Meeting the needs of the deaf retarded child

M. Carmelita Smith

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MEETING THE NEEDS OF THE DEAF RETARDED CHILD

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by

Sister M. Carmelita Smith, S.S.J.

A RESEARCH PAPER
SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS IN EDUCATION
(EDUCATION OF MENTALLY HANDICAPPED)
AT THE CARDINAL STRITCH COLLEGE

Milwaukee, Wisconsin
1972
This research paper has been approved for the Graduate Committee of the Cardinal Stritch College by

[Signature]
(Adviser)

Date [Date]
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Doctor Philip Bellefleur of the Pennsylvania School for the Deaf for the use of that particular school's library facilities.
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MEETING THE NEEDS OF THE DEAF-RETARDED CHILD

INTRODUCTION

Recently there has been an increase of interest in children with multiple disabilities. The current interest has logically come about by the increased number of children with multiple disabilities. Educators of both the deaf and the mentally retarded realize the need and the problem of educating children with multiple handicaps, but there is still a question as to the best way to educate the deaf mentally retarded child.

The number of children with multiple handicaps is on the increase and mental retardation occurs most frequently as one of the handicaps. Among deaf children, mental retardation occurs more frequently than any other second handicap. The problems involved in educating these children involve identification, determination of I. Q., satisfactory audiological testing, and adequate preparation of teachers to work with the children who are both mentally retarded and deaf.\(^1\)

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The purpose of this paper was to consider the special needs of one type of multiple handicapped child, namely the deaf retarded child. Of primary importance is the identification and prevalence of such children. Once these have been established, further classification can be made and educational procedures set up. In other words, the focus of this study was on identifying and classifying the type of child with whom this report concerns itself, and the methods used most effectively in teaching the deaf-retarded.

The main question was: What is being done for the deaf-retarded, since it is recognized that the number of deaf children with multiple disabilities is increasing?

Varying classification schemes based on disability, confusion in terminology, diverse criteria for defining deafness, and the difficulties involved in differential diagnosis and the unreliability of tests make it difficult to compile statistics and to estimate the number of children in a specific disability group.¹


years later, Leshin and Stahlecher estimated that about ten percent of
the populations in residential schools for the deaf were mentally re-
tarded. 1

In 1969, Lloyd reported that some schools for the deaf have offered
programming for the slower learner, but only recently has there been any
effort to include the moderately to profoundly retarded child with a
severe auditory defect. The little that was being done for the deaf-
retarded child was not in programs for the deaf, but for the retarded. 2

In the past, many people thought that all deaf children were mentally
retarded. Some deaf children are; but deafness itself is not an indication
of mental retardation. Intelligence tests which do not require language
are usually more adequate tools for measuring the mental ability of a deaf
child. The deaf child with normal intelligence is capable of competing
with the hearing child in many learning situations. Pages of bibliography
could be provided on this aspect alone. Many hearing impaired children are
thought to be mentally retarded until they are tested and the results show
that deafness is the main problem.

Whether the child whom both deafness and mental re-
tardation are diagnosed should be primarily considered
a mentally retarded child and educated as such has been
an issue. While the practice has been to assign priority
to one or other of the disabilities, no adequate rationale
for the assignment of priority of one disability over an-
other presently exists. There does not appear to be a
theoretical basis for establishing the primacy of one dis-
ability over another disability. 3

1Doctor Knute Espeseth and Mr. Gary Nix, "Mentally Retarded, Mentally
2Lyle L. Lloyd, "Evaluation Programming For The Hearing Impaired Men-
tally Retarded," National Institute of Child Health and Human Development,
Bethesda, Maryland, Rehabilitation Research and Training Center in Mental
3Robert M. Anderson, Ed.D. and G. D. Stevens, Ed.D., "Deafness and
Mental Retardation in Children: The Problem," American Annals of the Deaf,
There have been instances of misdiagnosis. To guard against this, deaf children should be identified as early as possible so that special programs can be planned. Many times, unless a hearing loss is moderately severe, auditory impairment frequently goes unnoticed in the mentally retarded.

There is general evidence to suggest that the prevalence of mental retardation among deaf children is increasing. Research into the etiology and treatment of communicable and infectious diseases, the establishment of improved health services, advances in prenatal care and reduction of infant mortality, improved nutrition, increased education, and better housing have contributed to the higher incidence and prevalence of deaf children with multiple disability.¹

Nace suggests, instead of spending time and energy in trying to decide which is the greater problem,

... to get to work on the one problem which is present in all multiply handicapped hearing impaired children— that of hearing impairment or deafness. Actually, this handicap is the least understood of all handicaps and the one which involves the greatest amount of patience, understanding, and love. If the communication barrier imposed by deafness is not broken down, not much can happen and the teacher cannot attack additional handicaps, whatever they are.²


DEFINITIONS

Many times terms are confusing; thus it seems advisable here to de­
fine the following:

A. Multiple Handicapped or Multi-handicapped refers to children who
have more than one disability. The largest group of multiple handicapped
children is the deaf-retarded child about whom the writer is concerned in
this paper. According to Nace,

... the multiply handicapped hearing impaired chil­
dren are those who, in addition to having a hearing
loss, have one or more additional handicaps, either
educational or physical, which increase the number and
intensity of problems associated with instruction.¹

B. The Deaf. A classical differentiation between deafness and hear­
ing loss that has not precluded the acquisition of speech and language is
frequently found in the literature. It is:

... deafness is a condition in which hearing is im­
paired to the degree that it is nonfunctional for the
ordinary purposes in life. From an educational stand­
point, the deaf may be divided into two groups based
on the time of loss of hearing:

(1) the congenitally deaf are those born deaf
or those who have lost their hearing before
the acquisition of speech and language.

(2) the adventitiously deaf are those born with
normal hearing but who lost their hearing
through illness or accident after the ac­
quisition of speech and language.²

¹John C. Nace, Ed.D., op. cit.
²George J. Leshin and Lotar V. Stahlecker, Academic Expectancies of
There are different degrees of hearing loss which can be classified approximately according to the following:

- Normal for Speech . . . 0 to 15 dB
- Mild Hearing Loss . . . 15 to 30 dB
- Moderate Loss . . . . 35 to 60 dB
- Severely Impaired . . . 65 to 85 dB
- Profoundly Impaired . . 90 dB

The following scale will give some idea of type and degree of hearing loss, and how much hearing each type of loss has.

Table I

<table>
<thead>
<tr>
<th>Class Name</th>
<th>Loss for Speech, in Decibels</th>
<th>Remarks</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Normal</td>
<td>Not more than 15 in worse ear.</td>
<td>Both ears within normal limits; no difficulty with faint speech</td>
<td></td>
</tr>
<tr>
<td>B Near normal</td>
<td>More than 15 but not more than 20 in either ear.</td>
<td>Has difficulty only with faint speech</td>
<td></td>
</tr>
<tr>
<td>C Mild impairment</td>
<td>More than 30 but not more than 45 in better ear.</td>
<td>Has difficulty with normal speech but not with loud speech</td>
<td></td>
</tr>
<tr>
<td>D Serious impairment</td>
<td>More than 45 but not more than 60 in better ear.</td>
<td>Has difficulty even with loud speech</td>
<td></td>
</tr>
<tr>
<td>E Severe impairment</td>
<td>More than 60 but not more than 90 in better ear.</td>
<td>Can hear only amplified speech</td>
<td></td>
</tr>
<tr>
<td>F Profound impairment</td>
<td>More than 90 in better ear.</td>
<td>Cannot understand even amplified speech</td>
<td></td>
</tr>
<tr>
<td>G Total loss of hearing in both ears.</td>
<td></td>
<td>Cannot hear any sound</td>
<td></td>
</tr>
</tbody>
</table>

C. Mentally Retarded. Mental Retardation refers to the subnormal intellectual capacity of an individual.

Mental Retardation is a condition in which mental age is less than chronological age to the degree that learning is very difficult or impossible in the typical school environment. The mentally retarded include all individuals whose level of mental development, as determined by a reliable intelligence test, ranges from approximately ninety percent of average to zero percent when these are placed on a continuum ranging from high to low.¹

This wide range is divided into distinct categories or groups as educable and trainable children. They may be further divided into groups termed borderline, mild, moderate, severe and profoundly retarded. Heber² suggests an I. Q. from 70 to 84 (Binet I.Q.) for the borderline group and

- 55 to 69 - mildly retarded
- 40 to 54 - moderately retarded
- 25 to 39 - severely retarded
- below 25 - profoundly retarded.

He further clarifies these groups as borderline - a slow learner or educable mentally retarded child. The slow learner could remain in the regular classroom, and the educable mental retardate is placed in a special education class. The mildly retarded need special education, and the moderately retarded are considered to be "trainables." These children can be trained to take care of themselves. The severely retarded, the upper end of the range, usually can function in a trainable class; the profoundly retarded are totally dependent.

¹George J. Leshin and Lotar V. Stahlecker, op. cit., p. 599.
D. The Deaf-Retarded. A deaf-retarded child is one with a hearing loss and an I. Q. below normal. The American Annals of the Deaf, (1964), listed the mentally retarded deaf as those who fall more than one standard deviation below the mean on a standardized test of intelligence. Educators of the deaf would rather refer to the deaf child with low intelligence as a "slow learning deaf child." It is hard to distinguish between deafness and mental retardation, or to decide where either one begins or ends.

Consequently professional workers tend to look at the child who is deaf and mentally retarded in the light of their own particular professional frames of reference. The person whose orientation is in mental retardation generally speaks of "the deaf mentally retarded." Conversely, the person whose background is primarily in the education of the deaf, and who works in a facility for the deaf, may refer to "the mentally retarded deaf."2

E. Educational Retardation. Another term confused with the mentally retarded is educationally retarded. These children are retarded educationally or fall behind in achievement. At times this is due to late entrance into school, illness, or lack of proper learning opportunities. Children who are educationally retarded are not necessarily mentally slow.

F. Residential School: A boarding school or institution that houses, cares for and educates the handicapped child. In the early part of the nineteenth century, the first residential school was begun, being the oldest plan for the education of exceptional children. Although the attendance at residential schools is decreasing, there will probably always be a need for

these schools. Children with unfavorable home conditions, hearing impaired children with other handicaps and those with other special problems can best be educated in residential schools.¹

Sonoma State Hospital (1947), in Eldridge, California, became the first institution in this country to set up a program for the deaf mentally retarded. Their program was to provide an integrated educational program to meet the needs of the patient's physical, social, mental and emotional growth. Their goal is to develop each child to his maximum capacity and help him to enter or return to society. Where the mental retardation is more severe and the patient has to remain in the institution for custodial care, the goal then is to train the child for a more enriched life within the institution. The children are grouped according to ability, not age. The oral method of communication is used by one teacher, and the manual by another.²

G. Day Class or School: A school for exceptional children whereby children attend certain classes during the day and return to their homes and families each evening. In this way they have the opportunity to be integrated with hearing children. The establishment of this type of educational facility has had rapid growth.

H. Classification. There are different ways of looking at the problem of the deaf child who is mentally retarded. Those working with the mentally retarded see a mentally retarded child with a hearing impairment.


Deaf educators would see a deaf child who is also mentally handicapped. Others see a child who is multiply handicapped. "The degree of hearing handicap would be the primary determinant of modalities to be used."1

I. Communication: The means by which one person understands or exchanges words, signs or information with another. Communication is the main problem for the deaf-retarded child. There are three methods of communication used among the deaf:

(1) The oral or speech reading method, (lip reading), involves the teaching of speech and language. It is a widely accepted means of communication for the deaf, because it is felt that the deaf person can communicate with the normal hearing population and will not be cut off socially.


(3) The combined or the simultaneous method of communication which includes speech instruction along with the manual method. Many children who are retarded, but not deaf, have no speech or very poor speech. Therefore, if it takes a certain amount of intelligence for the hearing child to learn to speak, it naturally takes as much intelligence or more for the deaf child to learn to speak.2

SUMMARY

The number of children with multiple disabilities is on the increase. The intention of the writer, therefore, was twofold: (1) To investigate the problem of the deaf retarded child and the problems involved in overcoming this multiple handicap if the child is to have an opportunity to live a normal life in society; (2) After identifying this type child, to look at the role the classroom teacher can play to help the deaf-retardate attain his ultimate life goal and live a happy, useful life in society.

1Knute Espeseth and Gary Nix, op. cit., p. 54.

CHAPTER II

REVIEW OF LITERATURE

Apparently, because it has only been during the past two decades that any thought has been given to the problem of the multiple handicapped child who is the deaf-retardate, there has been little research done on this topic.

Estimates on the number of deaf retarded children vary because surveys that have been made were made on populations in residential schools for the deaf, while many of these children have not been in any school until recently or are in schools for the mentally retarded.

The writer has reviewed some of the research done on the etiology, identification, classification and education of the deaf-retarded child. In connection with this, the important aspect of the training of teachers for these children has also been touched upon.

ETIOLOGY

The causes of deafness and mental retardation are many and they have a large number of common etiologies. The literature has shown that premature birth, rubella (German measles), Rh factor incompatibility, meningitis, drugs, and birth injury are the leading etiologies of deafness and mental retardation.
Hearing losses are not 'caused' by mental retardation but many stem either from the same pathology of which mental retardation is a symptom, or the two conditions may be wholly unrelated etiologically.¹

Rubella: The rubella epidemic of 1963-1965 was the worst in recorded history. "Many of these estimated 20,000 to 30,000 post-rubella children have profound hearing losses."² In addition to the hearing loss, there are also other disabilities among which the most common is mental retardation.

Rubella in the first trimester of pregnancy may have a devastating effect on the fetus. Deafness results most frequently if rubella is contracted during this time. The earlier in her pregnancy a mother contracts rubella, the more severe will be the effect on the unborn child. Even though a mother has had German measles during her own childhood, she should avoid exposure during the first three months of pregnancy, because immunity from a previous attack may not protect the unborn child from serious anomalies.

In a study done in Berkeley, California School for the Deaf, the percentage of congenitally deaf children rose from 45 percent in 1943 to 74 percent in 1958.

Many of these children may have had deafness resulting from diseases in the mother during pregnancy. With such etiology, the incidence of multi-handicaps can be expected to be high.³


Vernon found that the average post-rubella deaf child has a lower I. Q. than the normal child, plus a greater rate of mental retardation. Because of this, more of these children are not admitted to school or are dismissed from school programs.

... among those who remain in school, there seems to be, compared to other deaf children, poor academic achievement relative to level of intelligence. In other words, there is a greater prevalence of learning disability.¹

Many times, mental and physical development are affected, as well as the hearing of rubella children. Vernon in 1968 examined the relationship of deafness to intelligence in a series of studies on the intelligence of deaf children:

Based on these studies and on an understanding of the disease conditions causing deafness, it is apparent that many of the etiologies of profound hearing loss are also responsible for other neurological impairment which frequently results in lower intelligence. The point to be made is that the relationship, if any, between mental retardation and deafness is not casual but is due to the common etiology which brought about both the deafness and the retardation. The fact that certain of these etiologies and conditions - maternal rubella, purulent meningitis of early onset, premature birth, tuberculosis, etc. - are responsible for an increasing percentage of the school-age population suggests that there may be proportionately more retardation among deaf children in the future.²

In another study Vernon³ indicates that there will be a great influx of post-rubella deaf children in the immediate future in educational programs for the deaf and hard-of-hearing. Many of these children have behavioral problems along with severe learning disorders over and above the

¹McCay Vernon, op. cit., p. 183.
problems normally associated with deafness.

Because of its cyclic occurrence, its frequent association with multiple handicaps and its possible eradication through immunization, rubella has been of general and practical interest in the 1970's.

Prematurity: Premature birth accounts for much of the increase in the number of multiple handicapped deaf children. In most instances the causes of premature birth are unknown. Infections and maternal toxemia increase the probability of premature delivery; congenital syphilis was previously a frequent cause. Maternal malnutrition is an important factor in premature births.

The advances in modern medical science are saving more infants born prematurely than ever before. It is believed that the prevalence of premature deaf children will increase because of the trauma of prematurity. The lower the birth weight, the more disabilities a deaf child may have.

Vernon found that of 1,468 deaf children, 257 had been premature; thus, since about 17 percent of deaf school-age children are premature and more than two thirds are multiply handicapped, this problem should not be taken lightly or overlooked.

Rh Factor Incompatibility: Certain combinations of the mother's and father's blood types result in Rh factor incompatibility which can

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cause complete or partial deafness, and also mental retardation in many cases. It occurs when the mother has Rh negative blood and the fetus is Rh positive. In the past this condition led to brain damage or death. If discovered early enough in pregnancy and blood transfusions are administered at the appropriate time, the child could be spared many times.

Kernicterus is a condition which is due to Rh incompatibilities and is usually associated with mental retardation and hearing loss. With treatment, Kernicterus is reduced to a small percentage.\(^1\)

The recent development of the Rh immunoglobulin to the Rh factor has opened up an entirely new way of dealing with this disease.\(^2\)

It has been only twenty-five years since the Rh factor was discovered. It is a major medical advance to the medical profession moving from treatment to prevention. "... in terms of treatment and the etiology of which was unknown may in a generation's time become so rare as to be only of historical interest."\(^3\)

Meningitis: The most important postnatal cause of deafness is meningitis. Frisina\(^4\) found from his study of the etiology of the mentally retarded deaf, that eleven percent of the cases were attributed to meningitis. Streptomycin is used many times in the treatment of purulent meningitis.


\(^3\)Ibid.

and it is difficult to know whether the drug or meningitis caused the hearing loss.¹

The relationship between deafness and tuberculous meningitis is relatively new because previously the disease was invariably fatal. For this reason little research has been reported:

... the earliest reported case of post-tuberculous meningitic deafness involved a child who had contracted the disease in 1946. From this date until 1964 there were seven cases.²

At the onset of deafness, five of the seven children were infected during the first two years of life. One child had the disease twenty-eight months; and the seventh child was afflicted for seven years. The important fact to note here is that all were prelingually deafened except one, and two of the children had no physical handicap except deafness.³

With meningococcus meningitis the survival rate is higher. As can be seen in a study of meningococcal meningitis done by Slesinger between 1927 and 1932, drugs have reduced the mortality rate. There was an immediate thirty percent mortality when some 84 cases were treated. Fifty-four of the 68 children who survived were apparently cured, and the remaining 14 had some complication when discharged. In 1933, 42 of these subjects were re-examined and it was found that 25 were in good condition physically and mentally and had no defects which could be attributed to the illness, but 17 showed some effects of the disease. Three children were discharged with hydrocephalus; in one the disease eventually became arrested; the other two apparently recovered. Among the 17 children with other defects there


³Ibid.
were four cases of deafness, 4 cases of mental deficiency; three children with delayed speech, one child with arrested hydrocephalus, one blind child, and two cases of strabismus; also, one case each of focal epilepsy and spasticity of one leg.

When six of the 17 children were discharged, no residua were noted; but when re-examined there were three children with delayed speech, two deaf children, and one with mental deficiency.¹

As stated above, modern drugs have reduced the mortality rate among children contracting meningitis. However, there is no striking reduction in the number of children handicapped as a result of the disease.

**DIAGNOSIS:**

Today there are more multiply handicapped deaf than ever before. Possibly, because of the improved diagnostic testing methods, more of these children can be located; also, there is greater interest shown today in efforts to educate these children. However, there is still much to be done because of a gap that exists as a result of the lack of trained personnel and available funds.

One of the greatest problems in diagnosis is getting a retarded child to respond to a hearing test, because of his limited ability to understand and follow directions. A careful examination is needed when diagnosing the child. At times, children who are deaf are misdiagnosed as being mentally retarded. A battery of psychological and audiological tests should be given.

Certain diagnostic procedures must be carefully applied before judgment is passed. It should be clearly established through otological and audiological evaluation that this is truly a deaf child. When deafness is established, a neurological examination may help to rule out the possibility of organic damage. A complete case history is important to assess the possibility of learning difficulties based on emotional interference. Only after these steps have been accomplished, can the intellectual appraisal of mental ability be considered valid.¹

For a thorough diagnosis then, we find case history, otologic and audiological evaluations great sources of information.

IDENTIFICATION:

Identifying the deaf-retardate is a major problem. It is hard to know who they are and to know their exact number, for they must first be located and then identified. This process is most difficult, due to the considerable variation in range in the use of terms, and in defining mental retardation. This latter varies from one institution to another. The great differences in I. Q. and hearing levels of deaf-retarded children present a problem. The two rating scales used in Mitra's study showed that about 80 percent of the deaf-retarded children in residential institutions have borderline to mild retardation with severe to profound hearing loss.²

Identification is first necessary before any programs can be set up for the deaf-retardate. Many times, as was mentioned before, in the case of the deaf, a child is labeled mentally retarded whereas he may have impaired hearing. Care must be taken not to label a child, but if help is to be given this type child he must first be identified.

¹Leshin, George J. and Stahlecker, Lotar V., op. cit., p. 600.
Too often, children have been branded early in life by labels which cling to them as long as they live - labels that many times have been assigned in all good faith by evaluators whose experiences with hearing-impaired youngsters have been minimal. How many times have parents taken their children to clinics, hearing centers, schools for the deaf, university programs, and private practitioners, only to end their evaluative journey with as many labels as there were evaluations?

Mitra suggests a team evaluation made by teacher, physician, social worker, psychologist, speech pathologist, audiologist and neurologist. The means of identification most frequently used is a medical report, the I. Q. of the child, teacher's judgment, the child's hearing level in the better ear, and speech evaluation. The Wechler Intelligence Scale for children, (the performance part of the test), and the Vineland Social Maturity Scale are two standardized tests given to the deaf-retarded child. Psychological and audiological tests are also used many times to identify this type child. The audiological tests are the pure-tone air conduction; pure-tone bone conduction tests, and speech audiometric techniques. Frisina found that deaf retarded children scored highest on the Knox Cube Test, and that they scored significantly higher on this test when compared to six other mental tests.

Testing the deaf-retarded child is very difficult because the examiner may not be able to distinguish whether the child cannot hear, or if he doesn't understand directions given. A retarded child may not be able to follow the directions and may have to be taught to respond. In the case of mentally retarded children, several audiograms should be made before

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1 Nace, John G., Ed. D., op. cit., p. 16.
3 Frisina, D. R., op. cit., p. 81.
a record of a retarded child's hearing level can be considered correct.

At the Vineland Training School in New Jersey, 498 mentally retarded subjects were given pure-tone audiometric tests. The subjects were classified according to the degree of their hearing impairments. From the results of the tests, one may conclude that the auditory acuity is of vital importance in diagnosing a mentally retarded child. The findings indicated that about:

- 35 percent had normal hearing
- 14 percent had a slight hearing loss
- 28 percent had moderate losses
- 6 percent were hard of hearing
- 1 percent were deaf.

There is a great need for research to discover a series of tests which will prove useful in evaluating the potentials of the deaf-retardate.

It appears that the techniques like the tangible reinforcement operant conditioning audiology (TROCA) found useful with profoundly retarded and difficult-to-test children, and the evoked response audiology capable of discriminating evoked auditory responses from spontaneous brain-wave activity have great promise with retarded deaf children.

Brill (1962), found that deaf children must have close to average intelligence to achieve even a vocational diploma. To attain an academic diploma, a child must have intelligence that is well above average.

Vernon (1967), states that 16.3 percent of the 257 children in his study had I. Q.'s below 70.

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2 Netra, op. cit., p. 229.
4 McCay Vernon, op. cit., 175-185.
Myklebust found that a deaf-retarded child must have an I. Q. of 65 in order to be educable.

From the above-mentioned studies may be seen the problems involved in diagnosis and identification of deaf-retarded children, and the reason for agreement on terminology and nomenclature if help is to be given this type child.

It is thought that it may be well to classify the retarded deaf child as we do the retarded hearing child; namely, as the educable mentally handicapped and the trainable mentally handicapped. However, because of the multiple handicap it may be well to set the dividing points higher.

Children with intelligence quotients in the range of 60 to 85 should be designated as educable mentally handicapped; whereas those with intelligence quotients below 60 should be classified as trainable mentally handicapped. These limits should not be used in an inflexible manner.

EDUCATIONAL PROGRAMS:

The important question regarding the education of the deaf-retarded child is, Where does one begin to work with this type child? The answer is: Begin where the child is able to comprehend, and set out from there. The trend nowadays is to "fit the curriculum to the child, not the child to the curriculum;" and where does this apply better than to the multiple handicapped child? Parents, teachers, and all who have anything to do with this type of child must never over-fatigue the child. Goals must


never be set too high, and experiences must always be provided within reach of the child or he may become frustrated. Education should be kept as concrete as possible for the deaf-retarded child because of his limited ability. Some schools for the deaf, as was previously mentioned, have had programs for several years for the slow learner; but only very recently has there been any real effort to include the moderately, severely, or profoundly retarded child with a severe auditory impairment.

In a study made by Anderson and Stevens on the admission of mentally retarded deaf children to residential schools for the deaf, they suggested a need for improved educational services for the deaf with low intelligence. The study also revealed the need for further research and agreement on terminology. They also emphasize the necessity of a more precise study of the incidence and prevalence of deaf-retarded children in residential schools for the deaf and also day schools and day programs for the deaf. They further stress the great need to develop a standard terminology and nomenclature which would be accepted by all educators of deaf and retarded.

According to Henriella, the problem is that the education of the deaf and the mentally retarded hasn't kept pace. The curriculum used in schools for the deaf is in many cases a "watered-down" curriculum for the deaf-retarded until they can be placed. She feels that many of these children would have a greater opportunity to develop skills if they had the benefit of a differential curriculum which would enable the deaf-retardates to support themselves in later life.

A questionnaire study was done recently by Mitra\(^1\) on the educational provisions for the deaf-retardate. The purpose of the study was to learn what provisions were being made to develop programs for this type child. From 71 questionnaires returned, it was learned that:

- 34 institutions had programs for the mentally retarded deaf;
- 24 had no specific programs;
- 8 reported that they had unidentified retarded deaf students;
- 5 had no mentally retarded deaf residents.

Those who have an interest in and who are involved in the field of Special Education today realize the problem of the child who has more than one handicap. The problem of educating this child is a very serious problem, and one which is growing in importance each day - especially in regard to the deaf retarded child.

The education of the deaf child should begin at the earliest detection of deafness, when the child is just a few months old. The first three years of a child's life are very important because it is during these years that he learns to comprehend and develop language. If a child has a hearing impairment during his earliest years, he will have difficulty in acquiring language and will acquire it at a much slower rate. Because of the handicap in developing speech and language, the deaf child falls behind educationally; therefore the deaf-retarded child has an even greater problem. Signs of a hearing loss during the first years of a child's life are shown in the table on the following page.

TABLE 2

Signs of Hearing Loss in Children Under Five Years*

Newboen . . . No reflex response to intense sounds;
3 months . . . Not turning eyes towards sound, e.g., bell;
6-9 months . . . Not localizing quiet sounds automatically;
12-18 months . . . No simple comprehension - (show me the . . .);
24 months . . . No response when called from another room;
30 -36 months . . . Not using phrases, short sentences;
36 -48 months . . . Defective articulation accompanied by com-
prehension difficulty; using speech-reading (lip-reading)
48 months plus - Does not follow story.

*Geoffrey C. Robinson, M. D., op. cit., p. 316.

The question then arises, What is the greater educational handicap -
deafness or mental retardation?

It appears that limited mental potential to
learn is the greatest of all educational handi-
caps. From this standpoint, the severely mentally
retarded deaf should be housed and educated to
whatever extent possible in the institution for
the mentally retarded.1

There is a great deal of disagreement about this: Will putting a
deaf child in an institution for the retarded help or hinder his educa-
tion? It is thought that if the deaf-retarded were in schools for the
deaf, they would have better social contacts. Warren and Kraus, (1963),
disagree with this for they maintain that:

. . . since all teachers, whatever their specialty,
are trained in problems of learning, one might better
plan to have the communication and language problem
given primary consideration; the degree of learning
difficulty could be taken into account in training.
The problem of trying to develop techniques of com-
munication with deaf children is a highly specialized
one. Few, if any, teachers of the mentally retarded

1George J. Leshin and Lotar V. Stahlecker, op. cit., December 1962,
p. 602.
have been given instructions in techniques of communication with the deaf. One would assume that all teachers of the deaf have been given instructions in how to help children learn.¹

There are many viewpoints as to how and where these children should be educated. According to Sellin,² (1964), the educable child should be taken care of by the schools for the deaf; but the trainable child should be in an institution for the mentally retarded. He suggests that if the child's mental ability is more limiting than the auditory loss, that child should be in an institution for the mentally retarded.

MacPherson,³ (1952), stated that the education of the deaf retardate should be taken care of and educated by teachers trained in both deafness, and mental retardation; and that they should be in schools for the deaf, rather than in institutions for the mentally retarded.

In a study done by Anderson, Stevens and Stuckless,⁴ they found that eleven administrators believed residential schools for the mentally retarded were the best facilities for deaf children with I. Q.'s below 83. Twelve thought that residential schools for the deaf would be the best place for the deaf-retarded child. Twenty-two believed that this type child would be best served in a separate facility.

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COMMUNICATION:

If a child is to learn, he must learn to communicate in some way; therefore communication is the main problem for a deaf-retarded child. Communication skills consist of speech, speech reading, reading, writing, finger spelling, and sign language. Language and speech development is as important to a deaf retarded child as it is to a deaf child. Speech and language should be taught as part of the regular classroom curriculum and should be interwoven with all school subjects. Speech therapy will be a slow process and must be made simple. A child who cannot grasp speech and lipreading may be able to communicate by finger-spelling or sign language. Even when a child is not handicapped by deafness, speech problems are frequently encountered among the mentally retarded. A child with a severe hearing loss has great difficulty in differentiating between many sounds - especially consonant sounds that look the same on the lips - and also between breath, voiced and nasal sounds. The mentally retarded child also encounters this problem, but for a different reason than a deaf child does.

Many times a person who has no speech or language ability has been thought to be mentally retarded. Even though it is a slow process, the deaf-retarded child may learn enough speech and language for his needs in life. The methods of teaching speech to the deaf-retarded should be adapted to each child's special needs. Materials should be concrete in the beginning and meaningful. If repetition is necessary for the deaf child or the retarded child, it is doubly necessary for the multiple handicapped deaf child.

The speech program should be developmental, from day to day building
speech skills.¹ The speech and language program that is a "must" with a deaf child also plays a very important part in the daily life of a deaf-retarded child. These programs should be an integral part of each day and not just a correctional program at certain times by a speech therapist.

There is very little literature about the difficulties of communication of the deaf-retarded child, and little has been published about the teaching of language and lipreading to the deaf-retarded. However, from a language and lipreading program at the Vineland Training School, (1960), can be seen the good that can come from a program such as this. Any structured learning situation that can help even one child is good. At the Vineland School there were six children enrolled in an experimental class which was organized to develop and promote greater awareness of auditory and visual communication. At the beginning, the children were little aware of their own speech or that of others. Communication contact was difficult to make because many of the children were withdrawn. Visual attention and responses were poor, and eye contact between the teacher and pupil could not be held more than three to four seconds. During the first few weeks, one of the biggest problems which had to be overcome was in developing lipreading techniques. Normal lip movement used with gestures proved to be more satisfactory and successful; over-emphasis was a hindrance in teaching lip reading. There was a fifteen-minute auditory training period three times a week. Words used in class were presented again simultaneously through lipreading and through auditory training. The words the children learned were also given to the house mothers so that these words could be used as often as possible.

Children who could not identify even one word at the beginning of the class could, at the end, choose the correct word through lipreading. They could also choose a correct picture or point to its written symbol. Only one child was unable to identify any words, and one child was able to identify almost all of the two hundred and fifty words through lipreading. Another child who at the start was very inattentive and hyperactive could, at the end, focus his attention on the teacher for the length of the period which was forty-five minutes.1

The following table provides data on each child's hearing level, chronological age, mental age, I.Q. and cause of handicap.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Etiology</th>
<th>Intellectual Level</th>
<th>Chronological Age</th>
<th>Mental Age</th>
<th>I.Q.</th>
<th>Type of Hearing Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>L. R.</td>
<td>Unknown</td>
<td>Moderately Retarded</td>
<td>11-8</td>
<td>7-1</td>
<td>61</td>
<td>Severe bilateral sensori-neural impairment</td>
</tr>
<tr>
<td>C. F.</td>
<td>Meningitis</td>
<td>Moderately Retarded</td>
<td>17-10</td>
<td>7-6</td>
<td>50</td>
<td>Severe bilateral sensori-neural impairment</td>
</tr>
<tr>
<td>E. L.</td>
<td>Meningitis</td>
<td>Moderately Retarded</td>
<td>15-7</td>
<td>6-6</td>
<td>44</td>
<td>Severe bilateral sensori-neural impairment</td>
</tr>
<tr>
<td>G. G.</td>
<td>Unknown</td>
<td>Mildly</td>
<td>11-0</td>
<td>4-9</td>
<td>38</td>
<td>Bilateral sensori-neural impairment of moderate degree. Slight superimposed conductive element on left side.</td>
</tr>
<tr>
<td>S. K.</td>
<td>Maternal</td>
<td>Moderately Retarded</td>
<td>16-10</td>
<td>6-9</td>
<td>42</td>
<td>Severe bilateral sensori-neural impairment</td>
</tr>
<tr>
<td>W. D.</td>
<td>Prenatal</td>
<td>Retarded</td>
<td>16-11</td>
<td>5-7</td>
<td>42</td>
<td>Severe bilateral sensori-neural impairment</td>
</tr>
</tbody>
</table>

* Leon Glovshy and Seymour Rigrodsky, Ibid.

There has been great controversy over whether the oral method - (lip-reading and speech), or the manual method - (signs or finger spelling) - should be taught. The sign language does not have to be taught like the phonemic learning of oralism because a sign is a clearly visible language symbol. Children who have early manual communication have good communicative skills. According to Meadow, we should not discourage oral training in favor of manual communication because "children who are most likely to be judged as having good communicative skills are those who were exposed to both oral and manual training at an early age."

In a survey study done by Anderson, Stevens, and Stuckless, on the primary means of communication used by teachers in teaching the deaf-retarded, they report that of the 139 teachers responding:

- 44 teachers or 32 percent used the oral method of communication;
- 22 teachers or 16 percent reported using the manual method;
- 73 teachers or 52 percent used the simultaneous method or the oral and manual method.

From the above-mentioned study it is evident that the most widely used method of communication with the deaf-retarded is the simultaneous method. The writer agrees with this conclusion, in the belief that the deaf-retarded child who cannot master oral language should not be deprived of whatever means of communication he is capable of learning.

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Stuckless and Birch,¹ (1966), noted, in comparing deaf children of deaf parents with deaf children of hearing parents, no significant difference between the two groups on scores for speech intelligibility, nor for "psycho-social adjustment." However, significant differences were found on reading, speech-reading, and written language scores. Higher scores were achieved by children who had manual communication early.

Brill² (1960), compared 45 deaf children of deaf parents with 45 deaf children with hearing parents; also, 45 deaf children with no deaf relatives. No significant differences were found, except that when boys were compared separately, the children of deaf parents showed better adjustment. Of the forty-five deaf children with deaf parents, the average I. Q. was 111.7. The average for the group of single deaf children was 111.2, while the average intelligence quotient of the group of siblings in the study was 109.8.

This study shows that the child's adjustment is greatly influenced by having other deaf people in his immediate family, especially deaf parents, because there is more communication between a child and deaf parents than there is between a deaf child and hearing parents. There may also be a greater degree of acceptance on the part of the deaf parents.

The number of schools with special programs for the multiple handicapped deaf child is growing. In 1947, Sonoma State Hospital in California became the first hospital in this country to set up a program for the deaf-retarded child. To be eligible for the program, the child, whether he is deaf or not, must have an I. Q. of 70 or less. The primary objective is


to provide a program to develop each child to his maximum capacity and prepare him to enter or return to society. In cases of more severe retardation, where the patient may remain in the institution, the objective is to train him to live a more enriched life within the institution. The children are grouped on the basis of ability, not age.¹

TEACHER ORIENTATION:

It is very important to diagnose a deaf-retarded child, to know the cause of the handicap and to make educational recommendations. Another matter of vital importance is the training of teachers for the deaf-retarded child. There is a great need of speech teachers for handicapped children who do not possess the ability to develop speech and language. This area of instruction is of vital importance, even when the results are disappointing and discouraging. For this reason, teachers of the deaf-retarded need a great deal of patience. Audio-visual aids and teaching devices are a great help to instruction, but nothing can take the place of a good teacher.

The first thing any teacher of the handicapped must realize is that this special child is, first, a child - then a handicapped child. The same philosophy that applies to teaching normal children also applies to the handicapped. Leenhouts describes the qualities and skills necessary for the "ideal" teachers of these children and summarizes the qualities as:

...infinite patience, proper sympathy and devotion, and empathy for the pupil and his needs and emotions.

¹W. Calton James, op. cit., 573-577.
He lists the special proficiencies needed as:

- artistic skills
- versatility in communication skills
- ability to pantomime
- skills in establishing manual communication
- skills in discovering a child's plateau of learning
- skills in exercising the principles of simplicity of presentation and of repetition.

Interest is the prerequisite of all learning - therefore the teacher must create interest. She must have a variety of means in presenting material. She must encourage and motivate the children. Repetition is greatly needed, but it must never become monotonous. According to Sister Henriella, "The teacher must retain an open mind and an experimental attitude so as to be ever ready and eager to try a new approach when other methods fail."²

We need teachers trained in both fields of deafness and mental retardation. Many teachers of the deaf are not qualified to teach the retarded child, nor is the teacher of the retarded pupil automatically qualified to teach the deaf child.

In a study done by Mitra,³ in regard to special training, fifty percent of the teachers had practical experience in teaching mentally retarded children; nineteen percent had practical experience in teaching deaf children. Thirty percent had practical training in teaching various combinations of the deaf, the retarded, and the deaf-retarded. Only one percent had no training at all.

Who, then, is a good teacher of the multiple handicapped child? A

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teacher of the multiple handicapped child should possess the qualities of any good teacher of normal hearing children, along with an understanding of the needs of the handicapped. Teacher training institutions need to broaden their curricula to offer special education for the teacher of the multiple handicapped child.

According to Leshin and Stahlecker, every teacher of the deaf should be trained to help the retarded child. In their studies on the subject of educating the deaf child, they have found that in both residential and day schools for the deaf, teachers have been confronted with the problem of teaching the deaf-retardates. These latter children cannot learn in the same way or at the same rate as their classmates because of their limited mental ability, despite great effort on the part of their teachers.

In a survey made in regard to teacher preference in teaching deaf children with no other handicap, or mentally retarded deaf children, the response was as follows:

... Ninety-eight teachers (66 percent) reported that they preferred to teach deaf children with no other disability. Forty-two teachers (28 percent) indicated a preference to teach mentally retarded deaf children, and eight teachers, (5 percent) had no preference.2

In response to another survey made by Anderson, Stevens and Stuckless in regard to the basis for assignment of teachers to classes for deaf retarded children, 43 administrators replied according to the Criteria listed in Table 4 on the following page.

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1George J. Leshin and Lotar V. Stahlecker, op. cit., 599-602.
2Anderson, Stevens and Stuckless, op. cit., p. 51.
3Ibid., p. 50.
### TABLE 4

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Administrative Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher has a high tolerance for limited educational progress</td>
<td>31</td>
</tr>
<tr>
<td>Teacher prefers to teach such children</td>
<td>24</td>
</tr>
<tr>
<td>Teacher is well adjusted</td>
<td>20</td>
</tr>
<tr>
<td>Teacher is specially trained to teach deaf children below 83 I. Q.</td>
<td>15</td>
</tr>
<tr>
<td>The teacher has hearing loss</td>
<td>6</td>
</tr>
<tr>
<td>Teacher is adept in manual method</td>
<td>9</td>
</tr>
<tr>
<td>Superior teachers are assigned to classes for retarded deaf</td>
<td>5</td>
</tr>
<tr>
<td>New teachers should start here</td>
<td>1</td>
</tr>
<tr>
<td>Teacher has not been successful in regular classes</td>
<td>1</td>
</tr>
<tr>
<td>Teacher is not capable of teaching orally</td>
<td>0</td>
</tr>
</tbody>
</table>

*Anderson, Stevens and Stuckless, op. cit., p. 50.

In addition to training and experience, Elena D. Gall\(^1\) lists the following extra qualifications needed by the teacher of multiply handicapped children:

> Wherever multiply handicapped children are being taught, and will be trained in the future, the teacher will be in the most advantageous position to assist in the development and maximum education of severely handicapped children. In order to assume such responsibility, the

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teacher has to be well trained in several fields of exceptionality and have had successful experience with normal children. In addition, she needs to have:

1. A sense of humor to overcome the many frustrations.
2. A feeling of friendliness to be able to work well with others under any circumstance.
3. Sensitivity to know the innermost needs of those who cannot express themselves.
5. Strength to hold on to her convictions in face of controversy.
6. Energy to work endlessly for and with her few charges.
7. Patience to wait years for minimum results.
8. Feeling for art to see beauty where perhaps others have not yet seen it.
9. Hope to believe that others in allied fields may contribute answers to what seem to be unsolvable puzzles.
10. Charity to know the inspiration that comes from working for others.
11. Love to attempt difficult tasks.
12. Faith to realize that there is a plan and purpose in teaching even the least of them.

SUMMARY:

In submitting this paper, the writer intended to discuss the problem of one group of multiple handicapped children - the deaf-retardates.

In surveying the literature available, not too much research could be found. This is probably due to the fact that it has been only during
the past two decades that much thought has been given to the problem of the deaf-retarded child.

Etiology is one of the major areas where research is needed so that medical science may be instrumental in helping to prevent these disabilities. By knowing the causes of these afflictions, it may some day be possible to predict the number of deaf or retarded children who will need help during a given period. Special remedial education could then be provided for these children, with agreement on terms and nomenclature so that greater help to the children would result.

Programs for teachers of multiple handicapped children are needed now as never before because: "As research provides more information about these children, it may be possible to have special training programs for teachers who desire to teach classes of multiple handicapped deaf children." 1

CHAPTER III

SUMMARY AND RECOMMENDATIONS

It was the intention of the writer to review the needs of one multiple handicapped child, that of the deaf-retarded. It is an ever-increasing problem for educators, because of the longevity, nowadays, of children with multiple handicaps.

Much progress has been made in the last two decades, for many interested and influential people are becoming more and more aware of the problem. As stated by one physician:

Enormous progress has been made during the past five years, both in the status of our services for special children, and in our concepts and our current expectations.¹

Not too many studies have reported on the causes of deafness and mental retardation, for it has been only in recent years that children have been able to survive many of the diseases that young children contract. Since modern medical science is saving more and more lives of the multiple handicapped, there is a great upsurge of interest in this type child.

Much more research is needed, especially in the area of education. Communication is the greatest handicap the deaf-retarded child has to face. It was found that most schools for the deaf do provide for the children who have a wide range of intelligence, but it is the deaf individual that falls below this wide range of intelligence that is our concern in this paper.

All those interested in this type child should try to encourage young men and women to enter the field of special education of the deaf children who are also mentally retarded. If from time to time articles were written for the public, telling and showing the possibilities of these children, many more individuals may become interested in helping to develop the hidden potential in each child in this particular group.

Other problems of great importance that must be settled are: (1) agreement on terms and nomenclature; (2) the educational facility that can best help these children.

If the deaf-retarded child can best be helped in schools and institutions for the deaf, why not have trained teachers of the deaf-retarded in schools for the deaf? It is felt that the social contact that deaf children enjoy there would help them become better adjusted citizens of the community in later life.

Since the number of multiple handicapped children is growing each day, many more teachers are needed - teachers trained to teach the deaf-retarded child. Teachers of these special children should possess the characteristics of all good teachers, plus other exceptional qualities to help in understanding the problems of handicapped children.

It may be that one of the frontiers in science in this country lies in what we will do with these handicapped people that in a measure science has bequeathed to us.1

Research is also needed as to the number, incidence and prevalence of deaf-retarded children so that the number of teachers needed can be estimated and plans set up for the education and later vocational training of these children.

1Powrie V. Doctor, op. cit., pp. 156-158.
The following are a few of the services and facilities rendered at the present time to the hearing-impaired, mentally retarded child:

1. The Illinois School for the Deaf offers a comprehensive diagnostic guidance and tutoring program to all children with a hearing loss. This includes speech and hearing examinations, and also social and mental evaluations.

2. The California School for the Deaf in Riverside, California, also has a unit for multiple handicapped children which provides for thirty educable mentally retarded deaf children.

3. California has also conducted classes for the retarded deaf child at Sonoma, Porterville and Pacific State Schools. Deaf teachers are members of their basic teaching staff.

4. As was mentioned earlier, the Lapeer State Home and Training School in Michigan has a program for the mentally retarded deaf child. At this school the habilitation of the deaf mentally retarded children has made it possible to help a number of deaf inmates to be placed in sheltered workshops.

In addition to the above facilities for handicapped children, it was necessary to institute programs for teacher training. Illinois was one of the first states to offer such programs:

Northern Illinois University has recently started a two-year program in which the teacher trainee achieves competency in both the areas of the deaf and the retarded. The graduate receives certification in both areas.\(^1\)

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\(^1\)Knute Espeseth, Ph.D. and Gary Nix, *op. cit.*, p. 61.
CONCLUSIONS

In considering the problem of the deaf-retarded child, it is very clear that research is greatly needed in many areas if progress is to be made in assisting such a child to become a satisfied, self-reliant person. Until sufficient research is completed, it may be well to evaluate what has been done and decide on future steps to be taken in this great work.

Recently, the Life Sciences have entered the field of special education with instructional materials for the mentally retarded so as to enable "the mentally handicapped child develop interests, skills and positive attitudes through experiences with science and biological concepts."¹

The Instructional Materials Centers for handicapped children provide a very valuable service to teachers of handicapped children in that they make teachers more aware of existing materials, and also evaluate the items. These centers also make the materials available to teachers of handicapped children. The Division of Research² is now supporting five research centers concentrating on problems of handicapped children. It is expected that within the next few years, because of the combined efforts of research and development centers and also programmatic research, that instructional procedures will be greatly improved.

Captioned Films for the Deaf produce materials for the instruction of deaf children which include films for teaching reading and language; also lipreading and fingerspelling. They also supply such items to loan as filmstrips, movies, overhead projectors and other visual aids and instructional materials. In 1967 Public Law 90-247 expanded the program to an Educational Media program for all handicapped children.¹

The answer might well be the pooling of resources for the deaf and mentally retarded; for combined facilities for children with multiple handicaps.

It is highly desirable that professional organizations working in the fields of mental retardation and deafness should join hands in developing programs, formulating curriculum guides, and promoting research projects in their training and habilitation.²

If the multiple handicapped child is found and helped very early in life, he may be able to fit into and function in a work situation later. Federal, state and local governments have also recognized that pre-school and early childhood are the critical years for the child's development. In recognition of this most urgent need, the Handicapped Children's Early Education Assistance Program was established to meet the needs of these children.

Programs of vocational rehabilitation began after World War I, but greatly expanded after World War II. The President's Task Force on the Mentally Handicapped, October 1970, recommended a national "Joint Council


on Disabilities" which would direct and bring together not only the President's Committee on Mental Retardation, but also the two new Committees: The President's Committee on Mental Health and Illness, and the President's Committee on Physical Disabilities.

The Vocational Rehabilitation Amendments of 1965 have done much to help the multiple handicapped deaf persons, enabling them to gain employment.

Early identification of the handicapped child seems to hold out the greatest hope for assisting the deaf retarded child. Since more of these children are surviving and living longer, education of the parents is likewise needed because many parents of handicapped children seem to "... lack the ability to understand the complex nature of the problem; or misunderstand, or refuse to accept the situation."

As late as May 1970, the American Association on Mental Deficiency met in Washington, D. C., and devoted two and one half days to the problems of the mentally retarded deaf. At this meeting there was established a Joint Committee of members of the American Association on Mental Deficiency and the Committee of Executives of American Schools for the Deaf - the AAMD-CEASD.

The Joint Committee AAMD-CEASD has been exploring areas of cooperation and delineating specific ways in which it can meet its charge to encourage and promote effective programs.


The following quotation seems a most fitting ending for the conclusions presented in this paper:

As we read medieval history we study the history of the Madonna in the Church, the Madonna of the fields, the Madonna of the various groups, each pinpointing some particular idea. I am wondering if it may come to pass that the symbol of our 20th Century may be, not the atomic bomb, but the Madonna gazing in bewilderment at the handicapped Child in her arms while seeming to say to us: 'Why have you neglected him?'

May the Madonna not be saying, "Why have you neglected him?" - but may she say, "You have done all possible for him."

---

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**UNPUBLISHED MATERIALS**


PROCEEDINGS


OTHER SOURCES


