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Cuerpos Cautivos: La Sobremedicación como Violencia Estructural Contra Las Mujeres
Captive Bodies: Overmedication as Structural Violence Against Women

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Resumen

Este artículo explora cómo la práctica médica puede reforzar los cautiverios de madres, esposas o 'putas' (de acuerdo con Marcela Lagarde) de mujeres y niñas, al afirmar y reproducir tabúes sobre el conocimiento, la salud y la atención oportuna de síntomas para el restablecimiento de su salud. En esta dirección su actuar es una forma de violencia estructural en Guanajuato, México, que sustituye la salud sexual y reproductiva. Basado en entrevistas con 21 mujeres de entre 19 y 72 años, de diversos contextos socioeconómicos, y un profesional de la salud, la investigación revela que medicamentos como analgésicos, tratamientos gastrointestinales, antibióticos para infecciones urinarias y vaginales, y terapias hormonales se prescriben sin una explicación completa ni consentimiento informado. La medicación se convierte en una respuesta no a necesidades individuales de salud, sino a problemas sociales más profundos, como el dolor emocional, la limitada educación sexual y la violencia no abordada.

Fundamentado en *Los Cautiverios de las Mujeres* de Marcela Lagarde, este estudio examina cómo las instituciones médicas crean un cautiverio simbólico que silencia a las mujeres para disciplinarlas. A través de entrevistas con 21 mujeres de entre 19 y 72 años, con diversos antecedentes socioeconómicos y un médico líder, se revela que el malestar emocional y las experiencias de violencia a menudo son desestimadas en consultas breves. Muchas siguen las prescripciones sin entenderlas completamente y reportan juicios morales de los proveedores sobre su historial sexual. Los profesionales de la salud confirman que muchos síntomas son emocionales, pero carecen de tiempo para atenderlos.

El artículo destaca cómo la medicalización controla la autonomía corporal de las mujeres, reforzando una violencia estructural que refuerza la disciplina del desconocimiento y los tabúes sobre sí mismas, en lugar de sanar o empoderarlas. Este cautiverio va más allá de la violencia física y sexual y se sostiene por la limitada educación sexual, normas patriarcales y la negligencia institucional hacia la violencia emocional y de género, todas sistémicas, normalizadas y profundamente arraigadas en las prácticas médicas y culturales de México.

Palabras clave: Violencia estructural, Cautiverio simbólico, sobremedicación, educación sexual, violencia institucional, control médico

Abstract

This article explores how doctors use overmedication to enforce the captivity of women and young girls, a form of structural violence in Guanajuato, Mexico, substituting sexual and reproductive health. Drawing from interviews with 21 women aged 19–72, from diverse socio-economic backgrounds and a healthcare professional, the research reveals that medications such as analgesics, gastrointestinal treatments, antibiotics for urinary and vaginal infections, and hormone therapies are prescribed without full explanation or informed consent. Medication becomes a response not to individual health needs but to deeper social issues, such as emotional pain, limited sexual education, and unaddressed violence.
Grounded in Marcela Lagarde's *Los Cautiverios de las Mujeres*, this research examines how medical institutions create a symbolic captivity that silences women into discipline. Through interviews with 21 women, 19–72 years old, with varied socio-economic backgrounds and a lead doctor, interviews reveal emotional distress and experiences of violence are often dismissed in brief consultations. Many follow prescriptions without completely understanding and report moral judgment from providers regarding their sexual history. Medical professionals confirm that many symptoms are emotional but lack time to address them.
The article highlights how medicalization is used to control women's bodily autonomy, reinforcing structural violence that disciplines rather than heals or empowers. This layered captivity extends beyond physical and sexual violence and is sustained by limited sexual education, patriarchal norms, and institutional neglect of

emotional and gender-based violence, all of which are systemic, normalized, and deeply embedded in medical and cultural practices.

Introducción

Women's health in Guanajuato is shaped by disciplinary symbolic systems that exert control over the autonomy granted to women (Foucault, 1977; Lagarde, 2005). In pre-colonial times, indigenous cultures such as the Aztec, Maya, Zapotecs, and Mixtecs had healers known as curanderos or curanderas. Curanderas typically practiced plant-based medicines and spiritual cleansings (limpias), midwifery, and massage (sobaderos). Healing was seen as a sacred, communal responsibility that was passed down by women throughout the generations and spiritual healers.

When Spanish colonizers arrived in 1492 they viewed this type of healing as heresy or witchcraft and inserted religious institutions at the heart of hospitals. As hospitals were intertwined with Church doctrine, the erasure of Indigenous and female roles in healing began (Anzaldúa, 1987; Davis, 1981). Women, in roles of curanderas, still played a pivotal role in empowering women in a social context in spite of institutional pressure and blended with Catholic symbolism (Moraga & Anzaldúa, 1981).

Colonial practices began to prioritize the salvaged birth of a fetus over the well-being of the mother, marking the imposition of patriarchal ideals, centering women's value through the lens of motherhood and obedience, positioning them as reproductive vessels rather than whole individuals (Lagarde, 2005; Davis, 1981).

Following the Mexican Revolution, in the early to mid-20th century, state-led medical institutions implemented coercive sterilizations and eugenic interventions that targeted marginalized communities, usually poor and Indigenous women. These practices were framed as a moral effort to "purify reproduction" (Briggs, 2002; Davis, 1981). Despite the moral authority role, the Catholic Church did little to oppose these new practices, which perpetuated an institutional captivity that governed women's reproductive agency (Lagarde, 2005).

In Guanajuato, healthcare systems were guided by Catholic norms, which shaped and influenced policies that constrained women having control over their own bodies and reproductive choices (Lagarde, 2005). Religion dictated socially acceptable roles for women as caregivers and moral custodians, reinforcing symbolic boundaries around their bodies and sexuality (Anzaldúa, 1987; Lagarde, 2005). A lack of resistance during the eugenics era created a world where women's bodies were seen as sites to be disciplined through sterilization and moral purity narratives (Davis, 1981; Foucault, 1977).

This legacy of practice is not a relic; the policing of women's bodies has not disappeared but has adapted. My investigation picks up from these historical patterns and seeks to examine forms of control that persist for everyday women.

Healthcare systems today continue to reflect this history, constructed by the criminalization of abortion and reproductive decisions controlled by both religious and state influence (Davis, 1981; Foucault, 1977). Without agency and the right to govern their own bodies, women are left trapped in a captivity formed by centuries-old systems of moral, religious, and medical control. Today, women face institutional silencing, overmedication, and limited control over their reproductive decisions (Lagarde, 2005). This dynamic perpetuates layered forms of captivity formed around women's bodies, maternity, and sexuality, which limit their autonomy and further reinforce gendered inequalities (Lagarde, 2005).

This investigation examines the experiences that women encounter with healthcare systems in Guanajuato to explore how medicalization functions as both a tool and a mechanism of control. The research lies within a context of limited sexual education, patriarchal norms, and institutional neglect of emotional welfare and gender-based violence. These factors collectively silence women's narratives and restrict their ability to make informed reproductive health choices.

Objectives

- To examine the layered forms of captivity—bodily, reproductive, institutional, and symbolic, experienced by women in Guanajuato's healthcare system.
- To identify the institutional practices and cultural norms that silence women's pain and restrict their reproductive autonomy.
- To analyze how these systems manifest through mechanisms such as medicalization, overmedication, and moral control.
- To understand how gender-based violence is embedded symbolically and institutionally in healthcare encounters.

Methodology

This research utilizes a qualitative methodology, with a feminist guided lens that guides how participants are chosen, how the questionnaire was created, and formed by an ethnographic fieldwork in Guanajuato, Mexico.

This method prioritizes women's voices, their lived experiences, and recognizes that their experiences are valid reference points of knowledge that challenge institutionalized silence and structural violence.

From a feminist approach with a gender perspective it is understood that women's identities have been socially constructed to fulfill expectations that "destine" them to a private life. In particular, to guarantee the reproductions of the species (Beauvoir, 2019), the care of family members, domestic tasks, and the service of the man with whom they are partnered with. Based on this scenario, dominant Western culture, women's access to public life was culturally denied, reinforcing the general normalization that "women should only be at home."

One of the tools to guarantee the captivity of women as mother-wives (Lagarde) is the lack of knowledge about one's body, in particular, in relation to reproductive organs and sexual education. As a consequence, although not directly, sexual pleasure becomes a taboo for culture and for women. Who are taught that the sexual experience is directly related to reproduction, anything outside of that is perversion which is to be avoided.

It's important to note that this lack of knowledge about their bodies and reproductive organs make women vulnerable to adolescent pregnancies, which are both encouraged and stigmatized within communities. This contributes to the lack of recognition of sexual violence that may occur within religious family environments.

The hegemonic medical system demonstrates the lack of knowledge about women's bodies (Bohannon, 2024), since medical procedures are generally determined based on results from "neutral" (male) bodies. Also in conservative context, the medical discourse promotes reproductive education, in particular, the process during a woman's most fertile years, or once she is married, where she is seen as obligated to impregnate, mostly to justify heterosexual marital union.

Participants and Sampling

Participants included women aged 19 to 70 from diverse social and economic backgrounds across Guanajuato. Data were collected from both in-person interviews and an online questionnaire via Google Forms. Additionally, one healthcare professional (a lead general doctor) participated to provide an institutional perspective and insight on protocols.

Data Collection and Ethical Considerations

Data were gathered through semi-structured in-person interviews and a questionnaire distributed online. Given Guanajuato's strong Catholic cultural context, particular care was taken to approach sensitive topics with cultural respect and awareness of religion and history.

Data Analysis

The data from interviews and questionnaires were analyzed using thematic coding. Themes related to women's experiences with medicalization, healthcare, and silence regarding sexual and reproductive health were identified. This allowed an in-depth critical understanding of structural and symbolic violence and how these captivities manifest in healthcare spaces.

Results and Reflections

Medicalization as Symbolic Captivity of the Body

Across all interviews, women were provided with quick pharmacological fixes, usually without explanation. This pattern reveals that healthcare models prioritize efficiency paired with obedience, rather than education and autonomy over their own bodies. When women discuss pain, emotional concerns, or reproductive issues, the typical response is symptomatic relief, often through medication—without any deeper investigation into potential underlying causes such as gender-based violence, chronic emotional distress, or social stressors.

> *"Nunca me explican nada. Solo dicen que es normal o me recetan algo y ya."*—Participant 9, Questionnaire, July 2025

The absence of clear explanations or informed consent during medical visits perpetuates a hierarchy of knowledge and power, where women are expected to comply—without question. In brief consultations lasting only 10 to 30 minutes, emotional care becomes virtually impossible. This model fails to recognize the complexity of women as emotional and social beings, reducing them instead to a list of symptoms to manage. This is especially evident in public healthcare spaces, where the demand for efficiency leaves little room for communication or trust-building.

Participants reported being prescribed the following medications: analgesics, cabergoline, doloneurobion (dolobedoyecta), iron supplements, urinary tract infection medications, hyoscine, omeprazole, probiotics, antidepressants, and anxiolytics. This is a long list of medications—some of which require careful monitoring if taken regularly. It is important to acknowledge that these drugs alter hormones, bone density, brain chemistry, and other bodily functions—often with minimal explanation or follow-up.

Conditions that bring women into medical spaces include endometriosis, anxiety, severe menstrual cramps, urinary tract infections, and yeast infections. The question becomes: Why are these health conditions so commonly expressed among women?

Lack of Education About one's Body

Urinary tract infections and yeast infections are common among women. Yet, women are not given adequate education about how their bodies work, especially regarding reproductive health and how to care for themselves to reduce the occurrence of such infections. Urinary, vaginal or yeast infection were a common thing that was represented in this study. Despite the frequency, the responses from medical staff reflected that education or preventative measures were not being discussed. Participants had responses such as:

> "Sí, he tenido infecciones... pero no te explican de dónde vienen o por qué pasan." and "Fui por una infección en la orina, me dieron antibiótico pero nunca me preguntaron sobre mi higiene o relaciones sexuales" (Participant 6 & 10, Questionnaire, July 2025).

Gastrointestinal Issues From Stress

Another recurring theme is the presence of IBS (irritable bowel syndrome) and gastritis. Why is this important? Both conditions are closely linked to chronic stress, anxiety, and the somatic expression of trauma. Participants are prescribed omeprazole, antacids, and probiotics in an attempt to manage these symptoms—yet there is little to no exploration of the psychological stressors at the root.

> "Me dijeron que es colitis, pero también tengo ansiedad. Todo es estrés." — Participant 13, Questionnaire, July 2025
> "Cuando tengo problemas o me enojo, me duele el estómago y me inflamo." — Participant Ana, 44, In-person Interview, July 2025

This is a clear example of how overmedication replaces mental healthcare, reinforcing silence around emotional pain. Though these conditions may not be immediately life-threatening, they are chronic and deeply connected to lived experience.

Pain Relief in a Bottle

Perhaps the most commonly prescribed medications are analgesics, or painkillers. These drugs are cheap, readily available, and often casually recommended by both doctors and community members. Painkillers mask pain rather than investigate its origin. Moreover, many women self-medicate with these drugs, fueled by distrust in the medical care they receive.
"Se recetan analgésicos como primer paso. Es práctico. Pero no siempre se investiga la causa" (Doctor Interview, July 2025).
This reflects a shortcut in the system: since appointments are short, emotional and sexual violence cannot be named, and gendered symptoms are often dismissed. When pain is medicated instead of examined, there's no space left to ask the essential question: Why are you in pain?
68% of participants explicitly reported taking some form of analgesics—most commonly naproxen, ibuprofen, diclofenac, or general medications described as "para el dolor" (Participants' responses, July 2025).

Sexuality and Symbolic Punishment

> "Sí me hubiera gustado que me explicaran las partes de la vulva, no todo es una vagina; la importancia del autocuidado integral — emociones, comida, ejercicio. Una mujer del área de la salud podría ser la encargada de esa información. De mi madre hubiera sido muy enriquecedor" (Participant 11, Questionnaire, July 2025).

A shocking recurrence emerged from the cultivation of responses, silence or really a lack of conversation around sex, pleasure, and reproductive health. Not only does this play out as taboo but also as symbolic violence restricting women's agency over their own bodies. As one participant expressed,

> "En las escuelas principalmente, temas sexuales no solo sobre anticonceptivos, sino sobre llamar a las partes por su nombre, la libertad sexual y limpieza y enfermedades comunes como las infecciones vaginales" Participant 8, Questionnaire, July 2025).

This demonstrates the need for education that includes accurate terminology and information that is more in depth than just contraceptives, including preventative measures for common health problems such as vaginal infections. Knowledge is pivotal. This also reflects the lack of knowledge around the complexities of female

anatomy and self-care. What is being lost is much more than just information, it is their dignity, guided by the clinical gaze that monitors and disciplines through morality, sharing messages that sexual desires are shameful.

Medical Silence and Lack of Informed Consent

The following findings reveal how silence shapes women's knowledge of their own bodies. Only 36.4% of participants confirmed that they were explained their medications. All women responded "no" when they were asked if they were completely informed. One participant described it as "solo me dicen que es bueno para mi" which highlights the assumption that as women - obeying without questioning is the norm. This type of medical authority affirms what Lagarde calls a *cautiverio institucional*, expected and subtly guided to remain silent in the face of medical expertise. Another participant shared that "*tiene miedo a hablar*" and another that 'se guarda lo que siente." Why? Because women feel invisible. This fear isn't just emotional- it's structural. (Largarde, 2005) Women's captivity is sustained by family roles, silence, and institutions. The body becomes a site of not just invisibility but obligation, regardless of if they are in pain, women must continue to care for others.

Medical Captivity

Medicalization is a form of captivity without the proper information. The medications that are commonly mentioned included fluoxetine (an antidepressant), naproxen and acetaminophen (painkillers), and a variety of hormonal contraceptives, including contraceptives pills and monthly injections. Furthermore, some were even encouraged to take "algo para los nervios" or "algo para dormir", yet information about dosage, name, or even clear instructions were always missing.
Women shared they must look up the medications online if they wanted more information. Others shared that they would prefer to go to farmacias since there they could find immediate relief regardless of the lack of oversight. When did it become a privilege, not a standard to understand one's treatment?

Silence Across Generations

A crucial piece of information was gathered from one participant aged 72. She described her experience when she started her period for the first time, bleeding in silence for 8 days in complete silence. Until her father took her to the doctor-unaware that she was menstruating. She was given several injections without explanation, without informed consent. She views this as a "good thing" since she shares she never experienced menstrual pain, or lower back pain again. Her bodily experience was managed through uninformed erasure instead of care.
The same participant described her later experience with childbirth. After tearing during labor, she attempted to advocate for herself and requested to be stitched. The doctor refused. And commented, "¿Para qué quieres que te cosa si vas a seguir con las piernas abiertas?" This moment was symbolically violent, an attack on her autonomy and dignity, filled by misogynistic judgement- a moment she never forgot. Decades later, in her older age, she now suffers from untreated complications to both her reproductive system and her bladder.
This moment is a symbol of institutional neglect. "El dolor de las mujeres es minimizado y silenciado, considerado 'normal' o exagerado, lo cual las condena a padecer sin recibir apoyo ni reconocimiento" (Lagarde, 2008, p. 44).
Every single participant in this study mentioned that they felt as if the doctor didn't explain the medication or were told "this will be good for you" or had to look up the information on their own account. That speaks to a deeper problem-about the power dynamic and the lack of autonomy over their bodies, an expected social assumption that these women are going to do as they are told without asking questions. It's pivotal to understand that we are talking about medication, some of which are intended to be taken long term.
A physician interviewed shared that he doesn't always provide full information about the medication he prescribes. According to him it depends on the patient, "some may get too anxious if told too much" or according to him may have no effects (Doctor Participant, Interviews, July 2025). This reinforces harmful stereotypes that frame women as being emotionally fragile.

Furthermore, participants regularly reported their pain was being minimized, ridiculed, dismissed, or they were told they were exaggerating their symptoms. This brings up an important question; Who decides what the threshold of acceptable or bearable pain is?
It is not surprising that most of these women wait until their symptoms are severe before ever contemplating taking a "day off" to take care of themselves.
Key Findings:

- 63.3% of participants admitted to being given medication and not understanding what it was or what it was for.
- 72.7% reported feeling silenced, dismissed, or ignored by the medical system itself and their pain usually minimized or ridiculed.

Silence as Captivity

Silence has been socially constructed for generations. Participants described being afraid to ask questions, feeling embarrassed for being curious about their body, and finally being taught to normalize their pain. Many are told they were exaggerating, so they stay silent.

However, women are not only silenced by society, norms or the medical system. Women silence themselves. Why? Out of fear of being dismissed?

So we return to the initial question: Who decides when pain becomes bearable or unbearable for women? And when does it become unbearable enough to deserve care? This silence is not only enforced but internalized.

Fragmented Knowledge of the Body and Sexuality

The findings demonstrate that across generations, women have been consistently taught to remain silent about their bodies, their symptoms, and especially their curiosities. Story after story, women's fear echoed in their responses: "se guarda lo que siente," "se siente invisible," and "tengo miedo de hablar". This fear is inherited across generations. As Lagarde reminds us, symbolic violence is passed down. Women learn to internalize this violence, silencing themselves and policing their own voices. This silence is not only taught, it is expected.

Most participants reported having very limited knowledge about their bodies, particularly on topics related to reproductive health, sexuality, menopause, and menstruation. Many shared that the only time they had ever visited a gynecologist was during childbirth or when facing menstrual problems, never even considering asking questions about sexual health, pleasure, or emotional well-being. No one felt comfortable freely discussing these topics. This is fragmented knowledge, which ensures that women's bodies are only seen as vessels for reproduction, while all other aspects are ignored and erased. Curiosity, desire, and health are left out of formal care, abandoning women to either investigate within a sea of misinformation or remain in the dark.

The participants in this study provide a diverse perspective across generations, with ages ranging from 19 to 72 years old. This brings a rich, intergenerational lens to comprehension and experience. Yet regardless of their stage in life, the rhetoric remains the same: lack of information or clarity about their bodies, menstruation, reproduction, and sexual health, all wrapped in layers of shame, embarrassment, and fear. These feelings emerge whether they are at home, in school, or in a healthcare facility.

As Lagarde (2005) states, women are trapped in a multitude of *cautiverios*—whether symbolic, institutionalized, or corporal, that limit their autonomy and their right to learn about and make decisions over their own bodies. These *cautiverios* are not exclusive to one generation; they perpetuate a cycle that repeats across time, ensuring the silence continues.

Several participants expressed similar concerns and curiosities about their bodies. Many mentioned they would have liked to know more about their sexuality and reproductive systems. The consequences of this are painfully visible in their daily lives: limitations in making decisions freely, anxiety about their health, and strained relationships with family and society, often marked by silence and misunderstanding. These women are being treated by professionals without fully knowing what medications they are receiving, what the side effects are, or how those medications might affect their physical and mental health in the long term (participant interviews and questionnaire responses, July 2025): "*A las mujeres se nos enseña que la sexualidad sólo tiene sentido dentro de la maternidad. Todo lo demás es desvío, peligro o pecado*" (Lagarde, 2005, p. 122).

Lagarde highlights how this becomes a tactic to ensure women's obedience, even controlling who we choose to be in a relationship with and who we have sex with. Sex becomes a form of captivity tied to motherhood, constrained by the expectation to reproduce. Conversations about sexual health, precautions, or pleasure are denied. "*La falta de palabras, de discurso propio, es una forma de exclusión simbólica que impide a las mujeres nombrar su experiencia*" (Lagarde, 2005, p. 47).

Lagarde touches on how this becomes a tactic to ensure women's obedience, and even controlling who we choose to be in a relationship with and who we have sex with. Sex becomes a form of captivity tied to motherhood, constrained by the expectation to only reproduce, denied any conversation about sexual health, precautions, or even pleasure are discussed. This is more than just exclusion, it's deliberate control.

Conclusión

Women in Mexico face a systemic force that leaves them at the mercy of structural violence to endure pain, confusion, and neglect all alone. This violence is a widespread open secret. Known by many but almost exclusively left unspoken, by fear, shame, and cultural norms. What kinds of pain are women expected to swallow quietly through pills, silence, and obedience? The silence perpetuates a healthcare that limits their knowledge, erases their stories, and controls their bodies through medication and lack of education rather than care. At what point does endurance stop being strength and start being evidence of neglect?

While it may be difficult to frame overmedication as a device of control, the results express it's difficult to sustain. However, based on this working hypothesis, it becomes evident that the medical care provided to women is shaped by cultural prejudices, far removed from the ideal that the primary focus should be on attending to and restoring women's health. Overall, the way women are treated as patients restricts access to quality care. The

medical gaze assumes that women feel unwell, or report feelings of physical discomfort because they are somatizing emotions. While that may be the case at times, it does not validate dismissing or lacking to follow up on their physical symptoms.

Medical care related to women's reproductive organs is deeply influenced by prejudices about their sexual lives, or the absence of one. In this regard, women have received crude and inappropriate comments from their doctors. According to the responses from women who have been interviewed, we can state that medical practice protocols function as mechanisms that reinforce women's captivity, particularly upholding the idea that their destiny is to become mothers and wives. In that context, when they are not mothers or wives, they are seen as promiscuous or "whores". These early findings help us identify a medical practice shaped more by gender prejudices than by a genuine concern for the organic functioning of women's bodies.

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