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GENDER, DOMESTIC VIOLENCE AND SICKNESS IN MEXICO

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INTRODUCTION

A vast social science literature exists devoted to women's health problems in developed nations.* A great deal has also been written about women's health in developing nations, but the majority of these investigations have centered around women's health in association with their reproductive capacities.† Little attention has been paid, however, to women's *sub-acute non-life threatening* conditions in developing nations, impairments not directly related to women's reproductive capacities and for which biomedicine lacks remedies.‡

In my study of patients seeking treatment from Spiritualist healers in Mexico I found, in a randomly selected sample of 1212 patients (Finkler, 1994a) that 58% were women. Similarly, out of a sample of 267 patients in an outpatient clinic of a government general hospital, 76.2% were women. At both sites the women sought treatments for non-life threatening disorders. We must, therefore, ask what lies behind these high frequencies of morbidity among women? A facile response would be to reduce the answer to biological factors and/or to an overall propensity to illness associated with sex status.§ However, biological explanations are unsatisfying because they only partially explain women's non-life threatening disorders.¶

To address the issue of women's morbidity is to attend to theoretical issues about the nature of sickness, and to the interaction between sickness, gender and society. An anthropological analysis of women's health adds new dimensions to an epidemiological and biomedical grasp of women's morbidity. Of course, the anthropological gaze requires close scrutiny of individual women's lives from their perspective and the nuances of meaning they each give to their disorder within an ethnographically appraised context of personal experience.|| A comprehension of these meanings must also be buttressed by an analysis of women's position in society, the ideologies that sustain it, and by probing into male–female relationships. I will propose here that women's disorders are embedded in large measure in their social relations, especially with their mates. Significantly, even Freud recognized that for women marriage was a conflicting institution (see Freud in Young-Breuhl, 1990).

Elsewhere (Finkler, 1994b), I examine in great detail women's marital relations coupled with their subjective evaluations of other components of their existence to delineate the ways in which existential aspects of women's lives influence their morbidity. In this paper, my focus is specifically on domestic violence experienced by women in the impoverished classes of Mexico as but *one* aspect of the marital relationship that influences women's health.

*See Brown and Harris (1978), Doyal (1995), Freud (1990), and Freud in Young-Breuhl (1990), Gove (1978), Gove and Hughes (1979), Jack (1991), Kane (1991), Krieger and Fee (1994), Martin (1987), Nathanson (1975, 1979), Pandolfi (1990), Rosenfield (1980), Roskies (1978), Travis (1988), Verbrugge (1978, 1990), Weissman and Klerman (1977). An extensive bibliography can be found in Apple (1990).

†Browner (1989, 1990), Davis and Low (1989), MacCormack (1994), Martin (1987), Morsy (1978), Raymond (1993), Secretaria de Salud, 1990.

‡However, see Finkler (1991, 1994b), Doyal (1995) and Morsy (1993). Brief discussion of women's depression and violence against women is noted in Secretaria de Salud (1990), but the major focus of this publication is on women's reproductive problems and their sequelae.

§In addition to biological risks, intrinsic genetic and hormonal differences between men and women, Verbrugge (1990) identifies such reasons for the differences as "psychosocial aspects of symptoms and care; called "illness behavior" in medical sociology," and "health reporting behavior, this concerns how men and women talk about their health problems to others".

¶For a fine discussion of the different variables contributing to women's sickness see Verbrugge (1990). Verbrugge discusses the various factors that impact on women's health, but even taking into account the biological differences, Verbrugge emphasizes that there still remains a "black box" which fails to explain women's non-life threatening conditions.

||See also the compelling argument of this point by Kleinman (1988).

Domestic violence has been of great concern to researchers and to the public at large particularly within the last 20 years, but little attention has been devoted to the profound association between such violence and women's experience of diverse symptomatologies, other than to give obvious recognition that beatings produce bruises.*

To comprehend the pernicious effects of domestic violence on women's morbidity is to explore the nature of sickness from an anthropological perspective. For this reason I begin the discussion of women's symptomatology occasioned by domestic violence in Mexico with a brief exploration of the notion of sickness. I then move to analyze domestic violence within its historical and contemporary settings in Mexico and the conditions that tend to mitigate against wife beating. To illustrate my assertion that domestic violence with its attendant symptomatologies is associated with marital interaction, cultural ideologies, but attenuated by residence practices, I present Juana and Anselma's cases. These vignettes reveal the dynamic tension between domestic violence and sickness.

THE NATURE OF SICKNESS

I employ the term sickness to mean an assault on the very being of the human body. Sickness speaks to anatomical dysfunctions expressed symptomatologically and to suffering and pain. Normally, as we attend to our daily activities, we take our bodies for granted. When we experience our body in a way we have not felt it before for a sustained period of time, we begin to sense we are sick. We feel discomfort and disorder. Sickness affects our entire being, the body and the mind both inextricably intertwined in human experience. For this reason, scholars have argued, as I do, against the prevailing distinction between body and mind, against the "myth of two pains—mental and physical" (Morris, 1991).†

By and large, biomedicine attributes disease to anatomical lesions, or pugnacious pathogens, independent of the human context. Contemporary biomedicine explains disease "as an altered structure and single causes" (Cassell, 1991, p. 8). These attributions usually revolve around physical breakdown, noxious organisms attacking the body, and wear and tear through aging and environmental hazards. When customary interpretations of causality fail to explain the disease, biomedicine usually relies on concepts of hereditary predisposition and behavioral risk factors (alcohol and drug abuse, diet), or on behavioral medicine's notion of stress, including stressful life events and absence of social supports.

Theories of stress and their derivatives recognize the role of extra somatic factors in sickness and take us beyond biomedical theories of disease causation. Still, they remove the individual from his or her embodied self, and the social context in which he or she is embedded. Theories of stress tend to model themselves after biomedical paradigms by reducing disease etiology to a single cause. By stripping the patient of his or her capacity to judge, evaluate and experience his or her existence the concept of stress has become just another sort of pathogen assaulting the human body. Because of the shortcomings of the stress concept and its derivatives, I have proposed the notion of *life's lesions* (Finkler, 1991, 1994b).

By life's lesions I mean perceived adverse existence, including inimical social relationships, and unresolved contradictions in which a person is entrenched that gnaw at the person's being, and fester through time, producing myriad non-life threatening symptomatologies. They intrude on the body in much the same way as any pathogen, or anatomical lesion but they are not fatal, as heart attacks or cancer tend to be. Life's lesions express through the body deleterious conditions of existence, be they poverty, malnutrition, adverse life events, or perceived discrepancies in our culturally shaped image of ourselves and attributes of our body, or unreconcilable contradictions. When, for example, concepts of social justice and cultural understandings of proper human conduct are violated, especially between mates, or, when culturally shared tacit understandings of moral imperatives of what constitutes proper behavior in day-to-day experience of social relationships are contested and *remain unresolved.* They forge templates for life's lesions. Moral indignations become inscribed on the body and ensue symptomatologically in overall discomfort, pain and suffering. Moral indignation is often expressed in anger, occasioning and intensifying life's lesions. In fact, in Mexico anger is culturally recognized as sickness producing. Generally speaking, one experiences anger through the body, as in the words of one sick woman, "I feel anger in my body." Emotions such as anger are interpretations

*In an extensive computer search in various indexes, including medline, psychlit file, anthropological reviews, there were few citations that associated women's health with domestic violence. In Secretaria de Salud (1990), a short paragraph is devoted to family violence in Latin America. It is noted that "the real prevalence of women's abuse is not known" and it is rarely reported (1990, p. 14). See, however, Loseke (1992) and Koblinsky *et al.* (1993), as well as Doyal (1995). It has been often pointed out that doctors may treat physically abused women but they fail to ask questions about the causes of their impairments. See Solinger (1994).

†See also Engel (1977), Finkler (1991), Good (1994), Kirmayer (1988), Kleinman (1980), Kleinman (1988), Osherson and Amara Singham (1981). There has been a movement in medicine as in new pain clinics to eschew the duality of body and mind, and to regard chronic pain, at least, "as perception rather than sensation and understand the unity of body and mind" (Morris, 1991, p. 76).