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ABSTRACT

Five papers are presented from a 1980 conference on the role of social work in the core curriculum of University Affiliated Facilities (UAFs), centers designed to train practitioners in working with handicapped students. F. Cyphert ("Some Personal Observations") suggests approaches to the development of a core curriculum and notes the importance of both early exposure to interdisciplinary practices and field experiences. In "A Prescribed Mandate," R. Hormuth reviews the history of the interdisciplinary approach and discusses the beginnings of the UAF movement. A. Carten considers the needs in a core curriculum to address issues facing minority handicapped students and their families ("An Issue within A Pluralistic Society"). Areas of social work content relevant to a core curriculum are identified in "A Responsibility of a Center" by B. Borland. In the final paper, "A Multi-Dimensional Framework," J. Parnicky presents a model with components of prevention (primary, secondary, and tertiary); humanism (life saving, life sustaining, and life enhancing); and social systems (person, family, and society). (CL)

PROCEEDINGS OF THE NATIONAL CONFERENCE ON THE SOCIAL CONTENT OF INTERDISCIPLINARY CORE CURRICULA IN UNIVERSITY AFFILIATED PROGRAMS

Sponsored by:

The Nisonger Center
The Ohio State University
Columbus, Ohio

In cooperation with:

The Office for Maternal and Child Health
Bureau of Community Health Services
Health Services Administration
Public Health Services
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Edited by:

Joseph J. Parnicky, Ph.D.
Conference Director

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CONTENTS

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There are many persons who deserve credit for their contributions to this National Conference; namely, Virginia Insley and the Office for Maternal and Child Health for their continued support and funding; the members of the Advisory Committee for giving direction to the conference in both content and format, the keynoters for stimulating ideas for the conference participants to consider; and the group leaders and recorders for facilitating the group discussions focused on identifying the social content of interdisciplinary core curricula.

In addition, I am grateful to the members of the local planning committee who provided the technical assistance to make it a physical reality: Ted Kern, project assistant; Tom Fish, social work colleague, and Gail Parnicky, chairperson of arrangements.

Also, appreciation is due the Media Resource Center at the Nisonger Center--Dan Kramer, media specialist, and Karen Hardway, technician, who captured on videotape the essence of the conference. This Proceedings would not have gone to press without the editorial assistance of Catherine Gore, graduate associate, and the services of a range of typists, particularly Debbie Britton, Christine Damiene and Debbie Donaldson.

J. J. Parnicky, Ph.D.
Conference Director

THE OHIO STATE UNIVERSITY

THE HERSCHEL B. NISONGER CENTER

confers upon

VIRGINIA INSLEY

Special recognition and appreciation for her many years of service and dedication in behalf of individuals who are mentally retarded and otherwise handicapped.

Francille M. Firebaugh College of Agriculture and Home Economics	Henry G. Cramblett College of Medicine
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Robert A. Burnham College of Education	Robert O. Washington College of Social Work
Michael J. Kindred College of Law	Michael J. Guralnick The Nisonger Center

THE OHIO STATE UNIVERSITY

COLLEGE OF SOCIAL WORK

RESOLUTION

WHEREAS, Miss Virginia Insley, Chief Medical Social Work Consultant, Bureau of Community Health Services, Department of Health and Human Services, has been a fearless advocate for social work and child health; and

WHEREAS, she has served this nation in the field of public health for a quarter of a century; and

WHEREAS, she has provided leadership to NASW and related organizations; and

WHEREAS, her personal and professional influence upon social work practice, training and research and health care has been immeasurable;

BE IT RESOLVED, that the faculty and students of the College of Social Work, The Ohio State University, on this 14th day of June, Nineteen hundred and eighty, express their sincere appreciation to a noble warrior and wish her a fruitful retirement.

Robert O. Washington, Dean
and
Faculty
College of Social Work
The Ohio State University

FOREWORD

Joseph J. Parnicky, Ph.D.
Professor and Chief of Social Work
The Nisonger Center
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The signing of Public Law 88-164 by President John F. Kennedy in 1963 launched a major change in the training of practitioners for the field of mental retardation. As noted by the Long Range Task Force on University Affiliated Facilities, this legislation committed educational institutions who obtained grants under its provision "to give high priority to training professional workers in theory and practice of interdisciplinary training programs centered on models of service."[1] In the recently adopted AAUAP Membership Criteria interdisciplinary training is defined as:

> ...an integrated educational process involving the interdependent contributions of the several relevant disciplines to enhance professional growth as it relates to training, service and research. The interdisciplinary process promotes the development, use and comprehension of a basic terminology, core body of knowledge, relevant skills, and understanding of the attitude(s), values and method of participating disciplines.[2]

With this in mind, a proposal for a national conference was made at the AAUAP meeting in Miami in the spring of 1979 for all twenty-one of the centers funded by MCH, resting on several propostions:

- That each UAF carries a mandate to develop a core curricula designed to advance the inter-disciplinary training mission;
- That the UAF core curricula should address the bio-psycho-social aspects of mental retardation and related handicaps;
- That social workers in UAF's should take a leadership role in developing guidelines with regard to the social content of core curricula; and
- That the process of developing the social content should incorporate input from other disciplines participating in UAF's.[3]

The proposal for a conference on the social content of the inter-disciplinary core curricula received positive support from the social work participants attending the AAUAP meeting. As a follow-up, a questionnaire was mailed to each Chief of Social Work at MCH funded UAF's to obtain a broad sample of UAF social workers' thinking on the subject. Two-thirds of the respondents indicated that they "strongly supported" holding a national conference devoted to the social content of core curricula. Respondents indicated that they perceived benefits from sharing their thoughts and experiences in developing interdisciplinary training with those of other centers. There was also agreement on a plan to include a representative from other UAF disciplines in the conference.

The goals of the conference were to include the following.

- To conduct a conference in which keynoters would orient participants to current status of knowledge, attitudes and skills with regard to social aspects of mental retardation and directions which inter-disciplinary training programs should consider in the near and more extended future;
- To provide a medium in which participants could discuss and consider the points made by keynoters, along with sharing and learning from each other's experiences in developing the social component of core curricula;
- To provide opportunity for considering inter-disciplinary perspectives on the issue of the elements of social content that are generic to a core curricula;

To formulate guidelines with regard to social content that would assist UAF's and other interdisciplinary training units in developing core curricula; and

To edit, publish and distribute proceedings of the conference to UAF's and other training units concerned with mental retardation and related disabilities.[4]

The conference plan was submitted to the Office for Maternal and Child Health and was approved for funding under Project Number 9003. It called for the formation of an Advisory Committee, composed of UAF social work faculty and members of the central, regional and state offices for Maternal and Child Health, whose function was to formalize and oversee the planning of the conference with reference to its content and format.

The outcome was a four-day conference held from July 14 through July 17, 1980, at The Nisonger Center on the campus of The Ohio State University, Columbus, Ohio. The conference consisted of plenary and small group sessions devoted to topics related to the conference theme, "Social Content of Interdisciplinary Core Curricula in University Affiliated Programs." Keynoters analyzed the state of knowledge within specifically assigned areas and addressed the questions and issues related to the direction of the interdisciplinary training programs for the immediate and more distant future. Participants provided input regarding core training through the medium of small group discussions which were facilitated by group leaders. Recorders summarized key content areas that the work groups identified.

While the Conference was primarily organized for chiefs of social services in MCH-UAF's to convene and deliberate issues related to the core curricula, the planning included three complimentary groups of participants.[4] The first was drawn from social workers and administrators in national, regional and state MCH offices, with seven participating, to provide the deliberations a perspective related to service delivery and identified health needs. Consistent with the interdisciplinary philosophy of UAF's, six faculty members from other disciplines involved in MCH funded centers were invited to participate. Representatives from the following disciplines contributed to the work group discussions: genetics, nursing, pediatric medicine, psychology, public administration and special education. In addition, the keynote speaker was a prominent educator. Completing the roster of participants were three OSU social work students fulfilling their master degree requirements with the assistance of MCH traineeships, and one doctoral graduate who was a former Nisonger fellowship student.

[4] Nineteen of 21 MCH-UAF funded centers were represented at the conference

The publishing of the Proceedings is done with the intent that it may provide references for advancing and evaluating UAF programs, and also other health units concerned with training personnel to serve retarded and otherwise handicapped clients. The papers that comprise this monograph are those that were presented at the opening sessions of the conference.[5] A one-half hour videotape, giving the highlights of the speakers' presentations, is available as a companion to the Proceedings to be used either separately or in conjunction with it. Another publication entitled, The Social Content of Interdisciplinary Training Toward Prevention of Handicaps in Children and Youth--A Social Work Perspective, addresses the question, "What do social workers think should be taught as the social content of the Core Curriculum?" and incorporates material derived from the small group sessions of the conference.[6]

A third document issued as a Nisonger Technical Report and authored by Martha Ufford Dickerson, is the paper she presented at the final session of the conference, directed specifically toward the social work discipline.[7]

The conference afforded opportunity for the participants from both UAF's and MCH to pay tribute to Virginia Insley on the occasion of her retirement from government service, and for her many contributions to maternal and child health programs. Distinguished Service Awards (see p.vii) were presented to her by Dr. Michael J. Guralnick on behalf of The Nisonger Center, and by Dr. Robert O. Washington, Dean of the College of Social Work, The Ohio State University. As further recognition for her efforts to advance professional services, this volume is dedicated to Virginia Insley.

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SOCIAL CONTENT

OF INTERDISCIPLINARY CORE CURRICULA

IN UNIVERSITY AFFILIATED PROGRAMS

SOME PERSONAL OBSERVATIONS

Frederick R. Cyphert; Ph.D.
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Introduction

By way of introducing myself to you, I shall recount three brief instances in my life which relate to the topic of this conference. The first goes back to my enrollment many years ago in the Social Science graduate program of the Maxwell School of Syracuse University. There, courses such as "Social Science Integration," in which representatives of the various social science disciplines contributed their knowledge to the solution of hypothetical broad social problems, impressed me with the notion that "truth," in practice, depends upon one's frame-of-reference and more important, it is impossible to understand complex social problems by viewing them from only one point-of-view.

A second encounter involved a visit to an inner city classroom with three colleagues: a social worker, a physician, and an educator. Although viewing a common phenomenon (two small children sleeping in class), these professionals gave widely differing explanations of this deviant behavior which were directly related to the concerns of one's own profession. Again, there was value in each point-of-view and greater insight into the explanations when analyzed collectively and collaboratively.

The third instance, one more closely related to today's topic, occurred some 15 years ago when I was actively involved in writing

the proposal which eventuated in our Nisonger Center. At that time we developed three hopes and expectations for this Center and, in effect, for all centers

First, we expected that the various professions in their training programs would come to the Center to "do their own thing;" to use the facilities and the clients for an educational experience for their students, and then to return to their home base with little or no interaction with anyone at the Center other than clients. A legitimate educational endeavor, but primarily a uniprofessional one.

Second, we anticipated that students and faculty from the several involved specialties would come to the Center to work together, to observe each other in action, to dialog about clients and issues. In effect, to have an inter-disciplinary experience which emphasized the processes of working with other professions.

Third, we thought that professionals-in-training would enroll in a common set of courses where, side-by-side, they would learn concepts and understandings regarding the impingements that society makes upon them and their clients, i.e., a substantive core of knowledge, largely from the social and behavioral sciences, regarding the valuing and acting of people vis-a-vis human services.

If I were to assess the accuracy of our prognostications today--and I have no hard data--I would speculate that there is a considerable amount of activity one occuring in the various centers wherein, each profession uses the UAF for its own parochial purposes. I further expect that there is a modicum of team or interprofessional process experiencing taking place. The third portion of our projected program, an interdisciplinary core of socially focused substantive courses, would be found very seldom. Most of the remainder of my remarks will address this interdisciplinary core curriculum.

Some Assumptions

In proceeding further, I am assuming that virtually everyone in this room will agree that it is philosophically desirable and economically feasible to identify and teach a common base of knowledge and the universal skills inherent in effective practice in the human services arena. I shall further assume that we would accept Margaret Meade's statement that "We are becoming acutely aware that we need to build a culture within which there is better communication--a culture within which interrelated ideas and assumptions are sufficiently widely shared so that specialists can talk with specialists in other fields, specialists can talk with laymen, laymen can ask questions of specialists, and the least educated can participate, at the level of political choice, in decisions made necessary by scientific or philosophic processes which are new, complex and abstruse."[1]

As we think together for these few minutes regarding the promise and the problems of a "core," we need to be aware that we will be swimming against an educational and societal mainstream of the past twenty years. Education, at the behest of the man on the street, has downgraded the value of the common or shared and has prioritized the unique. We have emphasized our differences and minimized our similarities. In one sense, a move toward a core curriculum places us in step with the newly forceful "back to the basics" movement. Personally, I believe that society will soon demand more balance between these forces; that all of us must value and understand both our similarities and our differences to be effective. To me, it is a propitious time to consider the topic of this conference.

Clarifying a Concept of Core

Before going further, I should attempt to clarify what I mean by a common core. I emphatically do not mean that everyone should know what all others know. A core should not make professions and professionals interchangeable or enable them to switch functions. It should, I believe: (a) enable students to gain insight into the societal need for his and other human services; (b) help students to acquire an understanding and appreciation of the roles and activities of other professions; (c) clarify the role of one's own professional contributions and limitations vis-à-vis those of others; (d) provide a common vocabulary and common conceptual base to facilitate communication; (e) promote insight into the impact of one profession upon another in the action arena; (f) foster a knowledgeable trust in the differing rationale, processes, and data of the several disciplines, (g) promote a shared understanding of how our clients are products of their environments. To me, a common core does not necessarily imply a team approach to the delivery of human services. However desirable and/or feasible this approach may be, the core is not tied to any one delivery mode, but is, instead, dedicated to the proposition that no profession operates in a vacuum; that any effective practitioner must view his work in the light of the broader cultural and professional forces which impact upon him and his clients.

The State of the Art

As Tarzan remarked after consuming his third martini upon returning to the treehouse following a day's work, "Jane, it's a jungle out there!" Much has been written regarding the value of a team approach to human services and the importance of education to fostering this approach. This has stimulated the development of a number of interdisciplinary common core courses dealing with "how to work together" process questions, group dynamics, and the like. These are usually accompanied by opportunities to practice an interprofessional team activity in

a clinical setting. There are few "substantive" core courses in existence, however. Those which have evolved are chiefly concerned with technical topics such as "The Health Care Delivery System," "Biophysics for Professionals," etc. Many agree that more socially oriented and less technical courses are needed for a common core, but few are attempting to evolve them. Apparently, "Everyone wants to go to heaven, but nobody wants to die!"

No One Said it Would be Easy

I'm confident that we are all aware of the many factors which inhibit the development of core curricula. Excessive professionalism, inappropriate defense of prerogatives, status striving and status differentials, the lack of mutual respect, and the urge to "maintain the mystique" are major impediments to interdisciplinary education. So is the organization and tradition of universities where lines of authority are discipline centered, as are reward systems, course approval mechanisms, power groups, and the like The predominance of "we" and "they" rather than "us" thinking and the fear that some students are more mature and knowledgeable than others who would be included add to the disinclination to action on a core.

On the other hand, there is much to motivate us to plunge ahead. We know that we are unlikely to teach common concepts and mutual understanding in other than shared settings. A substantive core appears to be effective if not essential. We are confident also, that a substantive core approach is efficient through the avoidance of duplication. While admitting that we can place too much emphasis on common core curriculum and overstress the value of two people sitting in a classroom together, how better can we promote the full realization of the unique teaching potential of University Affiliated Facilities than by building core curricula?

How Might We Proceed?

What follows is a potpourri of ideas one might consider when engaging in this curriculum task.

1. Any approach to the development of a shared culture of human services must result in opportunities for faculty as well as students to have shared experiences in the analysis of phenomena. Faculty involvement is prerequisite to student involvement in core course development. However, core courses are not necessarily team taught.

2. Acknowledge publicly from the outset that what is being developed is experimental and difficult. Stress, also, that there are risks to be taken if program breakthroughs are to occur.

3. Students appear to be most receptive to shared interdisciplinary educational experiences if they are introduced early in their professional training. This is not to imply, however, that the total core curricula should be an early experience; rather, it should extend throughout the total program. A common exploratory course providing opportunities for professionally oriented students to sample several professions in a multiprofessional context before choosing to pursue any one in depth is not beyond imagination as an initial core experience.

4. Core courses should emphasize ideas, concepts, and principles as outcomes and utilize specific data or facts chiefly as vehicles to these more general ends. Core faculty must organize content so that skills and values as well as knowledge are learned. Attitudes are particularly easy to overlook in curriculum planning, and they constitute the very heart of an interdisciplinary core curricula.

5. The various elements of a common core course have more and/or different relevance for one professional group than for another, both in necessary depth of understanding and in mode or intensity of behavior change necessary. If we deny these differences, we reduce the effectiveness of our course--perhaps to the lowest common denominator. I have seen this "common, yet different" phenomenon accommodated by scheduling courses in two-hour blocks, the first hour being devoted to common understandings and the second hour spent in uniprofessional groups developing unique implications.

6. While core curricula, as we have conceived them, consist predominately of substantively oriented courses, they are undoubtedly most effective when they are associated with field and/or clinical experiences. To illustrate, one can seldom appreciate a multi-faceted inner city culture without visiting inner city homes and institutions and chatting with the inhabitants in their environment.

7. As we have implied earlier, the courses which comprise a core curriculum will undoubtedly form a continuum which on the one end emphasizes common activities and/or responsibilities of the

several professions and on the other end stresses our common social context and its affect upon us and our clients. Examples of topics which might be included in the former are the skills of counseling, the similarity and differences in ethical standards among the professions, parent education, ways of resolving interdisciplinary conflict, group processes, organizational, behavior, etc. Illustrations of possible content which fall on the broader social concern end of the scale include the processes of developing and influencing social legislation; ethnic, geographic and socio-economic subcultures; how public opinion is formed and analyzed; understanding our own and others' values; and the common heritage of the professions.

8. Obviously, all of the principles of program building should apply to one's efforts. For example, one begins as nearly as possible with student realized needs and proceeds to provide experiences so that unrealized needs begin to become felt. Likewise, one differentiates between those understandings which are relevant but nonmanipulatable and those phenomena that are relevant and which can be changed. A lecture in curriculum change principles is inappropriate here, but such literature is most helpful to the program developers.

In conclusion, let me congratulate you on your resolve to build core curricula so that we can have a trustful working relationship between the professions that is based upon mutual goals and shared understandings. I'm confident of your success.

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A PRESCRIBED MANDATE

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Specialist in Services for Mentally
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Office for Maternal and Child Health
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The University Affiliated Facilities for the Mentally Retarded came into being on October 31, 1963, when President Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Act of 1963[1]. The Act was designed to assist in the construction of university-affiliated clinical facilities with a full range of inpatient and outpatient services for the mentally retarded, and represented a step forward in providing demonstration and training centers in the field of mental retardation. While the Act as such was strictly limited to the planning and the construction of these facilities, the applicants for grants were required to describe the programs of care and training that the facilities were to house. One item in the guidance material on the construction applications required the applicant to:

> Describe in as much detail as practicable, the ways in which effective interdisciplinary training will be accomplished; e.g., provisions for assuring interdisciplinary and multidisciplinary emphasis in training, methods of providing and demonstrating clinical experience of trainees, description of course work for trainees, availability of observation, practicum, and field work experience ....[2]

We must keep in mind that this guidance material for construction of the facilities was developed by an interagency subgroup of the then Secretary's Committee on Mental Retardation. It was also involved in the construction site visits and participated in the subsequent support of the administration, operation, staffing, training and service base. Thus, while a description of course work for trainees was expected even as part of the original construction applications, the concept of "core curriculum" as a defined term and as a prescribed mandate did not appear in the guidance material or literature relating to the UAF's until early in 1970.

This is not to say that the elements of a core curriculum concept, consisting of a pooling of knowledge for the benefit of students and used as a base for interaction and development of their own unique disciplinary skills, were not recognized and present in many of the early efforts in behalf of the mentally retarded. There has traditionally been some recognition that the problems presented by the mentally retarded and their families were multifaceted--that they cut across a variety of knowledge bases and skills and that no single discipline or agency had the capability of resolving or mitigating these problems. Clearly a team of professionals and agencies was required to deal with these problems. The "team" was defined by constructing a composite of the kinds of specialists and services a multihandicapped, retarded individual and his family required. This "team" became not only the source of service, but was seen as the peer group which was to transmit the philosophy, the purpose, and the necessary professional competencies, as well as performance criteria, to students and other service providers.

Historical Perspective

One of the earliest identifiable peer groups to emerge in the United States with a focus on mental retardation consisted of superintendents of schools for mental defectives. It was organized as "The Association of Medical Officers of American Institutions for Idiots and Feeble-minded Persons" on the premises of the Pennsylvania Training School at Elwyn on June 6-7, 1876.[3] This group not only served to transmit a purpose and a philosophy of care, but through its subsequent development, meetings, and extension of membership, provided the basis for an interdisciplinary and multidisciplinary approach to the problems of the retarded.

Edward Seguin, who had followed Itard's work in France, was one of the organizers, and provided much of the inspiration for this new Association. Coming to the United States in 1848, he brought with him a worldwide recognition for his writings and demonstrations on the impact of his "physiological school", together with the royal approval of the Academy of Sciences in Paris, and the commendation of Pope Pius IX.[4] In 1866, he had published his textbook on Idiocy and set the stage for the new Association by

suggesting that "Every year the Superintendents of the various schools should meet to impart to one another the difficulties they have encountered, the results of their experience, and mostly to compare the books containing their orders and regulations."[5] There were high hopes for what was viewed to be in store for those of the human race whose minds had failed to fully function, including even the hope of their eventual restoration to society.

While few of these high hopes for the restoration of idiots and imbeciles to society were ever realized, the Association did grow, and expand. More importantly, it continued to maintain a position of leadership and elaborated continuously, on the concept that retardation was not a definite homogeneous entity. Members of the association began to emphasize more and more the fact that:

> The various signs and symptoms may be found in varying degrees and proportions in different cases (and that) an accurate and incontestible diagnosis of one of these cases can be made satisfactorily only after a thorough physical examination of the patient, knowledge of the family history, personal history, especially the story of his infancy and early childhood, school history and records, social and moral reactions, sex habits, emotional stability, associates, interests, and the fullest inquiry as to his general information and practical knowledge.[6]

Dr. Walter E. Fernald also formalized this multidisciplinary and interdisciplinary approach to the retarded by his design of his ten "Fields of Inquiry"[7] which were to provide a uniform basis for all individual case studies. These ten fields included the following areas:

1. Physical examination
2. Family history
3. Personal and developmental history
4. School progress
5. Examination in school work
6. Practical knowledge and general information
7. Social history and reactions
8. Economic efficiency
9. Moral reactions
10. Mental examination

A special syllabus for each field of inquiry was developed that not only indicated the general line of investigation to be followed, but provided for the recording of the facts that were obtained. Dr. Fernald was quick to add to the fields of inquiry that the varied sorts of information required "must be obtained primarily by different members of the staff."[8]

In this connection, it is interesting to note that in 1919, a law was enacted by the General Court of the Commonwealth of Massachusetts to determine the number of mentally retarded children in the Massachusetts' public schools, and to provide for their instruction. This law, as amended by the legislature of 1922, required that "The examination of the retarded child should be made by one of the clinics conducted by the Department of Mental Diseases or by a clinic approved by that Department."[9] Fifteen traveling school clinics had been established and the examination of all cases had to include Dr. Fernald's ten "Fields of Inquiry", which were outlined on an official form. The personnel of these traveling school clinics included a psychiatrist, a psychologist, a social worker, an assigned school teacher, the school nurse and the visiting teacher. Dr. Fernald took the personnel of these clinics to his school and trained them in the procedures of carrying out the examination in accordance with his well known "ten point scale examination."[10] This might well be considered the first prescribed mandate relating to a multidisciplinary evaluation and a core curriculum designed to implement it.

Influence of the Children's Bureau

Antecedents of your program and the core curriculum also came from the early concern of the Children's Bureau for the mentally retarded. Founded in 1912 with a broad mandate to "investigate and report upon all matters pertaining to the welfare of children and child life among all classes of our people,"[11] the Bureau not only included all children in its focus, but recognized that by making special efforts to aid those who were abnormal, subnormal, or suffering from physical or mental ills, it could more easily advance the health and welfare of all "normal" children. In its very first year of existence, the Children's Bureau undertook a study of the Mental Defectives in the District of Columbia.[12] While the published report was primarily a sort of social survey, it brought the problem to light and forced recognition of the fact that a child with a mental defect has the right to special and appropriate care just as much as a child who is blind, or who is born without an arm or a leg.

In the years that followed, from sources such as Bureau studies of dependent children, the juvenile courts, child labor in the oyster and shrimp canning communities, the cotton growing areas of Texas and on the streets and barges, a considerable amount of information about children was gained, concerning their normal growth and development, as well as their problems and the potential causal factors for developmental delay and deviations. With the completion in 1919 of the Medico-Psychological and Social Study of Mental Defect in a Rural County of Delaware[13] the value of attempting to combine the findings of different professions was again demonstrated. The idea of attempting to understand a child's

mental difficulties at an even earlier age, as well as the nutritional, postural and physical needs, was considerably enhanced by assistance from the Children's Bureau in a demonstration mental clinic for preschool children in Boston in the 1920's.[14] Demonstrations relating to the older age group were exemplified by such studies as the 1932 study of Employment of Mentally Deficient Boys and Girls.[15]

From all of these early endeavors, four basic objectives emerged which became the guiding principles of subsequent efforts of the Children's Bureau to deal with handicapped, retarded individuals. These were to:

1. find these children early,
2. provide a complete evaluation for each one,
3. interpret the findings to parents, and
4. use the findings as a basis for ongoing help and care.

Social Security Mandate

The year 1935, among other events, is noted for the passage of the Federal Social Security Act.[16] While the Act as a whole outlines a broad federal-state economic program which deals with such diverse aspects as unemployment compensation and old age insurance, it also mandates and prescribes some very specific protective measures for the care of "homeless, neglected, dependent and crippled children."[17] The logic of including these provisions for children in this basically economic legislative package can more clearly be understood if we review the report to President Roosevelt of the Committee on Economic Security, appointed by him to make recommendations for legislation that would provide for "safeguards against misfortunes which cannot be wholly eliminated in this man-made world of ours."[18]

In its report to the President, outlining the suggested provisions of the Social Security Act, this Committee emphasized the fact that "the core of any social plan must be the child" and declared, "Every proposition we make must adhere to this core."[19] The report then proceeded to enumerate the various parts of the plan and to point out their direct or indirect bearing on the welfare of the child, as follows:

> Old-age pensions are in a real sense measures in behalf of children. They shift the retroactive burdens to shoulders which can bear them with less human cost, and young parents thus released can put at the disposal of the new member of society those family resources he must be permitted to enjoy if he is to become a strong person, unburdensome to the State. Health measures that protect his family from sickness and remove the menacing apprehension of debt,

always present in the mind of the breadwinner, are child welfare measures. Likewise, unemployment compensation is a measure in behalf of children in that it protects the home. Most important of all, public job assistance which can hold the family together over long or repetitive periods of private unemployment is a measure for child welfare in that it assures them a childhood rather than the premature strains of the would-be child breadwinner.[20]

In brief, these were among the major reasons which led the Committee on Economic Security to recommend to the President the inclusion of special measures for public assistance to dependent children, and for maternal and child health and welfare, as an integral part of a broad economic and social program. These recommendations were transmitted by the President to Congress and were embodied in the Social Security Act, which was passed after extensive hearings and discussion, and was approved by the President on August 14, 1935. They constitute recognition of the fact that security and opportunity for children are dependent not alone upon family income, but also upon parental intelligence and understanding, and community provision for the health and social services which individual families, under modern conditions, cannot singly provide.

This prescribed mandate to provide "safeguards against misfortunes" and which viewed the child as the "core of any social plan" is, and must be, a basic component of your core curriculum, and the service base used to impart skills and knowledge to the indivduals you train.

Early Advocacy

It was this concept of the Social Security Act which was later used by the parents of retarded children as they organized themselves into vocal groups and went "public" in the mid and late 1940's. It provided the basis for their demands for community support services for their children and themselves.

By 1949, one of these groups, the New York State Association for Retarded Children was strong enough to develop and support some demonstrations of alternative community services. These demonstrations included support of two special outpatient clinical programs for mentally retarded children at Brooklyn Jewish Hospital and at Flower and Fifth Avenue Hospitals. The unique features of these clinics were that they were both pediatrically directed and involved a multi-disciplinary staff.

With the formation of the National Association for Retarded Children in 1950, these beginnings were the basis for the presentation

to the Appropriations Committee in 1955 by the National Association for Retarded Children of Proposals on a Federal Program of Action for America's Mentally Retarded Children and Adults, which outlined a life cycle plan of needed services.[21] All of the interest and information accumulated earlier by the Children's Bureau were used by Dr. Martha Eliot, then Chief of the Bureau, to support this position. In an address to the 1954 Convention of NARC, she stated, "When officials of public agencies ask what kinds of services should be provided for retarded children, my advice is 'ask the parents'...(they) are often best qualified to say what help they need, though professional persons will have to provide the hows."[22]

The combination of the NARC presentation to Congress, Martha Eliot's report to the nation in the same year, which listed the mentally retarded as one of four groups of children most in need of care and services, and the announcement of four demonstration grants to the District of Columbia, Hawaii, Washington and California from Title V of the Social Security Act for clinical services to mentally retarded children and their families, culminated in the unusual action by the Appropriations Committee of increasing the Maternal and Child Health Appropriations and earmarking half of the increase for the development of similar services for the mentally retarded as special projects of the States' Maternal and Child Health programs.

Here, again, we have examples of important elements that are part of any core curriculum--the understanding of the parents' movement, advocacy, coordination of efforts, legislative action, etc.

UAF Mission

President Kennedy's 1963 special message to Congress and the nation, in many ways not only combined many of these early mandates but provided the basis for the UAF mission and rather clearly outlined the elements of core curriculum content:

> It is my intention to send shortly to the Congress a message pertaining to this nation's most urgent need in the area of health improvement, but two health problems because they are of such critical size and tragic impact, because their susceptibility to public action is so much greater than the attention they have received, are deserving of a wholly new national approach and a separate message to the Congress. These twin problems are mental illness and mental retardation.[23]

President Kennedy in this message goes on to state:

> The fact that mental retardation ordinarily exists from birth or early childhood, the highly specialized medical, psychological and educational evaluations which are required and the complex and unique social, educational and vocational life time needs of a retarded individual all require that there be developed a comprehensive approach to this specific problem.[24]

The first focus in this comprehensive approach relates to prevention. This later statement provided the basis for the Maternity and Infant Care program as a first step. The message addresses the need for community services and facilities and the necessity to move from distant outmoded institutions to community centered agencies that will provide a coordinated range of timely services as well as training.

The most relevant part of the message for us is as follows:

> Because care of the mentally retarded has traditionally been isolated from centers of medical and nursing education, it is particularly important to develop facilities which increase the role of highly qualified universities in the improvement and provision of services and the training of specialized personnel.[25]

President Kennedy continued to outline the types of facilities for which grants would be authorized in the legislation he planned to propose. These included:

1. Inpatient clinical units as integral parts of university associated hospitals;

2. Outpatient diagnostic evaluation and treatment clinics associated with such hospitals, including facilities for special training;

3. Satellite clinics in outlying cities and counties for provision of services, including those financed by the Children's Bureau (Title V of the Social Security Act) in which universities will participate.[26]

The social content which needs to be included in a core curriculum is re-emphasized in this message. It encompasses a continuum which starts with prevention and ends with a mandate to the universities to enhance Title V's delivery system. Throughout the message there is reference to the need for service, to provide superior care as a basis for teaching or training specialists.

The products of the training program are not defined as a new profession, but are specifically described as specialists and leaders within their own disciplines, as physicians, nurses, psychologists, social workers, speech and other therapists, who as a peer group would be the change agents of the future.

The National Training Directors Council of the American Association of University Affiliated Programs defined interdisciplinary training in the following manner:

> Interdisciplinary training refers to an integrated education program involving the interdependent contributions of the several relevant disciplines to enhance professional growth as it relates to training, service and research. The interdisciplinary process promotes the development and use of a basic language, a core body of knowledge, relevant skills, and the understanding of the attitudes, values and methods of participating.[27]

Summary

This is the framework to which you are expected to add the social content which has been mandated and has evolved over these many years. While social work as a profession has traditionally borrowed from a broad range of arts and sciences, we must be certain that whatever content we incorporate into this curriculum design is based on valid data. You will need to avoid the acceptance of inappropriate social objectives, such as a charge to facilitate the institutional placement of a newborn infant merely because someone pinned a label of mongolism on him. Many of the recent major breakthroughs in biochemistry and genetics carry with them a number of potential legal and ethical problems relating to informed consent, individual rights and an array of possible destructive and anxiety-producing interventions which must be carefully evaluated and incorporated in a fashion that will result in more good than bad.

John H. Meier, former UAF colleague, and former Director of the Office of Child Development, and Chief of the Children's Bureau, some years ago constructed a conglomerate definition of an interdisciplinary training program by utilizing concepts encompassed by the meaning of train, trainer, educate, educator, discipline, disciple, inter, multi, profession, professional and para. While his ultimate definition had many similarities with the AAUAP definition, John Meier, by simply selecting secondary and tertiary meanings for his key concepts, arrived at the following definition of interdisciplinary training. "A group of cosmopolitan and sporty monks playing at potty training of domestic animals for a fee."[28] What this rather facetious definition illustrates to me is the kind of inappropriate and meaningless concepts that could be

attached to what might start out as perfect elements of social content to be added to the core curriculum.

A core curriculum which ignores the mandated historical social concerns and care for the physical and health needs of the mentally retarded can be as inappropriate as John Meier's facetious definition of interdisciplinary training involving a group of cosmopolitan, sporty monks. Inappropriate content which is mandated without concern for the individual needs and abilities of the students can be equally as disastrous, as John Meier tried to illustrate with the following curriculum fable:

> Once upon a time, the animals had a school. The curriculum consisted of classes in running, climbing, flying and swimming. All the animals were required to take all the classes.
>
> The duck was a good swimming student -- better, in fact, than the instructors. He made passing grades in flying, but was practically hopeless in running. Because he was low in the subject, he was made to stay in after school and drop his swimming classes in order to practice running. He kept this up until he was only average in swimming. But as educators, we all know that average is acceptable so no one worried about it. No one -- but the poor duck.
>
> The eagle was considered to be a problem pupil and was always being disciplined severely. He beat all others to the tops of the trees in climbing classes -- but he had used his own way of getting there.
>
> The rabbit started out at the head of the class in running, but he had a nervous breakdown and dropped out of school because of so much makeup work in swimming. The squirrel led the class in climbing, but his teacher made him start his flying lessons from the ground up rather than from the top of the tree down. The poor thing developed Charley-horses from over exertion at takeoff and began getting failing grades in both climbing and running.
>
> The practical prairie dogs apprenticed their offspring to a badger when the local school board refused to add digging to the school curriculum.
>
> At the end of the school year, the abnormal eel that could swim, walk, run, climb, and fly was given the honor of being made valedictorian of the class.[29]

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AN ISSUE WITHIN A PLURALISTIC SOCIETY

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As concerned professionals of all disciplines struggle with the aftermath created by the theory of "benign neglect," it is timely that this Conference is undertaken to address the social content of the interdisciplinary core curricula, and to give specific recognition to the issues related to ethnic, cultural, and racial factors associated with mental retardation and handicapping conditions.

Social work, with its holistic orientation to the individual and his problem, has long been aware of the social implications of mental retardation, and has traditionally integrated this knowledge in working with other disciplines. Social work recognized, long before the extensive formal documentation, that poverty, racism and mental retardation have been and remain closely, perhaps inextricably, bound together and that the overwhelming number of children making up the retarded population are ethnic minorities, who have been defined as "culturally," "environmentally," or "functionally" retarded. These minorities are primarily Black Americans, Mexican Americans, American Indians and Puerto Ricans, who have been victims of a way of life that has successfully operated to systematically deny them access to adequate health, social, and educational services.

In spite of the massive programs directed toward the alleviation of prematurity, lead poisoning, malnutrition, child abuse, inadequate

prenatal and postnatal care, rubella infection of the pregnant woman, and measles, they remain in the 1980's the major factors related to mental retardation in New York City and other major urban cities in this country. In spite of the many ameliorative and compensatory educational programs provided, questions raised by such researchers as Jane Mercer[1] related to Mexican Americans, and the research and policy statements made by the American Association of Black Psychologists[2] around the misuse of psychological and other assessment procedures, it remains a fact in the 1980's that minority children, particularly males, continue to be disproportionately represented in classrooms for the retarded. Causes and rationale for such situations can no longer be established as existing within the individual. We must begin to search for answers within the larger social order.

The University Affiliated Facility is mandated "to produce highly competent graduates, who are able to fill leadership positions in this field..."[3] and to provide "an integrated educational process involving the interdependent contributions of several relevant disciplines to enhance professional growth as it relates to training, service and research."[4] Experience has clearly taught us that it is not sufficient to acknowledge the need for the incorporation of "minority" into the training of human service practitioners. Specific models must be developed and incorporated into training programs if these issues are not to remain neglected--even if unintentionally so.

The individual practitioner is key. How he views his clients, defines goals, establishes priorities and identifies need is key. In his practice he enacts policy. His practice becomes the means for formulating the operational procedures of agencies. His practice becomes the basis for research and the undergirding of the theoretical knowledge base. His perceptions order and define the reality. How the practitioner gains his perspective must be impacted upon in the training process. It is our charge to train practitioners who can operate from a "pluralistic perspective," who can become diagnosticians capable of separating cultural difference from pathological deviance; therapists capable of formulating treatment strategies that capitalize on the strengths of individuals, families and communities; researchers capable of critically analyzing data for validity; and professionals with a willingness to assume a role of advocacy that comes from the acknowledgement that all attempts at primary prevention, an ultimate goal, must be directed toward the society at large.

Blacks and Puerto Ricans comprise the largest ethnic minority in this country and make up a significant percentage of the poverty population. A large percentage of this group is affected in some way by the problems of mental retardation, yet there is little literature available that relates to the provision of clinical services for the developmentally impaired, minority individual and his family.

There has been a wealth of general information compiled over the last several decades about the Black Experience. While some of it presents valuable insights for human service planners, others serve to reinforce the myths and stereotypes, and to perpetuate the faulty assumption that minority groups can be understood and assessed by using standards established for white, middle-class groups. Needless to say, these assessment techniques give little or no recognition to the pervasive influence of racism, nor to the fact that much of what is observed of minority group functioning is reactive behavior. Findings almost exclusively give a deficit interpretation to the differences observed in functioning which influence a policy and planning direction towards change within the individual, family and group. A situation that William Ryan comprehensively presents in Blaming the Victim.[5]

In discussing the provision of clinical services to and training practitioners for work with the developmentally disabled, minority client and his family, there are several major considerations.

Firstly, members of minority groups are not monolithic in characteristics. While there are universals shared by virtue of membership in a common ethnic or racial group, there are also many differences. How such groups are defined and understood is influenced by these differences. The minority family with an impaired member adds still another extremely important variable for consideration. This should become a part of the theoretical knowledge base.

A second consideration is that when formulating treatment plans and making assessments about individual, family or group functioning, the clinician must always be cognizant of the fact that the position held by such groups in the larger society is greatly influenced by racism, and functions within what Leon Chestang has characterized as a "larger hostile environment."[6] Much of what is observed may be understood as reactive, adaptive or coping mechanism that develop as a result of attempts to survive and to be maintained in this environment. Therefore, in training, it is important to focus on the kind of skill development that enables the practitioner to separate the adaptive behavior on which to capitalize, from the pathological or nonproductive behavior which should be the focus of change.

I have observed some characteristic behavior in my work with low income Puerto Rican and Black mothers in their interactions with their young children. Often there is a demonstrated tendency to treat the young child's natural curiosity to reach out, to know, and to

control his environment with an overprotective, sometimes harsh response, that stifles this inquisitiveness and says to the child that his outer environment is not safe. While we can readily find a very valid cultural understanding for such behavior, we also know that repeated experiences of this kind have serious implications regarding the child's ability to aggressively reach out and engage himself in the learning process later in formal school years. The question becomes, with the recognition of such culturally determined and valued behavior, does the practitioner, given his understanding of child development, encourage the persistence of this behavior or identify it as an area for modification.

Still another consideration in training for work with the minority client is the practitioner himself. As stated earlier, much of the literature has been fraught with myths and misconceptions, and has been concerned with indicators of instability and disorganization. In addition to these myths that proliferate in the literature, the beginning practitioner brings to the clinical scene, his own life experiences, attitudes and assumptions that need to be critically examined for impact on how he understands and provides service to the minority client. This situation is further exacerbated by the fact that the student almost always brings additional myths and misconceptions about the condition of retardation itself. A beginning point in my work with students has always been to explore the feelings related to the mentally retarded as well as the feelings related to the minority groups with which they would be working. As a large number of students are from middle-class backgrounds with little experience with the social problems presented in large urban areas, it becomes significant to supportively acknowledge their discomfort and fears. With one social work student it became a part of the supervision to assist her to understand that the inappropriate touching by an adolescent male was a function of the retardation and not of the perceived Black male sexuality.

While social work training prepares practitioners to understand the etiology of pathological behavior, its uniqueness is derived from its professional view of the individual from a holistic perspective, with a focus upon the identification of ego strengths with goals directed toward building upon and extending these strengths. This is perhaps the single, most important concept that social work can lend to other disciplines in the training of practitioners in the interdisciplinary setting.

With the publication of Andrew Billingsley's Black Families in White American[7], we began to see the literature take on a more positive view in the assessment of Blacks and other minorities. Researchers are beginning to move away from the utilization of the deficit or disease model of conceptualization of minority functioning. With this beginning new conceptual scheme, and the awareness of the significant role played by the larger society in the behavior of the minority community, service givers can begin to move toward the development of

a design and model that begins to effectively meet the needs of the minority community, accepting it as it is, and not as a deviation of the white, middle-class norm--respecting the client's cultural milieu.

A major task facing the family with a developmentally impaired child is the need to cope with the stresses that are presented as the child and family system passes through the various stages of the life cycle. Major among stresses is the tremendous sense of isolation and difference that is experienced perhaps more intensely by the minority family.

All parents view their children as extensions of themselves. The knowledge that the child's development is atypical is experienced as a serious blow to feelings of self-esteem. Some writers have indicated that low-income, Black families have found it easier to accept an impaired child, with less assault to feelings of self-esteem because they, in essence, have "less to lose." Although it is not founded in research, what I know of low-income Black families who have historically held to a faith in the educational process and the education of children as a means out of a cycle of poverty, tells me that they do experience this as a great loss. Because of their historical experience of coping, adjusting, accommodating and enduring, Black families are able to absorb more completely the retarded child with seemingly less disruption. A universal response inclusive of the minority parent, is the denial, hurt, anger, disappointment and guilt, which needs to be acknowledged by the practitioner in all disciplines.

Minority families often do not have kind, family pediatricians to cushion the blow or support the denial. Nor do they have the supportive, reassuring teachers to give extra time and instill hope that the child will "outgrow" the difficulty. Having been seen in poorly serviced medical facilities, they may question the quality of care as they seek cause and understanding, or place blame. Given the quality of medical care for the poor, they may often be correct in their accusations.

Minority Blacks have often been able to attain a true acceptance of the retardation and successfully marshal resources to cope with this additional stress through the use of religion. A frequent response is, "It's the Lord's Will," or "The Lord works in mysterious ways." Significantly they communicate in latent content that there is some redeeming factor even in a devastating experience.

Spiritualism plays an important role for the Puerto Rican family with an impaired child. The retarded child is also viewed as "special" and holds a valued status with the family and community. It is not unusual for the Puerto Rican family to see a spiritualist along with the regular, traditional therapist.

In dealing with the knowledge of the impairment, the parent may reject the diagnosis as the racist labeling of uninformed or prejudicial practitioners, particularly when the impairment is not visible. These feelings are often sensed, but frequently they are not expressed. If unexpressed and unexplored, the behavior will at best be confusing to the practitioner. The articulate, aggressive parent may raise some legitimate concerns about testing and the attitudes of the examiner. This reaction can make a difficult counter-transference situation for the minority practitioner. Such parental reactions to the non-minority practitioner can be intimidating and encourage a defensive stance. We are all very much aware of the many questions raised and founded in extensive research around testing procedures in all of the disciplines, particularly speech, language, and psychology. Questions are raised around the concept of intelligence itself, the content of testing materials, attitudes of the examiners, interactions with the child, concepts related to language style, Black English, bilingualism, and so forth.

As to how a family responds to the knowledge of the impairment, the overriding consideration is the availability of services. While many minority families are eligible for financial assistance, there remains a large group of marginal income families who do not qualify for it, but whose income cannot absorb the additional cost of the specialized services that the impaired member requires. Practitioners need to understand that a family's decline of ongoing treatment services may not be a resistance or misplaced priority, but a difficult choice of bread-and-butter issues.

Historically, the developmentally disabled group has been low on the priority list for services and has been a grossly underserved group. Given this as a fact, it can be a safe assumption that the developmentally disabled minority group holds even a lower status. This situation is being addressed and corrected for school-age children by the Education for All Handicapped Children Act of 1975,[8] while day care and headstart programs provide services for the pre-school child and his family.

Important in the area of service delivery are the practitioner's roles as advocate, educator and helper. Even with the Education Act, many minority parents feel that the acceptance of the impaired child into a school program is a benevolent gift and not a legal right. They need to understand that it is a process in which they should be involved and that the service is legally accountable to them. Of equal importance is the identification of the parent as a consumer, rather than a patient. When the primary presenting problem is being a parent of a disabled child, how helpful or ethical is the procedure of applying DSM III[9] labels?

In the late 1960's the Mental Retardation Institute, New York Medical College, where Lawrence Goodman is the Director of Social Work, began an innovative outreach program that

incorporated service, training and research components. With federal funding, this program embarked on a demonstration effort to reach minority families in New York City who did not use existing health services for their children until crises errupted. Like the UAP's, the project staff was interdisciplinary and included students. An integral part of the training offered was focused on relating minority content to the helping process. With modification, the project has not only continued but also has expanded its scope. The experience gained indicates that minority families did become better users of health services for preventive purposes when traditional approaches were altered and acceptable outreach strategies were initiated.

A large percentage of the social work students in this project have been from Atlanta University, School of Social Work. The School educational philosophy is stated as follows:

> The concept of humanistic values is our unique interpretation and extension of the philosophical base of social work. Our historical commitment to concerns of oppressed people, particularly Black people and the Black Experience combined with the School's philosophical base reveals that our societal structure often prohibits consumers of social welfare services and many other individuals from realizing their full potential. This commitment led us to select the general systems approach as the theory undergirding the problem solving/planned change approach to social work practice. This generalized Social Work Method of Practice is termed Autonomous Social Work Practice.[10]

The Institute's practice model and the School's educational model were uniquely complimentary. Such blending between centers and academic units is critical to training practitioners prepared to meet the needs of children from differing ethnic, racial and social backgrounds.

The following case of a family seen in one of the outreach programs established in a public school was selected for presentation here because students were the major service providers. It is illustrative of some of the concepts discussed.

> Ben, a thirteen-year-old, moderately retarded, Black child, at the time of referral was enrolled in a classroom for trainable mentally retarded children. He was an attractive child with no physical stigma. If it were not for his grossly abnormal speech patterns and inappropriate affect, relying on visual clues alone, the retardation would not have been suspected. His relationships with other persons indicated that he was a child who had enjoyed nurturing primary

relationships. He came to the attention of the outreach staff when he developed what appeared to be reactive behavioral problems. He was assigned to a second-year, social work student for beginning assessment.

The mother appeared to be a concerned parent, who presented information with inappropriate affect even as she described what she termed was her husband's "accident." He had been left completely paralyzed below the waist after being shot in a robbery attempt. During his course of treatment one leg was amputated. He was frequently hospitalized and when at home required almost total nursing care, a task that was shared by all family members, including Ben. Prior to the father's injury, the family functioned well and coped well with the retardation. Although the family was of marginal income, finances were supplemented by the father's playing the "numbers" and other "hustles." As the parents discussed the child, it was almost as if he were not retarded. Expectations, in terms of behaviors, were the same for him as for the other siblings. The father referred to Ben as being "a little slow," yet his pride in his only son was clearly apparent. Neither parent was a regular church attender, yet their religious faith had enabled them to come to a great acceptance of their two misfortunes. Statements were made such as, "Ben is a healthy child," and "Thank God he wasn't killed."

The father remained the center of the family, and was a strong and independent man with whom the child shared a close relationship. Ben was called upon to assist in the very basics of his father's care. Because of the retardation and his emotional response to the injury, he was much confused about the cause and duration of his father's incapacitated state. Because of his expressive language deficits, the level of his understanding was difficult to ascertain.

The mother had many underlying feelings associated with the loss of sexual activity; it was equally difficult for the father to acknowledge her continuing sexual needs and his own. How they viewed sexuality was deeply rooted in their Blackness and male-female relationship. The female adolescent siblings indicated a need for genetic counseling as they were vulnerable to the many myths that were present in the Black community about retardation.

The students from each of the disciplines were constantly called upon to incorporate a cultural perspective in their planning for this family. With the child, not only the effect of the retardation was considered in his use of language, but also his cultural style in the use of language. Student reactions to Black family life style were an integral part of the supervision. Learning for the students was theoretical, technical, and a good part affective. They were often spontaneous advocates for this family as a result of their investment in it and their confrontations with the reality of service delivery systems in ghetto areas.

Throughout the work with the family there was a constant appraisal of the impact of racism and service delivery systems on family functioning. There was a need for identifying and developing needed services; mitigating negative influences such as teacher attitude, inadequate health and support services; and supporting family resources and natural helping networks. The mother suggested sending the child South to maternal grandparents to "get himself together" and this plan was encouraged as a viable coping mechanism.

The use of religion in dealing with overwhelming stresses was not viewed as repressed anger or denial. The mother's inability to deal with the issue of sexual activity was not interpreted as deep-seated sexual conflicts with many treatment hours spent exploring the source, but as a culturally determined piece of behavior that was more accessible to direct and early interventive techniques. The father's playing the "numbers" and other "hustles" was not labeled as antisocial behavior, but as a resourceful means of meeting the additional financial needs of the family.

In working with minority families it is often necessary to take on a more directive approach. The question, "How do you feel?" is often met with a hostile stance. The unexpressed feeling is often that of "You're the professional. Tell me." Minority families may need more direct information about the developmental needs of the atypical child, specific role modeling, blueprints on child management techniques, and more direct assistance in negotiating the unfamiliar specialized systems of mental retardation services. Often it is necessary to provide concrete services to minority families before they can move into a purely counseling relationship. This does not imply that such families are not amenable to psychotherapy,

or are lacking in verbal skills or cognitive competencies to profit from such treatment. However, their problems must be understood within broader perspectives incorporating systems and ecological orientations. Certainly if the financial needs of minority families were fully met this would indeed provide much relief. Nevertheless there would still remain the pain and stress that is associated with the lifelong task of rearing a developmentally impaired child.

Summary

This presentation has endeavored to highlight issues that need to be examined in planning and implementing a pluralistic perspective in the interdisciplinary core curricula. In summation, I would like to share with you a statement made by Miquel, a twelve-year-old, Puerto Rican boy, whom I came to know in my work in East Harlem. He was a child who had the ability to move with great facility and ease between two languages, capturing all of the subtle nuances and affective meaning in each. Yet Board of Education psychological testing revealed that he had difficulty with abstract thinking and conceptualization. Other testing procedures had found him equally lacking in reading acquisition skills, symbol recognition and formation, logical thought and sequencing of events, and other cognitive and linguistic areas. Yet Miquel could negotiate the New York City subway system, from Queens to the Bronx, and arrive at his destination. When he was not using public transportation, he rode the bike that he had built himself from parts scavenged from here and there, from the Bronx to his own East Harlem. He seldom ventured out to the unfamiliar territory of Upper Manhattan, where he said, "The white people lived." We shared a close relationship in the two years that I knew him; the time that it took to have him inappropriately placed in a class for Educable Retarded Children. It was said to be the only class available for "a child such as Miguel." Once he said to me, as we worked together on his reading, "It's funny, but I can't seem to do it unless you're with me." Miquel in his person-situation and ability to continue to reach out, makes an eloquent and challenging statement about the social content with which we are concerned, the significant role that is played by the enabler/practitioner, and the urgency for us to respond.

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A RESPONSIBILITY OF A CENTER

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Social work has been one of the most organized disciplines in the University Affiliated Programs (UAP's) around the country for training and curriculum development. In many respects, it has been a standard-setting discipline for inter as well as intra-disciplinary training. Social work has gained its leadership role in the UAP's, in part by the standards it has set for training. One of the best examples of this is found in the Instructional Manual and Evaluation Guide for Graduate Social Work Education in The University Affiliated Facility,[1] edited nearly a half-dozen years ago by Frances McGrath, David O'Hara and Duane Thomas, which incorporates contributions from a number of the participants attending this conference today.

Documents developed from this conference, have a good precedent to follow in that manual, even though its focus was on graduate social work training per se. It can serve as a standard in terms of its completeness, attention to, and identification of knowledge and skills critical to the field of mental retardation and related handicapping conditions. It also sets an example through its methods and procedures of evaluating levels of trainees' contingencies in areas identified as essential. In short, the instructional manual provides a model for the organization of social content for interdisciplinary training, and it gives us a base for specifying the content we can recommend for an interdisciplinary curricula.

A Standard-Setting Profession

Social work has been a standard-setting profession in UAP's because of its particularly well-developed body of knowledge and skills pertaining to mothers, children and family units. Traditionally, social work has taken an holistic approach to individuals: assessing the person-in-situation, identifying the competencies of the individual and exploring the resources available to him within his family and community. This particular perspective provides a problem-solving model for the delivery of service within the health care system, (mothers, children and family units). These approaches and perspectives can also be generalized to other professions practicing in clinical facilities and covered with the health status of individuals and families.

Social work has been attuned to working in interdisciplinary and multidisciplinary settings as well, and there are a number of reasons for this. The profession has a substantial history of working cooperatively with other professions in a wide range of public and private settings. Its clients have spanned a broad demographic and personal range of backgrounds, i.e.: social, cultural, racial, ethnic, and emotional aspects of health and disease that effects the access of the individual to the health care system. This knowledge and understanding is critical to the delivery of services to children and families that are experiencing handicapping conditions.

To summarize a bit here, social work has evolved and applied a set of values, a perspective of the individual in society, specialized knowledge and skills, and a problem-solving approach. The questions for us here, then are. What specific knowledge derived from social work do professionals from other disciplines need to know? What do other professionals need to know about social work as a profession? What is the social content that needs to be included in an interdisciplinary training program?

Social Work Knowledge

MCH has had a distinguished role in generating and disseminating social work knowledge relevant to interdisciplinary curricula for University Affiliated Centers. It has sponsored conferences on Health Content in Health Concentrations in Schools of Social Work, on Social Work Education and on Practice in Community Health Settings. Other conferences have identified areas of special social work knowledge and skill for working with mothers, children and families.

While proceedings of such MCH conferences offer a rich source for developing a solid, generic base of interdisciplinary training,

let me identify some conditions that social work must consciously address in making its contribution to the core curriculum. Historically, in the health field, social work has been perceived as ancillary. While this is diminishing with increased appreciation of the significance that social factors have in the etiology and remission of physical diseases and disorders. Such is by no means universal. Nor is the role of social work fully acknowledged and utilized in all health settings. In fact there are hospitals and clinics in which social work is not available. Furthermore, we appear to be entering a period when social welfare services are being sanctioned as condoning dependency and the "unworthy". As a profession we have been committed to evaluating our services and to being open about the results, whether positive or negative. However, all too often the deficiences have been emphasized in the public media and the merits of the services have gone unheralded. I am not proposing that our profession become defensive and engage in a campaign to promote self-interest. What is important, is that each of our curricula deal with the issues of the mixed perceptions that exist of social work and the negative stereotypes of welfare clients that are present not only in society at large, but also among those whom we are training in UAPs.

An Interdisciplinary Perspective

The purposes of interdisciplinary training within UAP's can be viewed from different perspectives. On the one hand, it can be perceived from the discipline's particular educational goals and objectives. In such instances, the issue is how does the interdisciplinary training advance the competencies and understanding relevant to becoming a practitioner of the specific discipline -- i.e. medicine, education, psychology, social work et. al. That perspective certainly must be given due attention in each center's training program. However, that perspective alone does not fulfill the educational mission of UAP's. The mandate to our centers requires that disciplinary perspectives are complimented by consideration of what elements must be incorporated in the training across disciplines so as to advance the understanding and the capabilities of <u>all</u> to serve handicapped persons and their families more humanely and more effectively.

Thus some of the central questions for us in this conference are: What can social work appropriately contribute to the core training of other disciplines that is derived from our profession's unique knowledge, value and practice base? What is it that we have learned from decades of helping people who are coping with social problems that should be shared with the other professions? What skills have social workers acquired that practitioners of other disciplines should be helped to learn and apply? What understandings have we gained from observing the impact of disease and disorders on people's

functioning that should be understood by UAP team members across discipline lines? How can we help other disciplines to gain sufficient appreciation of the contributions social services can have in health care systems so that they are better able to help clients access such services?

One element of the social content that certainly warrants consideration in this conference on the core curriculum is historical. Obviously not just as a chronological documentation of our profession, but rather as a background for understanding what social work is about today, from what origins it has emerged and in what directions it is moving. This should be particularly focused on those social services that have relevance to the problems which handicapped individuals and their families characteristically experience.

Another component that merits strong consideration is the person-in-situation concept. Clinical disciplines are generally focused primarily on the person, the individual, the conditions which he/she exhibits. Appreciating social functioning, social coping patterns requires that the focus be enlarged to consider the context within which the individual exists - lives, works, worships, relaxes. Thus social work's problem-solving approach introduces contingencies that may not be given weight by other disciplines in the course of their diagnostic-treatment procedures. Concomitantly, the contributions of other disciplines to the core curriculum will orient social work students to conditions that are not within the scope of our profession.

In the field of individual development, the life cycle approach has gained prominence through the works of such pioneers as Erikson[2] and Piaget[3]. As a result more disciplines are relating the onset and course of handicaps to the stage in the person's life at which such occur. Social work, along with relating to individual life cycles, has perceived the importance of the family as a basic unit in health management. With the extension of the life cycle concept to families, social workers have found that considering the interaction between the stages in the individual and the family can lead to a more comprehensive appreciation of the social impact that physical disorders can have. A schematic presentation of the interaction between individual and family life cycles has been presented in detail by Kunabe, Nishida, O'Hara and Woodruff[4]. The life cycle orientation has utility not only in formulating team intervention strategies, but also in anticipating crises at various points in the life of the child and of the family. The latter provides a basis for taking preventive action. Thus the life cycle concept, as it applies to the social development of both the individual and the family, is another element of core curriculum content proposed for conference consideration.

Beyond the Handicapped Individual

The knowledge areas that are important extend beyond the effects of the handicapped individual himself and his family to the larger social group. In this respect, content that social work has to offer should include information on the policies, programs and services for handicapped persons and their families as well as cultural, racial, and ethnic conditions which stand as barriers to full access to the health care system.

Advocacy for the full rights of the handicapped person within the social, medical, and educational systems must be an interdisciplinary effort. Social work does have special knowledge of social policy programs and group process methods that are specific to advocacy programs. It can use this knowledge to enhance the abilities of others to serve as advocates for the shared population.

A final knowledge area, or area of social work content relevant to a core interdisciplinary training curriculum is interagency coordination for delivery of services. Linkages with other training and service agencies has become increasingly important and will continue to be important in the future due to budgetary restraints on social and health programs. Social work may have to teach others how to access services that are available in other community agencies and how to use these resources to gain services for clients.

Summary

I have reviewed a number of knowledge areas that social work as one of the several disciplines represented in UAP's has a responsibility for integrating into the core curriculum. One additional point regarding such may be indicated. Trainees from other disciplines within UAP's may be more interested in social work's professional skills than in its knowledge and orientation to human beings and services. We frequently hear such requests as, "I want to know how to talk to parents." Such requests do need our response. However, in responding, we should be certain that the trainees do not perceive that establishing and maintaining a meaningful relationship with clients rest solely on interviewing ability. Furthermore, while social work does deserve recognition for its professional skills, the curriculum should establish that the professions is increasingly attentive to expanding the knowledge base related to helping people develop their competence to function more satisfactorily and more satisfyingly.

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A MULTI-DIMENSIONAL FRAMEWORK

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Coming at the end of this series of presentations, my task is certainly a formidable one. The previous speakers have already provided you with a massive volume of solid content to consider and a range of intriguing challenges to tackle. From the opening session you have been presented more than can be fully assimilated and undertaken within the time frame of this workshop. I am certain that adding more grist for you to consider violates a number of educational principles that you could cite. Yet the objectives we formulated collectively impel my stretching your patience and attention to think with me about a model that may assist us in meeting the conference goals before we leave two days from now.

Some weeks ago you were mailed a folder of ready references (see page 46) to generate your thinking so that when we divide into work groups the tasks of the conference will be addressed with minimal lag. The readings were not provided as finalized or fixed perspectives, but rather as starting points for launching mutual deliberations leading toward some consensus as to the social content that should be included in interdisciplinary training programs -- first, within the university affiliated facilities, but not exclusively so. It is the planning committee's intent that, whatever publications or media are produced from this conference, such should be prepared for dissemination in the health field as widely as resources will permit.

While the readings were drawn heavily from social work publications, it should not have escaped anyone's attention that the writers represented a range of disciplines. And in the aggregate, the writers identify three distinct, yet related, perspectives: prevention, humanism and systems. I submit that these three perspectives provide a framework for designing the social content of core curricula -- perhaps even other components of the curricula. The idea struck me when I read the opening paragraph of Jane Karkalits' article[1]. In case you haven't met her, she is here as a participant and member of the planning committee. She observes that:

> Preventive social work has been defined by Wittman as an organized and systematic effort to apply knowledge about social health and pathology in such a way as to enhance and preserve the social and mental health of individuals and families.[2]

The necessity for a multi-dimensional model was further enforced by the concluding remarks made by Chapman and Chapman in the readings' packet:

> Although the goal of humanistic helping is a needed one and worthy of being held in high value, it does not automatically exist everywhere.[3]

They say "everywhere," but for our purposes we can ponder if humanistic content exists within our respective centers with sufficient emphasis in the training programs.

Furthermore, both articles bring out the importance of inculcating health providers with a systems orientation. Chapman and Chapman alert us to "the influence of sociocultural systems factors over which the patient has no control that affect ease in seeking help as well as personal expectations."[4]

Karkalits reinforces systems content by quoting Whittaker:

> How does one continue to justify any form of treatment or remediation when massive social problems like poverty, inferior education, and urban blight so clearly demand large-scale programs aimed at basic systemic change? Aren't any efforts directed toward remediation just futile attempts to apply band-aids when what is needed is major surgery?[5]

Let's look at each of the parameters I have identified -- prevention, humanism, and systems -- to see what guidelines they provide for a

multi-faceted curriculum approach to social content. From the field of health, I submit that we draw on its conceptualization of prevention as a basis for our deliberations. The public health model has identified three levels that need to be attended to in a comprehensive preventive program. By substituting social function for "health" and social dysfunction for "disease," the three levels could be defined as follows:

> Primary prevention includes those activities or interventions designed to prevent social dysfunction through the promotion of social function and protection against threats to social function.
>
> Secondary prevention is concerned with the early identification and treatment of social dysfunction to eliminate it or control its course.
>
> Tertiary prevention includes those activities directed toward ameliorating the seriousness of social dysfunction by reducing disability and dependence resulting from it.[6]

Those of us who are social workers know that pioneers in the profession, like Mary Richmond,[7] were alert to the importance of developing a society that "would learn to apply knowledge about human behavior and social systems to develop humane social policies and to create mechanisms that would eventually prevent the onset of problems for individuals, families and communities."[8] From the "reformers" of those early days to contemporary advocates and policy-planners, "a small but important segment of the social work profession has been concerned with designing social policies to enhance social functioning and prevent social breakdown."[9]

Social work, like other disciplines offering therapeutic and rehabilitative services in agencies and clinics, has been devoting much of its resources toward tertiary prevention. However, the movement toward primary and secondary prevention of social dysfunction is gaining momentum and should be a substantial subject within the interdisciplinary core curriculum. I again draw on Wittman from the current Encyclopedia of Social Work for preventive content that merits our consideration:

> At the primary level, the eradication of poverty, the assurance of adequate health care through some form of health insurance, and welfare and institutional reform to insure wise and humane support and care for dependent populations require the restructuring of social, political and economic institutions. In addition, education and dissemination of knowledge about human development and social

interaction to parents, teachers and all who work in the human services are essential.[10]

> Secondary prevention (should) occur in homes, schools, industries, health clinics, and even in neighborhood centers, where early detection could lead to helpful resolutions before problems become more serious and pervasive... (and) better structures in such natural settings as the... leisure time facility and the church can contribute to success at this level of prevention.[11]

By nature of the caseloads that university affiliated centers see in the course of their clinical missions, tertiary prevention is a prominent component of the practica. What this conference should determine is what content should be included within the core curricula regarding prevention of social dysfunction at all three levels.

Turning now to the humanism dimension of the model, the tri-level conceptualization again appears appropriate: life-saving, life-sustaining, and life-enhancing. It is proposed that social content of core curricula must go beyond prevention of dysfunction and incorporate social content that attunes practitioners to maximizing the potential of handicapped persons for self-direction, self-fulfillment and strong self-identities.[12] Converting the Chapman and Chapman health concepts[13] into a social-functioning context, the three levels could be conceived as follows:

> Life-saving: Prevention of social dysfunction so severe as to threaten the persons' survival.
>
> Life-sustaining: Maintenance of or restoration of social function that is within acceptable bounds to the individual and his social environment.
>
> Life-enhancing: Maintenance, restoration or development of the individual's social function at a level of high well-being and productivity.

For professionals serving individuals who are experiencing chronic and profound physical disorders, it is particularly crucial that their training establish the relevance of fusing strategies for enhancing the patient's potentials for self-actualization along with the necessary medical procedures.

The rationale for the third dimension of the curriculum framework likewise has special significance for interdisciplinary training. According to Anderson and Carter a social systems approach "has the potential for providing a common language to various disciplines." (Secondly,) "it offers greater possibilities

for description and integration of seemingly disparate theories into a single framework."[14] In view of the "increase of social science knowledge that bears on practice in the various human services"[15] the problem of designing core curricula becomes staggering without a concept that fosters an integration across theories and across disciplines. Even though the systems approach is still in an early stage of development, its pertinence for training is increasingly realized with regard to evaluating

> ...the status of the person who is ill and the significance of changes that may or may not have occurred in patterns of behavior. This content will help students to develop a broader concept of the relationship between health and illness, the wide variations of "normal" behavior, and changes that may occur as a consequence of illness and/or hospitalization.[16]

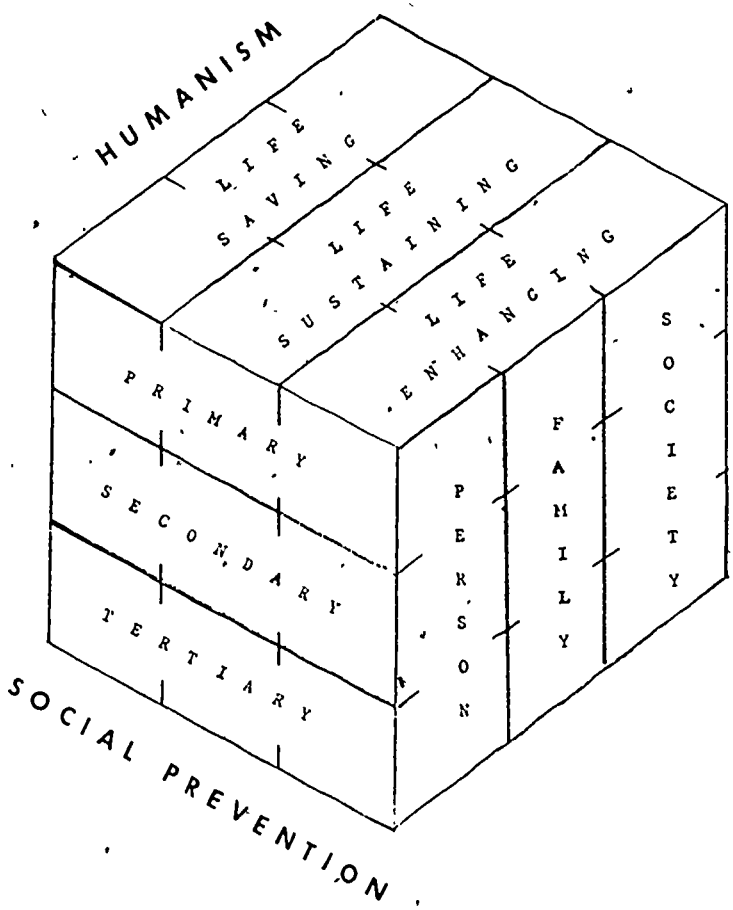
The social systems approach, which was derived from the concepts of von Bertalanffy in the field of biology,[17] defines a system as "an organized whole made up of components that interact in a way distinct from their interaction with other entities and which endures over some period of time."[18] Systems are rather commonly divided into three segments: micro, midi, and macro. Translated into social systems terms, this dimension of the curricula framework should encompass three elements: the person, the family, and the society. I perceive no questioning of the relevance of these three for the curricula. The issue for us will be identifying the pertinent elements in each for interdisciplinary training.

In presenting the three dimensions for the core curricula -- prevention, humanism, and systems -- I indicated that they were interrelated. To consider one without the others, or all three in separate channels, would fall far short of providing trainees with a comprehensive understanding of individuals experiencing handicapping conditions and for providing such individuals the services they may require to develop as social beings. One way of perceiving the three graphically is as the interlocking faces of a cube (Figure 1).[19] By attending to the principle aspects of social functioning which such a three-dimensional framework highlights, hopefully we can identify the key elements that should be addressed in the core curricula.

As a final observation, it may strike you that a fourth dimension has been overlooked: <u>the life span</u>. Changes over time must be appreciated with regard to all three dimensions of the cube model. New perspectives and modes of applying them to the assessment and facilitation of social functioning are bound to evolve. Their relevance at different stages of individual, family or community development will need to be identified particularly within the systems component of the curricula as herein conceived. A chart identifying sequential program needs

Figure 1

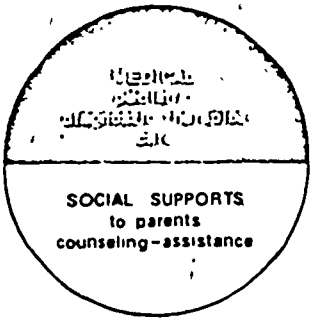
SUGGESTED FRAMEWORK FOR SOCIAL CONTENT OF UAF CORE CURRICULA



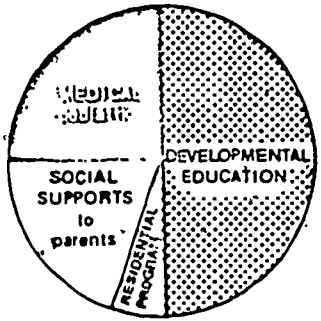
J. J. Parnicky, 1980

Figure 2

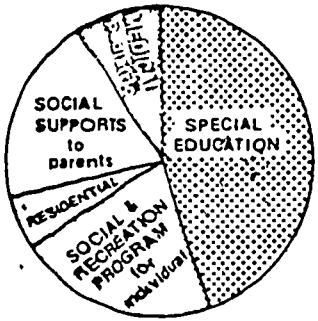
SEQUENTIAL PROGRAM NEEDS OF AN INDIVIDUAL WITH MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES



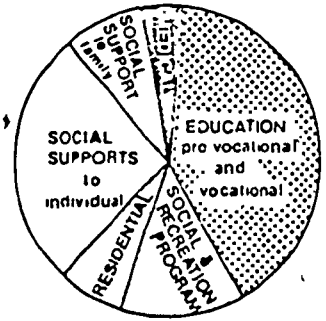
BIRTH TO 6 MONTHS



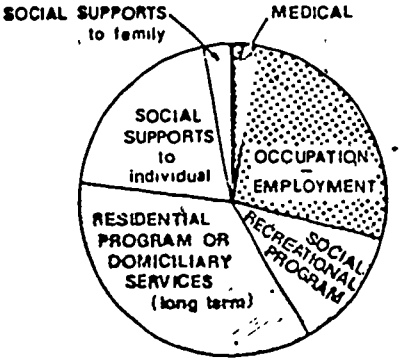
INFANCY & EARLY CHILDHOOD



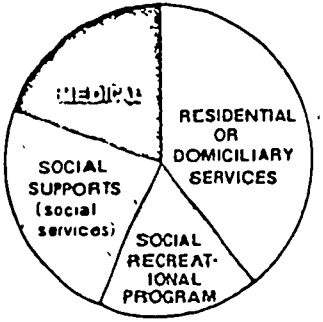
MIDDLE & LATE CHILDHOOD



YOUTH



ADULT



ELDERLY

(Courtesy Marie M. Cullinane, Children's Hospital Medical Center, Boston, Massachusetts.)

of handicapped individuals through various life stages (Figure 2)[20] produced at the UAF of the Boston Children's Hospital is included as an additional reference for workshop deliberations.

The task ahead of us is certainly a substantial one. While the mass of information to be considered is staggering, two factors make me optimisitic about our conference deliberations. First is the conviction we have collectively in the importance of the task -- we generated the focus for this week's joint effort. Second is the substantial experience and competence this group has in interdisciplinary education for the field, both individually and collectively.

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MEDIA PRESENTATIONS

Slide-Tape

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