Congenital Brain Damage and Birth Injury
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Congenital brain damage or birth injury may range from minimal brain dysfunction to catastrophic brain damage. The former is often not detected for years, often not until the child reaches school age. More serious damage can be diagnosed sooner, but will require extensive testing to determine the degree of impairment that will be experienced during the child's lifetime so that appropriate plans can be established to fulfill the child's future needs and rehabilitation.

Brain injury in the newborn can, of course, result from as broad a range of causes as brain injury in an older population. Examples of causes can range from injury to the fetus from an external blow, such as might be experienced in an automobile accident or fall; damage or impairment secondary to poor prenatal care and nutrition; brain injury resulting from medical malpractice (in the prenatal stages or at time of delivery); as well as a variety of other causes. The etiology of such injury is typically unimportant except in that instance where it provides insight into the types or areas of damage, which have resulted.

As with brain injury in any other age group, a broad range of sequelae can result. In some instances the outcomes may be difficult to detect and, in fact, a causal relationship between the event and the subsequent sequelae may never be established. Examples include trauma which results in minimal brain dysfunction (learning disability) which goes undetected until the child reaches school age, and which may never be related to events during or preceding birth. There is no definitive recommendation, which can be made to the attorney regarding cases of this nature. Certainly it is important to make certain that whenever trauma and possible brain damage are suspected, someone quite knowledgeable in this aspect of rehabilitation and evaluation be consulted for advice on coordinating a health care team for evaluation and assessment.

Evaluation of the Infant or Child with Brain Injury

The rehabilitation counselor can be instrumental in making certain that all of the child's needs are met, not only in the immediate future, but also with respect to long-term care needs. All major contingencies and complications which are typically associated with severe and permanent brain injuries can be evaluated and assessed in relation to the child's living circumstances and family to determine the optimum long-term care program. For those children with mild to moderate brain injury resulting in communication disorders, sensory or motor deficits, complex integrated cerebral function disturbances, and/or behavior disturbances, who are not potentially permanently dependent on family or nursing care services, long-term planning will probably be directed only to the school years through traditional vocational rehabilitation intervention (beginning at age sixteen), and ending with placement on the job. For those children with similar sequelae of a much more severe nature requiring permanent dependent care, long-term planning should include not only the developmental years, but also the adult years through life expectancy.
Clearly the age of the individual being evaluated will play an important role on the extent to which all available assessment tools can be brought into play. It is essential that all of the possible sources of data for client assessment be included in the pediatric evaluation process. Where possible the child should be interviewed, tested, and observed in a variety of settings. Consideration should be given to social development, adaptive behavior, functional communication, motor skills development, and intellectual development, to name but a few. In addition, careful consideration should be given to all of the medical and psychological evaluations, which have been accomplished prior to the rehabilitation evaluation.

The family interview during the evaluation of an infant or child with severe brain trauma plays an important role for several reasons. Detailed information on siblings, parents, grandparents, aunts, and uncles can be most helpful in developing better insight into pre- and post-onset potential. Such interviews, coupled with an assessment of the child's living environment, can also be helpful in development of a long-term care plan.

It is critical that it be kept in mind that the development of a life care plan for the child must meet the needs of the child and not be designed to satisfy the emotional conflict or guilt feelings of the parents. Far too often, the parents press for services, equipment, and/or participation in the treatment process which are contraindicated if the child is going to reach a maximum developmental level. Although it is certainly important to maintain family participation wherever possible, the family (because of tender loving care) is not the best source of optimum care plan development without the assistance of appropriate professional intervention. A careful assessment of the needs of each individual family member and child is critical. An optimum care plan usually represents a healthy balance between family and professional participation in the long-term care and treatment process.

The counselor can also develop important insight into the needs of the parents and family members (in terms of counseling and education) by allowing them to participate in the development of the life care plan. For example, one set of parents requested extremely expensive electronic stereo equipment in the hopes that such equipment would play a role in providing music therapy assistance which would help in the developmental potential of the child. Their insistence upon such equipment, even in the face of repeated statements by the professionals that little or no gain can really be anticipated by this therapeutic approach may be an expression of their own need for counseling to aid in overcoming feelings of guilt regarding the brain injury. Certainly, the severely brain damaged child, requiring 24-hour-a-day care and unable to communicate with or even identify the parents, is going to be unable to distinguish a $9,000 electronic stereo system and a much less expensive record player or stereo unit. The more expensive system designed to allow a severely handicapped child to
operate the unit may be appropriate in those instances where motor dysfunction exists but no intellectual impairment is apparent, but it is certainly of little use when the child can never reach a point where independent operation (even with specialized equipment) is possible.

Although this example is provided as one possible means of identifying parental emotional needs, it also serves as an example of the need to plan for future cost. Certainly, there are those who would suggest that in some cases (if not all) it will be difficult to determine the developmental potential of the child and therefore such contingencies as this unique stereo system should be included in the life care plan so that the monies will be available in the future if the contingency arises. Such a suggestion can be met with a twofold argument. First, a knowledgeable counselor accustomed to working with brain injuries can delineate developmental potential within reasonable rehabilitation probability and identify appropriate future care contingencies, which may arise. Although it is not possible to plan for the provision of services and/or equipment which have yet to be developed or invented and which may appear on the scene 20, 30 or 40 years hence, it is not difficult to assess the application of existing services or equipment as they relate to the specific types of cerebral trauma and brain injury with which the counselor is confronted. Second, it is important in making such an assessment for litigation purposes to remain within reasonable bounds of conservatism. Perhaps another way of stating this is that the counselor is bound by professional ethics to develop a life-care plan which meets the criteria within reasonable rehabilitation potential and which does not represent unreasonable and costly items of equipment, therapeutic intervention, or personal care services which are unlikely to be utilized. It is also essential that the counselor, in developing a life-care plan, base economic calculations on reasonable and current ranges of cost for those services. Listing a $100,000.00 van for transportation when a $20,000.00 van provides the necessary equipment and services does not meet the standards of professional ethics in completion of a life care plan.

Impact on Family and Siblings

It is also important in this type of case to assess the impact that the injury has had on the parents and siblings. A wide range of psychological complications and behavioral problems can develop, in both siblings and parents of a brain-injured child. It is important not only to meet the needs of the child with cerebral trauma, but also (within the context of the life care plan) to outline the services, which must be provided to siblings and parents to help them develop and maintain as nominal a life pattern as possible. These services will typically focus primarily on individual, marriage, and family counseling, as well as family education. Counseling is designed to deal with the specific emotional needs of the family members, while education is designed to help the family members learn how to deal with the needs and problems of the brain-injured child.
Vocational Implications

In severe developmental disability (brain injury), the vocational implications are quite obviously severe and represent permanent and total disability from participation in both the competitive labor market and the sheltered labor market. The actual extent to which a developmentally disabled child is vocationally impaired does, of course, depend upon the limitations, which exist in sensory and motor areas, communications, and complex integrated cerebral function. The extent to which emotional disturbances, consciousness disturbances, and episodic neurological disorders exist will also play an important role.

The mild or educable mentally retarded child can typically participate in most activities of daily living and enjoy entry-level occupations in the competitive labor market. Such individuals may not be dependent on others for personal care services and can in many instances reside alone.

The trainable or moderately retarded child can be educated to handle most activities of daily living (personal care services). He or she usually is dependent on others and remains unable to reside alone, although this is not always the case in individuals who have intelligence levels at the higher range for this level of development. They usually can function in sheltered workshops but rarely will be found in the competitive labor market.

The severe profoundly retarded child generally has difficulty in activities of daily living and personal care services and remains totally dependent upon others. They will not be found working in the competitive labor market and rarely will be found in sheltered work settings.