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ABSTRACT

A philosophy of interdisciplinary management of the severely and profoundly regarded is described in the monograph which also includes reporting and evaluation processes. Ten clinical reports of an actual case are provided to demonstrate the adequacy of the multidisciplinary method. These reports assess the medical condition, psychological adjustment, and biosocial status of an 8-year-old mongoloid girl. It was concluded by the authors that careful study and wise direction of program staffing committees can do much to alleviate some of the difficulties in residential management. (Author)

MANAGING THE MENTALLY RETARDED THROUGH INTERDISCIPLINARY ACTION

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FOREWORD

Although the following paper was written and presented some time ago, it was never published. Perhaps one of the many reasons why it was not was because of the quality and polemic nature of its style which is not suitable for conventional journal writing. One would like to think that in some respects, however, it was "ahead of its time". But the truth of it is that it is too "literary" and perhaps too pretentious.

Nevertheless, we have "reread" it lately and we think that there may be some small value in publishing it with some minor changes, despite the fact that it does not represent the customary work of a "scientific researcher". Indeed, as I look around a number of residential institutions, I see so-called "interdisciplinary" staffing committees, or, at least, people sitting together who seem to be acting "in an interdisciplinary way". But one wonders just how much of that essential quality is being provided; and whether all of us are not in our professional meetings and classrooms, in our dayrooms, and in our offices turning our backs on an important principle.

If we are, it is tragic! If we are, we are establishing again some of the older ideas that were blind and rigid! If we are, I wonder how much we are contributing to the well-being of the individual we were trained to help! But I believe we are not! Some progress is being made but, unfortunately, one wonders if it is enough.

In that spirit and perhaps because of a philosophical interest and that alone, we are publishing this in an attempt to blend both idealism and action!

Earl E. Balthazar
July, 1971

ACKNOWLEDGEMENTS

This small monograph if it is that, does not merit a dedication to anyone or to anything. After all, there are even limits to the gratitude of those who are thankful for small things. We would like to think however, that it does recognize in a modest way the talents of those who sit in program staffing committees, program planning organizations and planning groups, or such whose business it is to plan for the well-being of the handicapped. In particular, we refer to those who sit in these committees who speak in small voice, without authority, but who know and recognize the difficult task of managing and "living with" the retarded individual. They, along with their charges, are frustrated and suffer the most from the vicissitudes of programming.

And most certainly, we acknowledge and are thankful for the work of Mrs. Alice Rocca, who executed the administrative details of this publication, and Mrs. Bonnie Missall, who typed the manuscript.

MANAGING THE MENTALLY RETARDED THROUGH INTERDISCIPLINARY ACTION[1]

by

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Introduction

Currently it is quite fashonable to describe the joint efforts of various professional or technical groups as being "multidisciplinary" or "interdisciplinary" in action. This usually occurs when a number of different disciplines are used to attain what are assumed to be common goals. We would submit, however, that "multidisciplinary" and "interdisciplinary" efforts, like democracy, are easily proclaimed but difficult to achieve. It will be pointed out that there is an essential and basic difference in the meanings of the two terms. This difference is highlighted when they are applied to the resolution of the problems encountered in the management of the mentally retarded individual.

The presentation, critique, and subsequent analysis of an interdisciplinary program for the management of the retarded resident reflects a specific doctrine in this study. It is firmly based upon the recognition that residential services must be extended beyond the limitations of routine care and management. The extension of services beyond the general needs of the retarded person must start, however, with the emergence of rigorously critical concepts of coordinated action.

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[1] Presented at the 90th Annual Meeting of the American Association on Mental Deficiency, Sheraton Hotel, Chicago, Illinois, May 12, 1966.

Careful consideration of the conceptual perspectives encountered in the management of the resident entails a giant step forward. Such a step must be taken by first considering the salient professional and sub-professional skills and talents at hand within the institution. The diverse contributions and skills must somehow be ordered into a community of services.

The study begins by analyzing terminology, then proceeds to evaluate actual clinical reports, and concludes with a brief survey of the major difficulties encountered. Its primary aim is to achieve a community of services and a plan of action based on urgent necessity: that of the service-oriented community.

Meaning of Terms "Multidisciplinary" and "Interdisciplinary"

A discussion that immediately begins with the delineation of the meaning of terms runs the risk of defeating its own purpose. Moreover, the compulsions of the authors are likely to far surpass those of the reader and there is always the danger of presenting an anticlimax.

In making distinctions in meanings, such as between the terms "multidisciplinary" and "interdisciplinary" there is the risk of being pedantic. Frequently, a didactic speaker or writer goes beyond the limits of the patience of his audience. There is an anecdote that may apply to this situation. A small boy, the son of an ornithologist, once asked his mother to describe a penguin. His mother, taken by surprise, replied by saying, "Your father is an ornithologist, why don't you ask him?" "Because if I go to my father," the boy replied, "he would tell me more about penguins than I would really want to know!"

In the professional literature the words "multidisciplinary" and "interdisciplinary" are frequently used interchangeably and yet there frequently seems to be an implied difference in meaning. Distinct differences in meanings between the two words, however, are not immediately indicated in Webster's Dictionary (1963). Here one finds that the prefix

"multi" means more than one, more than two, or many times. "Interdisciplinary" is described as meaning more than one discipline. The latter is used in the sense of involving two or more academic disciplines.

As Latin prefixes, however, "inter" as opposed to "multi" refers to the ideas of "reciprocal", "carried on between", or "occurring between". ONE MAY CONCLUDE THAT THE WORD "INTERDISCIPLINARY" CAN CARRY THE MEANING OF A TRANSACTION BETWEEN OR AMONG DIFFERENT DISCIPLINES. ITS MEANING IS NOT LIMITED TO THE NUMERICAL CONCEPTS OF SEVERAL DISCIPLINES. THIS WOULD SEEM TO BE AN IMPORTANT DISTINCTION.

The distinction would appear to take on added meaning when one speaks of the administration of complex programs for the mentally retarded resident. To adequately administer the varied clinical and service programs required in the diagnoses, treatment and management of retarded individuals entails a rich investment of professional talents. The thoughtful administrator cannot ignore nor can he invest in the inheritance of traditional professional conflicts. He cannot support inter-service competition when such competition merely reflects professionally rationalized self interest that minimizes overall interdisciplinary effort.

The art of administration is often described as the art of compromise. But the art of compromise, if it is to be useful, must incur the least possible risk and cost in services to the retarded resident. It must also strengthen the activities of all those who may contribute talent and skill to his care and adjustment. The focus of all effort, whether or not it be service oriented, clinically directed, or administratively rendered, is the retardate himself!

On the other hand, enlightened self interest and healthy competition among professional groups and services are obviously desirable. Such self interest and competition among the various disciplines must subordinate themselves to devising programs to enhance the well being and biosocial

status of the retarded resident. Reciprocity, communication, and mutual interaction to achieve these ends are also necessary and wise. It is often communication that is essential. Communication can begin most effectively by the use of multidisciplinary reporting, i.e., the reports given by the various clinical disciplines that have observed or worked directly with the retardate. The historical problem of the institution, however, is essentially the failure of communication between disciplines and the exchange of information. It is essentially a failure in the mutual interaction between various clinical services to attain desirable programs for the resident. It is a failure in planning for him so as to help him attain comprehensive and realistic goals. Administrative policy in seeking to guide and direct residential programs, however, often finds itself facing a hierarchy of professional and technical services where interaction and reciprocity are the exception rather than the rule. Such services must, nevertheless, rely on interdisciplinary methods to direct their efforts in managing the retarded individual who must spend a portion or all of his life in an institution.

Without careful consideration of such matters, the administrative direction of comprehensive planning for the retarded resident will fall short of its goals. To evaluate properly the retardate's problems and to plan the best solution to them is, to say the least, a complex matter. Examination reports and professional contracts by the recreation therapist, the aide, the nurse, occupational therapist, physician, physical therapist, psychologist, religious leader, social worker, speech and hearing correctionist, the teacher and vocational counselor must be effectively coordinated and utilized. The parents, the home and the community must also be considered in all aspects of planning. When these contributions are not harmoniously or properly applied, the mentally retarded individual is the one who really loses!

Multidisciplinary Reporting and Evaluating

How much the retarded individual loses in not being provided necessary services is ordinarily a matter of conjecture. Ten separate reports were obtained to demonstrate the adequacy of the multidisciplinary method. The reports assessed the medical condition, the psychological adjustment factors, and the biosocial status of an eight-year-old Mongoloid girl. These reports have been included with the sole intent of examining some of the assumptions underlying the use of multidisciplinary action. We have underlined what we think were some of the significant parts.

M.H. was admitted to a Middle Western institution in 1962, when she was four years old. We asked the various professional services at an institution to evaluate her on a routine basis. The following clinical reports are reproduced here without omission or elaboration.

(a) M. H. is an essentially non-verbal Mongoloid girl of seven. She makes sounds in response to objects presented to her but words are not distinguishable. Her attention span seems to be limited and, while she will respond to objects by grasping, looking, etc., she does not maintain interest for more than a few seconds. She smiles and likes to be pulled up and down, but does not seek personal contact. The aides report that her ward behavior involves an alternation of activity: one day she uses the potty, the next day she does not; one day she plays with other children, the next day she will not; one day she eats with a spoon, the next day she eats with her fingers.

I would guess that M. H. has some sort of an emotional disturbance as well as being retarded. This is suggested by her on-again, off-again behavior. I think that her case ought to be brought to a staffing with the thought that she may have some more specific problems such as speech and hearing, etc.

(b) The above mentioned patient was born on 10-9-57. The mother's age at the time the child was born was 18 and the father was 21. M. H. was the 2nd child born 10-1/2 months after the 1st child. Since, 3 more children were born and all are reported to be healthy and normal. M. H.'s weight at birth was 6 pounds, 3 ounces. She was diagnosed as Mongoloid immediately after birth.

The child showed slow development right from the beginning, having very poor suction and being unable to digest anything but fluids. Later on it became more apparent that her mental development was rather slow. She was admitted to X institution in 1957 and to Y institution on 9-6-62. Her further development in Y institution has been very slow. She speaks only a few words, her school program was discontinued since she showed no ability to participate in any teaching programs. She shows some manual skills (stringing beads, stacking blocks, etc.). Her eating habits have improved and she even steals from other patient's trays when she has finished her own.

From the medical point of view, she had multiple upper respiratory infections and recurrent tonsillitis; therefore, T & A was performed on 4-13-65. Post operative course was uneventful. While checking her files, I noticed that for years there was a radiological problem in diagnosing a chest shadow and, therefore, ordered and performed barium enema examination which was helpful in diagnosing a rather large hernia of Morgagni on the left side.

In my opinion, this condition should be treated surgically as there is a danger of obstruction of this rather huge large bowel loop. Elective surgery means much less danger than surgery when it becomes an emergency.

(c) The oral-peripheral mechanism functions quite satisfactorily for speech production. There is good motility of the tongue, lips, and mandible, and good chewing, blowing, sucking, swallowing action. There is no expressive language evident. She has no verbal vocabulary and does not even attempt verbal communication. The type of vocal activity observered included crying, screaming, sighing, some tongue clicking sounds, the vowel sounds (ah, e) and the consonants (m-and unvoiced th). She does not use gestures (after much playful stimulation from the clinical examiner and two aides, M. H. waved goodbye).

M. H. responded inconsistently to sound regardless of intensity or source (tuning forks, noise makers, voice environmental noises, music). Hearing is questioned because of the erratic response pattern.

Inner language development is minimal and even this is to be questioned. Prognosis for speech and language development is highly unfavorable. M. H. has a low frustration threshold, a short attention span, and actively explores her environment flitting from one thing to another. She responds negatively to most disciplinary actions or structured environment. In short, she poorly tolerates any limitations placed on her.

(d) M. H. first entered the school in October of 1962 with two other children for one-half hour daily. Transferred to more advanced class with four others in April of 1963 for one hour daily. At that period, attempts to verbalize meaningfully were reported, and mouthing of objects decreased. Began sharing materials and related to group. Disruptive behavior appeared necessitating change to one-half hour individual daily class in October, 1963. Behavior seemingly improved, but speech diminished. Continued individual class. Attention span increased to almost 10 minutes for specific activities. Words "baby" and "ball" recorded. Wetting self began in Spring of 1964 as soon as entering classroom.

In June of 1964 began attending class with one other child. Easily distracted but interacted with other child. Vocabulary increased. Often moaned, appeared to cry, pushed away from table. Class increased to three, seeming to change behavior negatively. Crying subsided, wetting decreased but moaning, gnashing of teeth and blank staring increased. Little interacting with peers or teacher. Overturning of furniture and inappropriate laughing. Seemed unaware of others in room and often seemed to lose contact with surroundings for short, frequent periods. Requested withdrawal from school program in June, 1965, because of lack of progress. Emotional problem apparently interfering with learning ability. M. H. may require much more supervision as she becomes older.

(e) M. H. has been in an O. T. program since September, 1965. M. H. is capable of sorting 4 colors, stringing beads, both large and small, and working non-interlocking puzzles and occasionally can do interlocking puzzles of very few pieces. She is a self-feeder and needs minimal assistance in dressing. M. H. is easily frustrated and it appears that with the increase in difficulty of a task, various abnormal activities dominate her chances of success. These activities--licking, chewing, spitting, or hitting either her hands or the materials--begin almost rhythmically and increase as anxieties increase.

Often while hitting herself M. H. will laugh inappropriately. Praise usually will alleviate the undesirable activity and the task can be restarted. Making M. H. slow down or pause during a supervised task also seems to increase her tolerance for an activity, and decreases anxieties if the task is somewhat difficult or new.

(f) M. H. lacks the usual happy responsive Mongoloid personality, requiring almost constant supervision. Enjoys all activities, has a brief attention span, does not relate well to her peers. In group play will often become aggressive, knocking other children down and hitting them. The therapist reports this often happens on the ward when M. H. is seeking attention.

She seems to have a good potential, I feel she would make more progress on an individual basis and in small group situations.

Present program: bus rides, swimming pool, basic crafts (brush and fingerpainting, coloring, paper pasting) and group play.

(g) The resident's behavior, as reported, displayed considerable variation since her admission. Initially she was passive and complaisant. Six months later she displayed aggressiveness toward others whenever placed in a group situation, but played well when left alone. Subsequently, there was a generalized aggression toward peers with stubborn and negativistic attitudes toward aides. These displays diminished and behavior improved until this summer when she again reverted to her prior asocial behavior. Since the move to Infirmary 1, she has been playing cooperatively with others and has become demanding of attention from the aides.

The resident related easily to the examiner and displayed a relatively good attention span. Her comprehension of language appears to be limited to those instructions encountered in ward situations while her vocalization has not progressed beyond infantile vowel sounds. A decided preference for either hand in reaching and grasping is not clearly defined but her eye-hand coordination is considered adequate.

M. H. has made no significant developmental gains since the evaluation of 12-29-64. Social developmental age remains at 2 years, 7 months, while mental age is between 19 and 20 months.

The resident is profoundly retarded in intelligence, severely retarded in social development and motor ability. Previous recommendations for participation in group activities remain

unaltered; however, her continuation in formal class activities should be contingent upon whether her attendance will deprive another resident, who might derive more benefit from structured instruction, of this opportunity.

(h) M. H. is a seven-year-old Mongoloid who has not had contact with her family since admission in 1962. She has spent most of her life in an institution.

Her appetite is good, she feeds herself, sometimes steals food from others if not watched closely. She presents no medical problem, receives no medications and is in apparent good health. She is not toilet trained but is regulated.

Although she has participated in school and activity therapy, she does not work well with a group and would rather play independently. When she is left on her own, she is frequently seen rocking back and forth. She plays with the personnel and enjoys receiving their praise, responding best on a one-to-one basis. She would rather play roughly than really be loved. She has no expressive speech but responds to her name and understands simple commands.

(i) M. H. is not the typical picture of a "Mongoloid" child, although she does have the physical appearance of a Mongoloid. She is not carefree and easy going but, rather, she is constantly striving for individual attention and, when she does not receive it, she misbehaves. She seems to be satisfied when people work with her on a one-to-one basis but she is unwilling to share. I feel she would benefit from a family setting in which she received love and discipline in proper proportions. She needs to be able to trust someone and to have her limits consistently set for her.

(j) M. H. is a small 8-year-old Mongoloid. She is seldom sick. Does not play well with other children. Is quite aggressive to them. She enjoys this as she laughs when they cry. She has been quite a problem in the dining room, throwing trays and having temper tantrums. Has improved in the last few weeks. She has been praised a great deal and we feel this has helped. M. H. enjoys going in our living room, and likes to color and have the attention of the aides. Does not function as well in a group as on a one-to-one basis. Does not have any expressive speech, but responds to her name and command. Is not toilet trained but is regulated.

Critiques of the Reports

Several conclusions may be drawn from this phase of multi-disciplinary reporting. We find, for example, that a hitherto undetected hernia, if untreated, might very well have resulted in a bowel obstruction. Corrective surgery then became a matter of essential programming. Still another report stressed the need for a referral to a residential staffing committee in order to obtain further evaluation of a possible difficulty in speech and hearing. We are also able to perceive a child presenting some unusual problems of adjustment. In assessing these reports to obtain a precise clinical picture, we find the following:

(a) A verbally retarded girl who has no expressive speech beyond infantile vowel sounds but who is gaining in expressive vocabulary;

(b) a withdrawn youngster who does not relate to peers but who plays cooperatively with other children;

(c) a socially maladjusted child who does not seek personal contact but who demands attention from the aides;

(d) a patient who has had a recent history of frequent upper respiratory infections and a recently disclosed hernia but who presents no acute medical problem;

(e) a mentally retarded and maladjusted youngster who seems to have "good potential" for programming but whose attendance in a specific program "....will deprive another resident who might benefit from structured instruction";

(f) a hyperactive child who displays a relatively good attention span but who is extremely distractible;

(g) a behaviorally disturbed youngster who, when her instructional activities are "slowed down", significantly increases her frustration tolerance but who cannot tolerate structured supervision; and

(h) a recalcitrant girl who cannot accept behavioral limits but who can achieve progress in small group situations.

In summarizing these reports, and accepting the fact that the resident was seen at different times, some of the inconsistencies in the findings are such that they may endanger clinical accuracy and reliability. One would wonder what an administrator would do if he had to use these reports to immediately reply to a professional inquiry. More important, perhaps, is the conclusion that it would be difficult to limit clinical considerations of the case to the multidisciplinary stage of reporting in order to develop a comprehensive program for the child.

The staff members who prepared these reports are very highly regarded professionals whose competence and achievement would not suffer by comparison with any other staff. It is not, therefore, the level of professional skill that is at issue here but some of the basic assumptions in the reports themselves. These assumptions may be described as follows: (a) that one-half or one hour or more of examination time is sufficient to account comprehensively for the status and behavior of the child; and (b) the often implied stereotype that because she is retarded, distractible, and unstable, that very little can be done for her. This judgment carried through to her possible emotional problem. (One staff member stated subsequently, for example, that he felt that it was unnecessary to mention the presence of an emotional disturbance. He felt that most, if not all, of the institutionalized residents are emotionally disturbed!)

Overriding most of these reports is a concept essential to medical practice and applied in a rather loose and prejudiced fashion in non-medical areas. It is the assumption that non-medical evaluations and reports should be concerned directly and even exclusively with the pathology of the resident. The resident is seen by diverse non-medical disciplines as having patient status. The biosocial and behavioral aspects of adjustment are stereotyped in terms of physical illness and in the dolorous image of functional inadequacy and social incompetence. Whatever unique features there may be in development and personality are ubiquitously evaluated

with those of the physically sick organism. Unique and individual features in growth and behavior that may influence the development of a positive remedial program are lost. In some of the reports, very general references to relatively intact elements in behavior are made. We are told very little of the motivation and maturation of the resident. Psychology and related disciplines seem not to be sufficiently concerned with devising measures to estimate with reasonable accuracy the features in the adaptive behavior of the retarded individual. They seem content with establishing measures of intelligence derived from noninstitutional experiences and standards far different from those encountered in a residential population. What is needed is a thorough investigation of the environment of the retarded resident and the manner in which he can relate to his institutional experiences.

The Need for Multidisciplinary Reporting

In defense of multidisciplinary reporting, it must be recognized that there are currently no theories which form the basis of creating programs for managing the mentally retarded person. There are at present no obtainable procedures in remedial training and education that will touch upon all phases of adjustment in institutional living. This does not imply that medical treatment cannot reverse and change the course of illness; nor that remedial educational measures and appropriate psychotherapy may not contribute modifications in learning and adjustment over a period of time. What we are saying is that there is minimal appreciation and professional understanding of his responses to a world of normative standards and customs imposed on him. An understandable reaction to this problem in multidisciplinary reporting is often the reversion to sophisticated professional terminology. We are sometimes in the position similar to Molière's "hero" in the play, "The Doctor in Spite of Himself". When asked to diagnose an illness after casually observing the patient, he disquised his "diagnosis" in questionable Latin to the complete satisfaction of the patient's family.

The Next Step: Interdisciplinary Action

In further defense of multidisciplinary reporting, we must say that incomplete as these reports are, they furnish the initial step in individual program planning. What we must do is to proceed beyond the stage of multidisciplinary reporting. Reciprocity and interaction in communicating ideas among the various disciplines, the essential ingredients of interdisciplinary action would seem to be the next stage. An additional stage in planning is also the periodic evaluation of the programs required to achieve a "therapeutic atmosphere". The surprising success of the Stockton, California, program for chronic and almost hopeless psychiatric patients seems to be a case in point. It has been successful primarily because of achieving changes in ward procedures and in creating a therapeutic environment. This has apparently been achieved by breaking down status barriers and bringing professionals and non-professionals into close cooperation (Belknap, 1956).

Strategically, we are basing our attack on the problem by applying the classical empirical approach to program development by utilizing our experiences with the retardate. An empirical procedure would now seem necessary since we have not the benefits of an inclusive theory of long-term residential management. Observation and experimentation, characteristic of the empirical approach, must be applied to the problems presently encountered in residential adjustment. It would appear that interdisciplinary action in association with experimental investigations to evaluate programs may reinforce and direct our knowledge of remedial practices. Cooperative effort and the discussion of ideas and methods to devise projects for residential adjustment should be accomplished by means of interdisciplinary conferences. Professional and technical individuals should be utilized in a conference setting to review older programs and devise newer ones in residential adjustment and management. Such conferences should utilize simple language to describe practical concepts in order to circumvent semantic barriers among professionals and non-

professionals. The effective expression of ideas in meaningful language should incorporate directly the efforts of aides and other non-professionals who are in daily physical contact with the retarded individual.

The crucible that may harden and crystallize the reasoning basic to the difficulties besetting the biosocial and psychogenic status of the retarded person is the use of the residential staffing committee. The general purpose of the residential staffing committee would be to employ multidisciplinary reporting and interdisciplinary action. It would apply program recommendations to specific adjustment problems. Operationally, the residential staffing conferences or committees utilize multidisciplinary reporting and group discussion to arrive at a detailed plan of action. In our experience, we have developed and are using rotating chairmen of such committees. The chairmen are drawn from the diverse areas of education, medicine, nursing, psychiatry, psychology, and social work. The respective chairmen set a dominant theme in discussion and planning consistent with their own backgrounds and disciplines. It is anticipated that the various residential staffing committees will proceed through stages of evolution and development. Such stages of development will draw upon diverse skills and interests to broaden and benefit the life adjustment of the resident.

The Problems Encountered in Residential Staffing Committees

We hope that with the adoption of meaningful language and a common purpose an interdisciplinary effort may emerge that will contribute positive programs in residential adjustment. Such programs may be rated objectively on the basis of their value and effectiveness in benefiting the retarded person. It is conceivable that at some future time we may arrive at a comprehensive theory of residential management.

Before we can consider obtaining a workable theory of residential management, however, there is the recognition that a large number of complex problems must be solved. One of the many problems lies in the multidisciplinary area: that of redefinition of the roles that each clinical service must play in contributing to the life adjustment of the resident.

The authors realize that in further defining the roles of the various clinical services there is the likelihood of penetrating traditional spheres of influence. It is axiomatic, however, that no one discipline can have complete responsibility over the total life adjustment of the retarded individual. It is evident that each discipline will be strengthened by its contributions and efforts rather than weakened by the process of interacting with other disciplines.

The effective operation of the residential staffing committee depends upon the realization of the supremacy of each discipline within itself. It also depends upon the realization that each discipline is the sole authority within its own field. It requires an awareness of the specialized role that the aide, the nurse, the occupational therapist, the nutritionist, the physician, the physical therapist, the psychiatrist, the psychologist, the recreational therapist, the social worker, the teacher, and all those who must contribute to residential programming.

Each discipline, therefore, must have absolute priority in adapting opinions and proposals to facilitate its unique contribution to the retarded individual. Priority in the various service disciplines to be effective, however, must have definitive boundaries. Such boundaries lie in the direction of meaningful services to the specified needs of the resident. The boundaries themselves will shift when the needs of the resident are further identified or undergo dynamic change. In this context, program contribution and services can be effected in meeting the acute needs of the retarded person. They can also be effected in adapting longer term goals and programs to his life adjustment.

Another problem area lies in the development of objective methods to evaluate service programs for the resident. It is evident that desirable or undesirable behavior in the interpersonal experiences of the resident, in his self-help skills, and in his general adjustment will emanate from program development. Program evaluation is comparatively useless, however, without the baseline of objective study. The choice of program

cannot rest upon the guidelines of group consensus alone but must be based on some measure of objective evaluation. Without an evaluation of behavior, the selection and development of appropriate programs would be considerably weakened.

The authors plan further studies dealing with the definition of the role of the various clinical services in contributing to residential programs. These studies will be concerned with the difficulties encountered in the need for increased personnel to perform services and carry out program assignments. Additional studies are planned to consider the development of methods of objective evaluation of program services to the resident.

Finally, it may be said that we approach the task hopefully but with an awareness of the challenge. Careful study and wise administrative direction of resident staffing committees and program development, however, can do much to alleviate some of the difficulties.

Summary

In the professional literature the words "multidisciplinary" and "interdisciplinary" are frequently used interchangeably and yet there would seem to be an implied difference in meaning. "Multidisciplinary" would seem limited to a numerical concept of several disciplines. "Interdisciplinary" can carry the meaning of reciprocity or a transaction between disciplines. The distinction would appear to take on added significance when one is concerned with the administration of complex programs for the mentally retarded resident. The historical problem of the institution is essentially the failure of interdisciplinary communication and of the interchange of necessary information. This is often reflected in the failure in vital planning for the retarded resident so as to help him attain comprehensive and realistic goals in adjustment.

How much that is lost to the resident in failing to implement and utilize interdisciplinary resources is ordinarily a matter of conjecture. To obtain a more accurate assessment of the loss, ten separate clinical reports were obtained to demonstrate the adequacy of the multidisciplinary

action. The evaluations were designed to assess the medical condition, the psychological adjustment factors, and the biosocial status of a retarded resident in a midwestern institution. The ten evaluations were first presented, then critically studied, in terms of their sufficiency in meeting needed program requirements. Although it was determined that multidisciplinary reporting is essential, the consequent limitations in program development for the retarded resident left much that is desirable. In defense of such reporting, it was expressed that in the total life span of the retarded resident there is no comprehensive theory of overall residential management. One way to attain a comprehensive method of management is to improvise and utilize empirical trial and error methods of study. Substantiation and confirmation of the reasoning inherent in these problems lies in the functional use of the residential staffing committee. The committee itself is essentially an interdisciplinary instrument incorporating the use of multidisciplinary reporting and interdisciplinary program planning. Through the use of such residential staffing committees for adequate program development, we may at some future time arrive at a comprehensive basis for residential management.

There is also the realization that a large number of complex problems must be solved. Some of these problems were identified. The authors propose to consider in future papers some of the difficulties that may be encountered in utilizing an interdisciplinary approach to provide appropriate services for the mentally retarded.

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