

who can design a program to stimulate and guide each child to achieve his or her functional goals.

An active therapy program involves the family; the physical therapist; and often other members of the health team, including the nurse. The most common approach uses traditional types of therapeutic exercises that consist of stretching, passive, active, and resistive movements applied to specific muscle groups or joints to maintain or increase range of motion, strength, or endurance.

## Prognosis

The prognosis for the child with CP depends largely on the type and severity of the condition. Children with mild to moderate involvement (85%) have the capability of achieving ambulation between 2 and 7 years old ([Berker and Yalçin, 2008](#)). If the child does not achieve independent ambulation by this time, chances are poor for later ambulation and independence. Approximately 30% to 50% of individuals with CP have significant cognitive impairments, and an even higher percentage have mild cognitive and learning deficits. However, many children with severe spastic tetraplegic CP have normal intelligence. Growth is affected in children with spastic tetraplegia, and many children remain below the fifth percentile for age and sex.

As children with CP become adults, about 30% remain in the home and are cared for by a parent or caregiver; 50% of individuals with spastic tetraplegia live in independent settings and function at appropriate social levels considering their disability ([Green, Greenberg, and Hurwitz, 2003](#)). Vocational rehabilitation and higher education are possible for adults with CP. Children with severe CP mobility impairment and feeding problems often succumb to respiratory tract infection in childhood. The few survival rate studies on children or adults with CP show that survival is influenced by existing comorbidities ([Nehring, 2010](#)).

Prevention of some cases of CP may become a reality in the near future. Studies indicate that early neuroprotection in term infants with moderate encephalopathy due to hypoxic-ischemic injury with the use of **therapeutic hypothermia** (head cooling or whole-body cooling to 33° to 35° C) within 6 hours of birth improved survival without CP by approximately 40% ([Johnston, Fatemi, Wilson, et al, 2011](#)). A *Cochrane Database Systematic Review* of 11 randomized