Voices and experiences of health/illness from female victims of gender violence in Tabasco, Mexico. Because this happens to me, I have to suffer

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Abstract

Violence against women has a great impact on health and the health system, they present a greater number of physical and emotional diseases. This phenomenon has been constructed under processes of invisibility and naturalization as a result of a patriarchal society. This work focused on exploring the effects of different forms of violence against women: in terms of health, physical as well as psychological. Under a qualitative methodology, the experience of eight battered women from rural and urban areas of the Mexican state was recovered of Tabasco. To do this, the interview was used through the autobiographical story technique. The findings show that women suffer different types of violence ranging from physical to economic, identified incidence of diseases, suffering and mental suffering caused by violence of any kind. On the other hand, the social constructions about what it means to be a woman in certain circumstances allow to justify the violence exercised by men, in addition in the production of subjectivities of the feminine gender a process of socialization prevails that reduces the woman to her traditional functions and it places it as the sole guarantor of identity. Keywords: Violence against women, physical health, mental suffering.

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Introduction

Violence against women constitutes a significant cultural, social, political and human rights issue. Deeply rooted in social structures and dynamics, its frequency and the high mortality rate associated with it severely affect healthcare systems and the health of women worldwide (WHO, 1998).

The profound impacts of violence on health reverberate through physical, sexual, economic and psychological dimensions. We observe a gradual increase in the intensity and frequency of violent acts, leading to an increased risk of morbidity and mortality for women. However, the most deleterious effects of violence can be seen in the mental suffering of women (Bergman et al, 1991, Ferreira, 1992, McCauley et al, 1995, Varela, 2002;).

The issue of intimate partner violence has begun to attract attention in Mexico (Fernández and Castro, 2012, Ministry of the Interior, 2016). However, in spite of its great relevance, its study remains a complex task. Because this kind of violence has been invisibilized, rescuing the voices of victims is crucial (Burín, 2007, Capapé, 2014). Our research, focused on the Mexican state of Tabasco, explores the effects of gender violence on the physical and mental health of women, based on victims´ accounts.

Our goal is to promote the establishment of feasible and effective public policies through an assemblage of knowledges based on the voices and experiences of women. In this way, we depart from the hegemonic paradigm of the biologically determined, ahistorical and asocial subject (Menéndez, 1997).

The triangle of violence against women

The use of the term gender violence is often rejected because it employs a category that conceals male domination (Rivera, 2001).

The term *gender violence* allows us to analyze, simultaneously, different forms of violence. It can be used to refer to direct violence (physical, psychological, sexual, economic or social), as well as to the more complex phenomena of structural and cultural violence (Galtung, 1990, Espinar, 2007a, Capapé, 2014).

We chose to frame this study within Johan Galtung´s (1990) Conflict Triangle theory, which formulates an intimate relationship between direct violence, on one hand, and structural and cultural violence, on the other hand.

In applying this framework to our research subject, we found that the various forms of direct violence (concrete acts of physical, psychological, sexual violence, etc.) must be understood in relation to the structural violence constituted by dominant gender relations, and in relation to cultural violence, which is comprised of justifications, myths, and beliefs about structural and direct violence against women (Capapé, 2014).

Violence against women has shifted from being conceived as a "personal problem" to being considered a "social problem" (Ferrer and Bosch, 2000, 2002). Intimate partner violence directed towards women had long been considered an issue to be addressed exclusively within the domestic arena (Lagarde, 2005). In fact, the setting in which violence against women is most prevalent is the family, with most aggressions being perpetrated by the current or previous partner (WHO, 1998, Sharps et al, 2001, Weinbaun et al., 2001, Kyriacou et al, 1999, Wilbur et al, 2001, Watts & Zimerman, 2002).

Violence against women has a great impact on women's health and on the health system in general, because when women become injured in an act of violence, they seek medical attention and care (Espinar, 2003). Abused women have a greater number of diseases than other women, and consume more anxiolytics, antidepressants and analgesics, as well as alcohol and other drugs (Raya, 2004). These effects on their physical health are associated with the psychological damage caused by violence of any kind (physical or psychological) (Espinar, 2003; 2007b; Capapé, 2014). Some of the physical ailments strongly correlated with psychological abuse are: chronic pain, migraine, arthritis, headaches and spastic colon (McCauley et al, 1995, Coker et al, 2000 a), as well as menstrual problems and sexually transmitted diseases (Capapé, 2014).

Studying the permanence of women in abusive relationships allows us to understand the ways in which they respond to physical and emotional suffering (Villanueva, 2012). Various explanations have been offered for women´s "attachment" to abusive relationships, from a relational pattern of frequent aggressions, to hope in the aggressor´s behavioral change, to the threat-induced fear of reporting the abuse and, lastly, to the naturalization of violence (Zabala, 2007; Villanueva, 2012).

The naturalization of violence implies its justification, either as something inevitable, as the fault of the person assaulted, or as part of the role played by the person in the relationship (Zabala, 2007). For this last reason, the adoption of a gender perspective plays an important explanatory role, as gender constructions imply the assumption of values and expectations linked to roles and processes of self-assertion.

Characterization of the research area

In Mexico, according to the *National Survey on the Dynamics of Relationships in Households* (ENDIREH), conducted in 2011 by the National Institute of Statistics, Geography and Informatics (INEGI), 42.2% of women aged 15 or over reported suffering emotional violence with their last partner. Another 24.5% reported having been victims of economic violence with their last partner. In the same indicator, 13.5% of interviewees reported having been victims of physical violence, and 7.3% of sexual violence (INEGI, 2011).

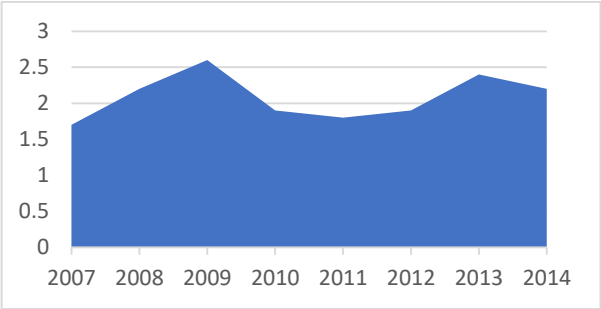
According to the *same survey, in Tabasco 39.1% of women married or in partnership have been the object of some kind of violence throughout the relationship.*

The survey also indicates that in Tabasco, 13.6% of women aged 15 or older have experienced physical violence during their relationship with their last partner. This figure is above the national average for 2011, which was 13.5%. Although Tabasco did not occupy the first place at the national level in terms of the percentage of women aged 15 or older who experienced economic violence (prohibition of work or study, restricting domestic spending, etc.) with their last partner,

19.7% of the women surveyed responded to this indicator affirmatively.

With regard to emotional violence, the *survey shows that 38.8% of women aged 15 or older, experienced emotional violence with their last partner*. In this indicator, Tabasco ranked above 9 other states.

Graph Number 1: Rate of female deaths (x 100 000) presumed to be homicides. Tabasco 2007-2014.



Source: Elaborated by authors, based on data from the Interior Secretary, National Institute of Women, and the United Nations Entity for Gender Equality and the Empowerment of Women. (2016). Executive summary.

Based on the data obtained by the National Institute of Women and the United Nations Entity for Gender Equality and the Empowerment of Women (2016), it is possible to observe the rate (x 100 000) of female deaths presumed to be homicides in Tabasco from 2007 to 2014. In addition to rendering an account of female deaths, the presumption of homicide implicates women as an object of violence. These results are shown below in figure 1.

In this graph we can observe that, although the rate peaked in 2009 (2.6), from 2011 to 2014 it has increased from 1.8 to 2.2.

Goals and methods

Overall goals

To understand the effects of intimate partner violence on the physical and emotional health of female patients in primary care centers and domestic violence centers, from the point of view of abused women.

Methods

Our research is qualitative and interpretive. Our method of choice was the life story interview, aimed at understanding the meaning of violent experiences for women, and their impact on the health-disease process. Qualitative approaches seek subjective and intersubjective approaches to the study of modes of life, understanding these as the essential space where the multiple dimensions of the human experience coincide. A central aspect of our research was exploring the subjectivity and recovering the voice of participants who, through narration, become meaning-creating agents. In this way, we situate them as subjects that carry a set of knowledges, experiences and practices (Menéndez, 1997, Mercado et al., 2002).

The number of subjects was not determined by convenience, since the purpose of sampling consisted not in generating a statistical representation, but in understanding the discourse generated around the research subject. The samples were made up of voluntary informants. This kind of selection is the least rigorous, "not being governed by any theoretical intention derived from preliminary knowledge about the phenomenon; rather, it depends primarily on the accessibility of the units, that is, the ease, speed and low cost of access" (Martínez -Salgado, 2012, p.616).

Eight female victims of gender violence were interviewed, two from rural areas and six from urban areas. They were contacted through organizations and shelters linked to the issue of gender violence, such as: Women's Center of the System for the Integral Development of the Family (DIF Tabasco), Women's Institute of the municipality of Macuspana, and the Health Center and System for the Integral Development of the Family DIF of the municipality of Nacajuca. After receiving authorization from the managers, the women with the most critical medical or psychological records were invited to participate in the study. Informed consent was used, since it provided confidentiality, anonymity, and allowed us to verify their authorization for the material to be recorded. The interview and observation guides were structured to account for the experience of violence, the women's beliefs, the effects on their health, as well as the history and type of abuse, including its onset, duration and the current situation of the victim.

Chart Number 1.
Main sociodemographic characteristics of the women interviewed and type of ailment

Pseudonym	Age	Level of Schooling	Occupation	Effects on physical and mental health
Martha	28	High School	Urban housewife	Two suicide attempts, anxiety, insomnia, abortion threat, fear, depression, low self esteem
Cristina	30	Incomplete High School	Urban housewife	Headaches, suicide attempts, gallbladder operation, anxiety, depression, low anxiety
Adela	35	High School	Urban housewife	Constant headaches, suicide attempts, neck damaged by blows, memory issues, anxiety, anguish, low self-esteem, overweight
Regina	34	High School	Urban housewife	Kidney infection, depression, three suicide attempts, death threats, anguish, depression, low self-esteem, fear, cyst in cervix, hospitalization for kidney infection, low blood pressure
Laura	38	Illiterate	Urban housewife	Constant memory loss (product of blows to the head), headaches, loss of dental pieces, gastritis, stomach pain, vomits, constant sleepiness, scars in leg and head
Leidi	26	High School	Rural housewife	Vaginal and urinary tract infections, bleeding, damage and tear to genital and vaginal area, constant sutures, depression, low self-esteem, sadness, anxiety, headaches, anemia, weight loss, insomnia, anguish, death threats, abortion, bleeding in ear and nose, head, suicidal ideas, scars, pregnant at moment of interview
Guadalupe	27	Incomplete High School	Rural housewife	Sexually transmitted infections, wounds and scars, product of stabbing, abortions, hemorrhages, alcoholism, drug addiction, suicide attempts, headaches, gastritis, colitis, depression, low self-esteem, poverty, lack of familial support networks, lived in the streets
Antonia	25	High School	Urban housewife	Depression, sadness, low self esteem

The interviews were conducted in the facilities of each institution, in some cases under the accompaniment of a social worker or psychologist. The duration of the interviews was approximately 5 hours, distributed between two or three occasions, depending on the availability of each victim.

Analysis and discussion of results: Women's physical and emotional health

We explored the women´s subjectivities, looking at their voices as agents that generate meaning through narration.

We looked at gender-based intimate partner violence and its impact on the health of these women through three central categories: 1. the forms of gender violence to which they were subjected and their relationship to physical and mental health processes, and to poverty, 2. The effects of this gender violence, and their relationship with physical and mental health processes, and to the poverty of these women, 3. The processes that keep women "tied" to these relationships in spite of being subjected to gender violence.

Forms of gender violence against women, and their relationship to physical and mental health processes.

Rather than a biological or domestic issue, we consider violence against women as a process of social construction through which differentiated values and expectations are transmitted to and taken on by both men and women (Burín, 2007).

In this sense, the violence to which the women studied have been subjected has its origins in the process of gender socialization that takes place

within the family. The family influences gender socialization in two ways:

One way has to do with a history of physical and verbal abuse, mainly perpetrated by the father. The other way is related to beliefs and attitudes that transmitted through the mother figure. Women are educated to learn the housework, and are prepared from an early age for marriage and having a family. This process leads to the construction of a social image that defines them as women, and of concomitant expectations around their behavior and role in an intimate relationship.

a. "[...] My father told me that a woman should not leave her husband [...]" (Adela).
b. "[...] My dad hit me at the age of 12 with a bicycle camera [...]. My dad beat me, education was like that, with blows [...] "(Martha).
c. "[...] The wife has to be dedicated, to take care of the children with love, to respect the husband [...] they told me the woman is meant to stay in the house [...,]" (Cristina).

Direct physical violence against women has been one of the most systematic forms of gender-based violence (Lagarde, 2005, Burín, 2007). This type of violence manifests itself with different degrees of intensity, ranging from blows perpetrated with hands, to the use of sharp objects such as machetes, which may represent an immediate threat to the lives of these women.

d. "[...] He hit me with the stove, I thought he had killed me. I am afraid, he threatens me with death [...] (Adela).
e."[...] At 16 I left with my partner. After a month he gave me a blow, the first time with a machete, and then he threw a horse saddle at me. Another time he kicked me, he wanted to kill me, he broke my nose, I have a scar [....] " (Regina).

Violence towards women can be understood as the expression of aggressive behaviors that men develop in the context of intimate relationships. These are recurrent behaviors, based on an unequal power balance in the relationship (Ferreira, 1992, Varela, 2002). Physical violence has been used by men as a way of subduing women, thus achieving both obedience and acceptance of all decisions made by him. This, ultimately, is a way of reaffirming his power as a man (Burín, 2007).

It has long been considered that intimate partner violence should be addressed exclusively within the domestic sphere, rather than being externalized. This conception has contributed to the construction of processes of invisibility and impoverishment that are aggravated by the rupture of the relationship, after which women have to start their lives all over again. She must face the change of residence, the assumption of family responsibilities, and, in addition, a deteriorated state of health. This situation of helplessness leads many women to bear the burden of abuse in silence (Espinar, 2007b).

f. "[...] He controlled the money, he paid for everything, he did not let me work. He attacked me with a machete. Then I fled, I went to several cities, Campeche, Veracruz, Mérida, I walked the streets, asking for alms [...] "[Martha]

Following the work of Burín (2007), Guzmán (2007), Roscón, (2007), Berbejillo and Wainberg (2013), and Orozco (2014), we come to understand male hegemony as a product of men's relationship to the system of production, and their position of privilege in both manual and intellectual work spaces.

It should be emphasized that poverty, for women, is both the cause and consequence of violence: that is, violence keeps women stuck in poverty. Women who suffer violence lose income and their capacity to deal with life is disturbed. Poverty can force women to make difficult choices that put them at risk for violence or keep them in a violent situation.

The process of male socialization is based on control and domination associated with physical power, certain sexual freedoms, the role of provider in the family, and the need to reaffirm their masculine identity through the exercise of violence.

Men limit women's possibilities to meet their needs for autonomy and material goods by mediating women's relationship to labor (Tortosa, 1994, Espinar, 2003). The barriers placed by men to women's betterment, are part of what has been called the "glass ceiling" (Burin, 2007) for women. This has an impact on the mental suffering of women who want to transcend their situation, but are ¨tied¨ to the responsibilities of caring for the home and the man.

The forced economic dependence of women on men entails a precarization of women's living conditions, which is in turn used by men as a mechanism of domination. In this way, women's abilities to make decisions regarding their bodies and their children become limited.

Understanding the impact of gender relations on the precarization of women's living conditions is a fundamental condition for the comprehension of their mental suffering and their possibilities for autonomy in the face of material precariousness (Espinar, 2003). However, traditional economic indicators do not consider the impact of gender relations on women, nor the value of their domestic work (Orozco, 2014).

The gender dimension is fundamental to an understanding of structural processes, their relationship to economic transformations and public policies, and the ways in which these reproduce inequitable processes and conditions that violate women from different social groups. Our results show that violence against women and the ailments that stem from it are imbricated in their social relationships, especially those they maintain withtheir male partners (Finkler 1997). According to this logic, traditional ideologies lead to the crystallization of women's economic dependence on men, of ideas about their role in the home, of their social inferiority, and of the ways in which these ideologies are also transmitted through biomedical practice.

The effects of gender violence, and their relation to physical and mental health processes, as well as to women's poverty

The direct violence that a man exerts against his partner or ex-partner is related to the structural inequalities on which gender relations are based and, especially, to gender relations within the family.

In turn, both forms of violence (direct and structural), interact with cultural violence; that is, with prejudices, gender stereotypes, macho ideology and beliefs about the role, functions and social position of women (Galtung, 1990, Espinar, 2007a, 2007b).

g. "[...] My feet were swollen. I was admitted to the hospital due to high blood pressure, I had bleeding. I had an abortion after 8 months of living with him, he pushed me, he threw me, I was 4 weeks pregnant. I kept forgetting things. I did not want anything, I wanted to be isolated [...] "(Martha).

In terms of physical violence, the women studied have suffered abortions, headaches, gastritis, colitis, and injuries in different parts of the body. In several cases, they have had a history of hospitalizations due to beatings and infections, which is related to the systematicity that tends to characterize physical violence once it has begun. This coincides with the findings of Espinar (2003).

Other repercussions of the physical, psychological and economic violence endured by these women are more subjective. Among them, we see anxiety, depression, insomnia, weight loss, fear of threats, and suicide attempts (more than one in several cases). These findings confirm the fact that the damaging effects of prolonged maltreatment leads to women's mental suffering (Bergman et al, 1991, Ferreira, 1992, McCauley et al, 1995, Varela, 2002).

For this reason, we feel obliged to showing the relationship that chronic disorders (such as irritable bowel syndrome, fibromyalgia, chronic pain syndromes or gastrointestinal disorders) may have with the endurance of prolonged violence.

With regard to the suicide attempts, Martínez´s research (2012) shows how suicide becomes an alternative, or an exit to the situations of mistreatment to which women are subjected.

While it is clear that these effects are the result of the violence to which these women have been exposed in a systematic way, there is also a central conflict with explanatory power, which is also related to the hegemonic form in which masculinity and femininity have been constructed in relationship to each other.

This conflict has explanations that range from the structural, to the direct relationships within the couple. Identifying and understanding this conflict implies answering the question: what keeps women "tied" to these relationships despite gender violence?

The processes that keep women "tied" to relationships despite suffering gender violence

The mechanisms that keep women "bound" to gender violence can be understood as part of two processes, one of identification, and another of the naturalization of violence. Both are linked to the gender constructions that women have socialized into.

Several women identify the link between weight loss, depression, suicide attempts, and the unbearable situation they have experienced or endure with their current partners. Despite this

identification, there are several processes that explain the submission to this relationship.

The historical process through which the role of women has been built on the basis of care and fidelity to men, has influenced these women through the expectations conveyed in their families´ discourse. This leads us to question inequitable structural processes that appear in the form of differentiated work and betterment options for men and women.

h. "[...] Because all this happens to me, I have to suffer. He did not take me into account at all. I had no voice or vote, because I did not contribute anything. I always had an infection, every time I had a pap smear and I had an infection. I had three suicide attempts [...] "(Regina).

Based on Vasallo's (2001) theoretical observations, our results shed light on a third process that "subjects" the woman to the relationship in spite of the violence that she suffers. This process has to do with the cycle of violence.

When men apologize or express repentance, women believe that there is a possibility of everything changing, instead of becoming conscious of the relatively stable determinants of that violence. Espinar´s (2003) research shows that apologies and demonstrations of repentance on behalf of the aggressors affected women's decisions to leave or stay in the relationship.

The naturalization of gender violence is a key point in our research, because it is shaped by women's self-image, which in turn justifies and legitimizes male violence. Gender violence is also naturalized through the gender roles women internalize. Moreover, the social construction of man as a provider goes hand in hand with the social construction of woman as an object that receives his maintenance. For some of the women we interviewed, a good woman must obey, unconditionally take care of man, and expect to be maintained. We can see evidence of this self-imposed subjection in the processes through which women blame themselves for the violence they suffer.

i. "[...] because I do not obey" "I provoked him [...]" (Leidi).

This pattern of self-blame corresponds to Espinar´s (2003) results. This scenario evidences the need to design intervention models that engage with the sociocultural systems and local beliefs where the issue is rooted.

Conclusions

Gender is constructed socially and culturally through expectations and values that are symbolically attributed to men and women (Buvinic, 1999).

Violence is not an individual act. Thus, we consider women's health to be linked to historical structural processes that have impoverished them. Women commonly go to the health center due to discomforts that may not be direct injuries from physical aggression, but which are nonetheless associated with psychological and economic violence (though the women themselves may not make this association). Most women come into contact with health services at some point in their lives: either during pregnancy, childbirth or in seeking medical care for their children.

In spaces that offer medical attention, the violence lived by women patients often goes unseen. At the root of this issue, lies a dominant, mechanistic conception of the human being, which leads to inconsistent conceptual separations between part and whole, between mind and body, and between individual, society, and universe. This model, in turn, leads to a search for certainties and absolute truths, to an exclusive belief in linear causality, and to the undervaluation of subjectivity.

Intimate partner violence acts as one of the main obstacles to the development of women by upsetting their lives, reducing their confidence and affecting their self-esteem. Moreover, it limits their participation in public life, violates their rights and limits their options by restricting their access to information and services.

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