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Research Opportunities on the Nature of Human Aggression

Thomas Richard Currier

Western Michigan University

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RESEARCH OPPORTUNITIES ON THE
NATURE OF HUMAN AGGRESSION

by

Thomas Richard Currier

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

Western Michigan University
Kalamazoo, Michigan
August 1975
ACKNOWLEDGEMENTS

Social scientists are vitally needed in our complex modern world. I am grateful to the Faculty of the Department of Anthropology for assisting me in developing social science skills and for providing counsel and assistance. I wish also to acknowledge the highly professional team of people working in Governor William Milliken's Office of Health and Medical Affairs. The director, Dr. Donald Smith, deserves special mention. While working with this research unit of the State of Michigan I had the opportunity of further learning and applying social research methods. A portion of this thesis reflects work accomplished with this professional team.

Thomas Richard Currier
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CHAPTER I

Introduction: Opportunity Knocks

Is aggression a biologically determined form of human behavior? Is aggression, on the contrary, a behavior man learns from his socio-cultural environment? Hans Hass (1970:67) states that at present we cannot tell "to what extent human behavior is hereditarily determined or influenced, simply because there has been almost no research in this direction." (Emphasis added). Hass was referring specifically to studies on human behavior as such. His remarks may have been occasioned as a result of his close association with Eibl-Eibesfeldt. This latter scientist made frequent use of filming as a technique for studying human behavior. He filmed, in particular, children and unsuspecting adults in an effort to get a picture of human behavior in an unstaged form. Hass was not, however, satisfied with a filming approach to understanding human behavior. This method will, at best, lend itself only to the study of expressions and gestures as a means for understanding interpersonal relations (Hass, 1970:67). Hass was, perhaps, reacting to the practice among some scientists of examining the behaviors of insects, fish or animals and then projecting the findings to human behavior.

The purpose of this paper is twofold: 1) to call attention to a nearly inexhaustible resource for studies on human behavior which Hass indicated as almost entirely lacking and yet desperately
needed today, and 2) to examine the role a social scientist might
play in governmental endeavors in the interests of society. These
objectives are closely intertwined.

The resource alluded to is research conducted by state and
federal governments as a means of formulating human resource
policies and programs. As a way of demonstrating the value of
these studies to social scientists and of social scientists to
such studies, one project in which the author has had a significant
role will be considered. The example will also illustrate the
important contribution a social scientist, with his or her singular
theoretical perspective, can make in the governmental realm. The
research project was a part of a recent study concerning the
disruptive behavior of a sample of mentally retarded and mentally
ill people in the State of Michigan. This paper will be restricted
to that portion of the larger study that gives insight into the
nature of human aggression.

The writer happily accepted the opportunity to participate
in this study of the mentally ill and mentally retarded, which
was already in progress. The costs have been in the millions
of dollars. The volume of data collected and stored has been
enormous, but the social science perspective has too often been
lacking. An examination of the specifications for well over one
hundred types of jobs in state government quickly revealed the
lack of a role for the social scientist in such operations.

There seemed to be no orientation toward the understanding of
human behavior. It was hoped that this deficiency might be
remedied in at least one government operation.

Along with the painful discovery of the pragmatic interests of government came the equally disturbing realization that the universities were training students more for academic jobs than for participation in the social change process that is now so much a part of the contemporary scene. Sadly, the huge amounts of data available in the State of Michigan and, undoubtedly, in other states, do not bear the impress of social science involvement in their acquisition or in their analysis and use. The writer considers this lack of involvement on the part of social scientists in general and anthropologists in particular most unfortunate. He is convinced that great opportunities are being lost, that studies of human groups - including those conducted by governmental agencies - require social science input as a vital ingredient. The use of film as the sole means of studying human behavior, as done by Eibl-Eibesfeldt, is judged inadequate as it requires little or no involvement in the social structure and culture of the people under study. The need for the anthropologist becomes glaringly obvious.

While the stated objectives of this paper are to point out the opportunities available to social scientists and illustrate by way of example a role that may be taken, it is hoped that this effort will also serve to jolt scientists from the complacency of their positions in the well-established social sciences so that, hopefully, more will take up the golden opportunity of
putting classroom theory to work in the social problems that currently plague state and federal governments. The turmoil of the sixties should be ample proof that government and social scientists must work together. Suspiciousness and unease with which bureaucrats so often approach new ideas and theories relating to societal change are regrettably matched by many social scientists who retain an air of indifference, seemingly preferring academia with its classrooms, grantsmanship, and production of learned papers for the academic world. Even as this is being written, indicating how my social science skills influenced a study of the mentally ill and retarded people of this state, a computer programmer, totally lacking in social science training, has been developing a code for dealing with mentally ill people in the state as a follow-up of the present study. This code will direct governmental operational policy and, consequently, will profoundly influence the lives of thousands of people for many years to come.

Anthropologists have much to offer but untrained persons continue to set policy regarding human behavior. Unfortunately, few social scientists have sought government positions and few in government feel any need for the contribution of the social scientist. Therefore, jobs are not readily available. If by sharing the experience of the writer's involvement, a few others are awakened to the possibilities of meaningful government employment, then this effort will have been a success.

Data are available in state archives on many aspects of
human behavior, but human aggressive behavior is singled out because the recent research touches on this dimension of human behavior and because aggression and conflict are key concerns in the operation of a government. It is now generally accepted among social scientists that in societies where values are held which often lead to violent conflict between persons and groups, there are institutions through which a modicum of peace persists (Scheffler, 1964:789). Gluckman (1955:25) argues, further, that the social function of any institution resides in its contribution to the maintenance or establishment of social order. There can be no doubt that intimate connection exists between institution and conflict. Those charged with the responsibility of governing are more likely ready to listen to social scientists in an area such as the causes of conflict since it is a subject that profoundly touches upon the social order the state is committed to maintain.

We shall first take a look at the circumstances relative to the study of the mentally ill and mentally retarded. We shall then use the data carefully collected by the project staff and look at them in the context of social science theory with a view to gaining insight into the causes of human agonistic behavior. The final portion of this paper will be concerned with contributions our study has made in the context of research done on the subject by anthropologists, limitations found in the example used, and what remains to be done for the future.
CHAPTER II

Opportunity Taken

William Mitchell, (1974:3) reported in the Detroit Free Press that the transfer of mental patients from state institutions to the community provides a picture of "fragmentation, confusion and discontinuity." This statement was aimed at an action taken months before by the Michigan Department of Mental Health. Large numbers of mental patients who had been in state institutions for many years were released without adequate preparation. The reason for the action reportedly was that the public needed to be prodded to change its attitude on the traditional mode of treatment of mentally ill people. The action would certainly precipitate a crisis and draw attention of the community to the situation. Apparently little concern was given the consequences of such action in terms of agonizing suffering brought upon the mental patients. Such action did arouse public reaction, but the cost in terms of human suffering was far too great. It was in the wake of public reaction that an emergency study was initiated on the success or failure of the community placement of the mentally ill and mentally retarded people of the state.1

1Introduction to the Statistical Design and the Survey Instrument utilized in this study is provided in Appendix A and Appendix B respectively, which follow the main body of the text.
A staff of fifteen people was engaged and given the mandate to report on what has happened to the people placed in the community by the Department of Mental Health with assistance from the Department of Social Service. It was felt by the authorities that a more comprehensive picture than that provided by vociferous but isolated critics was needed.

The study began in February, 1973 and was conducted by the Michigan Office of Health and Medical Affairs. It was deemed essential that the people who were to be included in the sample for the study were to have lived long enough in the community to allow for initial adjustment. Only those, therefore, who had been placed six months prior to the study were chosen. Selection for the sample was limited to those placed in the community between January 1, 1972 and September 30, 1972. Random selection was made of 212 mentally retarded individuals and 285 mentally ill persons. A voluminous file kept on each of these people by the state departments of Mental Health and Social Service was obtained and examined in detail. The files of the Department of Mental Health pertained to the assessment of need and treatment of the individual while the files of the Department of Social Services pertained to the behavior and placement process of the individual.

Project staff then visited each community facility throughout the state to interview the home operator and the persons included in the study. Instruments used in the interview are found in Appendix B. In addition to the interviews the staff was to make
detailed observations of the individuals included in the sample, the environment in which the people lived and the social interaction that was evident.

Many months of staff work resulted in a huge compilation of data. Since the objective of the study was to portray what was happening, the vast array of data was organized for computer processing under various categories of information. These included a description of the population, a description of the facilities in which sample individuals were placed, the procedure of placing the individuals, the process of follow-up, description of the behavior of the sample subjects and, finally, a description of the results of the placements.

The writer became involved in the project at the time the staff had just received a tabulation of all the data collected for a period of nearly a year. The staff was faced with the problem of how to handle such a volume of information. The writer pointed out that the gathering of scientifically accurate information is only one step in the social research process. Through discussion that followed the staff came to the determination that the primary purpose of the study was not to "film" through descriptive data what was happening but to produce a series of recommendations that would improve the situation. Consequently, in the last few weeks of the study the fundamental purpose, hitherto underlying the project, was shifted.

The next point that the writer proposed to the staff was that
the research should lead to an understanding of human behavior in order to make proper recommendations to guide state policy and operation. This thought had not occurred to the staff or if it had, the staff was unaware of social scientists' theories, procedures, and findings relating to human behavior. The main interest of the staff had been to examine the data in terms of disruption or non-disruption of social order. Apparently, the success or failure of the community placement program was considered to be based on the lack or presence of disruptive behavior.

The obvious and central questions to be faced were to what extent and for what reasons were disruptive behaviors present among mental patients placed in a community setting? If the staff could answer these questions there would be some foundation upon which to base future policy and programs relating to mentally retarded and mentally ill persons in the state.

Understanding human behavior involves much more than merely receiving a mass of descriptive data about a given population. Philip Newman (1964:8-17), in an effort to account for aggressive behavior in certain communities in New Guinea, suggests that one must take into account the community within which the individual displays the behavior, the effects the display may have on the opinion of the community toward the individual, the ideological background against which the behavior is played out, and determinants of human behavior based upon social, cultural, psychological and individual factors.
The approach as suggested by Newman is perhaps too comprehensive in the present situation. The framework suggested by Kroeber and Kluckhohn (1952:90) is more practical. They point out that, "There are four variables in the determination of human action: man's biological equipment, his physical environment, his social environment and his culture."

After the writer had pointed out a framework for organizing data such as that proposed by Kroeber and Kluckhohn, the staff determined to reorganize the data collected with a view to getting an understanding of the people included in our study in terms of physical, social and cultural environmental factors. The reorganization added new zest and clarity to the project. The first draft of about 500 pages was produced and sent to the Departments of Mental Health and Social Services. The "novel" reorganization of the data resulted in arousing a bit of agonistic behavior toward us from among the higher echelon directors of the departments. Apparently the study was considered "irrelevant" and "useless" because it was presented, as one of them said privately, in a way in which they "were not accustomed to think."

It was now the eleventh hour for the study, the Governor was anxiously awaiting the report and something had to be produced. The first draft was set aside by order of higher authorities, to be used as material for a "scholarly research article someday." A list of recommendations was hastily drawn up and the staff hurriedly searched through the data collected to find facts to
support the recommendations. Attention was also directed toward
the formulation of recommendations implicit in the information
collected. The effort resulted in a relatively thin booklet
presenting a series of findings with accompanying recommendations
for each finding. The computer printouts of unused data were then
packed in boxes and sent to a state warehouse for storage.

Subsequent to the study of mental patients, the author took
part in a project involving the study of state correctional
institutions. Once again, it was the case of but one voice
speaking out for the viewpoint of the social scientist in
developing a health care system for the state prisons. Once again
massive amounts of data were collected and left as grist for
academic mills because there was not sufficient involvement of
social scientists to make a difference.

Bureaucrats see themselves as being responsible for day-to-day
operation of society. There is not time for long, unending
research and theoretical discussion. This was illustrated in the
experience of one of the staff members who had participated in
the study of the behavior of mental patients. At the end of the
project this staff member began manpower studies for the state.
He related that, as a result of the current recession, the federal
government allocated to the state many millions of dollars in
emergency funds to hire the unemployed on condition that a program
could be developed and in operation within a few weeks.

The desperate lack of direction in government is not unique to
Michigan. The turmoil evident throughout the country today recalls the classic image of Nero fiddling while Rome burned. One cannot help but ask the question, Who is Nero today, the bureaucrat or the social scientist?

Comments in this paper are not directed against the praise-worthy efforts of the staff involved in this study but rather are intended to highlight the tragic absence of social science expertise within the research and decision making process of government. Certainly some good will be accomplished by well intentioned workers, but a vast amount of human degradation and misery could have been avoided if social scientists had played a vital role all along.

In order not to end up with an unresolvable academic question, we shall take another look at some of the data collected in the study of the placement of mental patients in the community from a social scientist's point of view. It is, unfortunately, too late to formulate recommendations for the operation of state departments based upon a more scientific approach. This is not the primary purpose of this paper. As stated, the gulf between theoretical pursuits and practical operation of society can no longer be maintained. Opportunity knocks in state and federal government operations and it is my purpose to make that "knock" louder.
CHAPTER III

Social Scientist at Work

The state is interested, primarily, in whether its policies and programs are successful or not in terms of social order. The social scientist, however, must penetrate more deeply, with a view to understand and explain human behavior, the process of social interaction and change. If the program of placing mental patients in the community leads to social disruption, then state policy will shift back to institutionalized treatment of these people. The social scientist must ask, Why does community placement provoke conflict? What changes are necessary to make such a program more successful? Is conflict that results from community placement above normal levels? To what extent is conflict detrimental to social order? What new possibilities are there for effective treatment? Is the origin of agonistic behavior genetic or learned?

State policy for treatment of mental patients would be greatly affected by resolving a question long discussed by anthropologists, namely, is aggression learned or a genetically determined behavior? If a behavior is biologically determined, treatment for modification of behavior must be aimed primarily at the individual. If, on the contrary, disruptive behavior is caused by the physical, social and/or cultural environment, then treatment must be aimed primarily at the influences surrounding
the disruptive individual.

The data collected on the behavior of the mentally ill and mentally retarded people in the state offer an opportunity to probe the nature of human aggressiveness and thus lay the foundation for treating these people in a way that is more than merely an expeditious one. The theory to be tested is whether aggressiveness is biologically or socio-culturally based. It is hypothesized that mentally retarded individuals will not be susceptible to socio-cultural influences to the extent as those afflicted with mental illness. On this basis one may suggest that if aggressive behavior is more prevalent among the retarded than among the mentally ill people, then one may suspect innate motor mechanisms as the cause. On the other hand, if the mentally ill patients display greater aggressiveness, then one should seek an explanation in external, i.e. socio-cultural causes to explain such behaviors.

Our course of inquiry will consist of the following steps: First, by way of background, we shall look at the demographic information pertaining to the sample population. We shall then compare the disruptive behavior of the mentally retarded and mentally ill people in the context of the physical, social and cultural environmental influences suggested by Kroeber and Kluckhohn (1952:90).

The mentally ill included in the sample population showed a predominant age range of forty-five years or older. The mentally retarded group tended to be much younger, as 36% were
between eighteen and twenty-four years of age. In the mentally ill group only 10% of the people were in that age range.

The state was divided between Wayne county which contains 30% of the population of Michigan and the outstate area which included the rest of the state. A larger percentage of the mentally retarded came from the Detroit area (73.5% versus 41.8%). Furthermore, only a small percentage (24.7%) of these people were placed in facilities in Wayne county. There is a significant outflow of people afflicted with mental retardation from the highly urbanized area to small town and country living settings. This radical change in environment may have significant influence on these people in regard to behavior, as will be reported later in this paper.

To gain a proper profile of the population under study, it is also useful to take note of the level of mental and physical disabilities. Mental retardation is taken as a term applied to an individual with an intelligence quotient of seventy or less. An IQ of fifty is viewed as more severe and one with an IQ of thirty is considered profoundly retarded. There were 22.7% of the mentally retarded with an IQ of less than thirty, 35.3% had an IQ ranging

\[\text{1A possible explanation is that it is more difficult for a family to keep a retarded person in an urban setting than it is in a more rural setting.}\]

\[\text{2No explanation was offered by the Michigan Department of Social Service or the Department of Mental Health for this practice.}\]
from thirty to forty-nine, 35.1% ranged from fifty to an IQ of sixty-nine; the few remaining cases varied between an IQ of seventy to ninety-eight.\(^1\)

The difference between the retarded and mentally ill groups included in this study in regard to physical disabilities was also significant. A large majority of those mentally retarded suffered from physical handicaps (60.7% versus 33.6%). The most commonly noted problems among the retarded were problems related to vision and hearing. In a number of cases among the retarded there were multiple physical disabilities. It should be noted, further, that within the mentally ill group there was a greater incidence of chronic and degenerative diseases, as one might expect in a group more advanced in years.\(^2\)

There is still one other category of variables that should be noted about the population under study, namely, personal limitations in regard to eating, dressing, bathing and toileting. In all instances those afflicted with mental retardation showed a much greater dependency on others. Thus, in regard to need of assistance in eating, 7.1% of the retarded people needed help

\(^1\)Very recently it was discovered that children diagnosed as mentally retarded were not actually so but rather were deficient in their ability to hear or see. New testing procedures are now being used to correct this situation.

\(^2\)The variable of physical disability is difficult to control in measuring behavior outcomes. While the proposed research method may be valid, allowance should be made when the method is applied to an exceptional group such as the subjects of this study.
versus 4.3% of the mentally ill people; for assistance in dressing, 20.7% versus 6.6%; bathing, 31.2% versus 9.6%; and for help in toileting the contrast is 10.6% versus 2.6% of the mentally ill people with the same need.

In order to assess the physical environment in which these people lived, a careful study was made of the community facilities in which the people were placed. Information about these facilities was obtained from two sources. The first source was the state records in which were reported regular inspections regarding sanitation, diet and food handling, fire safety, availability of drugs and medical supplies and the condition as well as the maintenance of the physical plant. The second source of information was gained through on site observations and interviews. While the research team interviewed each home operator and resident included in the study, personal observations of the interviewer were also recorded.

The results of record studies, interviews and observations showed a significantly different environment between the two groups. Generally, the living environment of the mentally ill people was considerably less comfortable than that of the retarded group. The bedroom of the mentally ill resident was crowded 15.9% of the times versus 9.4% for the retarded residents. The living environment rated fair to poor in regard to cleanliness in 26.3% of the cases among the mentally ill residents versus only 9.7% among the retarded. In regard to ventilation, it was observed
that there was poor ventilation for 21% for the mentally ill residents versus 11.1% for the retarded. Further, 11.1% of the mentally ill residents disliked the food while only 7% of the retarded people were reported to dislike the food. Finally, as learned from the home operators, the difficulty of getting medical care was somewhat higher among the mentally ill people (28.2% versus 21.4%).

The physical living environment of those afflicted with mental illness was considerably less comfortable than that of the retarded group. In view of this fact, how does the behavior of each group contrast in regard to disruptive behavior?

The interviewers questioned each home operator on the problem of disruptive behavior (see Appendix B for the survey instrument used). Included in the notion of disruptive behavior are such actions as running away, inflicting injury on self\(^1\) or on others, deliberately causing damage to property, attempting suicide, serious difficulty in getting along with others and other aberrant forms of behavior.

The home operator was asked, in the context of the violent forms of behavior just mentioned, whether he was comfortable with the behavior of the individual, experienced minor problems, experienced major problems or, finally, whether the behavior was

\(^1\)Running away as well as suicide are viewed as violent behaviors directed at self as an indirect protest against a home operator or a living situation.
so violent that the home operator felt the resident should be removed.\(^1\) Throughout the study the numbers of those whom the operator felt should be removed were too few to be treated separately and, therefore, they were combined with the group identified as having serious problems. Table I displays the disruptive behavior manifested by the two diagnostic groups.

\textbf{Table I}^2

\textbf{Home Operators' Report by Diagnostic Group}

<table>
<thead>
<tr>
<th>Home Operators' Satisfaction</th>
<th>Mentally Ill Residents</th>
<th>Retarded Residents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfortable with Behavior</td>
<td>61.7</td>
<td>64.2</td>
<td>62.5</td>
</tr>
<tr>
<td>Minor Problems</td>
<td>26.5</td>
<td>28.5</td>
<td>27.1</td>
</tr>
<tr>
<td>Serious Problems</td>
<td>11.8</td>
<td>7.3</td>
<td>10.4</td>
</tr>
<tr>
<td>(\text{NW}=)</td>
<td>1449</td>
<td>627</td>
<td>2076</td>
</tr>
</tbody>
</table>

\(^1\)Income of the operator from the placement of a resident in the home is assumed not to be a factor with regard to truthfulness of response, since a patient removed for uncontrollable behavior would be replaced by another. The operator would not suffer any economic loss.

\(^2\)Basis for the validity of statistics is given in detail in Appendix A of this paper. Data upon which the statistics of this paper are based are available to authorized persons from the Michigan Office of Health and Medical Affairs.
The mentally ill lived in less comfortable surroundings, and manifested a slightly greater tendency toward serious disruptive behavior (11.8% versus 7.3%). Since the mentally ill, whom we assume are more conscious of external influences than the mentally retarded, are more disruptive, we are inclined to conclude that greater aggressiveness is related to the external influences in the form of greater physical discomfort. However, since the physical environment for the mentally ill is more uncomfortable, then a greater level of disruptive behavior would be expected. A valid test would require a relatively similar physical environment in order to make any assessment as to the nature or nurture origins of behavior. Moreover, the percentage differences in Table I are not enough to draw definite conclusions.

As mentioned, socio-environmental and cultural factors should be taken into account if one is to determine the causes of specific human behavior. The research team gathered data giving a general overview of such factors impacting on the sample population. Nearly all the people under study (75%) were living in social environments provided in homes. Almost one-sixth of the mentally retarded were placed in skilled nursing homes. The remainder of the group included in the sample were distributed in homes for the aged and nursing homes with varying levels of nursing care.

Social interaction was measured in terms of facility size. It was assumed that residents in larger facilities had opportunity
for more social interaction. The resident population of the various facilities ranged from one resident to over four hundred. Of the entire group under consideration, 85.2% lived in facilities of fewer than one hundred residents, 69.7% were in facilities of fewer than fifty residents. For the purpose of measuring the level of influence accorded the social condition of population density, it should be noted that for the two groups under consideration, there was a nearly even distribution of individuals in the various sizes of facilities. In regard to social interaction for recreational purposes, it was noted that the insufficiency of recreational activity was about equal, with the retarded exhibiting a slightly higher level of complaint.

Other factors were also taken into account. Among the mentally ill, in one half of the cases, a physician visited once a month or more frequently, whereas only 41.5% of the mentally retarded reported contact with a physician once a month or more often. Visits to or from family were about equal for both the retarded and non-retarded people in the sample. There was, however, a considerable difference in terms of attending religious services and other community activities. Only 31% of the non-retarded attended church monthly or more often, whereas 43.5% of the mentally retarded did so. It was not necessarily a case of being less religious, because the same difference occurred in regard to other community events. Among those residents who were mentally ill, only 23% attended social events in the
community whereas 43.5% of the retarded did so.

Nearly all of the group under consideration (78.9%) went on a walk once a month or more often. However, 62.7% of those afflicted with retardation went shopping once or more a month versus only 53.6% of those not so afflicted. This contrasts with solitary, sedentary activities such as watching television, reading, listening to the radio, etc. Participation of mentally ill people in such activities was 25.4% versus 19% among the mentally retarded residents. Thus, the mentally retarded appear to be more inclined to social contact than do the mentally ill.

There are other social and cultural factors that could be taken into account. It is impossible to assemble for analysis all environmental elements influencing people included in the sample. The findings displayed in Table I are also applicable in terms of social and cultural influences impacting on the population under study. As mentioned, it is difficult because of the small percentage differences indicated in Table I to draw any conclusions regarding differences.

While it was impossible to obtain information on the relative influence of socio-environmental factors on each of the diagnostic groups in our sample, it was possible to measure the influence in the socialization process of both groups, combined in terms of the amount of information supplied to the home operator. The home operator was asked whether he had received sufficient information on the resident to be placed in his care. His answer is
compared to the incidence of descriptive behavior. Table II displays these data.

Table II
Home Operators' Satisfaction, by Need for More Information

<table>
<thead>
<tr>
<th>Home Operators' Satisfaction</th>
<th>Need More Information</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfortable</td>
<td>58.1%</td>
<td>68.0%</td>
<td>63.3%</td>
<td></td>
</tr>
<tr>
<td>Minor Problems</td>
<td>28.5%</td>
<td>26.3%</td>
<td>27.4%</td>
<td></td>
</tr>
<tr>
<td>Serious Problems</td>
<td>13.4%</td>
<td>5.7%</td>
<td>9.3%</td>
<td></td>
</tr>
<tr>
<td>(NW)</td>
<td>946</td>
<td>1001</td>
<td>2007</td>
<td></td>
</tr>
</tbody>
</table>

It is clear from this Table that significantly more aggression occurs when information for proper socialization is not provided. This finding argues against a biologically determined behavioral pattern in as much as it appears that serious aggressive behavior is related to an external factor, namely, the lack of adequate information (13.4% versus 5.7%). In addition, frequency of visits to or from family and friends shows a significant impact on the level of aggressive behavior. Those receiving or making a visit once a month or often manifest less deviant behavior than those with occasional or no visits (4.5% versus 10.5%).

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Such new environmental and cultural factors indicate a clear impact on the display of aggressive behavior.

Cultural influences are much more difficult to assess. A cultural viewpoint attempts to look at the values underlying social structure and socio-environmental factors. While it is the most difficult to measure, it may, in fact, be the most important determinant of human behavior. Some would not agree, such as J. Merritt Emilen (1967:513) who says, "The important question relating to human social behavior, is not whether biological directives exist, they are almost certainly all-pervading, but rather whether cultural directives can be considered separate and/or overriding. Folkways are based upon two considerations: First, the satisfaction of the biological needs of its members and, second, the biologically directed but socially disruptive behavior patterns. When biological needs and culture are in conflict, biological forces will be reasserted from time to time."

While interchange between social systems may be very difficult to measure in regard to determining human behavior, anthropologists have made significant contributions in the treatment of mental illness by pointing out the influence of social and cultural factors on human behavior. Thus John Weakland (1969:880) comments, "Viewing mental illness as behavior comprehensible in terms of communication and interaction within social systems - especially the family, rather than as individual pathology, has recently led to revolutionary development in psychiatric thinking and practice."
Anthropologists have had a central role in developing the concept of communication underlying this advance."

It would appear that the distorted behavior associated with mental illness is itself the product of socio-cultural influences. One might rightly expect that agonistic behavior manifested by the mentally ill has the same origin. Mentally retarded persons, since they do not apparently have the capacity to be conscious of cultural influences to the same degree as the mentally ill, would be expected to evidence less deviant behavior if aggression is related to cultural influences rather than biological determinants. This appears to be the case within the group of people suffering from retardation. When the group so affected was studied in terms of the level of intelligence, it was found that among those with an IQ less than seventy, the level of disruptive behavior rose with the level of IQ. A possible but debatable explanation of this is that aggression is not related to biological factors but to the ability to learn certain behaviors.

In attempting to assess the influence of culture on behavior, one should take note of the high level of violence present in American culture. Roger Johnson (1972:155) points out that the American culture is one in which people appear to love violence. They flock to movies that display unrestrained violence on the grounds of being "entertained." He points out that 93.5% of cartoons intended for children display violence. The major characters in more than half of the programs were violent.
The "innocent" were as violent as the "guilty." Nearly half of those displaying aggression, Johnson comments, suffered no consequences. Individuals in our sample spent much of their time watching television. It was not possible to measure the impact of such cultural factors on the two diagnostic groups separately to determine variation in agonistic behavior. Many professionals are convinced that the violence saturating American culture as portrayed on television has a powerful influence on viewers.

For purposes of measuring the variable of cultural influences on our sample, it may be assumed that cultural influences become greater in situations where a resident resides for longer periods of time under the supervision of the same home operator. Table III displays evidence that the more extended the contact of the home operator is with the residents, the more disruptive the behavior of the resident becomes.

Table III

<table>
<thead>
<tr>
<th>Home Operators' Level of Satisfaction with the Behavior of the Resident by Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Operators' Satisfaction</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Comfortable with Behavior</td>
</tr>
<tr>
<td>Minor Problems</td>
</tr>
<tr>
<td>Serious Problems</td>
</tr>
<tr>
<td>NW=</td>
</tr>
</tbody>
</table>
It would have been helpful to view these data comparatively, in terms of the two diagnostic groups, in order to measure the relative influence of extended supervision over both the mentally ill and mentally retarded. However, only combined data for the entire sample were available. The data were, nevertheless, sufficient to underscore external influences as conducive to deviant behavior.

Perhaps a better variable to gain perspective on culture as a determinant of human behavior is to study the sample population from the aspect of sex. Our culture portrays the male as large, strong and much given to fighting. One who argues for the genetic basis of human behavior could seize upon this fact as proof that nature and not nurture is the determinant of behavior.

The population under study was examined to see if the theory relating aggressive behavior genetically to the male sex held true. As Table IV indicates, there is no evidence that aggressiveness is related to the male sex. If anything, it would seem to be that women are more aggressive.

Table IV
Agonistic Behavior According to the Sex of Resident

<table>
<thead>
<tr>
<th>Home Operators' Satisfaction</th>
<th>Sex of the Resident</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Comfortable with Behavior</td>
<td>64.5</td>
<td>61.5</td>
<td>63.0</td>
<td></td>
</tr>
<tr>
<td>Minor Problems</td>
<td>30.2</td>
<td>24.5</td>
<td>27.4</td>
<td></td>
</tr>
<tr>
<td>Serious Problems</td>
<td>5.3</td>
<td>14.0</td>
<td>9.6</td>
<td></td>
</tr>
<tr>
<td>N=</td>
<td>1026</td>
<td>1029</td>
<td>2055</td>
<td></td>
</tr>
</tbody>
</table>
It is unfortunate that the study did not contrast the mentally ill with the mentally retarded to determine the influence of sex, extended contact with the same home operator, as well as other factors. Table I, which takes into account environmental, social and cultural factors, merely hints that mentally ill residents respond by manifesting more aggression. The other tables attempt to show the extent of influence of various factors on the behavior of the whole sample population. From consideration of external variables, there is indication that, taken as a whole, the findings concerning the influence of physical, social and cultural environmental factors on human actions are such that a proposition holding that human behavior originates from biological impulses is difficult to substantiate.

The observations reported thus far pertain to a group of adults who formed the main concern of this study. There was also included, in a separate study, a group of young people ranging in age from two to eighteen. The children and young adults formed a group comprised of sixty mentally ill persons in residential homes, 112 retarded persons in residential homes and seventy-two retarded youth in nursing homes. The level of retardation roughly paralleled that of the adults included in this study.

It is of interest to digress a moment from the adult study, that constitutes the main example used in this paper, to take
a brief look at the results of the youth study to see how its findings compare with those of the report concerning the agonistic behavior among adults. The comparison is significant in as much as what is hinted at in Table I concerning adults is also true with regard to the youths. There is a much greater incidence of aggressive behavior found among the mentally ill and a much higher level among the home operators of feeling comfortable with the behavior of the retarded.

The home operators reported a comfortable relationship in 77.8% of the cases regarding those afflicted with retardation in nursing homes and 57.1% of the retarded in residential homes. In contrast, the home operator reported a comfortable relationship with only 42.2% among those not suffering with retardation. The reports of serious problems of violence were very much higher among the mentally ill residents (17.8% versus 9.5%) than found among the retarded people. It would appear from these findings, granting that the retarded respond more faithfully to biological influences in regard to agonistic behavior than the more alert mentally ill persons, physical and socio-cultural environments provide a better explanation for aggressive behavior than genetic impulses. It appears that the more the environmental elements are removed, the less frequently aggressive behavior occurs. Table V summarizes these data.
Specific types of deviant behavior among the youths were analysed to obtain a closer look at the contrast between the behavior of the mentally ill and the mentally retarded. Table VI displays this contrast in terms of behavior dangerous to self, dangerous to others, annoying to others, destructive of property, difficult to care for, sexually aberrant and other deviant behavior. The violent actions of the mentally ill resulting in destruction of property (23.1% versus 5.6%) are found to be among the most significant differences in behavior.

Hopefully, at this point, it is clear that research for government policy and planning must involve more than mere data collection, if we are to determine how programs, arbitrarily adopted, are working. In the final portion of this paper we shall look at the contribution made by this study of human disruptive behavior in the context of theories held by
anthropologists and other specialists who have done research on human aggression, using various methodologies. The evaluation of the contribution of the present study will be in terms of its conclusions, its limitations and what needs to be done for better results in the future.

Table VI
Specific Types of Behavior Reported by the Home Operators

<table>
<thead>
<tr>
<th>Types of Behavior</th>
<th>Mentally Ill Residents</th>
<th>Retarded Residents</th>
<th>Retarded in Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dangerous to Self</td>
<td>3.8</td>
<td>22.2</td>
<td>25.0</td>
</tr>
<tr>
<td>Dangerous to Others</td>
<td>15.4</td>
<td>11.1</td>
<td>12.5</td>
</tr>
<tr>
<td>Annoying to Others</td>
<td>34.6</td>
<td>22.2</td>
<td>37.5</td>
</tr>
<tr>
<td>Destructive of Property</td>
<td>23.1</td>
<td>5.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Difficult to Care for</td>
<td>30.8</td>
<td>44.4</td>
<td>37.5</td>
</tr>
<tr>
<td>Sexually Aberrant Behavior</td>
<td>3.8</td>
<td>5.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>28.0</td>
<td>10.0</td>
<td>0.0</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
CHAPTER IV

Prospects for the Future

The range of thought among anthropologists and other specialists concerning the causes of aggression in man covers the entire spectrum of the nature-nurture question. Desmond Morris (1967:84) proposes as a major thesis that "biological process molds social structure." This theory was expounded also by Robert Ardrey in *African Genesis* (1961) and *The Territorial Imperative* (1966). While Ardrey and Morris were the popularizers of theories concerning biological origins of aggressive behavior, Konrad Lorenz, whom Berkowitz calls the "father of ethology" (1973:39), is responsible for a more scientific approach to the subject. He did extensive research in observing the behavior of fish and animals as a method for understanding the behavior of man. He postulates that a rational creature from another planet viewing man's behavior would find earth, "devoid of morality and reason and guided only by instinct, in particular, the instinct of aggression" (1963:28).

Eibl-Eibesfeldt (1972:3) chose a middle ground and emphasized the "dynamic relation between the biological and the cultural." He insisted that neither aspect is to be seen as static. He states as his basic premise, "If a certain behavior pattern or disposition are inherited, this by no means implies that it
is not amenable to conditioning, nor must it be regarded as
natural in the sense that it is still adaptive, that is, conducive
to survival. A behavior pattern, developed in the course of
the history of the species, can lose its original function. Thus,
aggressiveness may have stimulated the intellectual development
and universal distribution of man" (Eibl-Eibesfeldt 1970:3).
He states, further, "a clear proof for the inborn aggressive
drive in man has not yet been presented" (1970:327).

Other scientists reject studies on the genetic origins of
human behavior as a practical impossibility. Earl Count (1958:
1067) writes, "It has proven practically impossible to pin any
specific behavioral item to genetic heredity, so that a rigid
proof based on the presence of genes in not available for human
behavioral patterns as it is for certain physical traits."

Fried, Harris and Murphy agree with the conclusions of
Count and emphasize the nurture aspect of the question. They
propose that, "Man is not inherently aggressive but his intelli-
gence gets him into scrapes he cannot handle without being
aggressive. Since his dilemmas are inescapable, the result is
much the same as if he were inherently aggressive" (1968:118).
Montagu takes a similar position emphasizing, however, the
learning aspect of human aggression. He states, "The notable
thing about human behavior is that it is learned. Everything
a human being does as such he has had to learn from other human
beings" (Montagu 1968:12). Alexander Alland (1972:39) adds to
this latter view that a capacity for aggression is determined by hereditary factors while its expression is patterned by culture and environment.

While anthropologists have long sought for the explanation of human aggression, it is not to be viewed as merely an academic discussion. If aggression is viewed as a learned behavior rather than as a blind, irresistible, biological urge, then conclusions are quite different. If it is a learned behavior, it can be unlearned. Cultural causes that evoke useless and unreasonable aggression can be identified and modified. It seems odd that man is the only species that frequently and with no apparent reason kills his own kind. Culture has a role to play in man's behavior patterns that is tremendously powerful. Depending on one's judgement as to the basis of man's behavior, one will tend to turn primarily to surgeons and biochemists or to social scientists to chart man's future.

The study of the disruptive behavior resulting from the community placement of mental patients tends to support the theories of Eibl-Eibesfeldt, Fried, Montagu, Alland and others who see man as neither aggressive nor non-aggressive but influenced by his physical and socio-cultural environments. There appears to be no evidence that man's behavior is predetermined by biological or genetic causes as suggested by Ardrey, Morris and Lorenz.

Table V, in particular, shows that the mentally ill, who are more receptive to environmental influences, are also more aggressive
than the mentally retarded people included in the study sample. This study strongly suggests that state policy and programs should tend to discourage the use of surgeons and biochemists as a means of controlling deviant behavior, while encouraging the involvement of social scientists.

The present study may also serve to emphasize the need of research directed at human behavior as such. Many more studies on human behavior are needed rather than on animal behavior. Hirsch (1967:282) was aware of this when he said, "It is clear the results of laboratory population experiments cannot be extrapolated to man."

Some may criticize this study in that if one is to examine the behavior of mentally retarded and mentally ill people, then it stands to reason that one should also include a sample group drawn from the general population of normal people. The behavior of all three groups then could be contrasted with some merit.

Such criticism is valid but is only one of a number of other criticisms indicating the limitations of this study. Other questions should be asked such as, To what extent does the behavior of people discussed in this paper deviate from normal human behavior? Murphy (1971:31) suggests that conflict and instability of intersocietal relations is the "constant condition of social life rather than an interruption of it." While we search for order, we find instead chaos in social life. Conflict, then may be viewed as having functional importance in that society.
is constantly undergoing development toward new kinds of orders.
It must be acknowledged that the study of mental patients does
not take into account the beneficial functions of deviant behavior.

Social scientists may also question the arbitrariness of
the field workers' personal judgments used to assess environmental
factors which are considered in measuring influences on mental
patients' behavior. Thus, what constitutes a crowded room or
what standard is to be applied to assess cleanliness of a resident,
may vary significantly among field workers.

Still another limitation to this study is the fact that
efforts are directed exclusively to viewing the behavior of the
mental patients. What may be of equal significance is a comparison
of the behaviors of the home operators. To what extent is the
disruptive behavior of residents a reaction to aggressiveness on
the part of the home operator? To what extent does the home
operator use tranquilizers to subdue restless patients?

The study of the behavior of mental patients is only one
side of the coin. Emilen (1967:736) points out that further
investigation is necessary to determine whether societal aggressive
behavior follows laws different from those that individuals
within a society follow. Even if this study demonstrated the
nurture aspect of human behavior, according to Emilen, this conclu-
sion could not automatically be generalized to human behavior.

This study appears also to leave out the influence of
family relationships, an important factor. A Dutch anthropologist,
vanVelzen (1960:169-200), has found support for the hypothesis that societies with fraternal or family interest groups are more likely to have feuding than societies without such groups.

While these criticisms are justified, nevertheless, they underscore the point being made by this paper. It is not enough for a social scientist to become involved for purposes of interpretation after data have been collected. It is of critical importance that anthropologists be involved in the design of a study, interpretation of data collected, application of theories that are substantiated by the findings and evaluation of theory and practice on an on-going basis.

It is unfortunate that more social scientists have not taken the opportunity of being involved in building a future for mankind through government-sponsored studies. Many of the criticisms cited above could have been avoided had social scientists been involved from the beginning of the study. Without a doubt, society will continue in its current rapid pace of social change. Social scientists must assist in this process of change so that resulting conflict will not result in useless chaos but in a much more renewed and enlightened human society.

The contribution of social scientists is an unfelt need in governmental bureaucracy. Your people setting out on a career in anthropology should not expect a breathless, open arms
reception. Individuals seeking a position in civil service should take state examinations in as many different job categories as possible. It may be necessary to accept a job that is less desirable for a time. Once civil service status is achieved, however, it is not difficult to gradually transfer to the many research and development units operating in nearly all bureaus of state government.

It is strongly felt that students should be encouraged to seek employment in applied anthropological research. The academic world should stay in close contact with students who venture out in efforts to deal with current social and political problems.

While the purpose of this paper was not to resolve the nature-nurture question regarding human agonistic behavior, the study of mentally ill and retarded patients, which was used as an example, may awaken uninvolved social scientists to the opportunity and need for participation in governmental research. If we are to maintain and develop a free democratic society, which all claim to cherish, then insight into human society as voiced in classrooms must be brought to the marketplace. A society that loses a vision and understanding, soon prizes mindless conformity and ends in the bankruptcy of dictatorship.
APPENDIX A

Statistical Design

Exploration with the Departments of Mental Health and Social Services and preliminary site visits suggested that three dimensions should be taken into account in order to select a sample representative of the population placed in community facilities. These dimensions included: 1) whether the person was placed from a state institution for the mentally ill (state mental hospital) or for the mentally retarded (state home and training schools); 2) the type of facility in which the person was placed (skilled nursing home versus basic nursing home versus home for the aged versus residential home); and 3) whether the placement was arranged and supervised by the Department of Mental Health or the Department of Social Services. Since Department of Mental Health placements are made almost exclusively in residential facilities, it was determined that a ten-cell sampling framework would accommodate all three dimensions. This is shown in Table VII.

The figure of approximately sixty cases per cell, or a total sample of 600 people, was determined as adequate for statistical analysis. Dummy calculations showed that a randomly selected sample of that size would give reliable representation of the total population and would adequately support statistical distinctions of the type likely to be made in the study.
### Table VII

Sampling Scheme Utilized in Community Placement Project

<table>
<thead>
<tr>
<th>Level of Care and Agency of Placement</th>
<th>Institution of Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mentally Ill</td>
</tr>
<tr>
<td>Skilled Nursing Department of Social Service</td>
<td>60</td>
</tr>
<tr>
<td>Basic Nursing Department of Social Service</td>
<td>60</td>
</tr>
<tr>
<td>Home for the Aged Department of Social Services</td>
<td>60</td>
</tr>
<tr>
<td>Residential Department of Social Service</td>
<td>60</td>
</tr>
<tr>
<td>Residential Department of Mental Health</td>
<td>60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>

In anticipation of attrition from correction of errors in the sampling list, and losses of people who could not be located or who declined to participate, an additional ten cases per cell were to be selected, giving initial totals of 70 per cell, or a total sample of 700 people.

It was deemed important in designing the study to ensure that the people to be studied all had a reasonable length of time during which they could experience life in a community facility.
or return to the state hospitals or training schools. People who were placed after September 30, 1972, who would have had fewer than six months of opportunity to function in community facilities before follow-up, were thus excluded from the study. Differences in the referral and placement mechanisms of the Departments of Mental Health and Social Services led the investigating team to use slightly different criteria for identifying the earliest placements to be eligible for the study. People placed by the Department of Mental Health were defined as eligible if placed between January 1 and September 30, 1972. Persons placed by the Department of Social Services were included in the sampling universe if they were referred to DSS between January 1 and June 30, 1972 and placed before September 30, 1972.

A list of people placed by the Department of Mental Health during the study period was supplied by that department. The Department of Social Services and its nine regional offices provided a list of people referred to DSS for placement in the time period chosen. The lists were then transcribed and alphabetized by surname using index cards. Duplicate listings were eliminated where possible. Duplications resulted largely from situations in which both DSS and DMH were involved in the same placement. In such instances the case was attributed to the agency first involved in placing the person. Other cases of duplication involved second or multiple admissions to state institutions followed by additional placements. In such
circumstances all but the first admission/placement series were removed from the list.

The culled population list was then sub-divided into ten strata, based as noted earlier on the diagnosis (MI vs MR), the agency which made the first placement, and the level of care provided in the first placement. This is illustrated in Table VIII. Where adequate information was not originally supplied, additional data were sought from the agencies or other sources.

A stratified sample was next drawn, cell-by-cell, from the array shown in Table VIII. To accomplish this, each case was given an identifying number, and 70 cases were selected from each cell by means of a table of random numbers. Exceptions were the mentally retarded who had been placed in basic nursing homes and homes for the aged. Because there were fewer than 70 cases in those cells, all cases were taken.

Despite elaborate precautions, it was later found the 97 cases were not eligible and 33 cases had been misclassified into the wrong stratum. Cases not eligible for the study were dropped, including those who were too young, had been referred or placed outside of the study period, or were otherwise inappropriately sampled (eg. a placement had been arranged but the person never actually went there). Cases belonging in other strata were transferred to those strata. Tables IX and X show the nature and frequencies of these adjustments.
Table VIII
Sampling Universe, Before and After Corrections, Showing Strata Populations

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Uncorrected*</th>
<th></th>
<th>Corrected**</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mentally Ill</td>
<td>Retarded</td>
<td>Total</td>
<td>Mentally Ill</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>125</td>
<td>98</td>
<td>223</td>
<td>122</td>
</tr>
<tr>
<td>Basic Nursing</td>
<td>212</td>
<td>37</td>
<td>249</td>
<td>186</td>
</tr>
<tr>
<td>Home for Aged</td>
<td>72</td>
<td>14</td>
<td>86</td>
<td>60</td>
</tr>
<tr>
<td>Residential - DDS</td>
<td>447</td>
<td>212</td>
<td>659</td>
<td>366</td>
</tr>
<tr>
<td>Residential - DMH</td>
<td>927</td>
<td>457</td>
<td>1384</td>
<td>793</td>
</tr>
<tr>
<td>Total</td>
<td>1783</td>
<td>818</td>
<td>2601</td>
<td>1527</td>
</tr>
</tbody>
</table>

*Sampling list as provided by Departments of Social Service and Mental Health
**Projected population estimate after correction for ineligible and misclassified cases
Table IX

Cases Dropped from the Sample Because Ineligible, by Stratum from Which Dropped

<table>
<thead>
<tr>
<th>Ineligibility Due To</th>
<th>Mentally Ill</th>
<th></th>
<th>Mentally Retarded</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SK</td>
<td>BAS</td>
<td>H/A</td>
<td>DSS RES</td>
</tr>
<tr>
<td>Duplicate Listing</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Age under 18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Referred Prior to 1972</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Placed Prior to 1972</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Placed After 9/30/72</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Placed with Relatives</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Not placed within Sampling Period or Never Were in State Institution</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>14</td>
</tr>
</tbody>
</table>
Table X
Cases Found Eligible for Sampling, but Drawn Initially from Incorrect Stratum

<table>
<thead>
<tr>
<th></th>
<th>Mentally Ill</th>
<th></th>
<th>Mentally Retarded</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SK</td>
<td>BAS</td>
<td>H/A</td>
<td>DSS RES</td>
</tr>
<tr>
<td>Originally Sampled from</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriately Transferred to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dropped</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
After making indicated corrections, the final sample was composed as shown in Table XI. To compensate for the unequal proportions of cases sampled, all findings presented in this thesis are weighted by the inverse of the sampling ratio, to give statistical representation of the actual numbers of people in the general population who would fall in the respective cells.

Table XI

Corrected Study Sample Cell Frequencies and Sampling Ratios

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Mentally Ill Freq.</th>
<th>Sampling Ratio</th>
<th>Weight</th>
<th>Mentally Retarded Freq.</th>
<th>Sampling Ratio</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>61</td>
<td>.52</td>
<td>2</td>
<td>58</td>
<td>.70</td>
<td>1.5</td>
</tr>
<tr>
<td>Basic Nursing</td>
<td>62</td>
<td>.32</td>
<td>?</td>
<td>24</td>
<td>1.00</td>
<td>1</td>
</tr>
<tr>
<td>Home for Aged</td>
<td>40</td>
<td>.61</td>
<td>1.5</td>
<td>11</td>
<td>1.00</td>
<td>1</td>
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<tr>
<td>Residential - DSS</td>
<td>61</td>
<td>.17</td>
<td>6</td>
<td>60</td>
<td>.28</td>
<td>3.5</td>
</tr>
<tr>
<td>Residential - DMH</td>
<td>61</td>
<td>.08</td>
<td>13</td>
<td>59</td>
<td>.20</td>
<td>5</td>
</tr>
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<td>Total</td>
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<td>212</td>
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</table>

The accepted methods of demonstrating the extent a sample truly represents the population from which it was drawn are documentation of appropriate sampling techniques and statistical comparisons between the samples and the population from which they were drawn. The first criterion was clearly met.
population universe cannot be meaningfully presented in this instance because of differences in the nature of the available data. That is, comparably corrected information about the total population of people placed during the study period is not available and cannot readily be reconstructed from the lists provided by the Departments of Mental Health and Social Services. To do so would involve subjecting the case record of every person placed during the period to the same degree of scrutiny as was applied to those in the sample. Table XII indicates the number of cases in the study sample for which complete data were not available. Table XIII notes the specific reasons why 51 of the cases had to be dropped from the study. Table XIV indicates the sampling ratios and corrections.

Because of the composite stratified sampling techniques, a single confidence interval for the magnitude of differences could not be calculated. One should not place heavy reliance on very small proportionate differences. Only those proportions and differences which all of 5% magnitude are significant.
<table>
<thead>
<tr>
<th>Sampling Stratum</th>
<th>No Detrimental Case Records Found</th>
<th>No Facility Interview</th>
<th>No Resident Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. NW</td>
<td>Freq. NW</td>
<td>Freq. NW</td>
</tr>
<tr>
<td>Skilled Nursing-MI</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Basic Nursing -MI</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Home for Aged -MI</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Residential DSS-MI</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Residential DMH-MI</td>
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<td>0</td>
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<tr>
<td>Skilled Nursing-MR</td>
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<td>2</td>
<td>0</td>
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<tr>
<td>Basic Nursing -MR</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Home Foraged -MR</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Residential DSS-MR</td>
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<td>0</td>
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<td>Residential DMH-MR</td>
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</table>
**COMMUNITY PLACEMENT OF YOUTHS**

### Table XIII

**Reasons Cases were Dropped as Ineligible**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Department of Mental Health</th>
<th>Department of Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DMH - MI</td>
<td>DMH - MR</td>
</tr>
<tr>
<td>Not Placed by Closing Date</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Not Placed Directly from Institution</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Was Never in Institution</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Temporary Placement</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Placed Outside of Michigan</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Age 18 or Older</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>
Table XIV

Sampling Ratios and Corrections

<table>
<thead>
<tr>
<th></th>
<th>Department of Mental Health</th>
<th>Department of Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DMH - MI</td>
<td>DMH - MR</td>
</tr>
<tr>
<td>Total on Sampling List</td>
<td>90</td>
<td>157</td>
</tr>
<tr>
<td>Total Cases Sampled</td>
<td>77</td>
<td>70</td>
</tr>
<tr>
<td>Uncorrected Sampling Proportion</td>
<td>.86</td>
<td>.45</td>
</tr>
<tr>
<td>Cases Dropped as Ineligible</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>Cases not Sampled</td>
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<td>.29</td>
</tr>
<tr>
<td>Unsampled Cases Projected to be eligible</td>
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<td>62</td>
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<tr>
<td>Cases Projected Eligible in Population</td>
<td>60</td>
<td>112</td>
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<tr>
<td>Cases Studied</td>
<td>51</td>
<td>50</td>
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<tr>
<td>Corrected Sampling Proportion</td>
<td>.85</td>
<td>.45</td>
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<td>Multiplier</td>
<td>1.18</td>
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<tr>
<td>Proportion of Cases Sampled Found to be Ineligible</td>
<td>.34</td>
<td>.29</td>
</tr>
</tbody>
</table>
APPENDIX B

Survey Instrument

Field workers visited each facility where persons included in this study were placed. The questions contained in portions of this survey instrument were used to cull information from records available on persons included in the same. In another section a list of questions addressed to the home operator is found. In addition, the interviewer was carefully instructed to make his own assessment and write his observations.

I. Resident information from sample cards

1. Name:

2. Department of Social Services case number:

3. Department of Mental Health case number:

4. Birth date:

5. Sex:

6. Facility of jurisdiction:

7. Affliction (MI or MR):

8. Recommended level of care:

9. Date of referral from state facility:

10. Date of first placement.

11. County of first placement:

12. Placement level of care:

13. Agency making first placement:

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II. Resident information from DSS and DMH records

1. County of commitment for the most recent stay in a state institution:
2. Race and ethnic origin:
3. Resident's marital status:
4. List of all relatives indicated in the case folder:
5. List interested persons indicated in the case folder:
6. Location of first placement:
7. Distance from nearest relative:
8. Indicate location of current or last placement:
9. Distance from nearest relative in last placement:
10. Additional non-physical disability factor:
11. Physical impairment:
12. Other limiting factors:
13. If mentally ill, indicate educational attainment:
14. If mentally retarded, indicate resident's I.Q.:
15. Indicate other test scores:

III. Resident information - pre-release care plan information

1. Prior to the release from the institution, what goals were stated by the institution with respect to this individual?
2. Do the records from the institution describe the resident's needs and limitations?
3. Indicate the degree of supervision recommended:
4. Indicate the level of care required by the resident:
5. Do the records recommend specific services?

6. Referring facility if other than facility of jurisdiction:

7. Number of months remaining in intervening placement:

IV. Resident information - post-release care plan information

1. Is there a post-release care plan in the case folder?

2. What are the goals stated?

3. Are the resident's needs and limitations described?

4. Are specific services recommended?

5. Indicate the specific provisions for services stated in records:

V. Facility information

1. Type of facility:

2. Which level of care is the facility licensed?

3. Ownership:

4. Size of the facility:

5. Licensure status:

6. Specific items in default:

VI. Field interview

1. How long has the home operator been there?

2. What community centers are located near the facility?

3. How far away is the bus stop?

4. How do the neighbors feel about mental patients living near by?
5. Indicate objectionable behavior:

6. Do residents have difficulty getting prescriptions?

7. Do residents have difficulty getting medical care?

8. Does the resident in the study need physical assistance?

9. Does the individual need reminding to care for himself?

10. Is the resident in the sample belligerent?

11. Is more information needed about the sample resident?

12. What important information is needed?

13. Will this resident be here for life?

14. How would you describe his relationship to facility staff?

15. What kinds of problems do you have with his behavior?

16. Can the problems be managed?

17. Has the sample resident deliberately damaged property?

18. Has he run away?

19. Has he attempted suicide?

20. Deliberately inflicted injury to self or others?

21. How does he get along with other residents?

22. How often does he engage in social activities?

23. How often is he visited by family and friends?

24. How often does he go out on a visit?

25. How many hours does he spend sleeping?

26. What does he do during his free time?

27. Does he take tranquilizers?

28. Is there anything else that may be said about the sample resident?
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Montagu, M. F. Ashley

Morris, Desmond

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Newman, Philip L.

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