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Studying Domestic Violence in Chiapas, Mexico

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Conjugal violence is common in the Border Region of Chiapas, Mexico, with serious repercussions for women's health and well-being. To understand local perceptions of and responses to violence, the authors conducted focused, open-ended ethnographic interviews with 40 nonindigenous, economically marginal women of the community. This article describes the data collection, analysis methodology, and findings concerning informants' concepts of the nature of this violence, its antecedent causes and consequences, and the strategies they employ to confront it. Such qualitative methods have advanced the authors' understanding of conjugal violence in this region, which they believe will lead to the development of appropriate interventions to ameliorate it and perhaps will prove useful in other regions sharing similar conditions of poverty, rural dispersion, and profound gender inequity.

We began researching women's concepts and behaviors in reproductive health in the Mexican state of Chiapas in 1993 in the context of a larger research and action reproductive health project. Because the topic of reproductive health is especially sensitive to women in this area, and because understanding of the local cultural orientations to reproductive health issues was quite limited, we chose to employ ethnographic methods in this work. We have applied these methods to study a wide range of issues critical to reproductive health and sexuality, including domestic violence. To date, we have developed a research protocol and completed data collection. Currently, we are conducting descriptive analysis and examining relationships between key variables. In this article, we describe our methodology for exploring conjugal physical and sexual violence. In addition, we present some of our initial findings concerning informants' perceptions regarding

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the nature of this violence, its antecedent causes, its consequences, and the strategies employed to deal with it. It is our hope that this research will not only contribute to academic knowledge but will help to resolve people's problems by means of the application of the results in education, health, political, and other fields.

Chiapas, the southernmost state of Mexico, is an impoverished area in a rapidly modernizing country. Of its approximately 3.2 million people, 44.5% are women in their reproductive years (*Resultados Preliminares*, 1990). The ethnic diversity of the state is striking because 28% of its inhabitants belong to one of nine large indigenous groups. It is a mostly rural population that is largely engaged in agriculture (*Resultados Definitivos*, 1990). Chiapas suffers from the worst levels of health in the nation, with the lowest life expectancy at birth and the highest infant, child, and maternal mortality (Salvatierra, Nazar, Halperin, & Farías, 1995). The health of women as a group is significantly worse than that of men in Chiapas. Although their life expectancy is greater, as it is all over the world, recent research has confirmed what was expected: Health services are less accessible for women, and women who seek care receive a poorer quality of care than men. All of the illnesses surrounding biological reproduction, including sexually transmitted diseases (STDs), complications of pregnancy and delivery, and postpartum illnesses, are widely prevalent and poorly cared for. Deaths from the complications of illegal abortion and from cervical cancer, which both have causes that are easily preventable, are well above the national average (Leñero Otero & Elu, 1993).

Violence, both domestic and sexual, is a common problem in this area (Leñero Otero & Elu, 1993; *Ya no más!*, 1994). It affects reproductive health in a number of critical ways: It frequently results in severe trauma, both physical and mental, and can be lethal to the victim. Pregnant women are especially vulnerable. In addition, such violence is often centered on reproductive issues such as contraception, pregnancy and delivery, sterility, fidelity, and sexuality. Furthermore, this violence and the threat of such provide a powerful substrate that often undermines women's capacity to seek care for themselves and their children (Heise, 1994).

PREVIOUS RESEARCH EFFORTS

As part of the research and action project described previously, our research centers have conducted studies of reproductive health in this area, using standardized questionnaire instruments concerning STDs and a wide range of topics in reproductive health. These studies have often left us with anomalous data (e.g., women here are high users of contraception and have high fertility rates) or an inability to interpret findings (e.g., there is a high prevalence of STDs, but our survey data fail to demonstrate risk factors). We turned to qualitative methods to help explain these supposed paradoxes. These methods enable us to obtain a more complete insight into local cultural concepts and behaviors regarding reproductive health matters. In this effort, we have found ethnographic research to be especially useful because it is well-suited for examining intimate topics such as domestic violence, which is often hidden and only discussed in private, if at all.

We have developed a number of methodological strategies in this work that have helped us to better understand local social representations and cultural definitions and responses to domestic violence operative among this population.

First, we developed a focused, open-ended ethnographic interview that has permitted us to explore local orientations to reproductive health in general and domestic violence more specifically. This has produced a body of text-based data, amenable to analysis strategies, that do not require precoded categories. In this analysis, we have begun to identify categories, themes, and patterns that emerge directly from the data and are not restricted to the preexisting constructs of the researchers.

DESIGN AND IMPLEMENTATION OF THE STUDY

Consultants studying ethnographic methodology, gender, sexuality, and the status of women in rural Mexico assisted us in conceptualizing all phases of the project: the elaboration of a theoretical framework, creation and revision of instruments, data collection, and subsequent analysis. We conducted weekly meetings over the course of 6 months with four focus groups, each consisting of 10 to 15 low socioeconomic status women from a periurban community in the area. We also conducted one-on-one informal conversations with group members. We found that whereas women spoke openly regarding pregnancy, birth, and child rearing in the group setting, they were very hesitant to discuss questions regarding their body, sexuality, and marital relations, reserving discussions of their personal experiences with these topics for more private conversations. We, therefore, decided to conduct individual, focused ethnographic interviews with a sample of women to better understand their perspectives and experiences in these matters.

In the group sessions, it also became clear to us that violence is a critical issue in the lives of these women and, as we anticipated, is closely related and intertwined with various other facets of their reproductive health. Incorporating information from the group discussions and other prior experiences, we created an interview guide, using a semistructured format, designed to cover in depth a wide range of topics. In constructing the interview guide, we strove to suspend as much as possible our own preconceptions about the topics we wished to explore and to develop questions that were as neutral as possible to explore the local construction of these concepts. The interview guide covered 14 general topics: health and illness, family structure and relations, reproductive history, menstruation, adolescence, contraception, conjugality, virginity, violence, alcohol, body concepts, sexuality, self-identity, and STDs.

With this preliminary guide, we conducted four pilot interviews with women in the region. Based on this piloting, we modified the guide to better elicit open responses. After piloting this revised guide, it was finalized into a form that was then used, unchanged, for the rest of the interviews.

THE INTERVIEW GUIDE

This interview guide contains a number of innovative techniques that we have found very productive in increasing the ease with which informants discuss private themes. In the focus groups, we had found that women preferred to comment on the experiences of other women or other people. Therefore, we developed questions

that broached sensitive topics by first raising them in general or abstract terms or by referring to hypothetical characters in concrete situations.

One technique was to ask the informant to describe various phases of her life and then ask her to evaluate each situation. We asked, for example, "Could you tell me what your family was like before you got married?" followed by, "When you lived with them, what were your relationships like?" In answering these questions, the respondents often raised topics such as domestic violence, alcoholism, or abandonment, which might not have emerged with a more direct questioning method.

Another fruitful tactic was to ask the informants to describe ideal types of individuals. For example, we asked, "What is a good husband like?" "What is a bad husband like?" "What is a good mother like?" and "What is a bad mother like?" We found that in the course of answering these questions, people told us much, not only about the local moral value system but about their own experiences, often commenting on how the people in their lives compared to these ideal types.

In addition, we also used hypothetical narratives to enter sensitive topics and found this technique particularly useful in exploring the domain of domestic violence. We developed a narrative about a couple that was involved in conjugal and sexual violence. We read it in parts to the informants, asking for their reactions and interpretations to the evolving story.

During the focus group and pilot interviews, we had observed a close relationship between alcohol, violence, and sexual relations in the discourse of these women. Although these relationships have been observed and documented worldwide (Frieze & Browne, 1989; Gelles, 1974; Kantor & Straus, 1989; Leonard, 1985), little investigation has been done on the topic in Chiapas. The narrative we developed focused on this topic and included probes of perceptions regarding these relationships. Some sample passages from the narrative follow.

> At the wedding of Laura and Joaquín, there were music, food, and wine. Joaquín drank a lot, as he often did. That night, Laura did not bleed. Joaquín got very angry and hit her while she swore again and again that she had never had sexual relations with any other man, that this was her first time, and that she had only done it with him.
>
> Why should Laura bleed?
> What do you think happened to this couple?
> What do people here think about men who get drunk a lot?
> What do people here think about men who hit their wives?
> What do women like Laura do when they are hit?

When the respondent had finished responding to this, we continued the narrative.

> Frequently, Joaquín drank liquor, and when he got home, he made Laura have sex with him. If she did not want to, he hit her.
>
> What can happen to a woman who is forced to have sex?
> What can happen to her physically? Emotionally?
> What rights does the woman have in this situation?

INFORMANTS

Once we finalized the guide, we interviewed 40 women. This sample size allowed us to include certain important variables, such as geographic distribution and distribution of age and parity, while limiting the sample to that which we could manage given our financial and human resources for the study. In addition, in anticipation of the combination of our qualitative data with data from the concurrent quantitative study of reproductive health being conducted by our centers, we chose at least one woman from each of the communities surveyed in the quantitative study.

We chose a convenience sample of 40 women from 11 municipalities in the Border Region[1] of Chiapas. The women ranged in age from 19 to 62, with a median age of 32 years. Of the women, 82% were either married or living with their partner; the remaining 18% of the women were either separated or widowed (i.e., all 40 had been or were in union). All of the women had at least one child and some had as many as 12 (the average number of children was 4.6). Just 22% of the women had finished secondary school, 33% had finished primary school but not secondary school, and 45% had not finished primary school. Of the 40 informants, 18% lived in communities of fewer than 10,000 inhabitants. The 40 informants covered a wide range of circumstances, although almost all of the women were quite marginal economically. Subjects were all *mestizos*; indigenous women were excluded from this study.[2]

To contact potential informants, the interviewers, after arriving in a selected community, knocked on doors and entered shops, communicating their intentions. Interviewers identified final participants based on their willingness to participate, accessibility, and ability to express themselves. They only interviewed women who were currently or had previously been in a couples relationship and had at least one child. The majority of the interviews took place in the homes of the informants, and they were all tape-recorded with each informant's consent. Because this was a mostly illiterate population, informed consent was obtained verbally. The interviewer read a paragraph to each informant that explained the purpose of the study and the kinds of questions to be asked, assuring the anonymity of responses, assuring that there would be no effect on the informant's health care, and stating that her participation in the study was purely voluntary and could be terminated whenever she chose. The interviews ranged from 1 to 4 hours in duration and produced more than 4,000 pages of transcribed text.

Interviews were conducted by four mestizo women between the ages of 25 and 35 years. They had various professional training (two were professional nurses, one was a doctor, and another was a psychologist) and had prior experience in health development work and research in the region. In preparation for conducting interviews, all were trained in the areas of reproductive health, gender relations, and ethnographic methodology. The interviewers made great efforts to assure privacy, allowing each informant to select the time and place most convenient for the interview, explaining the confidential nature of the interview and resultant data, and emphasizing the importance of being alone during the interview. Many of the women interviewed employed additional strategies to ensure privacy, such as sending their children to play elsewhere and taking brief pauses when interrupted

by other people. Overall, 14 of the 40 interviews were conducted in the presence of another adult or child, aside from the interviewer and the informant. (Various women nursed, held, and tended to their infants during the interview.[3])

PRELIMINARY FINDINGS

Of the women interviewed, 33 lived in semiurban areas, and 7 lived in small rural communities. More than half were practicing Catholics and a quarter were members of one or another fundamentalist Protestant group. Their houses ranged from two-room huts of wooden plank walls, corrugated aluminum roofs, and dirt floors, to larger, more sturdy cement block and brick structures. Almost all had radios and half had televisions that they used both for entertainment and for keeping up with national news. Although all of our informants had piped water and electricity, many who resided in rural settings lived without proper drainage and cooked with wood, rather than gas, stoves. Devices such as washing machines, dryers, dishwashers, electric stoves, and microwave ovens were rare in this population.

There was a sex-based division of labor in which women were responsible for household chores, child care, procuring food, and preparing meals. Men, for the most part, were the authority figures in the household. The majority of our informants married in their late teens and soon started having children. In these communities, children represented the riches of the matrimony, and families with four or more children were the norm. Most of these women lived in close proximity to extended families, often living with their in-laws at the start of their marriage and continuing to live nearby after establishing their own households.

Although our informants structured their daily activities primarily around household and child care tasks, half of the women earned some kind of income as well. Nine of the 40 women prepared food for sale outside of the home. The rest of the women earned some money at home by growing vegetables, washing clothes, raising poultry, sewing, or selling basic household items (i.e., soap, sugar, matches, etc.) out of home-based shops. Four of our informants held professional positions (nurse, psychologist, radio announcer, and kindergarten assistant) but were not exempt from their roles as mothers and housewives.

Nearly all of our informants reported that they suffered from fatigue and stress as well as physical, reproductive health-related problems. Most sought modern health care as well as employed home remedies and visited traditional curers (*curanderos* and *hueseros*) and midwives.

The interview guide's format and the open-ended nature of the questions allowed the informants to speak at length and include spontaneous remarks. Domestic violence emerged as an important topic for these women, often being mentioned spontaneously prior to the introduction of the topic by the interviewer. For example, when asked, "When you lived with your parents and siblings, how did everyone get along?" several women revealed violent relationships between their parents. Questioned similarly about their own family, informants discussed physical violence between themselves and their spouses. Some women discussed violent episodes relating to pregnancies, births, and postpartum behavior. When asked to define good and bad husbands and wives, the informants often incorporated the presence and absence of violence in their definitions.

In the following discussion, we have chosen to limit our focus to physical and sexual violence perpetrated by adult males on their adult female partners. We wish to note, however, that other kinds of violence were discussed in the interviews: violence between parent and child, quarrels between siblings, other family fights, and violence outside of the home. For the purposes of this discussion, we include only events in which men have made harmful physical contact or threaten to make harmful physical contact with their women partners. Forced sexual relations are included, but sexual relations characterized by lack of pleasure are not. Many other types of violence emerged in the interviews, including emotional, psychological, verbal, and financial or economic (Ferreira, 1992). Our focus on physical and sexual violence is arbitrary, for the purposes of this article, and should not be taken to indicate that this fully represents the ways that domestic violence exists and is perceived among this population.

One hundred and fifteen separate events relating to conjugal physical and sexual violence were mentioned by the 40 women we interviewed. Of these events, 35% were mentioned spontaneously.[4] Much of the information was obtained in response to the violence narrative described previously and to questions directly related to violence. Of the events, 15% were personally experienced by the women; 11% were perceptions regarding events that the informants observed in other people, such as parents, other relatives, and friends; 74% referred to the hypothetical characters presented in the interview guide or to people or women in general. Of the 40 women, 12 voluntarily reported that they themselves had experienced conjugal physical and/or sexual violence.

DATA ANALYSIS

We conducted the data analysis in two phases: an initial descriptive phase and, based on this, a second interpretive phase. The descriptive phase consisted primarily of data reduction and data display tasks. This included creating a database of demographic variables, producing a brief summary of each case, and generating a series of tables for displaying data. The interpretive phase consists of searching for and substantiating patterns among the descriptive data through systematic comparison of the variables. The last phase consisted of the proposal of hypotheses related to the study objectives. At present, we have finished the descriptive analysis and have begun the interpretive phase. Here, we give some examples of the techniques that we have developed in this endeavor as well as some of our preliminary findings.

DESCRIPTIVE ANALYSIS

To begin the descriptive analysis, we developed a master list of central topics, including the 14 previously mentioned categories from the guide and other categories we expected to be important, such as social support network and economic situation. We also included topics and concepts that came directly from the informants, for example, the concept of what is normal. We then marked these categories and themes in all of the transcriptions while simultaneously creating page indexes,

TABLE 1: Typology of Characteristics of 115 Events of Conjugal Physical and Sexual Violence

Characteristics	*Number of Events Cited (N = 115)*	*Percentage*
Victim		
Hypothetical victim	87	75
Informant	14	12
Informant's mother	9	8
Informant's sister	2	2
Friend or neighbor	2	2
Informant's daughter	1	1
Perpetrator		
Husband or common-law husband of victim	113	98
Ex-husband or ex-common-law husband of victim	2	2
Nature of violence		
Hit, kick, and so forth	74	64
Forced sex	35	31
Threaten to hit, kick, and so forth	6	5

a general description of each informant, and concise, organized thematic summaries. These summaries, which reduced approximately 4,000 pages of text to some 400, permit a rapid review of specific themes for all 40 cases and, through the inclusion of transcript page numbers for all entries, allow a return to the transcriptions for more detail as needed.

Our initial analysis regarding conjugal physical and sexual violence resulted in a typology of the kinds of comments informants made. We classified statements into four broad types: (a) characteristics of the event, (b) causes, (c) consequences, and (d) strategies. We created a table consisting of all the information provided in these four categories for each of the 115 events mentioned. Tabulated results of this typology appear in Tables 1, 2, 3, and 4.

The characteristics of the event refer to who the victim is and who the perpetrator is, as well as the nature of the violence. We were able to identify the characteristics of all 115 events. The tabulated results regarding characteristics appear in Table 1. As mentioned earlier, the victims include the informants; the informants' mothers, sisters, daughters, neighbors, and friends; and hypothetical victims (i.e., the characters presented in the narratives and/or wives in general). The perpetrator in the cases presented here is either the victim's (ex)husband or (ex)common-law husband. Two separated/divorced women spoke about the violence they suffered at the hands of their ex-spouse. When describing events of a physical and sexual nature and the immediate threat of such violence, informants mentioned punching, kicking, pulling hair, shouting threats, and forcing sexual relations. A 31-year-old married mother of three mentioned the following situation, "I have seen a marriage in which the husband arrives good and drunk to hit her, pull her hair, and even throw her out of the house—he kicks her." Another woman, age 30, married with five children, revealed, "My husband comes home to do ugly things, scold, and kick everything around."

In describing what they saw as the causes of conjugal physical and sexual violence, informants spoke of the origin of violent behavior in general as well as what incited each specific violent event. Informants often identified multiple

TABLE 2: Typology of Causes Named for 64 Events of Conjugal Physical and Sexual Violence

Causes	*Number of Events in Which Each Cause Was Cited (N = 90)*	*Percentage*
Alcohol	29	32
Woman commits transgression/offense	29	32
Machismo (natural male behavior)	19	21
Social pressure	5	6
Jealousy	4	5
Lack of understanding within the relationship	3	3
Irresponsibility	1	1

NOTE: Because more than one cause was often mentioned for a single event, the sum of the numbers listed (90) exceeds the total number of events in which causes were identified (64).

TABLE 3: Typology of Consequences Named for 55 Events of Conjugal Physical and Sexual Violence for the Victim

Consequences for Victim	*Number of Events in Which Consequences Cited (N = 103)*	*Percentage*
Anger	11	11
Bothered and/or not at ease	11	11
Sickness and/or infection[a]	11	11
Bruises and/or lesions[a]	10	10
Suffering	7	7
Repulsion and/or hate toward aggressor	7	7
Unwanted pregnancy[a]	6	6
Lack of sexual satisfaction	6	6
Sadness	5	5
Fear	4	4
Mental harm and/or trauma	4	4
Sexually transmitted disease[a]	3	3
Nervousness and/or anxiety	3	3
Disappointment	3	3
Worry	3	3
Tumor/cancer[a]	2	2
Death[a]	2	2
Despair or frustration	2	2
Regret committing transgression	2	2
Regret for having married	1	1

NOTE: Because more than one consequence was often mentioned for a single event, the sum of the numbers listed (103) exceeds the total number of events in which consequences were identified (55).
a. Denotes physical consequences.

causes, and clearly, many of the causes mentioned were interrelated. The tabulated results regarding the causes named appear in Table 2.

It is striking that quite often the women cited the victim's offenses or transgressions of gender roles and expectations as a cause of violence. In the communities in which these women live, there was generally a strict definition of gender roles, in which the man was the dominant decision maker and the woman's role was to fulfill her husband's and children's practical necessities within the home (Lagarde, 1992; Riquer Fernández, 1995). For example, a 38-year-old married mother of four

TABLE 4: Typology of Strategies for Victims Named for 63 Events of Conjugal Physical and Sexual Violence

Strategies for Victim	*Number of Events in Which Strategy Was Cited* (N = 96)	*Percentage*
Leave the perpetrator	35	37
Endure	31	32
Resist or defend oneself	30	31

NOTE: Because more than one strategy was often mentioned for a single event, the sum of the numbers listed (96) exceeds the total number of events in which consequences were identified (63).

explained, "If they [the women] have committed some offense, they [the husbands] have a right to hit them because the food isn't ready, or he came home from work and the fire is not ready." A 61-year-old married mother related another example of an offense as she described giving birth to one of her 14 children, "The midwife got the baby girl out, but it was already dead. So my husband said, 'You killed the baby!' Then he began to hit me." Other transgressions include suspected infidelity and disobedience on the part of the woman.

Another frequently cited cause of conjugal physical and sexual violence is alcohol consumption by the perpetrator immediately prior to a violent event, as one 35-year-old mother of four living with her common-law husband explained. "I didn't live for very long with my other husband because we could not live well together. He drank and came home to hit me." Alcohol, informants often noted, causes men to feel superior and to display that superiority via physical violence.

A closely related cause our informants ascribed to violent behavior is machismo, which implies that for these women, men were violent simply because they were men. This idea of aggressive male behavior was accepted by many informants as natural and normal. A 20-year-old mother of two children who was living in a common-law marriage explained that men used violence "to ensure that things get done their way." A 27-year-old married mother of four told us that "men like to hit."

Informants also mentioned that pressure from other people could incite a violent situation. A 34-year-old married mother of four, speaking of her own experience, declared, "The man has a lover who tells him, 'leave your wife,' or 'go on and hit her so that she leaves you and you can marry me.' "

According to the informants, jealousy on the part of the aggressor, too, could provoke violent behavior. One 31-year-old victim living with her boyfriend and her three children described jealousy as a widespread illness. "Some men are jerks. They hit women. More than anything there is a lot of jealousy. Jealousy is a sickness. Maybe about 15% here are jealous."

Speaking about the consequences of physical and sexual conjugal violence, the informants often identified multiple effects on the victim. The tabulated results regarding these consequences appear in Table 3.

The informants, discussing the psychological consequences of conjugal physical and sexual violence, most frequently mentioned that victims may feel angry and bothered, may suffer, and may experience repulsion toward their aggressor. Other psychological consequences cited include sadness, fear, mental harm or trauma, nervousness or anxiety, disappointment, worry, despair, and regret.

More commonly, informants mentioned the physical consequences of violence (see Table 3) such as illness and infections, bruises, and lesions. For example, a

31-year-old mother of four living with her common-law husband commented that victims "go around without teeth, their arms are all black and blue." Other women specifically mentioned tumors and cancer. A few pointed out that the violent event itself or its consequences could result in the death of the victim. Another informant, a 31-year-old married mother of three, described the effect of the violence on a neighbor. "Doctors determined that she had been hit in her lower stomach. Where she was hit turned into cancer and the woman died." In addition, informants noted the direct negative effects of violence on women's reproductive health because it might cause unwanted pregnancies as well as STDs.

Many informants mentioned multiple consequences, identifying both short- and long-term effects and both physical and psychological effects. The following quotations exemplify the range of consequences, including the direct effects on reproductive health often presented in single interviews.

One woman, a 28-year-old married mother of three, told us,

> It's a trauma that's very difficult to overcome, because I know someone whose husband was a disaster. He would come home drunk and all and he'd hit her and who knows what else. Now the man doesn't drink anymore, but the woman is still in bad shape, traumatized. A man like that doesn't think about what he's doing, and he can cause problems in the woman's womb.

A 24-year-old separated mother of one stated,

> A woman obliged to have sexual relations will never be sexually satisfied. She will always be used as an object. The woman won't feel loved, and that will be something frustrating for her. She may get sick, become pregnant, and above all be physically abused. It depends on how much he hits her, that's what it depends on. But, if she is hit, she will be harmed, not so much physically, but mentally.

The strategies that informants discussed for responding to this conjugal physical and sexual violence fall roughly into three categories: leave the aggressor, endure, or defend oneself. Informants often mentioned multiple strategies. The tabulated results regarding these strategies appear in Table 4.

In these communities, marriage and family were virtually the only options for adult women. They were usually completely financially dependent on their spouse and highly dependent on familial and community acceptance for their overall well-being. There was no place—not physically or in theory—for single or separated women (Lagarde, 1992). Even so, many women cited leaving their mate as a possible strategy, although few have actually done this. Illustrating this option, a 31-year-old living with her common-law husband (father of her four children) noted generational differences in the use of this strategy.

> Before, the woman put up with it and always did what the man told her to. Now the women have to make their decision. Sometimes they get divorces. Another may return home[5] and tell her mother why, and sometimes the mother or the family helps her and they talk to the man, and sometimes he swears that he's not going to do it anymore, no. But when the man continues, the woman returns home.

This example also identifies various factors affecting the choice regarding whether to leave: age or generation, the woman's support network, and the actions

of the aggressor. Whether the victim has children may also influence her decision, as mentioned by a 25-year-old wife and mother of two. "Sometimes they abandon their children; they leave them with the husband because they are unable to support them. Other women don't leave their husbands if they have children."

As women here were encouraged to maintain their family intact at all costs, it was not surprising that most of our informants mentioned enduring (i.e., putting up with the situation) as a strategy for responding to violence. For example, a 38-year-old married mother of four maintained, "If there is an offense, the woman should stay home and wait for the husband and do whatever he wants." Another woman, a 35-year-old widow and mother of three, explained, "When one loves the husband, even if he's giving it to her, she puts up with it [the violence]." Marital status, a 31-year-old common-law wife and mother of four told us, could be an important factor as well. "Some just have to be strong because they are already married; they cannot return home, they just have to be strong and put up with it." Another, a 27-year-old wife with five children, suggested that the victim should simply succumb to her husband's wishes, "They hit us because we're at fault; we should obey."

The third strategy, that of defending oneself or resisting the violence, took on a variety of forms, ranging from victims who run and hide from the aggressor to those who, as a 31-year-old married mother of three told us, "both hit each other, but the man usually dominates because he is stronger." As mentioned earlier, the extended family network was very strong among these women, and seeking the help of parents and other family members was a common strategy as well. Rarely, women sought legal intervention, as described by a 21-year-old separated mother of two. "After the third time that they hit them, they [the women] go to the municipal agent so that they arrest and jail the man; they advise him not to hit her anymore, and they let him go free."

Possible determinants of the selection of a strategy were mentioned in 26 events and included the woman's idea of the cause of the violence, the love she felt for the perpetrator, the presence of children, her economic security, her marital status, and her support network.

INTERPRETIVE ANALYSIS

We have recently begun the interpretive analysis phase of the project. Currently, we are seeking to understand the relationships between these four categories (characteristics, causes, consequences, and strategies) as well as between these categories and other variables. We are evaluating the relationships between the causes reported for violence and the strategies mentioned. We are also examining other variables that may affect the coping strategies, such as the woman's position of financial dependence or independence and the type of social/family support network in which she finds herself.

In this phase of our analysis, we are attempting to identify patterns between different themes by further classifying the descriptive data and generating new, more abstracted data displays that compare patterns within and between cases. We have begun to examine thematic relationships through the following steps: the

TABLE 5: Master Table of Key Variables

Interview/Event	*Cause*	*Strategy*	*Marital Status*	*Age*
M-13/2	Alcohol	Leave aggressor	Common-law marriage	31
P-08/2	Transgression/offense	Endure	Married	27
M-01/1	Machismo	Defend self	Married	61

TABLE 6: Causes and Strategies Dichotomized

	Strategies	
	No Overt Resistant Action	*Overt Resistant Action*
Causes		
Victim as part of cause	10 events (23%)	7 events (16%)
Victim not part of cause	11 events (26%)	15 events (35%)

identification of possible patterns, the reduction of key variables into tables, and the analysis of these tables to examine trends.

The following is an example of our methodology for interpretive analysis. First, based on patterns we noticed in reviewing texts in the first phase of analysis, we identify a possible relationship between variables: Women name strategies to resist violence based on their perception of the causes of a violent event. Next, we make a new table, juxtaposing key variables related to the pattern (see Table 5) as well as relevant demographic variables.

Then, we review the completed table, examining how the variables group together. Reading down columns, we may see a way to dichotomize themes. In this example, we have dichotomized causes into a woman's own behavior versus an external cause and strategies into overt resistant action versus no overt resistant action.[6] Our initial work with these themes indicates that variables seem to group in a certain way: Women who cite the victim's own behavior as a cause tend to name enduring as a strategy, whereas those who consider the cause to be outside of the victim's behavior tend to name resisting or leaving the aggressor as a strategy.

To further probe the relationship between these two sets of themes, we collapsed these variables into their dichotomized categories and displayed them in a cross-tabulation table (see Table 6). Forty-three total events regarding conjugal physical and/or sexual violence in which informants mentioned both causes and strategies were cited.

We then examine the distribution of cases by cells. Table 6 indicates a positive relation in the expected direction: Informants who do not perceive the victim as part of the cause tend to suggest strategies of overt resistant action.

This example from our preliminary interpretive analysis illustrates how we create variables based on text content, assign codes to informants' responses, and then look for correlations between these variables. Such testing of emerging patterns is not the central goal of the research but an additional aspect to supplement text analysis and assist us in identifying existent trends and patterns in the data. We are in the process of examining this pattern as well as others emerging from the data

on causes, consequences, strategies, and additional variables (e.g., support network, economic situation, age, etc.). We continue to explore the differences between personal and hypothetical experiences.

CONCLUSIONS

In this effort to understand local cultural concepts and behaviors regarding the sensitive topic of reproductive health, and particularly domestic violence, we have found the systematic application and analysis of ethnographic interviews to be an extremely useful technique. We found that for this group, the use of hypothetical and third-person interview tactics were very fruitful in opening up discussion of hidden and private topics.

Although we are only beginning our analysis, we have already noted a number of unexpected and important aspects of how women in this area conceptualize and respond to domestic violence. For example, we have seen that women commonly blame the victims for the occurrence of violence because it is assumed that the woman is being punished for some transgression of her assigned role. We have seen that many women feel that they must simply endure the abuses and that that legal recourse is seldom sought, perhaps because when it is, the support of the authorities is not clearly forthcoming. We have also noted an apparent connection between what is thought to be the cause of the violence and the kind of strategic response pursued. This offers a promising potential for opening unexplored relationships to understand this phenomenon. We anticipate that this process will lead us to generate hypotheses based on the observed patterns, which can then be tested in a larger population and may be used as a basis for developing interventions and further other study objectives.

The use of qualitative methods has rapidly advanced our understanding of reproductive health issues in the Border Region of Chiapas, and perhaps it will prove useful in other parts of the world that share similar conditions of poverty, rural dispersion, and profound gender inequity. We believe that a better understanding of variations in local cultural concepts and responses will lead to the development of appropriate interventions to ameliorate domestic and sexual violence.

NOTES

1. This region, which includes some of the conflict zone proper, is contiguous with Guatemala, although it is not the part of the border with the largest migrant population.

2. Piloting of the study within indigenous communities proved our instruments to be inappropriate, not only due to the difficulty of translating into Tojolabal and Tzeltal (the two Mayan languages spoken in the region), but also because the Mayan *cosmovisions* provide very different models of health and well-being than that of the mestizo population (or *ladino* population as it is called here). The indigenous population represents approximately 13% of the population of the region, and the proportion of monolingual, non–Spanish speaking women is much higher than that of men. A study specific to this Mayan population began in July 1995.

3. It seems that the presence of noninfant children and/or adults during the interview did not seriously inhibit discussion of violence—7 of the 14 women interviewed in the presence of noninfant children and/or adults mentioned physical and sexual violence spontaneously, 11 of the 14 responded to the interview questions on violence, and 2 of the 14 even discussed their own personal experiences as victims of such violence.

4. We report percentages to give the reader an idea of how each phenomenon is distributed among our study group. Citing percentages is not meant to imply any attempt to make generalizations to a broader population or to suggest causality.

5. Most women in this area live with their parents until forming a couple relationship, at which point the majority then move in with their partner's family until the couple is able to establish their own home (a process often lasting years). Throughout this time, the women still consider their parents' residence as home so that going home means returning to their parents' house.

6. We classified mention of transgression, offense, or fault as indicating that the informant feels the victim is part of the cause. On the other hand, we classified alcohol consumption, jealousy, machismo, social pressure, and irresponsibility as indicators that the informant does not perceive the victim as part of the cause. In terms of strategies, we grouped strategies of defending oneself, resistance, and leaving the aggressor as overt resistant action, whereas those who endure violence were classified as no overt resistant action.

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