The Settings and Procedure of the Study

Egon Bittner

Bittner, Egon. 1961. Popular interest in psychiatric remedies: A study in social control, ch. 9: 156–70. Unpublished Ph.D. dissertation, University of California at Los Angeles.[1]

This chapter describes the research based on the theoretical discussion presented in the foregoing chapters.

A population of respondents was assembled which consisted of adult applicants to the Outpatient Department of the Neuropsychiatric Institute at the University of California, Los Angeles. The clinic is under the authority of the California State Department of Mental Hygiene, but its activities are controlled by the staff of the Department of Psychiatry of the School of Medicine at the University of California, Los Angeles. The clinic is located on the university campus in West Los Angeles, and by virtue of its location not equally accessible to the entire population of Los Angeles. Nevertheless, because of its association with the university it cannot be regarded as simply equivalent to any other psychiatric outpatient clinic in town. The public media of television, radio and the newspaper have on several occasions during the last few years brought the clinic to the attention of the people of the city by discussing some current research project, or by referring to mental hygiene in general. Thus, because the clinic is conspicuous in the city it is psychologically more accessible than its lesser known equivalents. Although the bulk of the patients come from approximately middle- and upper-class areas near the clinic (West Los Angeles, Beverly Hills, Hollywood, Santa Monica and the San Fernando Valley), a substantial number of patients come from other areas of the city, including such low status areas as East and South-East Los Angeles, and Venice. Thus, the population of applicants at the clinic can by no means be regarded as a balanced sample of all persons applying for psychiatric care in the Los Angeles area, but the population includes sufficient numbers of persons from all social strata to permit the control of gross biases.

According to its manual of operation, the clinic is oriented primarily toward teaching and research objectives; it is only secondarily concerned with service to

Ethnographic Studies 13: 115–122. 2013
ISSN 1366-4964. DOI 10.5449/idslu-001091496.

the community. Its staff includes psychiatric residents, medical students and occasional groups of physicians taking postgraduate instruction in the practice of psychiatry. The period of tenure of these staff members ordinarily extends over a period of one year. They are supervised, instructed, guided and helped in their activities by a permanent staff of supervising psychiatrists, clinical psychologists and psychiatric social workers, many of whom have academic appointments at the university. The patient load of the clinic varies from 275 to 310 patients per month from September to April.[2] The clinic record shows that approximately 125 to 150 persons apply for care monthly. Of these, averaging the monthly numbers over the course of a full year, about 12 to 13 percent actually enter clinic care. The remainder either are refused service by the clinic at the time of preliminary contact, or during or after an evaluation, or they drop out of the program themselves prior to entering care. On the average, less than one out of four applicants pass beyond the stage of a preliminary contact. In the majority of cases, the preliminary contacts are made by telephone.

Persons making contact with the clinic either by telephone or by appearing in person are referred by the receptionist to a psychiatric social worker. The social worker, on the basis of information provided by the applicant about the nature of his problem, and on the basis of knowledge of clinic load and clinic interests, decides whether the applicant should be considered for intake into the clinic's care. In the majority of cases she communicates the decision to the applicant on the spot, either by scheduling his appearance at an intake interview or by advising him to seek care elsewhere. In a few cases, she defers the decision and informs the applicant of the disposition at some later time. The social workers keep a continuous register of all preliminary contacts. In addition, they dictate a short statement about the substance of the contact. The continuous register is used only by social workers and is kept either in the offices of the social workers or in the office of the department of social service. The dictated statements are kept on file in the clinic's record library. The entries in the record library sometimes lag behind the entries in the register by as much as several weeks, and their content varies considerably, ranging from entries which merely state that such-and-such a person contacted the clinic inquiring about its services, to reports of several hundred words describing the applicant's complaint. There are some discrepancies between the continuous register and the records kept in the record library; in about five percent of the cases entries were made in only one of the two places. In the present study both sets of entries were used so as to avoid losing persons whose application to the clinic had been acknowledged by keeping some kind of record of them.

It is important to note that the records of applications do not include all inquiries received by the clinic. According to clinic personnel, losses occur at at

least two principal points in the clinic's operations. The first point is at the telephone switchboard; operators are instructed to direct all calls addressed to the clinic in general to the social worker on intake duty, but on occasions the social worker is unable to receive a call, for various reasons.[3] In the event the call cannot be forwarded to the social worker on intake duty, the operators are supposed to ask for the caller's name and telephone number, so that the call may be returned by the social worker. But, according the operators, from 5 to 10 persons daily refuse to give this information and say they will call back themselves. The social workers say that they invariably attempt to reach those persons who have left messages, and that they succeed in about ninety percent of the cases. If they are unable to reach the caller after making several attempts, they discard the memo sent by the operator. As far as the clinic's record of its own activities is concerned, then, all calls which do not put a prospective patient and a social worker in communication are treated as if they were never made. The writer tried, through observation and various inquiries, to estimate the magnitude of loss at this step and arrived at a figure of about twenty percent.

The second point at which losses occur is at the time of contact with the social worker. Social workers do not record all the calls they actually receive. They state that they record all calls which they judge relevant to the function of the clinic as a psychiatric facility. They point out that they routinely answer a variety of inquiries which are clearly irrelevant as far as the intake of potential patients is concerned. For example, some callers inquire about the availability of vocational testing services or ask for general information about the status of LSD as a legitimate psychotherapeutic remedy in the eyes of the profession. Again an effort was made to estimate the loss at this point, and it was found to consist of at least another twenty percent of all calls.[4]

We believe that additional loss of information about preliminary contacts for care occurs at other points of clinic operation. Thus, for example, some staff members who are not on intake duty, and are therefore not required to keep a record of inquiries which they receive, may nevertheless receive them, and so on. However, we are not concerned here with the description of clinic operations. We cite the above rough statistical estimates merely to indicate that a researcher who must depend on clinic records for assembly of a population of clinic applicants probably cannot expect to include more than about sixty percent of the respondents he would like to reach.

Since the respondents we wanted could be found only through the facility of clinic records, we defined our population as consisting of persons who had made contact with the clinic on their own or on whose behalf contact with the clinic was made, where the contact was considered a legitimate concern of the clinic as a psychiatric facility, and recorded as such by the intake social worker. In order to

assemble such a population, all 268 persons whose contacts with the clinic were recorded as having occurred between October 1 and November 30, 1959, were regarded as potentially eligible for inclusion.[5]

This population was then divided into three groups. The first group consisted of sixty-one persons who as a consequence of their preliminary contact with the social worker were admitted to the clinic as potential patients, and were subsequently actually seen by a member of the clinic's staff either for the purpose of evaluation or therapy. Although these persons are of obvious interest in the study, they had to be eliminated from our population, because the clinic, by expressing interest in them, barred other interests as possible sources of interference with their treatment.

The second group consisted of twenty-four entries about persons who did not themselves participate in the referral to the clinic. In terms of the definitions given earlier, these persons exemplified the prototype of the major psychiatric disorders. The writer scrutinized each of these cases by collecting information about them from the intake social worker, the referring person, and whatever other sources he could consult. Fifteen involved incompetent persons, such as severely retarded or psychotics, six were competent but either knew nothing of the referral or were vehemently opposed to it and could not be interviewed except at great risk to the referring person; the remaining three denied that either they themselves or anyone in their behalf made the contact with the clinic. These twenty-four cases were also eliminated from the population, as were five entries which were clerical mistakes (four of these were double entries and one was an intra-service communication regarding a patient in the case of another department of the hospital by a physician attending the case).

The third group was composed of 178 persons who were either refused care by the intake social worker at the time of the preliminary contact or were offered an appointment for an evaluation interview but failed to appear. That is, these persons whose relations to the clinic did not proceed beyond a preliminary contact, but who participated in their referral to the clinic in various ways, ranging from independent self-referral, to a mere passive acknowledgement that a referral was made on their behalf. All these persons were regarded as eligible for classification in terms of the scheme of types adapted in this study.

In order to determine whether the sustained desire for psychiatric care is related to a person's perception of his troubles in accordance with our types, it was necessary that there be a time interval between the date of the application and the date of an interview with the person. Although one may be able to draw some inferences from the manner in which a person appears in the clinic and from an interview about what it took to make him appear and what his desires are at the time, it would seem more efficient to let an interval of time lapse after rejec-

tion or failure to appear and then examine what he actually did or felt disposed to do. There is no fixed rule for determining the period of time required for a person to make alternative arrangements, if he so desires, after he is refused by the clinic. We were interested in locating persons who would seek and find care elsewhere, and it was necessary to allow enough time to make this practically possible. Although entry into private care or a psychiatric hospital can ordinarily be arranged in a fairly short time, entry into a clinic usually takes at least several weeks, and at times several months. On the other hand, the interval between the date of the application and the date of the interview cannot be so large as to permit some respondents to become entirely divorced from the concerns which motivated their appearance in the clinic. In short, the interval had to be long enough to permit those disposed to seek care to make the necessary arrangements, but short enough to find all respondents in pretty much the same life situation. We decided that an interval of no less than eight weeks and no more than ten weeks is reasonably compatible with both of these considerations.

In order to interview all respondents as closely as possible to the date of the expiration of the eight weeks interval, the first attempt to get in contact with the respondents was made seven weeks after the date of the application; this contact was made for the purpose of setting up an appointment for an interview. In practice, the time elapsed between the date of the application and the date of the actual interview ranged from 54 to 98 days. In all cases of deferment of the interview beyond the limit of 70 days the respondent chose the date of the appointment and the deferment was unavoidable, except at the risk of losing the interview altogether. No evidence was found that the lengthening of the interval had any consequences for the cases in which it occurred. That is, persons interviewed later did not make alternative arrangements with greater frequency than persons interviewed earlier.

At the time of the initial contact, the respondent was invited to participate in an interview at his home at an hour convenient to him – including evening hours, weekends, and holidays. He was told that the clinic regretted the fact that it was not able to help him at the time of his application but had continuing interests in the welfare of all persons who seek its care. Therefore, 'we' now inquire and would appreciate an opportunity to interview him. The merits of the interview were recommended to the respondent before he had an opportunity to interrupt to say, 'Thank you, no.' He was told that, 'as he knew' the clinic is a research and teaching institution and will soon expand its services considerably. In order to plan and administer the expansion sensibly the clinic must know the needs of all persons who seek its care. Therefore, his cooperation is solicited for his own, as well as the community's interests. He was warned that the interview would not necessarily lead to his entering clinic care at the time because the expansion is still

in the future. Respondents who inquired about benefits they could hope to derive from the interview were assured that the interviewer will advise them on the basis of the materials they will furnish to him, and help them plan a course of remedial action.

Of the 178 eligible respondents, 141 actually were interviewed and the following part of the report is based upon those 141 interviews.[6] The remaining 37 respondents could not be interviewed for various reasons which are summarized in the following table:

Could not be located	14
Refused when located	10
Broke many appointments	4
Moved out of state	4
Hospitalized	4
Deceased	1
Total	37

The interviews followed an interview guide (see Appendix A) and lasted ordinarily 1 to 2½ hours. There were three respondents in the population who had to be dismissed in somewhat less than an hour. The supreme principle which guided the interviewer was to permit the respondent as much freedom of expression as possible. When note-taking seemed to be detrimental to rapport it was avoided. In order to preserve the content of the respondent's statements, interviews were scheduled at least five hours apart, so that the interviewer could always complete his notes before approaching the next respondent. Respondents were always permitted to depart from the topic of any specific question and many in fact did anticipate later questions in their answers to earlier ones. These later questions were, however, always asked anyway, prefaced by a remark such as, 'You have already mentioned this; would you please now tell me more about it'.

As a matter of strict rule, the respondents were treated as entirely competent to state their own case, and their responses were taken literally. This rule was also applied to two respondents whom the social worker described as 'obviously' psychotic. On several occasions, family members of the respondent solicited the attention of the interviewer, to give 'their side of the story'; they were always listened to as a matter of simple courtesy, but their contribution was never included in the case. In all but one case, where a radical difference was found, the reports of the social workers, kept on file in the clinic's record library, were compatible with what the interviewer learned in the interview. However, the descriptions of the social workers were not included in the analysis of the cases.

The coding and analysis of the data was done by the writer. The judgements concerning the typical character of the respondent were made in accordance with rules and considerations explained in Chapter VIII. Other coded items, such as social and personal characteristics of respondents, earlier experience with psychiatric remedial agents, manner of referral to the clinic, steps taken following the application to the clinic, desire for care at the time of the interview, etc., were based on simple answers of the respondents to topical questions. The rules for making the discriminations employed will be mentioned each time a relevant set of data is discussed in the following presentation.

NOTES

1. We are grateful to Debora Seys for granting us permission to reprint this chapter.
2. Since the staff in training carries most of the patient load, the months from May to July are characterised by low case loads because old personnel leave the clinic and new enter it. It is a standing rule of clinic operation that only an unavoidable minimum of cases should be transferred to new therapists.
3. Social workers rotate on intake duty, and at any one time only one of the social workers receives preliminary contacts. During the period of the study, four psychiatric social workers were eligible for intake duty. It is not impossible but very rare that a preliminary contact is received by a social worker outside of the prescribed order of rotation. These cases constitute less than one percent of the recorded contacts.
4. Backed by the sponsorship of the Chief of Social Service and the Director of the clinic, the social workers were requested by the writer to keep a record of calls that they did not enter into the clinic's files, so that they caller may be included in the population of respondents. Unfortunately, the information furnished by the social worker on these cases turned out to be worthless for this purpose. Of the fifty odd entries received by the writer only 14 were cases in which the caller was identified either by telephone number or address; of these 7 were found also entered in the continuous register of preliminary contacts. Of the remaining 7, the first 3 the writer attempted to contact by telephone turned out to be wrong numbers. Further, the distribution of 'unrecorded' calls over time, and among the social workers who submitted them, was such as not to inspire confidence in their completeness. The social workers are aware of the fact that many of these contacts are crudely veiled or tentative attempts to solicit clinic care. The problem of how inquiries are judged as 'relevant' to the functions of the clinic is an important one. In our case, studying this problem would have involved a great deal of observation of the social workers' activities and interviews with them. Unfortunately, the social workers in the clinic felt obliged to deny to this writer the opportunity to pursue these interests because of their very heavy work load.

5. We refer to our potential respondents as a population rather than a sample because of respect for the formal definition of the latter term. Although we have no reason to believe that the callers in October and November differ from callers in any other two month period, we have no adequate evidence to support our belief. Further, we know that the 268 recorded contacts were a selection from a larger number of calls but we have no adequate knowledge about the principle which governed this selection.

6. The writer conducted 104 of those interviews himself; 37 were conducted by graduate nurses enrolled in a graduate course of social research methods under Dr. Miriam Morris at the School of Nursing, University of California, Los Angeles. These interviewers were trained by the writer in four consecutive 2½ hour sessions and were quite familiar with the intensions of the interview guide which they used. They managed to produce nearly verbatim protocols of their interviews in the majority of cases. The writer wishes to acknowledge, gratefully, his debt to Dr. Morris who participated in the special training sessions and contributed generously to them, and to Misses Lucille Agee, Sarah Brenessel, Donna Harris, Barbara Johnson, Mary Lynch and Edith Schulze for their competent help. In the task of managing a tight interviewing schedule, their availability prevented the loss of respondents.