Urbanities, Vol. 2 · No 1 · May 2012

The Power of the Field - Reflections on Field Work Improvisations[1]

Mahima Nayar
(Jawaharlal Nehru University, New Delhi)
mahimanayar@gmail.com

Women's mental health has been addressed from a variety of perspectives. The social and historical context in which they are viewed determines women's mental health. Violence, poverty and a life in lower urban socio-economic neighbourhoods have often been related to high levels of distress. This article presents the dilemmas faced by a researcher trained to study mental health largely from a biomedical perspective in carrying out research in a low income neighbourhood in the Jahangirpuri area, north-west of Delhi. It aims at exploring women's mental health issues in the context of their environment; an urban environment characterized by congestion of space, few civic amenities, poor sanitation and poverty. The article discusses my initial assumptions and the subsequent changes in my empirical strategies that were stimulated by the nature of the field. I emphasize the need for reflexivity in order to produce as real a picture of the empirical situation as possible.
Keywords: Mental Health, Dilemmas, Feminist Standpoint, Reflexivity

Introduction

Since statistics were first recorded in the early 19th century, women have outnumbered men in the population treated for mental health problems (Showalter 1987). According to data both from community surveys and hospital statistics, women are two-to-four times more likely to be identified as having neurotic (anxiety, depression and phobias) and depressive disorders. These statistics have been explained in different ways from various viewpoints. Physiological theories stress the role of female hormones in influencing certain neurotransmitter systems that are involved in psychiatric disorders (Sleye 1974). In contrast to the realist biomedical viewpoint, many feminists have adopted a social constructionist standpoint, arguing that psychiatric diagnoses are gendered practices that pathologize femininity (Chesler 1972; Stoppard 2000; Ussher 1991). Gender role stereotypes used by medical practitioners (see Sherman 1980) and gender bias in psychometric instruments that categorize normative aspects of feminine behaviour (such as crying or loss of interest in sex) as 'symptoms' (Salokangas et al. 2002) have been deemed to result in medical practitioners' diagnosing depression in women at higher rates than in

[1] I would like to thank Nilika Mehrotra for guiding me in shaping this article and the anonymous reviewers and the editors for their comments, which helped in developing my discussion.

men (Potts et al. 1991). Mainstream psychological approaches to mental disorders have also viewed mental illness from the biomedical perspective. These approaches usually take into account somatic and psychological factors in their diagnostic efforts, overlooking the impact of sociocultural factors. No research has been produced in India that specifically addresses the question of depression in women (and men) belonging to lower socio-economic classes. There is some evidence of psychiatric morbidity being high in the most deprived sections of society and among unclassified sections of the workforce, such has beggars, prostitutes and domestic maids (Davar 1995) and among low-income, slum dwelling and uneducated women (Blue et al 2001). A review of the existing literature indicates gaps in our knowledge about the actual experiences of women facing mental health problems and the manner in which macro forces influence their lives.

The study on which this discussion is based was conceptualized as a way to fill these gaps. Methodologically, I should note that in this kind of study the necessarily close relationships between researcher and informant increase the risk of exploitation. Here, I focus on the 'dilemmas' of feminist fieldwork bearing in mind that my multi-disciplinary training impacted on the field strategies that I adopted for data collection. I shall discus how certain strategies led to imbalances in power and were eventually ineffective and how dilemmas in the field led me to modify these strategies and to search for ways to address such dilemmas. I shall therefore offer a discussion of the influence of the field as instrumental in the selection of theory and 'methods'.

The Area of Study

The genesis of my research lies in my training as a psychiatric social worker in a hospital in Bangalore. As in the hospital set-up the psychiatrist was the designated team leader, our training had a decidedly biomedical orientation. In the hospital wards, the interaction was mainly with women who were suffering from severe mental disorders because space and monetary constraints made it so that only women who were very unwell or could afford hospital stay were admitted.[2] Many who suffered from common mental disorders were seen on outpatient basis; their visits to

[2] By severe mental disorders, I mean psychotic disorders which cause profound disability and need a multi-pronged approach, including medication and rehabilitation; they include schizophrenia and bipolar disorder and usually produce a marked change in behaviour.

the hospital were irregular and they were on medication for a long time. Very often these women reported no substantial benefit from such medication; most important, in the course of their out-patient visits, they described several difficulties in their family life, spanning from issues related to poverty, health, violence and so on. There was, among the staff, discomfort with the low priority given in the hospital to women's everyday lives and with the fact that we were able to provide only superficial care, without being able to address the root of the problem.

As poverty and lack of resources were recurring themes in women's accounts, the need arose to explore women's mental health issues in the context of their environment. A growing body of epidemiological evidence demonstrates the role of social determinants, such as poverty and gender disadvantage, as a major contributors to depression (Patel and Kleinman 2003; Patel et al. 2006). Theorists have suggested that one explanation for the social gradient in rates of minor psychiatric disorders is that people in lower social positions are confronted with a disproportionate number of chronic stressors and negative life events, and with relatively few material and social resources (Kessler 1994; Pearlin 1989). Feminist scholars support this theory, suggesting that, given their lower position in society, women are particularly at risk of experiencing psychologically morbid conditions (Hall, Johnson and Tsou 1993).

Low-income women report that financial limitations, stress and isolation wear them down emotionally and physically. Arguably, poverty undermines self-confidence, making it more difficult to be healthy and to provide a good environment for children. With limited resources, women must meet their own and their children's needs (nutrition, clothing and so on), and need emotional support from others. Many are trapped in a cycle that opens few avenues; as they struggle to meet minimal living standards, they are left with limited resources for change (Savarese 2005). These considerations led to my interest in studying common mental disorders amongst women in a low-income urban neighbourhood.

I chose to carry out my fieldwork in Jahangirpuri, a resettlement colony situated in north-west Delhi. The selection of the field site was determined by various factors. Jahangirpuri is a heterogeneous community including people belonging to different states of the country. The area where it stands today was originally a marshland, where people from the centre of the city were resettled. It reflects the changes in the macro-economic policies of the country (liberalisation, privatisation) over the decades, which have had an impact on the growth of this area. Finally, the

selection process was influenced by the presence of a community psychiatry programme in the local hospital.

The Field Site

The description of the field site that follows offers a (necessarily partial) picture of Jahangirpuri that hopefully will help the reader to understand, to a certain extent, the interactions that are described in the next section.

Jahangirpuri came into existence due to a restructuring plan of Delhi in 1976 and presents a mixture of slum and refugee resettlement. The colony is marked by congestion of space, few civic amenities, poor sanitation, unauthorized constructions and rampant encroachment of land. There is a mix of permanent housing structures and small, precarious, unstable hutments (*jhuggis).* The slum is divided into eleven blocks. It is largely populated by rural migrants from various states (Gujarat, Uttar Pradesh, Bihar, Haryana, Madhya Pradesh and Rajasthan) who entered various areas of Delhi in search of work. Earlier they lived in unstable hutments elsewhere in the city. Notably these migrants were overwhelmingly poor, generally belonging to deprived sections of society. They were allotted plots in the colony. Over time, however, most sold their plots and returned to building *jhuggis* (unstable hutments) in the colony (Mehrotra 1997: 22).

The total population is approximately 125,100, settled in about 1,061.22 acres.[3] The colony is overcrowded, the population density being high with five to six people often living in one room. Dwellings are small — on average, about 2.5 metres wide and 3 metres long. While there are some small open spaces in the streets, there are few formal community spaces, such as temple courtyards. The population is heterogeneous in terms of ethnicity, caste and religion. Each block consists of people who live together on the basis of ethnic, religion, caste and kinship. The occupational structure is diverse; there are people working for the government, for private establishments, in sales and in production, many are self-employed or run petty businesses. The majority is involved in the informal sector, barely managing to survive. A large number work as

[3] Source –City Development plan, Dept. of urban development , Govt. of Delhi, October 2006

drivers, mechanics, brush makers, factory workers, rickshaw pullers, construction workers, house cleaners and so on. Homemakers too are often engaged in the home-based production of items such as iron-edges and packing material. They are also engaged in activities where contractors give them certain vegetables to separate from the crop for around Rs 25 per day (0.45 $US). In some blocks, the main occupation is rag-picking — men, women and children all are involved in this activity.

The literacy rate in the colony is variable. In certain blocks children go to small schools run by various NGOs, which also help them to enrol in MCD schools. Overpopulation, poverty and illiteracy are factors behind the high crime rate. Gambling and alcoholism are very frequent, leading to violence within the households. In the daytime, groups of men can be seen gambling at most street corners. The problems related to drug addiction are increasing among the adolescent and now even among pre-adolescent boys in certain areas. Although men are considered to be the heads of households; women perform the dual roles of homemakers and breadwinners.

Early Encounters

My entry into the field was facilitated by a non-governmental organization running self–help groups for women in the various blocks. I initially planned to attend the meetings and to identify women who were distressed with the help of the group leaders. These women would then be screened using a standardized questionnaire consisting of around 20 questions; five to seven answers in affirmative would indicate that the respondent required further attention. The women who fell in the distressed category would be subsequently interviewed in detail. This methodology was more in keeping with my psychiatric social work training than with the ethnographic approach that I wanted to adopt.

My initial interactions with the women of the community (ranging in age between 20 and 70 years) were mainly conducted through focus group discussions. On these occasions, the women gave me a picture of the community — its history, norms, values and amenities (past and present), as well as of the ongoing changes. These discussions emphasized the mobility of the population and the fluid nature of the social space. After this brief introduction, I was ready to begin the main phase of data collection and started contacting group leaders about women in their groups who were suffering from mental health problems. I faced resistance from many of the women; in some groups they listened to me but were unwilling to talk or share anything with me.

This was especially true of women who were known as Bengalis from Kolkata (many of whom originated from Bangladesh and some were still going through a liminal phase of adaptation). The women would just turn their faces away from me — a sign that they had no interest in me and were suspicious of my motives. My inquiries about distressed women were usually unsuccessful, as group leaders often denied the existence of any distress. The assumption that people with mental health difficulties would stand out probably was carried from my training as a psychiatric social worker. As a researcher, I was endeavouring to understand the background of the women I was talking to, but I knew that too deep an inquiry into their backgrounds could raise suspicions very easily. Over time, I learnt that asking too many questions led to fewer answers.

When I stopped asking too many questions, the women started talking. They spoke about continuing aches and pains, about the problems related to being single or widowed, about the loss of children and the sadness that followed such loss. At first, their conversations confused me because they appeared contradictory to their group leader's earlier assertion that they were all happy. I realized that there was no contradiction; that it was my assumptions and the way I was asking the questions that was wrong. These communities were open to outsiders at a superficial level, since they were used to NGO workers, funders, government officials and others coming in to ask questions. They had mastered the art of giving exactly the information that they wanted to give and no other. Naples (2003) writes about the reflective practices employed throughout ethnographic investigation and implemented at different levels, ranging from being sensitive to others and to how we interact with informants to a deeper recognition of the power dynamics that infuse the ethnographic encounters.

Such encounters forced me to revise the methods that I was employing and the research templates that I had in mind. Harding (1987) differentiated between 'methods' and 'methodology'. According to her, 'method' stands for the techniques for gathering evidence whereas 'methodology' is to do with the 'theory and analysis of how research should proceed' (1987: 3). I was using a feminist methodology but the methods were not in keeping with this approach. Reflection on these experiences led to a change in my fieldwork strategies. Myerhoff and Ruby (1982) defined reflexivity as the process by which an anthropologist understands how his or her social background influences and shapes his or her beliefs and how this self-awareness pertains to what and how one observes, attributes meanings, and interprets actions and dialogues

with informants. It helps to produce a 'better representation' of the field. It makes both the researcher and key informants aware of the frame and the contents of social life. Thus, for Myerhoff (1979) reflexivity is at the core of grasping the 'broader' meaning of one's life and social action. A reflexive approach implies at once distance and unity and, because of this, it can make one aware of oneself as subject and object of the process that creates the consciousness of each. As ethnographers, we want to learn about our informants; but as reflexive ethnographers we also learn about our own lives through the process of grasping how the lives of others can teach us something on all lives (Prell 1989).

These dilemmas in the field raised further issues about the methodology. How was I to find the appropriate language to communicate with the women there? How was I going to explain psychosocial distress without asking direct questions? How was I going to find the link between cultural, political, economic and social factors and local women's psychosocial distress?

Dorothy Smith's version of the standpoint theory helped me to find answers to some of these questions. Smith (1987) argues that, among other things, the position of women is affected by their socio-historical circumstances. She adds that the category 'women' is not all-embracing, exclusive or fixed; its limits are constantly transcended, as each woman brings a unique perspective (Smith 1987). Smith's points out that it is at the micro-level, at the level of individual everyday practices that the collective, hierarchical patterns of social structure are experienced, shaped and re-affirmed. According to her, the 'standpoint' — that is, the design position in 'institutional ethnography' — makes a point of entry into discovering the social set-up that marks the knowing subject's ability not to be subordinate to objectified forms of knowledge of society or political economy. This method of inquiry addresses the reality of people's everyday lives and experiences to study the social, as it extends beyond experience. The standpoint in people's everyday life is integral to this method. The ethnographer looks at the social aspect in people's experience to discover its presence and organization in their lives and to explicate, or map, such organization beyond the everyday dimension. Smith proposes to start from the everyday world as it is actually lived and then proceed to conceptualize its properties.

Conceptually, this is what I wanted to do: understand psychosocial distress from the women's point of view. The strategies that I was adopting were, however, inappropriate. I have pointed out how my past training had informed my screening tools, and I have mentioned the anxiety attached to the individual interviews which I attempted to carry out soon after starting the

fieldwork. In brief, my methods were obviously being rejected by the women. Having realized this, I changed my data collection plans, which led to a change in my informants' responses.

Changing Strategies

Following the change in my approach, I conducted the interviews in spaces which were comfortable to the women and where they felt safe. Usually, such a space was not in their own homes. Many women even avoided talking to me when I proposed coming to their homes. They were mostly comfortable in public spaces surrounded by other women. One of them explained that they could get into trouble if they were overheard by anyone in the family. The account of difficulties at home might be construed as criticism and might lead to conflict. They found it easier sharing their experiences when there were other women present. Changing my way of approaching my informants resulted in more insightful discussions. When I spoke to them in places where they felt comfortable, they spoke in detail about the difficulties in their lives, giving various reasons. So, focusing on their narratives of psychosocial distress instead of using screening tools and direct questions helped me gain a better understanding of the relationship between the social world of women in Jahangirpuri and the level of distress that they were under.

One such interaction was with R. I met R at a group meeting, during which she invited me to come to her house. Finding the house was not easy, as many women in the street feigned ignorance (suspicious of strangers, people rarely give out information easily). Finally, one of them stood in front of me, blocking my way, and demanded to know why I was looking for that address. Satisfied with my explanation, she pointed to the second floor of the house behind her, saying that R lived upstairs. R lived in one room, all the members of her family were there, she was lying down, resting, as she had just come back from work. One of her daughters was doing some decorative work in a corner and two children were playing in the space outside. R's daughter-in-law was feeding her child; her married daughter was also there with her children and the neighbour was standing next to me. When I told R that I could come back later when she had time, she replied, "*har samay ek jaisa hota hai*" (All times are alike) and encouraged me to ask my questions. We sat next to the door in one corner of the room, her elder daughter often contributing to the conversation. After a little while, everyone went back to their work. R then spoke about her work as a rag picker, her distaste for it and about the things that worried her. She

explained what was happening to her because of the constant worrying. Working in the dark was one of R's main reasons for distress and fear. Family circumstances had forced her to do her job before dawn. R described several instances when she took longer routes to her work place in order to avoid areas where men hung around at night. Tanushree Paul (2011) describes how in Kolkata women avoided public areas which are seen as 'masculine spaces' (liquor shops, tea shops, garage, truck parking) because they 'feel uncomfortable'. There are community restrictions on women's movements; these injunctions are usually internalised by the women. Their sense of self leads them to reproduce, consciously or unconsciously, gendered behaviour articulated through various spatial patterns; for example, in terms of choosing a specific route and avoiding another (Paul: 259). According to Ranade (2007, cited in Paul 2011: 259), as safety is closely associated with avoiding physical violence, implied threats raise a strong sense of discomfort; a sense of being made to feel that one is in the wrong place at the wrong time. Circumstances had forced R to go out in the dark (at around three or four in the morning). Her internalised fear and excessive precautions had led to increased anxiety levels, as fearful scenarios of harm kept running in her mind. This, and other worries about taking care of the household, arranging dowry for her daughter's marriage and failing to receive financial help from her son, had led to frequent episodes of crying and loss of weight.

This account brings out the ways in which social norms and duties to be fulfilled led to R's psychosocial distress. Her narrative provides an insight into the links between social structures and psychosocial distress, which points to Smith's argument (1987: 157-161) that individuals' experience is key to discovering how the local organization of everyday worlds is connected to the 'relations of ruling'.

Conclusion

Unlearning the techniques I had acquired as a psychiatric social worker in a hospital set-up was an important step to take in my research, as communities embody an entirely different way of functioning. Listening to women instead of just asking questions led to detailed accounts of psychosocial distress, which helped me to understand how their social location often created mental health difficulties. Pursuing my earlier plan for data collection would have made me fail to find the answers to the questions that I had identified as key to my research. Letting go of control generated anxiety; but this anxiety helped me adapt to the field. It helped me to become

more flexible in my way of thinking and, consequently, contributed to generate equality in the researcher/informant relationship. Had I managed to obtain answers easily, I may not have explored new ways of seeking answers, and of being. Such is the power of the field, as it forces the researcher to reassess and change with every interaction and thus achieve new learning.

References

Blue, I. (2001). 'Urban Inequalities in Mental Health: The Case of Sao Paulo, Brazil', in D. A. Matcha, *Readings in Medical Sociology*. Boston: Allyn and Bacon.

Chesler, P. (1972). *Women and Madness.* New York: DoubleDay.

Davar, B.V.(1995). 'Mental Illness in Indian Women', *Economic and Political Weekly.*30 (45): 2879-86.

Hall, E.M., Johnson, J.V. and Tsou, T.S. (1993). 'Women, occupation, and risk of cardiovascular morbidity and mortality', *Occupational Medicine,* 8: 709-719.

Harding, S (ed). (1987). *Feminism and Methodology: Social Science Issues.* Milton Keynes: Indiana University Press.

Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M. and Eshleman, S. (1994). 'Lifetime and 12-month Prevalence of DSM-II-R Psychiatric Disorders in the United States: Results from the National Co-morbidity Survey', *Archives of General Psychiatry* 5(1): 8 19.

Mehrotra, N. (1997). 'Grassroots Women Activism: A Case Study from Delhi', *Indian Anthropologist.* 27(2): 19-38.

Myerhoff, B. and Ruby, J. (1982). 'Introduction', in J. Ruby (ed.), *A Crack in the Mirror: Reflexive Perspectives in Anthropology*, Philadelphia: University of Pennsylvania Press

Naples, N. (2003). *Feminism and Method: Ethnography, Discourse Analysis, and Activist Research.* New York: Routledge.

Patel, V., Kirkwood, B.R., Pednekar, S., et al. (2006). 'Gender disadvantage and reproductive health risk factors for common mental disorder in women: a community survey in India', *Archives of General Psychiatry* 63: 404–413.

Patel, V. and Kleinman, A. (2003). 'Poverty and common mental disorders in developing Countries', *Bulletin of the World Health Organization* 81: 609–615.

Paul, T. (2011). 'Public Spaces and Everyday lives: Gendered Encounters in Metro City of Kolkata', in S. Raju and K. Lahiri-Dutt (eds) *Doing Gender Doing Geography,* New Delhi: Routledge.

Pearlin, Leonard I. (1989). 'The Sociological Study of Stress', *Journal of Health and Social Behavior* ,30: 241-56**.**

Potts, M.K., Burnam, M.A. and Wells, K.B. (1991). 'Gender Differences in Depression Detection: A Comparison of Clinician Diagnosis and Standardized Assessment', *Psychological Assessment: A Journal of Consulting and Clinical Psychology* 3(4): 609–15.

Prell, Riv-Ellen. (1989). 'The Double Frame of Life History in the Work of Barbara Myerhoff', In The Personal Narratives Group, J. Webster Barbre, et al. (eds) *Interpreting Women's Lives*. Bloomington: Indiana University

Salokangas, R.K. R., Vaahtera, K., Pacriev, S., Sohlman, B. and Lehtinen, V. (2002). 'Gender Differences in Depressive Symptoms: An Artefact Caused by Measurement Instruments', *Journal of Affective Disorders* 68: 215–20.

Savarese, J. (2005). 'Women and social assistance policy in Saskatchewan and Manitoba, Project #109 of the Prairie Women's Health Centre of Excellence', Department of Justice Studies, University of Regina and Regina Anti-Poverty Ministry.

Selye, H. (1974). *Stress without Distress*. New York: Lippencott.

Sherman, J.A. (1980). 'Therapist Attitudes and Sex Role Stereotyping', in A.M. Brodsky and R.T. Hare-Mustin (eds) *Women and Psycho-therapy*. New York: Guilford.

Showalter, E. (1987). *The Female Malady.* London: Virago.

Smith, D. (1987). *The Everyday World as Problematic: A Feminist Sociology*. Boston: Northeastern University Press.

Stoppard, J.M. (2000). *Understanding Depression: Feminist Social Constructionist Approaches* London: Routledge.

Ussher, J.M. (1991). *Women's Madness: Misogyny or Mental Illness*? Amherst, MA: University of Massachusetts Press.