Identification and Placement for Deaf Students with Multiple Disabilities: Choosing the Path Less Followed

Education services for deaf students with multiple disabilities have been an increasing concern for professionals in the field of deafness and special education. Professionals serving these students have a common goal of finding effective ways to identify, assess, and place students, and using interventions that lead to successful learning environments. But progress in the development of appropriate services for deaf students with multiple disabilities is stifled by three specific problems. First, researchers have found that students with multiple disabilities often are misidentified or identified late, are placed in inappropriate educational settings, and consequently receive inadequate services (Ewing & T. Jones, 2003; Lennan, 1982; Powers, Elliot, Fairbank, & Monaghan, 1988; Powers, Elliott, & Funderburg, 1987; Roth, 1991). Second, the Gallaudet Research Institute (GRI) conducts an annual survey to identify the percentage of multiply disabled students in the United States who are deaf or hard of hearing. Unfortunately, the GRI researchers face many challenges that impede the process of collecting complete data. Third, research on deaf students with multiple disabilities is decreasing; thus, proven methods of identification and placement are not available. Although professionals have an increased need to understand how to serve deaf students with multiple disabilities, current research does not match teachers' needs. Therefore, professionals working with these students face serious obstacles in regard to identification and placement procedures (Silverstein, 1986).
The purpose of the present literature review is to discuss research on the identification and placement of deaf students with multiple disabilities. I address the following: How do professionals identify a deaf student with multiple disabilities? How do professionals apply the diagnosis of a multiply disabled deaf student to choose the most appropriate and effective placement for that student? In this literature review, I examine the evolution of identification and placement options for deaf students with multiple disabilities over the last quarter century. I provide an overview of research methods, assessment procedures, results, and implications of these studies. The literature review encompasses deafness and autism, emotional/behavior disorders, attention deficit disorders, and mental retardation. I do not discuss deaf-blindness because it is an area that has been studied in depth over the course of several decades. In addition, because of the numerous publications on deaf and learning disabled students, a separated literature review is warranted. Most important, in this literature review I determine areas that need further investigation.

**Which Path Did We Travel? A Data Dilemma**

Many children with additional disabilities are overlooked by the GRI survey, which attempts to reach as many programs and schools as possible in the United States serving one or more deaf or hard of hearing students. Mitchell (2004) systematically compared data from the 2000 GRI annual report with the IDEA Child Count demographic data (U.S. Department of Education, 2002). Although the prevalence of deaf students with additional disabilities remains relatively the same between the weighted and unweighted calculations, Mitchell concluded that the IDEA Child Count data identified twice as many children with a hearing loss as the GRI data. Unfortunately, when identifying students with a hearing loss, the IDEA Child Count provides almost no data beyond their school setting and ethnicity.

The GRI survey reaches a limited number of students with deafness for several reasons. When a student moves interstate to a new placement, he or she may be dropped from the database (Holden-Pitt & Diaz, 1998). Mitchell and Karchmer (2006) noted that a growing number of students with a hearing loss are moving into mainstream programs. Because of the increasing dispersion of students across academic settings, the GRI faces new obstacles to collecting comprehensive data. In addition, since the teacher or a school or program official is usually the person who completes the survey for a child with a disability, and is a secondary source, information may be incomplete. Unreported or unknown data increase when respondents are unable to answer some specific questions regarding the deaf or hard of hearing child. Administrators from charter schools, rural areas, and mainstream programs often do not receive the survey. Therefore, several education programs that have a small number of deaf students are uncounted. Mitchell (2004) notes several additional problems: (a) Not all programs that receive the survey respond; (b) many students under the age of 6 years are not identified nor are receiving services for a hearing loss; (c) new programs may arise during or after the year of the survey and are not included in the data collection. The GRI's survey data show that over 50% of deaf students have an additional disability (GRI, 2005). However, due to the data collection problems I have described, 50% may be an underestimation of the total population of deaf students with multiple disabilities who need services today.

There are problems with both the reliability and the validity of the current data collection system. Research cited throughout this literature review illustrates how large discrepancies exist between data reported by the GRI and that from independent researchers. Because the data on deaf students with multiple disabilities lacks accuracy across studies and over a long period of time, standardized measures of data collection are imperative.

Etiology, medical interventions, characteristics and terminology of the additional disability, diagnostic measures, placement, and programming procedures are the kinds of information the GRI survey has yet to include on multiply disabled students who are deaf or hard of hearing. Therefore, specific data on how deaf and hard of hearing students with multiple disabilities are identified and placed in educational settings is limited. What are we doing about this dilemma today?

**What Path Are We On? A Review of Research in the Last Quarter Century**

Even though the GRI survey has flaws, it is the best source of information about children and youth with hearing impairments in the United States. The statistical findings from the 2004–2005 Regional and National Summary (GRI, 2005) show that 37,500 deaf students live in the United States and U.S. territories. Of the 37,500 students, 55.2% are reported to have an additional disability. The percentage of students with additional disabilities is likely to be higher, since 5.6% of administrators or teachers from various programs did not report information. The distribution of deaf students with additional disabilities focused on throughout the present literature review is presented in Figure 1.

In the following section of the literature review, I discuss qualitative and
quantitative research, theories, and professional opinions in the literature over the past quarter century. I discuss research as it applies to each specific disability area: autism, emotional/behavior disorders, attention deficit disorders, and mental retardation.

**Autism**

**Identification**

Identification and placement options for children who are deaf and autistic have recently been studied by Roper, Arnold, and Monteiro (2004) in the United Kingdom. The researchers administered the Autism Screening Instrument (Krug, Arick, & Almond, 1993) to 13 deaf participants with autism, who were compared with two groups: 12 hearing autistic individuals and 15 deaf individuals with learning disabilities. Parents and teachers were given questionnaires that asked them to identify behaviors that described the child. Roper and colleagues found that there was no significant difference between the child's age at diagnosis and the age at which the parents began to suspect developmental problems. In addition, no significant difference was found between the age at which parents began to suspect a hearing loss and the age at which it was diagnosed in the deaf autistic and deaf learning disabled groups. The researchers reported that the deaf autistic children did not demonstrate any characteristics that would promote early recognition. Thorough assessment was recommended as well as educational provisions. Roper and colleagues reiterated the necessity of early diagnosis to assist in education planning.

Children with autism may also be at high risk for hearing loss. Rosenhall, Nordin, Sandstrom, Ahlsen, and Gillberg (1999) gave 199 autistic children, 153 boys and 46 girls, an audiologic examination to determine if they had a hearing loss. The boys' mean age was 7.0 years and the girls' 8.4 years at the time of the examination. Rosenhall and colleagues found the prevalence of hearing loss in autistic children to be 10 times greater than in the general population. In the general population of children, profound hearing loss has a reported incidence of 0.1% to 0.2%. By contrast, the reported incidence of profound hearing...
loss in autistic children is 3.5%. The researchers found that 10 out of 126 participants demonstrated a sensorineural hearing loss in the mild to moderate hearing range, 20–40 dB. Five of the participants had slight high-frequency hearing loss, and 4 demonstrated a falling curve from high to low frequencies within the speech range. Two of the participants had unilateral conductive hearing loss. A severe to profound bilateral hearing loss was found in 7 of the 199 participants. Rosenhall and colleagues suggested that children with autism be closely examined for hearing loss so that the appropriate habilitation services could be implemented.

Incidence
In the 2005 GRI annual survey, the authors noted that of the total population of deaf students in United States, including the Virgin Islands, Guam, and Puerto Rico, 341 were reported as having autism in addition to deafness. These 341 students account for about 1% of the total students in the survey. Jure, Raplin, and Tuchman (1991) found 61 cases of children with autism and hearing impairment from a total of 1,150 cases, approximately 5.3% of the total population in their study. The researchers concluded that autism and hearing impairment are concurrent more than by chance alone. They collected data from the population of 1,550 participants with a hearing impairment over a 10-year span. In contrast, the GRI annual survey covers a population of about 40,000 students with a hearing impairment every year. The GRI (2005) reported that only 0.7% of the population of students had a hearing impairment and autism, whereas Jure and colleagues reported 5.3%. The percentage of students with a hearing impairment and autism reported by Jure and colleagues is thus almost 8 times greater than the percentage reported by the GRI. The discrepancy between findings may be due to the limitations of the GRI survey or to Jure and colleagues generalizing to a larger population.

Placement
Additional researchers have examined hearing loss in children with autistic disorders to determine if hearing loss is related to the disorder (Jure et al., 1991; Smith, Miller, Stewart, Walter, & McConnell, 1988). Jure and colleagues found that 41 of the 46 participants in their study attended programs that were not specific to both autism and deafness. One student attended a program for hearing learning disabled, 2 students were placed in a deaf-blind setting, 4 children were not in school yet, 5 students were in a hearing autistic placement, 8 students were enrolled in a multiply disabled program, 8 students were placed in residential programs for deaf and hard of hearing students, and 12 students attended a school for the deaf. Brimer and Murphy (1988) conducted a case study of a 14-year-old boy with deafness and autism. They found that if autism were considered the primary disability, the child would be placed in an educational system for autistic children. In contrast, if the child were labeled “autistic-deaf,” programs designated for children with deafness would be the legal placement. Overall, researchers have identified deaf autistic children but have not found effective strategies for educational placement, academic assessment, and teacher intervention. Without the studies designed to investigate educational problems thoroughly, students who are deaf and autistic will not be adequately served.

Emotional/Behavior Disorders Identification
Research in the area of identification and placement of students with emotional-behavior disorders (EBD) and deafness was more common in the 1980s than was the case for other disability areas. Of the research I examined, all was conducted in the mid-1980s, with the exception of one study done in 2005. Meadow and Trybus (1985) reviewed existing data from studies involving children with EBD and deafness. The researchers found that identification of a deaf student with EBD was determined by the presence of one or more of the following traits: low need achievement, aggressiveness, anxiety, hostile isolation, academic disability, uncontrollable behavior, and hyperactivity. These traits are similar to those reported by Feinstein and Lyle (1987), who examined five students referred to counseling for help with psychosocial problems. Kluein (1985) surveyed discipline referral forms from five residential schools. Disruptive adolescents’ risk factors were reading ability, degree of hearing loss, age, and sex. Kluein was careful to point out that these risk factors are not causation for behavioral problems. However, students whose risk factors deviate from the norm are often referred for disciplinary action. The participants in a study by Flournoy (1985) had similar traits, plus inattentiveness, self-destructiveness, and being “nervous-overactive.” Glenn (1988) did not address the identification criteria for the participants in his study. Sinnott and T. Jones (2005) summarize data on deaf and hard of hearing students previously diagnosed with EBD and do not elaborate on characteristics used to diagnose these students.

Meadow and Trybus (1985) found that several of the students in their
study came from dysfunctional families, which may have magnified the symptoms of EBD. Often deaf children with EBD come from environments where communication is limited, they are socially neglected, and their families lack the discipline to meet the therapeutic needs of their child. A well-designed assessment is needed to accurately diagnose EBD in students at an early age.

Incidence
Sinnott and T. Jones (2005) identified characteristics of 115 deaf students with EBD by examining a database established in Illinois from 1994 to 1999. Since the students in this database already had a dual diagnosis of deafness and EBD, the researchers were better able to obtain helpful identifying background information than earlier researchers. Sinnott and T. Jones determined that 71% of the students were male; 51% were characterized as "white," 29% "African American," and 10% "Hispanic." Living arrangements varied: Twenty-one percent lived with both parents, 30% in single-family homes, 2% with their relatives, and only 1% with foster families. The remaining deaf students with EBD, 46%, lived in residential schools.

The research conducted by Meadow and Trybus (1985) and Glenn (1988) converges in several ways. These researchers reported a greater prevalence of EBD among deaf children than among hearing children. Glenn found that incidence rates varied from 8.3% to 22% depending on the researcher. Deaf students were 3 to 6 times more likely to show signs of EBD than were hearing students. Occurrence of EBD was approximately 8.4% to 9.6% of the total population of deaf students in the United States (Meadow & Trybus, 1985). Meadow and Trybus obtained their data from the 1975–1976 and 1970–1971 Annual Surveys of Hearing Impaired Children and Youth conducted by Gallaudet College. The researchers reported that out of every 10 cases, professional practitioners can expect to have 1 or 2 deaf children with EBD.

Schnittjer and Hirshorn (1981) asked teachers to rate 192 students with hearing loss by using the Behavior Problem Checklist (Quay & Peterson, 1975). The checklist had been previously used with children with hearing loss to determine behavior problems. Although the researchers found that fewer students in 1981 exhibited problem behaviors than was shown by research conducted in 1972, their conclusion that boys are more likely to have problem behaviors is consistent with current research.

Cohen (1980) conducted a literature review on the causes and characteristics of emotional disturbance among children with a hearing loss. Interestingly, researchers conducting research on students with EBD before 1980 identify 11% to 22.5% of students as having some degree of emotional-behavioral problems.

GRI (2005) shows that of 37,500 students found in its survey, 675 (1.8%) were reported to have emotional disturbance. In 2003, the survey showed that 58 students (0.2%) were reported to have a behavior disorder. The term behavior disorder was replaced with emotional disturbance for the 2005 survey. Rosen (1989) noted that teacher-reported and researcher-reported incidence rates were 3% to 20% higher than national averages being reported by the GRI in the late 1980s. Why is the percentage inflated? Perhaps identification of deaf children with EBD is problematic because no standardized method is available to identify such children. Almost 30 years ago Cohen (1980) stated, "A need exists for the development of more well-defined, standardized evaluative instruments" (p. 1047). Educational placement is of equal concern with developing a standardized method of identification.

Placement
Sinnott and T. Jones (2005) discussed urban and suburban placement of their study participants. Fifty-eight percent were from an urban county, versus 22% from suburban counties. The researchers noted that the students in the database attended one of three residential schools in Illinois, but did not specify the setting, urban or suburban. Interestingly, Sinnott and T. Jones found that deaf students with EBD living with only their mothers were more likely to be placed in a residential school.

Glenn (1988) created a "Deaf Re-education" model for educating deaf students with EBD. The program began with 5 students in January 1984 and grew to include 18 by April 1985. Students ranged from 8 to 18 years old. The program consisted of 4 girls and 14 boys, all having low self-esteem and an inability to learn at the same pace as their deaf peers. Glen designed this model for deaf students with EBD because the prevalence of such students who did not have the appropriate diagnosis or educational placement was overwhelming. The Deaf Re-education model was designed to place deaf students with EBD in a program emphasizing health, not illness, learning, not personality restructuring, and teaching, not treatment. Encompassed in the program design were 12 principles to help the teacher build self-esteem and the ability to learn. These principles were based on interdisciplinary models to combine behavioral, affective, and cognitive approaches. The Deaf Re-education program was successful in returning students with EBD to their homes, schools, and communities.
Meadow and Trybus (1985) noted that researchers in the 1960s and 1970s conducted studies to evaluate mental health services and service providers working with deaf students with EBD. Trybus (1977) evaluated 34 treatment centers serving 700 to 800 deaf clients with EBD, and found that the service centers and professionals working in them only reached about 15% of the total population of deaf persons with EBD needing mental health services (Trybus, 1977, cited in Meadow & Trybus, 1985). Currently, service centers for treatment of children with EBD are more abundant throughout the United States. Professionals such as psychologists, teachers, psychiatrists, and mental health specialists are well trained and competent. However, few of these highly qualified professionals are familiar with deafness (Meadow & Trybus, 1985). Professionals working with a deaf child can be more helpful if they are familiar with deafness, Deaf culture, and the language used by the deaf child. More EBD professionals are being prepared to work with children who are deaf, but certainly not enough are available to cover all service centers and schools sites where deaf students with EBD are served (Meadow & Trybus, 1985). A paramount concern is that professionals should be taught to understand deafness and the implications of deafness for development of a more effective and productive relationship with the child. Professionals who understand and are experienced with deafness are critical to helping deaf children with EBD grow to be competent citizens.

Flournoy (1985) noted that many deaf students with EBD were attending school in mainstream settings, whereas in the past the trend was to place these students in residential schools. The researcher found that male and female behavior patterns differed depending on placement. Boys attending residential schools exhibited more aggression and anxiety, whereas girls attending day schools exhibited more aggression, anxiety, and inattentive behaviors. Today, more students with a hearing loss are attending mainstream settings than residential schools (Karchmer & Mitchell, 2003). Therefore, the importance of quality placement and program evaluation for deaf students with EBD is of utmost importance to assure proper emotional development.

**Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder Identification**

Kelly, M. Jones, Moulton, Verhulst, and Bell (1993) and Kelly, Forney, Parker-Fischer, and M. Jones (1993a, 1993b) conducted the majority of research on deaf children with attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) in the 1990s. More recently, Parasnis, Samar, and Berent (2001) and Samar, Parasnis, and Berent (1998) have also conducted research on deaf students with ADHD. Researchers have noted that the causes of ADHD and ADD are unknown, making early diagnosis exceptionally difficult or impossible.

Kelly, Forney, and colleagues (1993a) forewarned professionals who assess and diagnose deaf students that obtaining an interdisciplinary evaluation encompassing teacher, parent, and counselor feedback is critical. The authors suggested that the evaluation process include interviews with professionals who diagnose and assess, teacher and parent observations, psychoeducational evaluations, medical evaluations, and standardized measurements of attention.

Parasnis and colleagues (2001) discussed distinctive behavioral patterns defined by the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) as key elements in detecting ADHD. Behavioral patterns included characteristics of inattentiveness, hyperactivity, and impulsivity. The researchers suggested a combination of assessment tools: clinical judgment, detailed history, academic evaluation, analysis of impulsivity, and objective measures from parents, teachers, and the student used collectively to achieve an accurate diagnosis.

Parasnis and colleagues (2001) compared norms based on the hearing population from two diagnostic tests measuring inattentiveness and impulsivity: the Attention Deficit Scales for Adults, or ADSA (Triolo & Murphy, 1996), and the Test of Variables of Attention, or TOVA (Greenberg & Waldman, 1993). Parasnis and colleagues found that deaf students given the TOVA tended to be overdiagnosed with ADHD. The researchers suggested that a separate set of norms be developed for individuals with a hearing loss. However, deaf students who took the ADSA had means and variances comparable to those of the hearing population. Thus, the ADSA was a more reliable diagnostic tool for identifying ADHD in students with a hearing loss.

Kelly, M. Jones, and colleagues (1993) conducted a survey of attention and activity ratings of 238 students with a mean age of 14.8 years. The researchers indicated that males showed evidence of fewer problems than when evaluated on a hyperactivity factor. In addition, they concluded that there was a relationship between having a hearing loss and the ability to maintain attention during a particular task.

Kelly, Forney, and colleagues (1993b) noted that several of the characteristics of ADHD, such as aggression, anxiety, depression, hyperactivity, inattenti-
ness, and impulsivity, are also typical of EBD and learning disabilities. This suggested to the researchers that misdiagnosis is a possibility among students with ADD or ADD.

Incidence

Kelly, Forney, and colleagues (1993b) found that over 38% of children with acquired deafness are at risk of having ADD, while only 14% of children diagnosed with a hereditary hearing loss are at risk. Samar and colleagues (1998) reported findings of 3.5% to 38.7% of the total population of deaf students having ADHD, with greater prevalence in students with acquired deafness. Samar and colleagues do not describe why children with acquired deafness are at greater risk of having ADD. However, they noted the potential for bias because parental ratings and objective measures of attention were not incorporated in the analysis. The GRI (2005) reported that 2,235 survey participants (6.3%) had attention deficit disorder or attention deficit hyperactivity disorder.

Placement

Once a confident diagnosis of ADD is obtained, classroom intervention strategies can be implemented. Kelly, Forney, and colleagues (1993a) suggested using traditional environmental modifications such as those implemented with hearing students with ADD. A traditional classroom has a closed style—the student is placed close to the front, near the teacher, away from the center of the room and other busy locations, in an area with minimal visual distractions, and among peers who will be the least distracting. Intervention strategies include reinforcement of basic study skills—provide outlines, give examples or charts to organize thoughts, and use large print to limit the number of questions or problems on the page. Teaching organizational techniques to deaf students with ADD is important so that they have the skills needed to finish work and complete assignments.

The authors noted here are the only researchers to date who have conducted qualitative or quantitative research in the field of deafness and ADD. They recommend that a system be developed to identify and track deaf students with ADD so that professionals can better understand a student's potential and the challenges he or she may face.

Mental Retardation

Identification

Most of the research on identification and placement of individuals with mental retardation and hearing impairment (MRHI) was conducted in the early 1980s (e.g., Brannan, 1982; Naiman, 1982). Mental retardation is a disability often diagnosed at birth. In recent years, it has become increasingly likely that deafness will be detected in the hospital after an infant is born. Consequently, individuals with MRHI do not face the prospect of misdiagnosis or not being identified at an early age, as do hearing impaired children with additional disabilities other than mental retardation. However, researchers have not reported whether infants with mild mental retardation and deafness are as easily identifiable at birth as infants with more severe mental retardation. Further research is needed to determine if detection of mild mental retardation is problematic in infants with deafness.

Incidence

Brannan (1982) distributed a survey to 212 facilities serving individuals with mental retardation. The purpose of the survey was to study if MRHI students did not fit in traditional programs developed exclusively for mentally retarded or hearing impaired students. The survey had an 85% response rate. Brannan found that 9.53% of these mentally retarded individuals had a hearing impairment, 7.24% were hard of hearing, and 2.29% were deaf. Two thirds of the 9.53% of participants with MRHI were over the age of 18 years and were severely to profoundly retarded. Total Communication was the primary mode of communication for these individuals. Of the administrators who responded, 48% reported that their facility had developed services to meet the needs of hard of hearing students. Seventy percent of the programs included speech services; only 10% of the individuals with MRHI wore hearing aids. Unfortunately, 56% of the programs had no research or university affiliations; thus, no apparent benefit from the community or from research was cited. Brannan concluded that services for individuals with MRHI were limited. It can be concluded from Brannan's findings that educators, researchers, and educational institutions need to take part in helping to develop programs that meet the needs of this unique population.

The GRI (2005) reported that 2,902 of 37,500 students in its annual survey (7.7%) had some form of mental retardation. The degree of retardation was not defined in the survey parameters.

Placement

Naiman (1982) evaluated a demonstration project to pinpoint curriculum and placement options for adolescents with MRHI. The program emphasis was that no two such students were alike and that each student needed individualized programming and assessment; educational placement was not in a "fixed" setting. Students were allowed to move between the vocational settings to regular classes for deaf students. Students who made exceptional progress were placed in a general education mainstream setting with the
support of a resource teacher or itinerant teacher.

Naiman (1982) noted that the most difficult portion of the program was parent participation. Parents were encouraged to participate by (a) creating lesson plans for student behavior in the home; (b) attending family counseling; (c) meeting with project staff to gather information about available financial, housing, medical, and social services; (d) taking part in sign classes, which would help them communicate with their child; (e) get assistance with home behavior issues by speaking with a behaviorist; and (f) contacting deaf adults so as to understand and accept their child's deafness.

The problematic issue concerning students with MRHI is appropriate placement and services. Naiman (1982) and Brannan (1982) agree that further research is needed to develop programs designed to meet the needs and demands of serving individuals in this population.

**Which Path Are We Going to Take? Recommendations for Future Research**

Until now, most research on deafness and multiple disabilities has been qualitative (e.g., surveys, case studies, interviews, and observations). Research methods have not included quantitative or empirical studies; thus, findings are nondirectional. For example, a case study that examines the academic progress of a deaf student with autism in a mainstream setting does not provide direction to the best educational setting for students who are deaf and autistic. The literature discussed in the present review shows that if researchers continue to repeat the practices of the past, the education system for deaf students with multiple disabilities will not advance, now or in the future.

While the incidence of deaf students with additional disabilities increases, the amount of research on this population has decreased significantly (see Figure 2). One reason for the wealth of research on deaf students with multiple disabilities a quarter century ago could be that researchers were more aware of and sensitive to elementary school-age students who were affected by the rubella epidemic, which had caused an increased number of multiple disabilities. In addition, students with various disabilities were often placed in the same programs, making a study population more accessible. That is not the case for researchers today. Students with a hearing loss, including deaf students with multiple disabilities, have a broad range of placement options, including mainstream educational settings. Mitchell and Karchmer (2006) noted that approximately 65% of students with a hearing loss are instructed in the regular education setting for more than 40% of the school week. Regardless of the challenges researchers endure in order to study students with multiple disabilities, changes need to be made to the existing approach.

I propose that researchers conduct valid and reliable research using (a) intervention designs (e.g., multiple baseline, control group, and single subject), (b) comparison of existing databases, (c) instruments normed on hearing and deaf populations, and (d) longitudinal designs. In doing so, the field will come closer to standardizing criteria for specific disabilities based on what a student is capable of doing, and thus aid in the identification and placement process. For educators, the "emphasis should be on what the student can do in given situations, not on his or her limitations" (Laurent Clerc National Deaf Education Center, 2007).

As T. Jones (1984) said, “Matching the characteristics of multiply handicapped hearing impaired students to available variations of learning situation parameters can permeate an entire system of identification, classification, and placement of MHHI students” (p. 149). Ewing and T. Jones (2003) suggested that for adequate placement and instruction to take place, professionals must acknowledge deaf students with multiple disabilities as individuals, focusing on their strengths and not on their deficits. More recently, T. Jones, K. Jones, and Ewing (2006) asserted that although the challenges of serving a deaf child with multiple disabilities are extensive and complex, every child is capable of developing skills when given the appropriate learning environment. Conducting intervention research that focuses on the knowledge, skills, and training of professionals who work with deaf students with additional disabilities may lead the field in the direction it needs to go. Now is the time to choose a path less followed and conduct evidence-based research that validates the measures needed to accurately identify and place students who are deaf and multiply disabled.

**Notes**

1. In the present article, the term deaf refers to students with any degree of hearing loss.

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Figure 2
Number of Studies on Students With Multiple Disabilities, by Disability Area, 1980–2006.

Research on MDD Students

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<th>Year</th>
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Notes: MDD, multiply disabled deaf. Comb, combination. MR, mentally retarded. ADD, attention deficit disorder. EBD, emotional-behavioral disorder. Research includes qualitative and quantitative studies. Research in the combination category encompasses information on more than one disability area.

als, this article would not have been possible.—The Author

References
DEAF STUDENTS WITH MULTIPLE DISABILITIES


