seguro?” [are you sure? (Extracted from conversation 2)

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

7.4. Coordination of the interaction

Sometimes interpreters have to cooperate when it comes to coordinate the interaction. The doctor will usually lead the conversation and interpreters will have to accommodate themselves (for example, they may have to lower their tone of voice) according to different situations. In our conversations we could find a husband trying to listen from the other side of the door and a brother continuously entering the consultation. Some information had to be disclosed paying particular attention to their absence or presence, and future consultations, of course, had to get arranged when the aggressors were not present.

The victims are usually alert and tend to give the information at the moment they feel the safest and to those they trust for whatever may be the reason.

Example 15.

*D2: te había contado a ti un, un episodio, ¿no?
[she had told you about an episode, hadn't she?]
(Extracted from conversation 2)*

In the second conversation the victim felt more at ease with the nurse and she waited until the doctor left the room to describe an episode of

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

maltreatment to her. The nurse then had to go find the doctor to alert about the fact that some information was missing for her. When the doctor came back to the consultation, she asked the nurse about it in front of the patient, so that both could encourage her to tell her story again.

8. DISCUSSION AND SUGGESTIONS FOR INTERPRETERS

Many are the authors who argue that knowing terminology is of utmost importance for interpreters working in a particular context. Gender-based violence assignments are not different in this sense. However, terminology is not the only challenge, as we have seen. Sometimes it is the purposeful avoidance of a term what is going to pose difficulties.

Apart from this, interpreters should be ready to process information given in particular constructions, such as requests, which are sometimes as strong as begs, and the particular use of reported speech. In languages such as Spanish there are different ways in which the reported speech is used, and the way the patients build their utterances might be confusing for the interpreter. The same happens with questions and personal pronouns in the Spanish language. As subject personal pronouns are not compulsory there are

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

some questions (and their answers) that might be confusing. It is important that interpreters clarify with the patient who the subject of her utterances is in order to avoid serious misunderstandings and be able to render the message accurately.

Interpreters must also be trained so that they can avoid emotional impact on them and can learn about how to deal with the emotions of the rest of participants in the interaction. It is not only that victims render messages which are full of emotional content and that they may burst into tears, it also happens that other situations raise from these emotions, such as doubts, lies and contradictions, and they have an impact on the discourse interpreters have to render. This climate is also the context in which particular conversation moves such as repetitions and insistence and interpreters should be able to understand them and render them without losing their effectiveness.

Finally, interpreters have to contribute to the coordination of the interaction although the main coordinator will usually be the member of the staff that is assisting the victim. This kind of encounters might be challenging because of the multiple speakers that take part in it, the (initial) lack of trust and possible intruders in the conversation, such as the aggressor or other relatives and acquaintances of the victim.

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

9. CONCLUSIONS, LIMITATIONS AND FURTHER RESEARCH

Along these pages a piece of research based on case studies has been presented. Our main aim was to describe the characteristics of medical consultations related to gender-based violence with the ultimate goal of offering suggestions for interpreters performing in this kind of situations. Three conversations were analyzed and a good number of characteristics were isolated and described. They can be grouped in four main categories: terminology, frequent constructions, emotional impact and coordination of the interaction.

After our findings we were able to suggest that interpreters should not only be trained in terminology, but they also should be given information about the most common constructions that appear in this kind of conversations, such as the use of reported speech and the formulation of requests. The emotional impact is one of the most frequent and difficult challenges interpreters have to face. They should be given tools to overcome the impact these situations might have on them and they also need to develop abilities that make it possible for them to recognize the consequences of the emotional impact in the discourse of the participants in the interaction. Last but not least, interpreters have to be aware of the peculiarities

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

related to the coordination of the speakers in this kind of interactions, and should be ready to cooperate with the medical staff with the coordination.

The limitations of this study are many. Although they can provide us with useful qualitative information, case studies are always limited in quantitative terms. A much higher number of conversations would be desirable to compile enough data to generalize the findings, have enough material to build a glossary and a compendium of frequent constructions, and further guidelines about the coordination of conversations. Apart from this, it would also be interesting to include interpreter-mediated conversations in our corpus. Unfortunately, this kind of conversations is very difficult to compile due to their delicacy. Patients usually refuse being recorded because of their feelings of fear, anxiety or embarrassment.

ACKNOWLEDGEMENT The research reported in this paper has been carried out in the framework of TRAJUTEC thematic network at the University of Malaga.

NOTES

1. For a wider description of the project and an overview of its results and deliverables, visit <http://cuautla.uvigo.es/sos-vics/>

Lázaro Gutiérrez, R. (2018) Analyzing the discourse of gender-based violence victims in the medical consultation. Reflections on the training of interpreters. *Current Trends in Translation Teaching and Learning E*, 5, 185 – 235.

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