

DOI: 10.5281/zenodo.12426544

# RESILIENCE AND SUPPORT NETWORKS IN RURAL WOMEN SURVIVORS OF VIOLENCE: PROTECTIVE FACTORS AGAINST MENTAL HEALTH DETERIORATION

Anahy Elizabeth Ordóñez Zea<sup>1\*</sup>, Fabricio Ruperto Arteaga Mendieta<sup>1</sup>, Lourdes Mendieta  
Lucas<sup>2</sup>, Mónica Elizabeth Zea Vera<sup>1</sup>

<sup>1</sup>Universidad Estatal de Milagro

<sup>2</sup>Universidad Católica de Santiago de Guayaquil

Received: 27/10/2025  
Accepted: 16/01/2026

Corresponding Author: Anahy Elizabeth Ordóñez Zea  
(aordonezz2@unemi.edu.ec)

## ABSTRACT

*This study closely examined the lives of 349 rural Ecuadorian women who have endured the brutality of violence. The research delved into this sensitive topic using a non-experimental design and a quantitative approach, aiming to understand the intricate web of relationships among gender-based violence, mental health, resilience, and the support networks that often serve as their only lifeline. The findings, while not surprising, are deeply concerning. The psychological impact is devastating. The results reveal lives scarred by depression, anxiety, and shattered self-esteem. The study highlighted the crucial, though often insufficient, role of informal support networks. The reality is that formal resources are scarce, almost non-existent, in rural areas. The findings underscore the synergy between resilience and social support as protective shields, compelling us to rethink our strategies. We need comprehensive interventions – the kind that genuinely empower women, restore their voices and dignity. And above all, we must strengthen formal support in rural areas, bringing these much-needed resources to where they are most critically required, so no woman faces violence alone.*

---

**KEYWORDS:** Gender-Based Violence, Resilience, Mental Health, Social Support, Rural Women.

---

## 1. INTRODUCTION

Violence against women is not just another "public health problem"; it is an open wound, which drags with it centuries of injustice and inequality. The United Nations, with the 1993 Declaration on the Elimination of Violence against Women, defines it as:

any act of violence based on belonging to the female sex that results or is likely to result in physical, sexual or psychological harm or suffering to women, as well as threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (United Nations, 1993).

Together with the Convention of Belém do Pará of the OAS (1994), laid the foundations to recognize it for what it is: a violation of human rights, a public health problem that concerns us all, and a matter of social justice that cries out to be addressed. Because women, in many corners of the world, are still trapped in a social, economic and legal condition that subordinates them (UNFPA Latin America and the Caribbean, 2025).

UN Women presents devastating statistics: almost one in three women on the planet has suffered physical or sexual violence by an intimate partner (a staggering 26% of women aged 15 and over), or has been a victim of sexual violence outside the partner, or even both, at least once in their lives. This means, 30% of women over the age of 15! (UN Women, 2023). The figures are really alarming.

Ecuador hides its own scars. Here, violence against women is not an urban legend; It is a problem entrenched in those historical inequalities of power and in those patriarchal norms that, although we do not want to admit it, continue to dictate destinies. It affects everyone, without distinction of age, ethnicity or social stratum. The Ecuadorian National Institute of Statistics (2019) corroborates it: 64.9% of women aged 15 or over have suffered at least one type of violence (whether physical, psychological, sexual, economic, patrimonial or gynecological-obstetric) at some point in their existence. Interestingly, the total prevalence is slightly higher in cities (65.7%) than in our countryside (62.8%), but this does not mean that rurality is safe. On the contrary. It is in the countryside where the situation becomes most challenging, where female vulnerability is exacerbated in ways that, from the comfort of the city, we can hardly imagine. Socioeconomic and structural factors intertwine to limit opportunities, to stifle autonomy, to nullify the capacity to respond.

If we break things down, psychological violence takes first place at the national level (56.9%), with a slight but significant inclination towards rural areas (57.4%) compared to urban areas (56.7%). Physical

violence also hits harder in our rural areas (38.2%) if we compare it to urban areas (34.4%). But gynecological-obstetric violence. These traumatic experiences during pregnancy, childbirth or the postpartum period, this dehumanized treatment in the health system are significantly higher in the countryside (54.8%) than in the city (44.7%). This not only tells us about the quality of medical care, but also about the barriers to access, the invisibility of these women, and a system that fails them. In contrast, sexual violence is reported more frequently in cities (36.6% vs. 22.9% in rural areas), a trend that is repeated with economic and patrimonial violence (17.0% in urban areas vs. 14.9% in rural areas) (INEC, 2019). These are data, yes, but behind each number there is a story.

Ecuadorian rural women are trapped in a web of vulnerabilities. Socioeconomic, psychosocial, community, demographic and geographical factors interact against it. The social isolation that surrounds them, the low level of schooling that closes doors to them, the economic dependence that binds them, the barriers to accessing simple mental health care, gender roles so rigid that they suffocate, the low participation in paid employment – because their work at home, although vital, does not count in the statistics, the overload of unpaid work that consumes them and the scarce access to the internet that disconnects them from a world that advances. It is a framework that magnifies the impact of violence on their mental health. It is a synergy of vulnerabilities.

Let's add to this equation those dysfunctional family dynamics, that consumption of alcohol by the partner that brings so many misfortunes, that low self-esteem that is eaten away little by little, and the previous exposure to violence, which condemns them to perpetuate cycles of abuse. As if that were not enough, the aging of the rural population adds another layer of complexity, and the institutional lag, together with this very limited access to support services, leaves our rural women in a situation of total lack of protection. The interconnection of all these vulnerabilities creates a complex system that imprisons them, that suffocates them in situations of violence, making it almost insurmountably difficult for them to seek help and, above all, to escape.

Despite irrefutable statistics, the role of resilience and social networks as protective factors for the mental health of Ecuadorian women in rural areas is little or almost not addressed in the scientific literature. For this reason, this study aims to contribute a grain of sand to this necessary debate.

### *Resilience as a Protective Factor*

Some ideas, which today we consider

fundamental pillars, take decades to permeate the collective. The concept of resilience, for example, began to appear timidly in the 1940s, but it was not until the 1960s that it made its way into fields as diverse as education, medicine, psychology and, of course, social work. At the beginning it was used in the active and passive analysis of patients, a face, a shape, was given to the innate ability of the human being to get up. It was explored, meticulously, in the analysis of each patient, adapting methods, building a personalized understanding for each history (Candanoza-Henríquez et al., 2021). Years later, the American Psychological Association gives us an accurate definition: it is the ability to successfully adapt to difficult or challenging life experiences. And it does not refer to an immovable strength, but to a mental, emotional and behavioral flexibility, which allows us to adjust to demands, both internal and external. (American Psychological Association, n.d.). It is not a gift that one is born with, it is not innate, it is a dynamic process. It is forged, built, polished in that complex interaction between what we are and the world around us. It is a path that allows us not only to survive, but to recover from the most overwhelming adversities (Arciniega, 2005).

When we talk about violent contexts, the term "resilience" takes on an even deeper resonance. In the midst of chaos and pain, resilience is the lifeline, the ability of survivors to face trauma head-on, to weave those effective mechanisms that allow them to maintain, or even recover, a glimmer of psychological well-being, despite having been exposed to experiences that, frankly, take your breath away.

Grotberg's model of psychosocial development ("I have", "I am", "I can") is fundamental to describe the capacity for resilience in adverse environments: "I have" tells us about those external supports, those networks that sustain us; "I am" immerses itself in our internal characteristics, in that identity, that self-esteem that sometimes costs so much to maintain; and "I can" refers us to those personal skills, to problem solving, to communication. Grotberg showed us how these resources, internal and external, dialogue, intertwine (Grotberg, 1995).

And despite the devastating nature of violence, research has shown us that women who have survived domestic violence exhibit a remarkable, almost implausible, capacity for resilience. Even in the midst of abuse, these women maintain confidence in themselves and their loved ones, feeling protected when seeking help (Cordero & Teyes, 2016). This contradicts the idea of doom and reinforces that resilience is not just a response to adversity, but a

universal quality, latent in each of us, and that can be, and should be, cultivated.

The connection between resilience and mental health has been a fertile field for research, and the results are a constant source of hope. Recently, the study by Meza et al. (2023) Confirms that: resilience is significantly and positively associated with low levels of depression and anxiety. The empirical evidence is conclusive: a negative and statistically significant correlation between resilience and anxiety ( $r=-0.108$ ,  $p=0.000$ ), and also with depression ( $r=-0.100$ ,  $p=0.000$ ). This tells us that resilience acts as a true protective factor, a "buffer" that mitigates the psychological impact of violence. Translated into a more relatable language: the greater the resilience, the less likely it is that the symptoms of depression and anxiety will severely oppress us!

And not only in contexts of violence. Positive correlations between resilience and various dimensions of mental health have been replicated in other populations exposed to significant trauma, such as community leaders who are victims of armed conflict (Ortegón et al., 2022). This only reinforces the irreplaceable role of resilience as a shield, as a lifeline.

The protective role of resilience goes far beyond mere individual adaptation; it is a transformative force that defies fate, that rebels against victimization. It allows individuals, despite the most disadvantaged social conditions and the most overwhelming adversities, to develop, adapt with amazing normality and harmony (Arciniega, 2005). The work of Ospina and other authors (2005) It's clarity in this regard: by promoting resilience, we not only empower people to face hardship, but we open the door to a radical change in the way we conceive social policies. From a merely compensatory approach to a proactive one! This implies accompanying people to become aware of their situation, to manage and overcome those traumatic experiences that mark them, to process losses, to enhance their vital capacity to ask for help, and to promote their active participation in community programs. By promoting resilience, we empower them to not only survive the storm, but to thrive, to flourish, to become agents of change in their own lives and in their communities.

### ***The Power of Social Support Networks***

But resilience does not act in a vacuum; it needs scaffolding, a support. And this is where social support networks (formal and informal) come in, that invisible, but very powerful, network of interpersonal relationships that connect an individual with their environment. Contributing to

their material, physical and emotional well-being, and acting as a firewall, preventing deterioration in the face of difficulties (Gúzman et al., 2003).

In rural areas, where formal services are often scarce, these informal networks are simply crucial. They are the ones that cushion the blows of violence, those that promote the psychological well-being of women, becoming a vital resource for their health and for their survival. Orozco and colleagues (2023) They emphasize it: in peasant families, these networks are diverse and essential for family health. The unmistakable presence of female figures – mothers, sisters, friends (Estrada et al., 2012) – in these informal networks it is no coincidence; it reflects those gender roles rooted in care and emotional support. A study by Zabala and other authors (2023) validates this "theory of the triple role" of rural women (reproductive, productive and community), highlighting the importance of the community role in unity and mutual support between them. These informal networks are, in essence, coping and coping mechanisms in the face of resource scarcity and social protection constraints (Gúzman et al., 2003).

But not everything is perfect. The informal nature of these networks and, sadly, the low male participation, can limit rural women's access to resources that go beyond emotional support. And here comes the big challenge: the reluctance to seek formal support can leave them legally or medically unprotected (Government Delegation against Gender Violence, 2018).

The effectiveness of support networks transcends simple help, acting as active promoters of psychological well-being. They are a key protective factor for those who take care of their families, reducing their discomfort. Social support, studies tell us, correlates positively with psychological well-being and negatively with psychological distress (Schoof et al., 2018). Community support is positively related to psychological well-being ( $\beta=.19$ ,  $p<.01$ ) and negatively related to psychological distress ( $\beta=-.28$ ,  $p<.01$ ). And emotional support is a vital component, with a strong positive association with social reinforcement and socialization (Schoof et al., 2018), facilitating both coping strategies and social integration, both crucial for recovery from any trauma.

### ***The Synergy Between Resilience and Support Networks***

This is where the magic happens, where the theory comes to life. Resilience and support networks are not two loose pieces of a puzzle; No, they interact

synergistically, reinforcing each other to mitigate this deterioration of mental health in women who have survived violence. The findings of Cordero and Teyes (2016) anchored in Grotberg's (2006) model, especially in that powerful "I have", they highlight external support as one of the interactive sources of resilience. This means that a high level of support from our environment is not just a passive resource; It is an active catalyst for the development of resilience, nurturing, above all, confidence.

And here comes the key, that "key" that opens all doors: trust in other people. Without it, how can resilience be built? Trust becomes the fundamental foundation for other resilient factors to flourish. A woman who has been a victim of violence, in order to begin to rebuild herself, to develop that vital resilience, needs the outstretched hand of someone she trusts blindly, whom she respects and loves, and with whom she feels a deep connection. That confidence, in turn, is the spark that allows you to activate your own inner strengths (your "I Am") and develop those coping skills (your "I Can") (Cordero & Teyes, 2016), creating a virtuous cycle that, little by little, mitigates the devastating impact on their mental health.

Resilience, then, is revealed as a social process, not merely an individual one. It can arise from social solidarity, manifesting itself in those collective efforts that we see in emergency situations. Promoting resilience implies orienting our interventions towards empowerment and the improvement of interactions, yes, but also in the provision of mentors who guide, accompany, and support women in their complex and courageous recovery process (Ospina Muñoz et al., 2005). Social support and resilience are positively correlated with mental health and quality of life, even in populations that have experienced trauma as severe as armed conflict (Ortegón et al., 2022). This, at least we believe, is proof that, even in the worst circumstances, the human capacity to rise again, to find light, is unshakeable.

### ***Mental health and its indicators of deterioration***

The World Health Organization (WHO) has reminded us time and time again that mental health is not even remotely the simple absence of a disorder, it is in its purest essence, a state of integral well-being (WHO, 2022). This definition ranges from how we feel about ourselves, that subjective well-being, to the deep conviction that we are capable, our perception of our own effectiveness. It includes that spark of autonomy that drives us, the competence to navigate the world, the rich intergenerational dependence that

nourishes us, and, of course, the self-realization of all that intellectual and emotional potential that we carry within. This perspective is crucial, vital, because, when we enter the painful context of violence, recovery cannot remain in the mere reduction of negative symptoms; No, true healing involves rebuilding all of those positive capacities.

The indicators of deterioration of mental health in women who have experienced violence are a bleak catalog. We are talking about depression, anxiety, post-traumatic stress disorder (PTSD), suicidal ideation; and, sadly, problems related to alcohol and drug use (WHO, 2021). Our individual mental health is a very complex tapestry, woven with social, psychological and biological threads. And, truth be told, these persistent socioeconomic pressures are a risk factor that the WHO (2020) has documented ad nauseam.

### ***Rurality: An Aggravating Scenario for Mental Health***

Mental health is already a challenge in general, in rural areas, it becomes a particularly acute issue. Mental Health America Numbers (2025) reflect that: in these areas, we find 20% fewer primary care providers. This represents a huge gap. Suicide rates, which are always an indicator of deep despair, skyrocket, ranging from 18.3 to 20.5 per 100,000 inhabitants, in stark contrast to large cities, where they stand at between 10.9 and 12.5. In addition, rural life brings with it other problems that threaten mental health: the terrible lack of adequate insurance to cover treatments, the financial instability inherent in the agricultural economy, social isolation, and stigma, that invisible monster that still hangs over mental health problems. These factors not only exacerbate deterioration; they greatly complicate measurement and treatment.

### ***Violence in the Mental Health of Rural Women***

Violence, in its various manifestations, has a devastating impact on women's mental health, with consequences that vary according to the type and severity of the assault. Intimate partner violence (IPV), for example, is strongly associated with a myriad of mental health problems. Depression and anxiety stand as the most prevalent disorders, as undesirable companions who do not abandon them. Comparative studies have revealed significant differences in the prevalence of depression and anxiety between women who are victims of IPV and those who have not suffered from it ( $p < .001$ ) (Lara Caba et al., 2019).

By analysing the literature in depth, we can see

how these direct and differentiated links between the types of violence and mental deterioration are woven:

- Psychological violence – that which does not leave bruises, but does leave indelible scars on the soul – emerges as the main predictor of depression. It is heartbreaking to know that it explains up to 26% of its variance ( $R^2=.26, \beta=.510, p<.05$ ) (Méndez Sánchez et al., 2022). This underscores the profound damage that emotional abuse does to the victim's mood, to their own perception of themselves.
- In contrast, sexual and physical violence are significant predictors of anxiety, explaining 31% of their variance ( $R^2=.31, \beta=.340$  for sexual,  $\beta=.295$  for physical,  $p<.05$ ) (Méndez Sánchez et al., 2022). These direct aggressions to the body, to autonomy, generate states of alert and a persistent fear that pursues them day and night.

In addition, in women who have been victims of violence, very high levels of emotional dependence have been documented; 79% of them have moderate dependence! And this is a vicious circle: there is a medium positive correlation (0.473) between emotional dependence and psychological violence. The fear of loneliness and abandonment stand as relevant indicators of this dependence, which suggests that this psychological factor can, sadly, perpetuate immersion in violent relationships. For this reason, if we want interventions to be truly effective, they must be differentiated and personalized, addressing the specific types of violence and, above all, those underlying psychological factors such as emotional dependence, which are real barriers for women to get out of this nightmare situation. (Chafra Quise & Lara Machado, 2021).

Domestic and sexual violence, more prevalent in women, are associated with very high prevalences of anxiety disorders (61.1% in domestic violence, 57.1% in sexual violence), major depression (38.9% in domestic violence), PTSD, and alcohol use disorders (Orrego et al., 2020). These data reinforce the imperative need for a comprehensive approach to survivors' mental health care.

In addition, the impact on the physical health of women who have been victims of episodes of violence is one of the most observable effects of the comprehensive damage that arises from constant aggression. Injuries to the body, chronic fatigue, muscle contractures and psychosomatic disorders highlight not only the physical impact of violence, but also the emotional pressure that has accumulated due to being permanently exposed to abuse. From this perspective, physiotherapy assumes a key role

not only as a tool for functional recovery, but also as a therapeutic space that facilitates body reconnection, autonomy and the recovery of self-esteem. Gender-based violence facilitates a high deterioration of mental health, where indicators such as depression, anxiety, insomnia, social isolation, loss of vital meaning and difficulty in building bonds of trust are incorporated. Hence, it is essential to approach health from an interdisciplinary and comprehensive perspective, where physiotherapy is articulated with psychological and social care, from there it contributes to the physical and emotional repair of women and thus to the reconstruction of their dignity and well-being.

### ***Rural factors that multiply women's vulnerability***

The rural environment presents specific risk factors that magnify the impact of violence on women's mental health, creating a synergy of vulnerabilities.

- Social isolation: The characteristics of agricultural tasks and the depopulation of many rural areas contribute enormously to isolation. It limits opportunities for social interaction and, therefore, sources of social support. This isolation not only makes it difficult for violence to be detected, but also stifles the search for help.
- Barriers to Access to Mental Health Care: Rural communities face an overwhelming shortage of mental health professionals, those who understand the agricultural context. Added to this is a deep distrust of "strangers," the high cost of services, the lack of free time to seek help, the limited internet connectivity that disconnects them from the world, and the lingering stigma that still weighs on mental health (Mental Health America, 2025). These barriers not only prevent access to aid, but also compound the stress they already carry.
- Financial Instability: Fluctuations in agricultural prices and structural changes in agriculture generate considerable economic insecurity (Smolski et al., 2023). Low schooling and economic dependence on husbands, a sadly common reality in these communities, are additional risk factors that curtail women's autonomy and their ability to escape situations of violence (Díaz Cárdenas et al., 2015).
- Rigid Gender Roles: The persistence of patriarchal hierarchical structures, that outdated mentality where women are seen as "mistreated", perpetuates violence and excludes them from decision-making (Díaz Cárdenas et al., 2015).

These traditional roles also influence how support is perceived and accessed, with a lower presence of male figures in support networks (Estrada et al., 2012).

It is essential to understand that these risk factors in rural areas do not act alone; They reinforce each other, creating a breeding ground for suffering. Social isolation is interwoven with lack of access to mental health services and economic dependence, generating an environment where violence is more difficult to denounce and, needless to say, to overcome. And that stigma, the damn stigma, further aggravates the situation.

## **2. METHODOLOGY**

The present study adopted a quantitative approach, with a non-experimental cross-sectional design, to unravel the intricate relationship between resilience, support networks, and mental health in a group of rural Ecuadorian women victims of violence. Far from trying to manipulate realities, the research focused on describing how resilience and support stand as protective shields in the face of adversity. Although the ambition was a national perspective, with special attention to rural areas of Ecuador, it is fair to recognize that the sample obtained was more representative in the provinces of Guayas, El Oro and Pichincha, which should be considered for the generalization of the findings, although we do not believe that it detracts from the voices that we were able to hear.

The study sample was non-probabilistic for convenience and was composed of 349 rural women victims of gender violence. Participants were selected based on accessibility and specific inclusion criteria: (1) residing in rural areas of Ecuador, (2) having experienced some type of gender-based violence, and (3) being 18 years of age or older.

Data collection was carried out through a structured survey administered through an online questionnaire. This instrument, which initially contained 79 questions distributed in 14 categories. For the purposes of this study, 22 closed-ended questions were specifically analyzed, grouped into 7 key categories: physical violence, psychological violence, community support networks, associated psychological symptoms, coping strategies, stress and anxiety, and self-esteem and resilience. The questions employed the familiarity of the Likert scales and the clarity of multiple choices to capture the essence of the participants' perceptions and experience.

Data were collected synchronously, using video calls to ensure compliance with the sampling criteria

and the reading and understanding of informed consent. The data analysis was carried out using descriptive statistics using Microsoft Excel software, and the results were presented visually through Figures 1 to 12, allowing a clear understanding of the patterns observed in the variables studied. The confidentiality of the participants was guaranteed and a gender approach was applied throughout the research process.

The analysis of each response strictly adhered to ethical principles, ensuring the informed consent of all participants, the confidentiality of their responses, and protecting their identity. A gender-sensitive approach was also adopted to the particularities of violence against women in the context studied.

### 3. RESULTS

Listening to survivors of violence is about much more than collecting data; it is to enter into the very essence of their pain, their silences and, sometimes, their cries of hope. This analysis, far from being a mere statistical exercise, immerses itself in the harsh reality of thousands of women, exploring how community support networks, psychological symptoms, coping strategies and the impact on self-esteem and resilience configure a complex web of challenges and, against all odds, resurgence.

The analysis of the demographic distribution of the sample studied reflected a remarkable heterogeneity in terms of age, educational level and marital status. In terms of age, young and middle-aged adult women (18-37 years) predominated, while older participants were underrepresented. Regarding educational level, polarization was observed: more than 50% of the respondents had completed at least secondary or higher education, but a significant 28.5% lacked formal education. Geographically, the sample showed a considerable concentration in the provinces of Guayas (44.5%), El Oro (14.4%) and Pichincha (11.8%), with a much lower representation in other provinces, which shows a territorial imbalance. Finally, in relation to marital status, there was a slight predominance of single women (34.7%) over married women (32.0%), followed by those in a common-law union (22.6%). Taken together, these biosociodemographic data offer a descriptive view of the sample composition, highlighting key trends that are crucial to consider when interpreting the overall results of the study.

#### *Physical Violence*

When addressing the category of physical violence, especially as it relates to the experiences of

women survivors, it is critical to understand how often they witness its manifestations. The data presented in Figure 1 are eloquent and reveal that physical violence in the communities studied is not an isolated event, but a daily reality and deeply worrying for a significant portion of these women. 62.9% of those surveyed perceive this violence as "Somewhat Frequent" (38.2%) or "Very Frequent" (24.7%). Although 33.6% consider it "Rarely" and 3.4% "Never", the overwhelming majority of the responses indicate a widespread problem, a considerable and widespread challenge that, in some way, has become normalized in the day-to-day life of these Ecuadorian communities.

Figure 2 sheds light on two crucial aspects of physical violence. First, a large majority of respondents, 82.8%, indicate that physical violence occurs predominantly within the home. This finding underscores the fundamentally domestic nature of this type of violence, suggesting that the family environment, which should be a safe space, unfortunately stands as the main stage of its manifestation. Second, and no less important, is the low rate of complaints: only 24.7% of victims of physical violence regularly report these acts, while 75.3% do not. This notable disparity is indicative of a serious problem of under-reporting, possibly attributable to fear, shame, lack of trust in institutions or economic dependence. This situation perpetuates a cycle of impunity and hinders effective intervention and support for victims. Both results underscore the urgent need to address domestic violence and to establish strategies that promote reporting, while ensuring effective protection for victims.

#### *Psychological violence*

The data on psychological violence, also shown in Figure 3, reveal its worrying prevalence and considerable impact. First, a vast majority of 69.5% of respondents consider psychological violence to be common in their communities. This indicates that this form of abuse, often less visible than physical abuse, represents a widespread reality that affects women. However, despite its widespread presence, only 58.3% of women believe that they are aware that they are suffering psychological violence. This suggests that about 40% may not identify it as such, which significantly complicates the search for help. Finally, an overwhelming 86.8% of the responses indicate that psychological violence has a greater impact on young women or older adults, highlighting the particular vulnerability of these age groups in the face of this aggression. Taken together, these results underscore the urgency of intensifying

awareness of psychological violence, its various manifestations and consequences, as well as developing specific support programmes, with an emphasis on the most vulnerable populations.

Data on other types of violence in the community, reflected in Figure 4, show that economic violence is the most prevalent, with 51.4% of respondents mentioning it. This suggests that control, deprivation or economic exploitation constitute significant forms of abuse that affect the population. It is followed by sexual violence, with a considerable 34.5%, indicating that this form of aggression is also a relevant concern in the community. Symbolic violence occurs at 10.9%, suggesting that norms, stereotypes, and messages that perpetuate inequality and discrimination are perceived as a form of violence. Finally, gynecological-obstetric violence is the least reported in this section, with 3.2%, which could indicate a lower frequency, a lower recognition as violence or a lower visibility for the respondents in the general context. If the country's statistics are taken into account. Taken together, these percentages highlight the complex and multifaceted nature of the violence experienced by women, highlighting the economic and sexual dimensions as the most pressing, but without underestimating symbolic and specific forms such as gynecological-obstetric violence.

### ***Community Support Networks: The Fragile Thread of Connection***

The Community Support Networks category seeks to unravel how support networks (or lack thereof) intervene in mitigating the impact of violence against women. It aims to analyse the voices of women survivors from the very voices: how they perceive the support of their family and communities, whether this necessary help only comes from their immediate environment or if they have community groups specifically designed for the prevention of violence, whether there is a real collective conscience or if it is just formalism or "lip service" when it comes to defending women's rights.

The data in Figure 5 shows that, for an overwhelming 90.3% of women, family and neighborhood stand as unbreakable pillars. They are that first refuge, that embrace that calms the first tremor. But how bitter is the taste of the following data: a desolate 62.2% of these women confess the painful absence of organized community groups, of those that, with structure and purpose, could really change things at the root. It's not just a gap; it is an abyss that separates necessity from action. And if that were not enough, the opinion on the recognition of

the rights of victims is split in half. 52.1% agree, yes, the community supports them. But what can we say about the 46.1% who categorically deny it? This is not ambivalence; It's a brutal breach in the collective consciousness that leaves us with more questions than answers. What kind of support is this? Is it a support that remains on the surface, without real commitment?

### ***Associated psychological symptoms***

Violence is not satisfied with leaving visible marks; it leaves deep scars, engraved in fire in the soul. The category "Associated psychological symptoms" is a mirror of this crude and undeniable reality. The numbers are overwhelming, a chilling 82.2% (Figure 6) of women victims of violence recognize symptoms of depression. It is almost a constant, a silent condemnation. Those who rarely experience it (17.2%) or, miraculously, do not experience it (0.6%) are the exception, an atypical flash in a period that swallows everything.

If depression is almost universal, anxiety (96.6%) and sleep difficulties (96.0%) are its conjoined twins (Figure 7). These data are not just cold figures; They are the reflection of countless sleepless nights, of a constant fear that does not let you breathe, of a daily anxiety that suffocates the soul.

### ***Coping Strategies***

The Coping Strategies category is interested in answering: How do you move forward? This is the question that underlies this category. Figure 8 shows us that the majority, 66.8%, cling to what is closest to them: family, friends, even their neighbor. It is the most immediate refuge, the port to which they run when the storm hits. A worrying 31.2% do not seek this support. What happens? This figure screams that there are barriers as big as mountains, perhaps fear, shame, or family dynamics so dysfunctional that they become part of the problem. This screams to us, without a doubt, the need to go far beyond informal support. This, by itself, is not enough.

If we talk about professional support, things get much worse. Only a measly 10.9% (Figure 9) "frequently" resort to specialized services. The majority (75.6%) use them only "sporadically", and a disturbing 13.5% "never" use them. The system fails miserably, leaving them adrift! There are no excuses: there is a lack of resources, there are too many economic, geographical, cultural barriers.

Figure 10 presents us with another uncomfortable reality, 73.4% of the participants state that there are no community support groups. In other words, the institutionalization of these networks is practically

nil. How are they supposed to recover? Alone?

### ***Stress and anxiety***

The data speak for themselves, and they do so with terrifying clarity. Violence does not let up: 99.7% (Figure 11) of women victims report high levels of stress and anxiety, and an overwhelming 98.9% see their daily activities affected. That is, it is not a "if it affects you", it is a "how it affects you", with an almost universal cruelty. Life, for them, becomes a constant struggle against anxiety, despair and exhaustion. There is practically no case where violence does not leave a deep and indelible mark on mental health. It is an almost absolute correlation: exposure to violence and the development of serious psychological sequelae. Acute stress responses? Yes. Anxiety disorders? Unavoidable. Functional impairment in every sphere of daily life? Of course. The minimal, almost negligible, variability in responses (that  $\leq 0.3-0.9\%$  in the negative categories) reinforces, with a shocking consistency, these symptomatological patterns. It is a clinical picture as clear as water, but with a terrifying darkness.

### ***Self-esteem and resilience***

If violence is a devastating earthquake, self-esteem is invariably the first thing to collapse. The data is living proof. A shocking 100% (Figure 12) of victims experience an impact on their self-esteem. One hundred percent. And the most tragic thing is that only 55.3% achieve a subsequent emotional recovery. This means that almost half of these women are left halfway, with scars that do not quite heal, with wounds for life. The process of overcoming is, sadly, incomplete for many.

Resilience, that human ability to get up again and again after each fall, is in a disturbing technical tie: 50.1% to 49.0%. Community initiatives, although they exist and are valuable, are insufficient or, worse, unequal. The abysmal disparity between universal damage (that heartbreaking 100%) and partial recovery (that uncertain 55.3%) is an urgent call for help, which should resonate in every government office, in every decision-making space. We need comprehensive public policies that address each and every one of the phases of the post-violence process. Not just band-aids, but major surgeries. This analysis

leaves an inescapable truth, one that we must engrave in our conscience: violence against women is not an isolated problem, it is not "theirs", it is everyone's problem. And if we do not act now, with the urgency that the situation demands, those silenced voices, those looks full of sadness, will continue to be the darkest shadow, the most shameful stain on our society. The final question is this: Are we willing to truly listen and, what is infinitely more important, to act with courage and compassion?

## **4. CONCLUSIONS**

Gender-based violence is devastating the mental health of rural Ecuadorian women. This is not a marginal problem! It is a silent epidemic, which feeds on the lack of reporting and invisibility. The figures are sadly heartbreaking. With an almost universal prevalence of severe psychological symptoms and a total impact on self-esteem. Most concerning is the persistence of this suffering, with nearly half of survivors without full emotional recovery.

Informal support networks (family and neighbors) provide strength, they are a fundamental pillar in this context of adversity. However, the research also reveals a critical and painful absence of organized institutional support. The scarcity of community support groups and the minimal use of specialized professional services reveal a palpable reality, the institutional vacuum that condemns many women to the loneliness of their struggle. The outlook is bleak, but resilience emerges as a light at the end of the tunnel, as an inherent capacity that, while challenging, represents a crucial protective factor. This finding forces us to rethink our strategies: it is clear that it is not enough to treat the symptoms, we need more, empower women and strengthen their coping capacities.

These results are more than academic conclusions; they are an unavoidable call to action. We urgently need to design and implement comprehensive and multisectoral public policies. This means going beyond the superficial, focusing on: the real empowerment of women, the strengthening of formal and community support networks, adapted to the particularities of the rural environment, and the eradication of stigma associated with mental health.

## **REFERENCES**

- American Psychological Association. (n.d.). *Resilience*. Retrieved June 23, 2025, from <https://www.apa.org/topics/resilience>
- Arciniega, J. de D. U. (2005). Resilience. A new perspective on developmental psychopathology. *Journal of Psychodidactics*, 10(2), 61–79. <https://www.redalyc.org/articulo.oa?id=17510206>

- Candanoza-Henríquez, A. E., Rojo-Gutiérrez, M. A., Candanoza-Henríquez, A. E., & Rojo-Gutiérrez, M. A. (2021). Measuring resilience in adult victims of conflict: Carmen de Bolívar case, Colombia. *Politics, Globality and Citizenship*, 7(14), 254–280. <https://doi.org/10.29105/PGC7.14-12>
- Chafla Quise, N. M., & Lara Machado, J. R. (2021). Emotional dependence and violence in women cared for at the Nosotras con Equidad Foundation, in Riobamba. *Electronic Medical Journal*, 43(5), 1328–1344. <https://www.redalyc.org/journal/3782/378277362013/html/>
- Cordero, V., & Teyes, R. (2016). Resilience of women in situations of domestic violence. *Omnia*, 22(2). <https://www.redalyc.org/journal/737/73749821009/html/>
- Government Delegation against Gender Violence. (2018). *WOMEN VICTIMS OF GENDER VIOLENCE IN THE RURAL WORLD*. Ministry of Equality. Publications Center. [https://violenciagenero.igualdad.gob.es/wp-content/uploads/vg\\_mundorural.pdf](https://violenciagenero.igualdad.gob.es/wp-content/uploads/vg_mundorural.pdf)
- Díaz Cárdenas, S., Arrieta Vergara, K. M., & González Martínez, F. (2015). Domestic violence and risk factors in Afro-descendant women in the city of Cartagena. *Clinical Journal of Family Medicine*, 8(1), 19–30.
- Estrada, C., Herrero, J., & Rodríguez, F. J. (2012). The support network for women victims of intimate partner violence in the state of Jalisco (Mexico). *Universitas Psychologica*, 11(2), 523–534.
- Grotberg, E. (1995). *A guide to promoting resilience in children: strengthening the human spirit*. La Haya: Fundación Bernard Van Leer.
- Gúzman, J., Huenchuan, S., & Zavala, V. (2003). Social support networks for older people: Conceptual framework. *Notes on Population*, 77. [https://www.researchgate.net/publication/242462526\\_Redex\\_de\\_apoyo\\_social\\_de\\_las\\_personas\\_mayores\\_Marco\\_conceptual/citation/download](https://www.researchgate.net/publication/242462526_Redex_de_apoyo_social_de_las_personas_mayores_Marco_conceptual/citation/download)
- INEC. (2019). *National Survey on Family Relations and Gender Violence against Women*.
- Lara Caba, E. Z., Aranda Torres, C., Zapata Boluda, R. M., Bretones Callejas, C., & Alarcón, R. (2019). Depression and anxiety in women victims of intimate partner violence. *Argentine Journal of Behavioral Sciences*, 11(1), 1–8. <https://www.redalyc.org/journal/3334/333463140001/html/>
- Méndez Sánchez, M. del P., Barragán Rangel, A., Peñaloza Gómez, R., García Méndez, M., Méndez Sánchez, M. del P., Barragán Rangel, A., Peñaloza Gómez, R., & García Méndez, M. (2022). Severity of intimate partner violence and emotional reactions in women. *Psicumex*, 12:1–20. <https://doi.org/10.36793/PSICUMEX.V12I1.400>
- Mental Health America. (2025). *Rural Mental Health Crisis*. <https://mhanational.org/resources/rural-mental-health-crisis/>
- Meza Peña, C., Álvarez Bermúdez, J., Meza Peña, C., & Álvarez Bermúdez, J. (2023). Anxiety and depression in times of COVID and the resilience factor. *Horizonte Sanitario*, 22(1), 75–82. <https://doi.org/10.19136/HS.A22N1.4981>
- United Nations. (1993). *United Nations Declaration on the Elimination of Violence Against Women. : General Assembly Resolution 48/104 of December 20, 1993*.
- OAS. (1994). *INTER-AMERICAN CONVENTION ON THE PREVENTION, PUNISHMENT AND ERADICATION OF VIOLENCE AGAINST WOMEN "CONVENTION OF BELÉM DO PARA"*. <https://www.oas.org/juridico/spanish/tratados/a-61.html>
- WHO. (2020, October 8). "There is no health without mental health" - PAHO/WHO | Pan American Health Organization. News. <https://www.paho.org/es/noticias/8-10-2020-no-hay-salud-sin-salud-mental>
- OMS. (2021, March 21). *Violencia contra la mujer*. <https://www.who.int/es/news-room/fact-sheets/detail/violence-against-women>
- WHO. (2022, June 17). *Mental health: strengthening our response*. Descriptive Notes. <https://www.who.int/es/news-room/fact-sheets/detail/mental-health-strengthening-our-response>
- UN Women. (2023, November 23). *Facts and figures to end violence against women | UN Women – Latin America and the Caribbean*. <https://lac.unwomen.org/es/stories/noticia/2023/11/hechos-y-cifras-poner-fin-a-la-violencia-contra-las-mujeres>
- Orozco Castillo, L., Betancurth Loaiza, D. P., & Giraldo-Osorio, A. (2023). Social support for peasant families to maintain health. *Colombian Journal of Social Sciences*, 14(1), 153–178. <https://doi.org/10.21501/22161201.3905>
- Orrego, S., Hincapié, G. M. S., & Restrepo, D. (2020). Mental disorders from the perspective of trauma and violence in a population-based study. *Colombian Journal of Psychiatry*, 49(4), 262–270. <https://doi.org/10.1016/j.rcp.2019.02.003>
- Ortegón, T. M., Vinaccia, S., Quiceno, J. M., Capira, A., Cerra, D., & Bernal, S. (2022). Social support, resilience,

perceived stress, post-traumatic stress, anxiety, depression, and health-related quality of life in community leaders victims of the armed conflict in Montes de María, Sucre, Colombia. *Eleuthera*, 24(1), 158-178. <https://doi.org/10.17151/eleu.2022.24.1.8>

Ospina Muñoz, D. E., Jaramillo Vélez, D. E., & Uribe Vélez, T. M. (2005). Resilience in women's health promotion. *Nursing Research and Education*, XXIII(1), 78-89. <https://www.redalyc.org/articulo.oa?id=105215401007%0A>

Schoof Aguirre, M. T., Manzanares Medina, E., & Grimaldo Muchotrigo, M. (2018). Red de soporte social y apoyo comunitario en miembros de una organización de desplazados por violencia política residentes en Cañete, Perú/Social Support Network and Community Support Among Members of an Organization of Persons Displaced by Political Viol. *Costa Rican Journal of Psychology*, 37(2), 107-129. <https://doi.org/10.22544/rcps.v37i02.02>

Smolski, A. R., Mosley, C., Brown, M. E., Schulman, M. D., Sedges, H., Court, C., Miller, L. E., Rathi, A., & Hossfeld, L. (2023). Farm and Ranch Mental Health: Stressors, Barriers, and Strategies Research Brief. *Farm Stress Brief*. <https://www.southernagexchange.org/>

UNFPA Latin America and the Caribbean. (2025). *Gender-Based Violence*. <https://lac.unfpa.org/es/topics/violencia-basada-en-género>

Zabala Murillo, M. A., Lobo Anaya, K. P., & Vargas Prieto, A. (2023). The three roles of rural women in the development of territories: productive, reproductive and community. *CLIO America*, 17(33), 137-145. <https://doi.org/10.21676/23897848.5208>



Figure 1: Frequency of physical violence in women in the community (page 17).

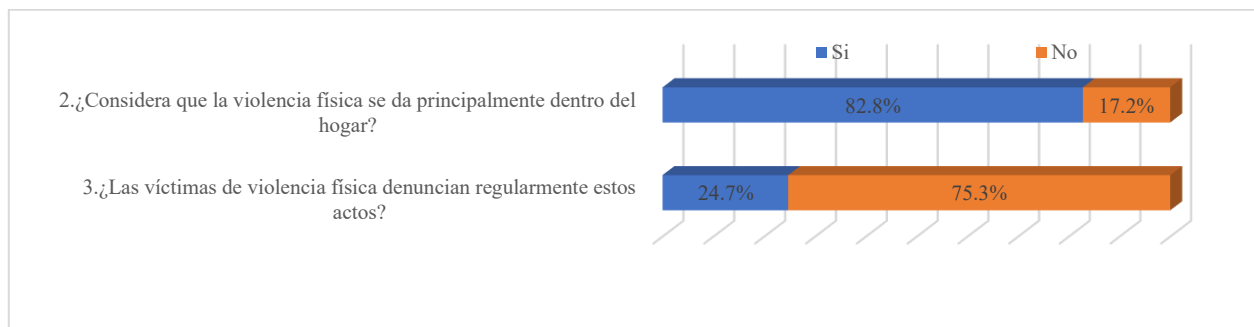


Figure 2: Physical Violence (Scope and Complaint) (page 18).

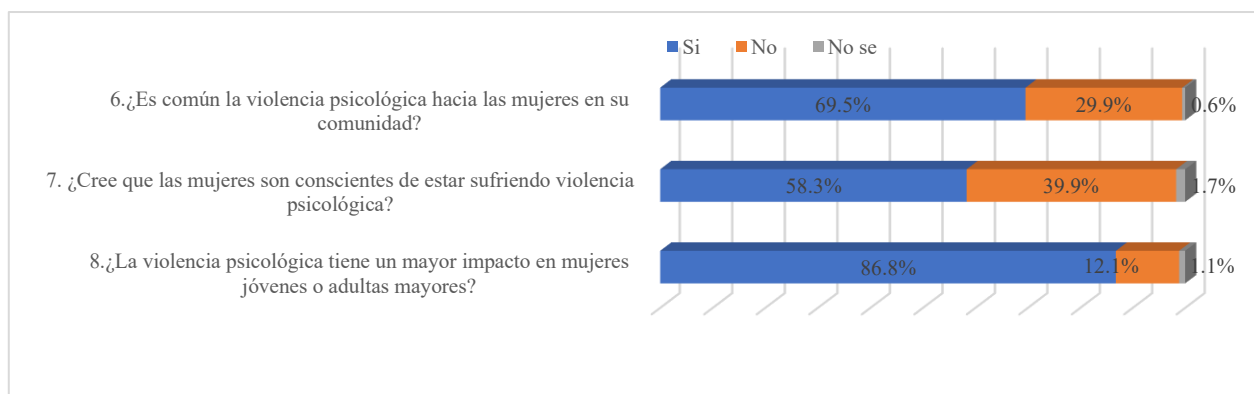


Figure 3: Views on psychological violence against women in the community (page 19).

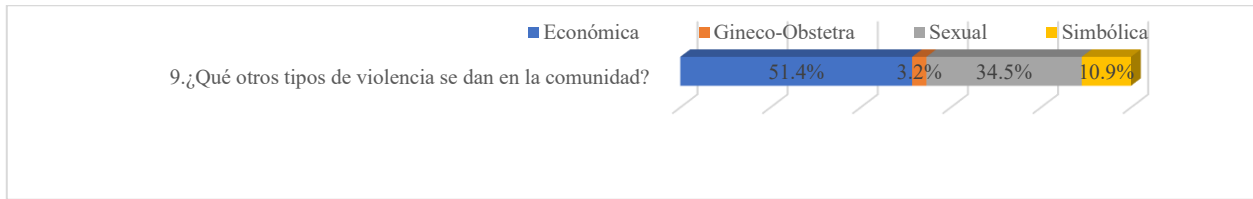


Figure 4: Other types of violence reported in the community (page 20).

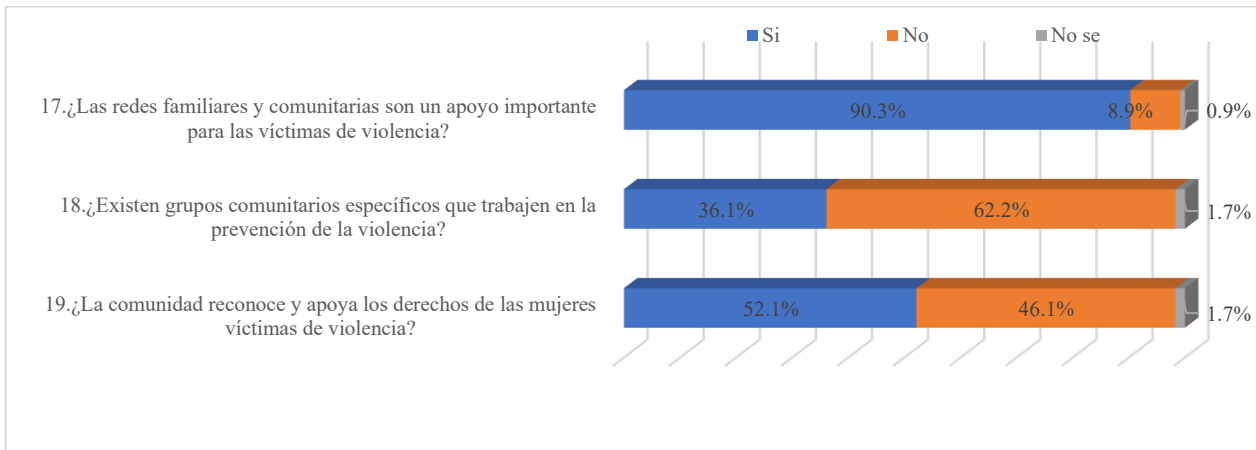


Figure 5: Community Support Networks (page 20).

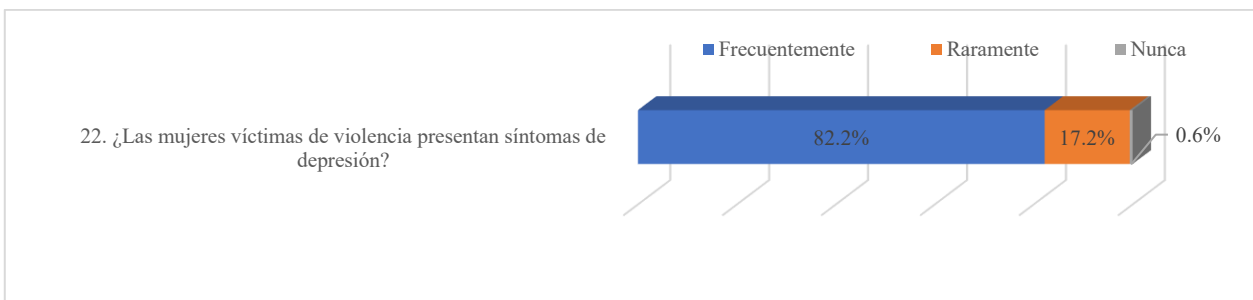


Figure 6: Presence of depression in women victims of violence.

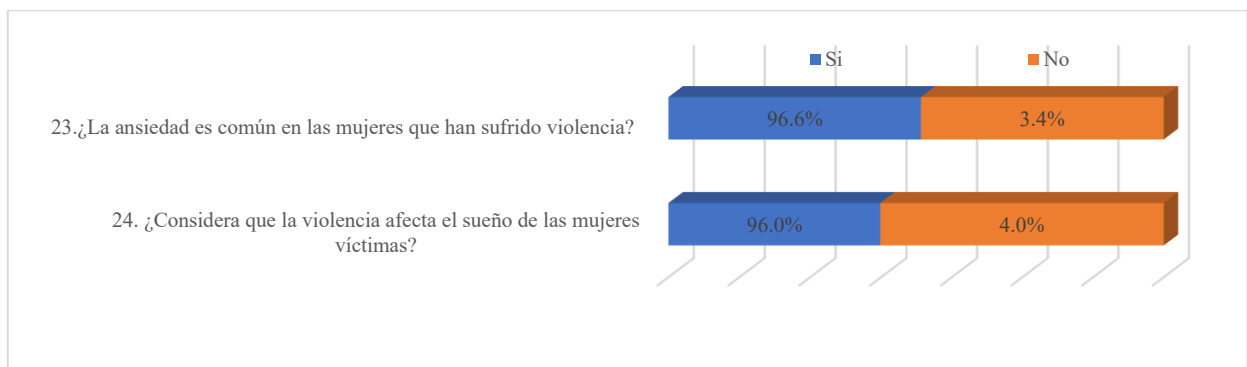


Figure 7: Presence of anxiety and insomnia in women victims of violence (page 21).

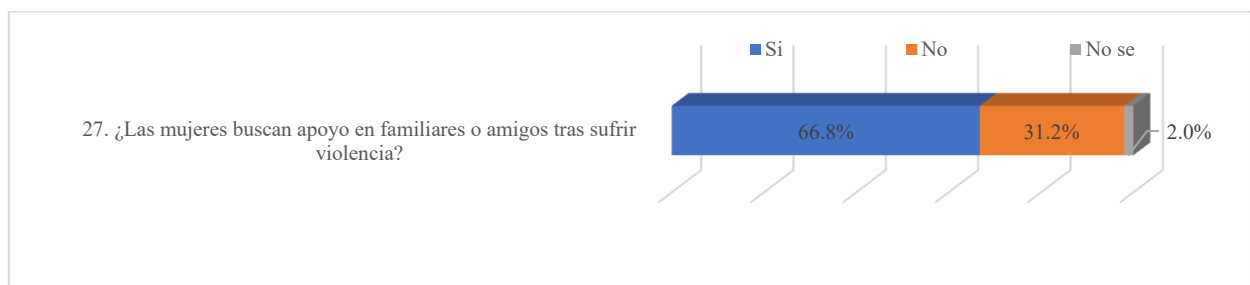
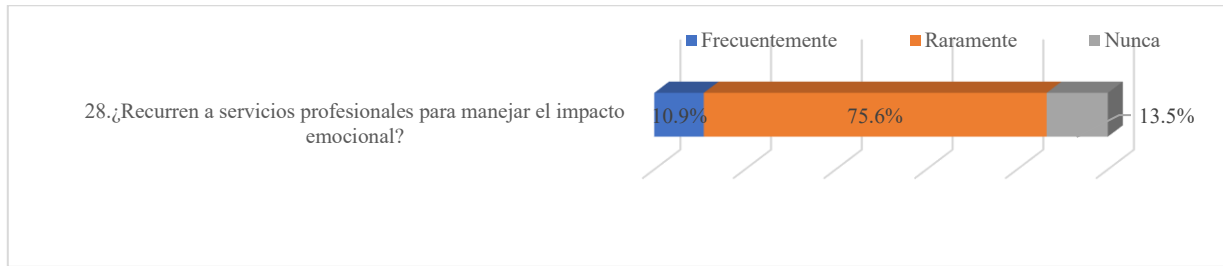
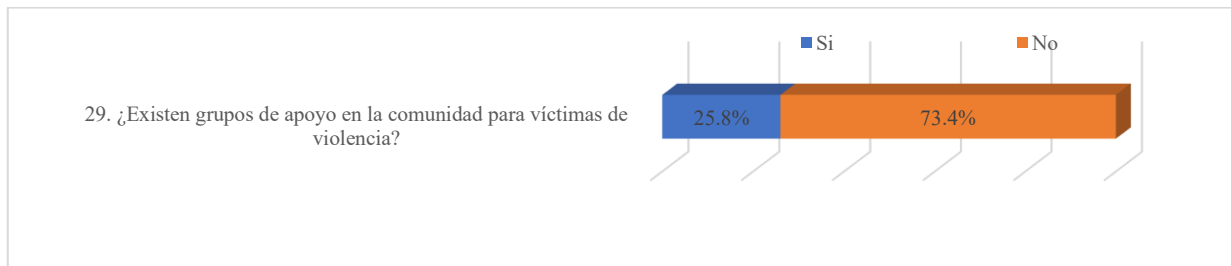


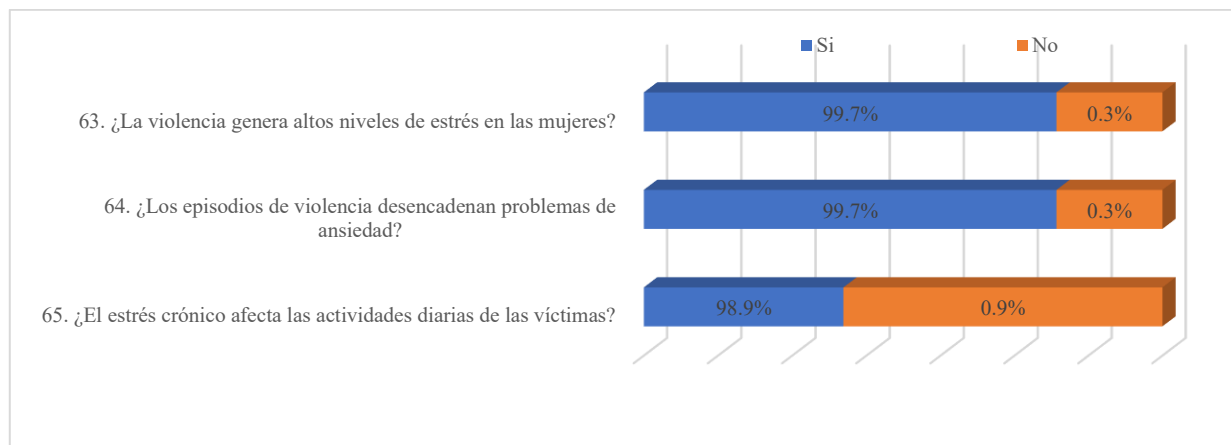
Figure 8: Emotional support networks for women victims of violence (page 23).



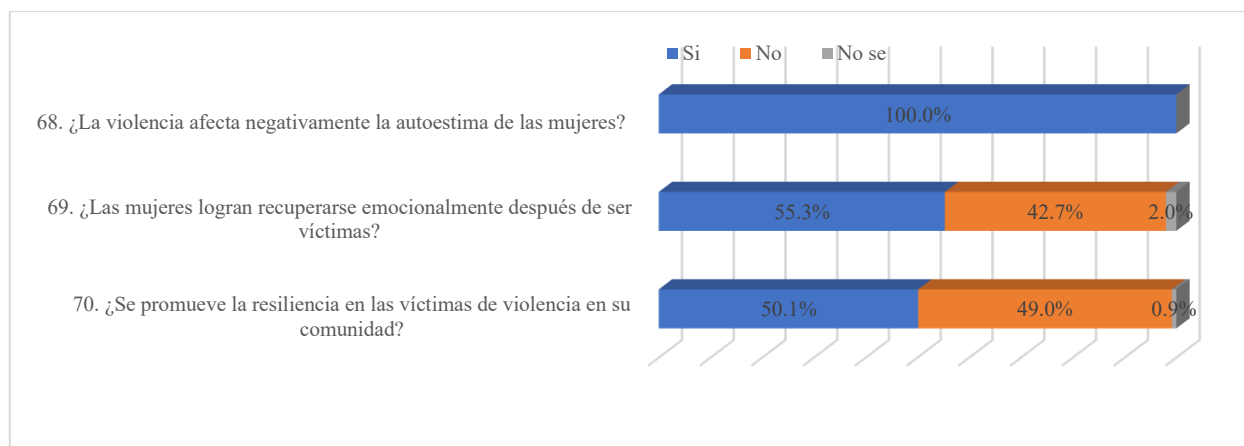
**Figure 9: Using Professional Services to Manage Emotional Impact (page 23).**



**Figure 10: Availability of community support groups for victims of violence (page 23).**



**Figure 11: Stress, anxiety and daily dysfunction in women victims of violence (page 24).**



**Figure 12: Self-esteem, recovery and resilience in women victims of violence (page 25).**