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Supporting Young Children With Multiple Disabilities: What Do We Know and What Do We Still Need To Learn?

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Abstract

Young children with multiple disabilities have unique needs and challenges. Many of these young children struggle to communicate their wants and needs, to freely move their body to access and engage their world, and to learn abstract concepts and ideas. Professionals and families working together must identify the individual supports each child needs to ensure that the young child with multiple disabilities is an active participant in all aspects of their lives and makes meaningful progress toward valued life outcomes.

Young children with multiple disabilities have unique needs and challenges. Impairments may occur in cognition, motor, and sensory functions and occur in combination with each other. Many of these young children struggle to communicate their wants and needs, to freely move their body to access and engage their world, and to learn abstract concepts and ideas. The intensity of their needs means that delays are likely to have a pervasive impact on the child's development and are likely to continue to impact the family and the child well beyond the early childhood years (Chen, 1997). In addition, however, these young children are a widely heterogeneous group in terms of their characteristics, capabilities, and learning needs. They may share some attributes, but they possess their own uniqueness as well. Thus as professionals and families plan for children with multiple disabilities, an approach that considers the special needs each child exhibits and necessary supports required to meet the needs must drive the process.

Four areas of need – medical, physical, learning, and social emotional needs - should be addressed in developing interventions for young children with multiple disabilities. Given that young children with multiple disabilities often have chronic health needs that may require substantial effort by adults, professionals and families must work together to help improve the child's experiences and learning opportunities. Young children with multiple disabilities often exhibit motor development delays, which can result in difficulties with mobility, sitting, and standing. As with all young children, the learning outcomes for young children with multiple disabilities center on the development of skills, membership, and relationship (Snell & Brown, 2011). To achieve these outcomes, professionals must implement additional supports to provide for a meaningful and individualized curriculum within the context of fully inclusive and natural environments. Finally, the area of social emotional learning needs including those relating to relationships and membership in community must be addressed (Soodak & Erwin, 2000). Given that children with multiple disabilities may need assistance in engaging in interactions with others and other individuals may need assistance in understanding the communicative behaviors of these children, positive social interactions opportunities must be created.

When professionals use a needs-based approach to support the learning of young children with multiple disabilities, it is possible to identify the individual supports each child needs to

have greater access and engagement across environments. In addition, professionals must also ensure that the identified practices are those that we have the greatest confidence at this point in time that they will lead to positive impacts for the child. In short professionals must align their practices with recommended practices in the field. The following two broad areas of recommended practices that address each of the four need areas (i.e., medical, physical, educational, social-emotional interaction) have been identified to discuss the unique issues that need to be addressed for children with multiple disabilities: collaborative practices and meaningful and individualized curriculum. In addition, the more narrow area of specialized instructional strategies, assistive technology, is also presented because of its potential pivotal role with young children with multiple disabilities. In the remainder of this paper these three recommended practices will be briefly defined, discussed in terms of what do we currently know, and what do we still need to know.

Collaborative Practices

Given the variety of combinations of physical, medical, educational, and social-emotional challenges that young children with significant multiple disabilities bring to each learning environment, a diverse set of individuals and disciplines is needed to provide support. As early as the 1950s, those in the field of special education have recognized that one or two individuals and/or disciplines cannot appropriately meet the diverse and often extensive needs of children with multiple disabilities (Snell & Brown, 2011).

What Do We Know?

The most effective approach is to call on the collective knowledge and expertise that various team members bring to the educational planning process (Hunt, Soto, Maier, & Doering, 2003). Each team member brings a unique set of skills and experiences to the team relationship. The way in which teams operate can have a significant impact on the outcomes both for the young child and for their families. A collaborative team model has been promoted as a recommended practice in early childhood special education (Sandall, Hemmeter, Smith, & McLean, 2005) and an exemplary practice in service delivery for learners with multiple disabilities (Snell & Brown, 2011). One of the key elements that contributes to the effectiveness of a collaborative model, is that through the process of working together individual team members acquire a shared understanding and knowledge of each other's expertise. New ideas are then generated and incorporated into collaborative evaluation, planning, implementation, and on-going progress monitoring of child and family outcomes.

A critical aspect of effective collaborative educational programming is the involvement of family members or the forming of partnerships with families and working collaboratively with them. Given that families know their child the best, they have the information needed to guide the team in the development of an effective and individualized educational program. Again, however, the way in which teams operate can have a significant impact on the outcomes both for the young child and for their families. The key elements that have been identified for effective family centered helping practices include: treating families with dignity and respect; sharing information to support informed decision-making; providing families with choices regarding services and their role; and building partnerships with families. In a review of the research literature on family-centered helping practices Dunst and colleagues (2007) found that these practices were related to positive parent, family, and child outcomes. The positive outcomes reported include improvements in parenting skill, sense of well being on the part of the parents, parents' overall satisfaction with services and supports, parents' feelings of their own competence, and parents' judgments of their child's behaviors.

What Do We Still Need To Know?

While we certainly have evidence from research, policy, and our collective wisdom of the appropriateness of the use of collaborative teaming and family-centered helpgiving practices, we still have the need to learn more. First, while many programs now strive to achieve a collaborative teaming process for the delivery of early intervention and early childhood special education services within their programs, roadblocks still remain for ensuring that all elements of the services and supports are integrated into the child and family's natural environments. In an integrated teaming model, instead of removing the child from their natural environments (e.g., home, child care, community preschool), team members bring their knowledge and skills to the child's natural environments and support the adults in those environments to provide the educational program (Horn, Lieber, Sandall, Schwartz, & Wolery, 2002). Thus, to achieve a truly collaborative, integrated model all of the services provided to the family and child across multiple settings and providers must be established.

Second, while we have evidence that family-centered helpgiving practices are related to positive outcomes for the family several limits to our knowledge remain (Dunst et al., 2007). First, our research to date has primarily documented the positive outcomes with families in which the mother was the source of the information and these mothers tended to be white and from middle to upper level socioeconomic status. In addition, the family-centered helpgiving practices represented only one of a number of services and supports that the family and their child were receiving and that could have contributed to the positive outcomes reported. Clearly, we must therefore use caution in assuming that the same outcomes would occur for all families and without being a part of broader early childhood special education services.

Meaningful and Individualized Curriculum

Because of the wide diversity in abilities and disability exhibited by children with multiple disabilities, their instructional needs typically cannot be fully addressed by the general education curriculum alone. Thus, educational teams must work together to develop a meaningful and individualized curriculum for each child (Horn et al., 2002). Individualization requires the best fit of content and sequence with the child's current needs and abilities. Meaningful, on the other hand, requires consideration of what content is most relevant to the child and family's interests, personal goals and limitations in reaching those goals. Some specific unique content areas that come to mind, which should be considered for children with multiple disabilities, include self-determination, communication, and self-directed movement. In the sections below each of these areas will be discussed in more detail.

What Do We Know?

Self-determination—The individual who is self-determined can self define what constitutes a good life and then pursue it. Wehmeyer (1996) defines self determination as “acting as the primary causal agent in one's life and making choices and decisions regarding one's quality of life free from undue external influence” (p. 24). The concept of self-determination has emerged as a guiding principle in curriculum development and prioritization of outcomes for learners with multiple disabilities. Research has shown that young adults with disabilities who leave school as self-determined are able to achieve more positive adult outcomes than those who are not (Wehmeyer & Palmer, 2003). These more positive adult outcomes include more active participation in educational and career planning, better self-advocacy skills, and higher responses on indicators of positive quality of life. Although young children cannot engage in as many independent or self-directed

activities as adolescents or adults, building the capacity for self-determination can begin in the early years.

Autonomy in the early childhood years occurs in the form of basic skill development such as learning independent mobility or independent personal care (Brown & Cohen, 1996). These early successes produce feelings of pride and begin to develop a foundation on which later successes are built. For very young children with disabilities, successes are often harder to come by because the nature of the disabilities experienced makes the acquisition of the “building block” tasks (e.g., independent mobility) a more challenging, and therefore, slower process. Slower acquisition, paired with well-intentioned, but overly intrusive instructional strategies, such as too frequent verbal and physical prompts, may limit opportunities for the young child with multiple disabilities to have autonomous experiences. As the child grows older, opportunities for critical thinking may also be limited. Family members and caregivers may fear the outcomes of poor decisions and thus guide the child’s safe passage through developmental stages to adulthood by making many, if not all decisions, for the individual.

A lack of successful autonomous experiences may actually lead to a pattern of dependency sometimes referred to as learned helplessness. Poor self-perceptions emerging from learned helplessness and limited opportunities for autonomous experiences may diminish the individual’s internal motivation to act in a self-determined manner (Brown & Cohen, 1996). Therefore, when designing a curriculum for young children with multiple disabilities, professionals must remember that learning to have control over critical aspects of life is essential. And, just as the typically developing child strives for control by demanding preferred foods, toys, or favorite activities, and often rejects decisions made by their parents or teachers, so may a child with multiple disabilities. Learning how to make choices, learning how to make those choices known to others, and having choices honored is a critical milestone toward achieving the valued life outcome of self-determination for young children with significant disabilities.

Communication—Effective communication is frequently a high priority outcome, as well as high need area, for young children who have multiple disabilities. Communication has been defined as expressing one’s needs and wants, developing social closeness, sharing information, and fulfilling social etiquette responsibilities (Schlosser & Sigafoos, 2006). Communication can take the form of verbal, written, or nonverbal messages and can include standard and non-standard gestures or pictures, symbols, or written words. Typically developing infants and toddlers communicate through gestures and vocalizations and then learn to speak words. Young children with multiple disabilities are often delayed in learning conventional forms of communication, such as speech, and may not develop these skills without the provision of more specialized interventions. One such group of specialized intervention is referred to as augmentative and alternative communications (AAC). AAC is used to supplement or replace verbal speech and compensates for limited verbal communication skills by integrating symbols, devices, techniques, and strategies to enhance or encourage communication (Schlosser & Sigafoos, 2006). AAC includes “unaided modes” of communications, such as gestures, signs, and facial expressions or “aided modes” including low tech (e.g., photographs, symbols, tangible symbols) and high tech (e.g., speech-synthesized devices, laptop computers) approaches.

Several studies have been reported demonstrating the effective use of aided AAC to increase early communication for young children with multiple disabilities. These studies targeted young children with dual sensory impairments and physical challenges (Mar & Sall, 1994; Schweigert & Rowland, 1992) and children with profound multiple disabilities (Saunders et

al., 2001, 2003, 2005). All of the studies successfully taught basic signaling skills and choicemaking through the use of switch interfaces, voice output, and computer technology.

In addition to aided communication systems, communication intervention for young children with multiple disabilities could be enhanced through the simultaneous use of unaided systems (Schlosser & Sigafoos, 2006). The use of natural gestures and nonspeech vocalizations has the practical advantage, in that they do not require access to equipment or other media. Typically developing infants and toddlers communicate with their caregivers through facial expressions, natural gestures, and vocalizations long before producing their first words. In fact by the time young children learn to say their first true words a complex prelinguistic communication system is well established between the child and their primary caregivers. Children with multiple disabilities also develop prelinguistic communication, but their communication may be idiosyncratic or contextually bound thus limiting correct interpretation to a few familiar communication partners (Carter & Iacono, 2002). It may therefore be particularly useful to teach young children with multiple disabilities to produce interpretable gestures or to produce their gestures at a higher rate.

A few studies have documented the effectiveness of teaching reliable, natural gestures to young children with multiple disabilities complex communication gestures. Pinder and Olswang (1995) successfully taught four young children with multiple disabilities including significant motor impairments to request through the use of eye-gaze and “reach-toward-objects” gestures. Calculator (2002) focused his parent-implemented intervention for a young child with multiple disabilities including significant intellectual limitations on increasing the interpretability and the rate of gestures the child was already occasionally exhibiting. The parents reported that after the intervention they were much more confident in their ability to interpret their child’s gestures and much more frequently requested gestural communication from their child to understand their needs and desires. Finally, Brady and Bashinski (2009) implemented an intervention program aimed at increasing intentional prelinguistic communication (i.e., natural gestures and vocalizations) of nine children with multiple disabilities including concurrent vision and hearing impairments. All nine participants increased their rates of self-initiated, intentional communication through the use of newly learned natural gestures. In this study, as in the two previously noted studies, the increased communications were limited primarily to requests as opposed to other communication functions related to inter-personal aspects of communication such as joint attention or social interaction.

Self-directed movement—For most children, movement in daily life activities is automatic and requires little thought, however, even a simple movement is based on a complex interaction of sensory, motor, and cognitive components. Young children with multiple disabilities frequently experience limitations in their motor abilities including delays or impairments in postural control and alignment, sufficient muscle tone and strength to allow movement to occur, and control of voluntary movement (Campbell, 2000). Young children who experiences limitations in their voluntary movements will find themselves limited in their ability to engage in social interaction, initiate intentional communication and explore and manipulate their environment. The sensory, social, and language input they receive may be drastically reduced or altered compared with their typically developing peers. Despite the fundamental importance of early motor development, research aimed at specifying effective and efficient early motor interventions has been hindered by a variety of conceptual and methodological problems (Campbell, 2000).

Research on early motor intervention was initially slowed by a narrow perspective of motor development that tended to portray it as a process largely driven by biology and relatively uninfluenced by the child’s experiences (Hadders-Algra & Prectl, 1992). Even though the

sequence and timing of typical motor skills development are still generally considered appropriate, the theories that explain the development of motor control are now viewed as being much more complex, with motor development being much more complex and influenced by the dynamic interaction of the individual's sensory, motor, and environmental experiences (Shumway-Cook & Wollacott, 2001). This more recent motor development theory known as a dynamic systems theory proposes that in response to sensory stimulation that motor and movement behaviors emerge from the interaction of the individual, the task at hand, and the environment. Furthermore research has demonstrated the following fundamental principle: Delays or impairments in motor skill development occur both within the child (e.g., appropriate muscle tone that enables the body to move against the force of gravity and allows the muscles to be in a ready state for movement at any time) and with external variables (e.g., opportunities to practice motor skills). This advance in our understanding suggests that interventions must be designed to address both within or internal variables (e.g., underlying components of movement) and external variables (e.g., functional, meaningful opportunities to participate in movement).

Internal Variables Affecting Movement: Essential internal components needed for functional movement include sufficient muscle tone and strength to allow movement to occur, postural control and alignment, and control of voluntary movement. Muscle tone is the readiness of the muscles in the body to move. All movements and even the maintenance of postures require some degree of muscle tone. Tone must be high enough for the muscles to move against gravity (e.g., raising the hand from a resting position to reach toward a picture communication board), support the position of the body during the movement (e.g., maintaining the upper body and arm in position during the reach), and maintain stable postures, yet low enough so that muscles can move the joints freely (Colangelo, 1999). Many children with multiple disabilities exhibit tone problems. Specifically their tone may be too high (i.e., hypertonia), which results in a stiffness that interferes with movement or muscle tone that is too low (i.e., hypotonia), which makes it difficult to stabilize joints in preparation for movement or to maintain a position. Children's muscle tone may also fluctuate from being too high to too low yet seldom in a state of normal tone. Abnormal muscle tone not only affects a child's ability to maintain and move within positions but also interferes with active movement and the use of ones extremities.

Postural control is defined as the ability to assume and maintain posture against gravity during static positions (e.g., sitting) and dynamic movement (e.g., walking) (Cupps, 1997). In static postures, postural control includes the abilities of maintaining a position (e.g., head and trunk control to maintain sitting in a chair), making small adjustments in posture (e.g., maintaining comfort in sitting by barely perceptible trunk movements or more obvious shifts in body weight), shifting body weight over the base of support to move an extremity (e.g., shifting weight, adjusting body posture to reach forward to pick up a crayon), and regaining the center of gravity when balance is disturbed (e.g., child reaches too far in sitting threatening his or her balance but is able to regain balance). This last postural control ability involves postural reactions or as it is sometimes call the righting and equilibrium reactions and protective responses of the extremities. Righting reactions align the head and the trunk toward an upright position in space, whereas equilibrium or balance reactions enable us to maintain or regain an upright position when our balance is disturbed. Postural reactions are an integral component of dynamic movement in space, such as reaching, changing position, crawling, and walking. As is likely relatively apparent, children with significant motor delays and/or impairments and thus limited in their postural control abilities are at a significant disadvantage for active participation and engagement for the daily activities of life and learning.

Control of voluntary movement or volitional control is the ability to initiate and carry out active and purposeful movement (Campbell, 2000). Sitting at the snack table, reaching for the spoon and scooping a spoonful of applesauce, are all tasks that require volitional control. The performance of these actions depends on the child's muscle tone and the muscles' ability to create motion at the child's joints in a coordinated manner in response to the demands of the activity. Children with multiple disabilities may have difficulty with volitional control for a variety of reasons including the presence of abnormal muscle tone levels, persistence of involuntary reflexes, and the lack of foundational positional control components of movement.

While professionals working with young children with multiple disabilities may encounter numerous approaches to providing intervention directed toward these internal variables, the most prevalent applied therapeutic perspective continues to be based on Neurodevelopmental Treatment (NDT) approach (Schoen & Anderson, 1999). The NDT approach, originally developed by Karl and Beth Bobath in the 1950s focuses on the use of handling techniques that allow the child to experience normal movement. Handling refers to the use "graded sensory input provided by the therapist's hands at key point of control on the child's body" (Schoen & Anderson, 1999, p. 108). This "graded sensory input" can be thought of in much the same way as scaffolded support in which physical guidance is adjusted moment by moment to adjust for the child's level of active participation and need for guidance for direction and control of movement. Handling includes both facilitation and inhibition techniques. Facilitation refers to handling activities that are intended to encourage more normal postural alignment, postural control, and active movement. Inhibition refers to decreasing a child's high tone, abnormal reflex activity and postures, and atypical movement patterns. Simply put facilitation and inhibition are also used to refer to the scaffolding of normalized movement patterns by the child (i.e., facilitating movement) and the discouragement of atypical movement patterns that interfere with the normal movement (i.e., inhibiting movement).

External Variable Affecting Movement: External components require us to look at the demands of the task and the opportunities and level of support provided for within the child's environment (Shumway-Cook & Wollacott, 2001). Drawing primarily from behavioral learning theory, a theory of motor learning has been proposed (Goodgold-Edwards, 1993). Four general principles provide guidance to how these external variables contribute to our understanding of how functional movements and motor skills are learned by the child. First, motor learning is enhanced when the child is actively participating and the movement has a purpose and is used to achieve a goal that is meaningful for the child. Second, repetition and practice are needed for a child to learn new movements or motor behaviors. Furthermore (and third), movements are most likely to be attempted, repeated and practiced when the context in which the child is participating is meaningful to the child. For example if grasping is a movement goal for the child, one among many important contexts in which the child could practice the movement is grasping a spoon at each meal or snack time. The final or fourth principle concerns assuring an optimal state of readiness for action. That is, the child must be able to achieve and maintain an appropriate level of alertness and arousal throughout the daily routines and activities of their day. The appropriate level is defined by looking at both the expectations of the environment and age and developmental appropriate expectations.

Blending Internal and External Variables for Intervention: Thus as noted earlier, over the last two decades a significant shift has occurred in the provision of motor interventions for children with significant movement limitations with the agreement that both internal and external variables must be addressed. Thus the primary focus is on the child's learning through systematically applied handling, facilitation and inhibition techniques to effectively

use the essential internal movement components to achieve a variety of functional outcomes (e.g., postural control for maintaining a floor sitting position to postural reactions to weight shift to reach for and play with a toy) (Horn, 1997). Key to achieving this goal is providing children with systematic instruction, feedback and opportunities to experiment with movement. Research has demonstrated that the practice of movement occurring in a functional context is more effective than the practice of the motor movement in isolation.

What Do We Still Need To Know?

We certainly have strong support through policy and recommended practice documents and from our collective wisdom, values, and beliefs of the appropriateness of the provision of meaningful and individualized curriculum for young children with multiple disabilities. Families and professionals supporting this group of learners are also likely to have strong agreement with the critical areas (i.e., self-determination, communication, self-directed movement) need to be addressed toward ensuring that young children with multiple disabilities are active participants and that they make meaningful progress toward valued life outcomes.

Unfortunately, our empirical evidence providing support for effective interventions for all young children with multiple disabilities across these three areas is limited. Limitations tend to cluster around three issues. Specifically, limitations are due to application of interventions designed for another age-group; limited number of efficacy studies with sufficient participants to reach levels of significance; and narrowly defined outcomes given time constraints for achieving broader outcomes by the children. The efficacy research around self-determination intervention is an excellent example of an area where the primary intervention research available is focused on adolescents and young adults (Brown, & Cohen, 1996). Clearly both the practices and the research need to be modified to address the unique needs and context for learning of the young child. The area of motor/movement intervention for children with significant motor impairments has long suffered from a lack of sufficient numbers of studies to assess the effectiveness of intervention approach. In many cases, the reports are clinical based reports reporting on a small number of cases without experiential control and at best provide for single-case research design approach. While single case design methodology is an appropriate design, in most cases there has not been enough independent replication of the same intervention model, targeting similar children around similar outcomes to develop a strong evidence base. Finally the area of communication provides us with an excellent example of the limitations of narrow outcomes. That is, while research has demonstrated that young children with multiple disabilities can learn to request through natural gestures, vocalizations, and other aided communication formats few studies are available that demonstrate communication of more sophisticated communication such as commenting (Brady & Bashinski, 2009). Given the intense needs of these young children, need for extensive repetitions, and long learning time professionals and research find themselves breaking skills into small steps and measuring success by achievement of these small steps building one upon the next. Often for the research, access to participants and funds to closely monitor the children's progress do not allow for such a lengthy time commitment.

Specialized Instructional Strategies

There are numerous evidenced based and recommended instructional strategies for use with all young children with special needs including those with multiple disabilities such as use of universal design for learning, access and progress in the general curriculum, inclusive and embedded instruction, assistive technology, and positive behavioral supports. While all of these strategies are important to providing effective interventions for children with multiple disabilities, use of assistance technology is of particular relevance to addressing their

learning and support needs (Cosbey & Johnson, 2006). Assistive technology equipment generally refers to items purchased, typically through specialized vendors, or typical materials modified to give children access to opportunities in all aspects of life. Assistive technology interventions involve a range of strategies to promote a young child's access to learning opportunities, from making simple changes to the environment and materials to helping a child use special equipment. Combining AT with effective teaching promotes the child's participation in learning and relating to others. Assistive technology interventions can support access to and participation in everyday learning opportunities for children with disabilities.

The term assistive technology equipment refers to many different types of items such as: self-help devices (e.g., bath chairs and feeding tools), special toys and switches, assistive listening devices (e.g., hearing aides), augmentative communication devices (e.g., picture communication boards or computer driven voice output devices), and mobility (e.g., power wheel chair, walkers) and positioning devices (e.g., standers) (Udvari-Solner, Causton-Theoharis, & York-Barr, 2004). The assistive technology available to young children is changing and expanding at a rapid pace. Assistive technology interventions for young children often include easy, inexpensive adaptations to the environment and materials. These adaptations frequently are made to existing materials and tools (e.g., toys, books, and spoons), "low tech" in nature, and created by professionals and families specifically for the individual child. For example, the handle of a spoon or other eating utensil might be enlarged by placing it in a foam hair roller to help a child who may not yet have developed the grasp strength to hold onto the handle independently or for long enough to complete the task.

Recommended practices in implementing assistive technology interventions for young children clearly states that simply providing assistive technology equipment to the child is not sufficient to support their access to and enhanced engaged with their daily environments (Sandall, et al., 2005). Professionals and families together need to help the child learn how to use the equipment and adaptations appropriately (Udvari-Solner et al., 2004). The ultimate intervention goal should be for the child to be able to use the device or materials in a self-directed and fully engaged manner as a part of the routines and activities of their daily life and natural environments.

Assistive technology (AT) intervention which includes the provision of individually appropriate devices and instruction on the use of the device has the potential to assist the young child with multiple disabilities in successfully accessing and then engaging their environment and thus, more readily attaining critical developmental milestones. The field of early childhood special education has promoted the provision of AT interventions for the young child through the three primary avenues of policy, family and professional wisdom, and research-based evidence. Specifically, policy support is found in legislative mandates (i.e., Individuals with Disabilities Education Act, 2004; Technical Related Assistance for Individuals with Disabilities Act of 1988), while, family and professional wisdom can be seen in the recommended practices documents and position papers of its professional organization (e.g., Division of Early Childhood of the Council for Exceptional Children). Finally, the research-based evidence can be found through a limited but growing body of research evidence of AT's positive impact on child developmental outcomes. Campbell and her colleagues in their 2006 research synthesis addressing AT use for young children that the existing literature points to AT interventions as a promising practice for support young children skill acquisition. However, further research is needed to evaluate the effect of AT not just on performing isolated skills but for promoting children's successful participation and learning within the context of everyday activities.

Conclusion

Ensuring that young children with multiple disabilities are active participants in all aspects of their lives and that they make meaningful progress toward valued life outcomes can be a daunting endeavor for families and educators. Given the myriad of educational, health, social, and emotional needs of these children, a successful outcome requires collaboration and planning among large numbers of individuals. Providing individualized instruction within high-quality programs is the way professionals ensure that young children learn and develop to their optimal level. Individualization--or put another way--ensuring a match between what is offered and what is needed is a critical component of quality program. Through collaborative family and team partnerships, young children with multiple disabilities can achieve meaningful outcomes. Educators have to come to the understanding that although these children may present substantial educational challenges, they deserve the right to grow, learn, and prosper, like everyone else.

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