In This Issue:

The challenges of integration in health care research ........12

Psychological distress and family burden following spinal cord injury: Concurrent traumatic brain injury cannot be overlooked ........................................16

Daring men to be caring men: The dilemma of disability for male caregivers .......................18
Neuro-Networking

Neuro-Networking is a new addition to AXON. Here individual CANN members and chapters may pose and answer clinical questions, exchange information and services, seek assistance with research recruitment, advertise educational events, and carry on the kind of networking activities that we often do locally. The key is to keep submissions geared to professional topics. For those of you who are Internet-savvy, a more immediate method of networking is provided on the CANN website www.cann.ca. Click on neuronurses discussion board. The first time you access the discussion board you will have to log on with Coolboard to create a user i.d. and password. Then reply to discussion threads or start your own topic.

Neuro-Networking -

Book review
by Diane Duff

I recently had the opportunity to review three amazing little books by Dayla Maisey. They are entitled: “The never ending journey”, “The never ending journey begins”, and “The never ending journey continues”. Dayla’s brother was severely injured in a motorcycle accident in the early ’90s. Dayla has recorded and compiled her thoughts and experiences, and those of other families who have faced similar situations. Collectively, the books are a guide for families who have begun such a journey with a family member with an acquired brain injury (ABI). The never ending journey begins... is a collection of insights and experiences concerning a patient and family’s time in the ICU. It includes simple but accurate explanations of brain injury, coma, equipment, procedures, and the effects of brain injury. She offers practical suggestions on how to respond to members of the health care team and well-meaning family members and friends. However, its greatest value, at least according to a family member I asked to review the book, lies in Dayla’s ability to capture the emotional essence of the experience and to provide hope and support tempered with a realistic and pragmatic perspective on the outcomes of severe brain injury.

Dayla is currently writing a fourth book for families of patients with ABI on discharge to the community. She will be presenting a paper at the CANN conference in Halifax this June. She can be reached by e-mail: journey@cadvision.com or by mail at Box 569, Okotoks, AB, T0L 1T0.

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AXON is the peer-reviewed journal of the Canadian Association of Neuroscience Nurses/Association canadienne des infirmières et infirmiers en sciences neurologiques. The journal is published quarterly in September, December, March, and June. We welcome the submission of original manuscripts in the areas of practice, research, theory, education, and policy, which are of interest to the neuroscience nursing community. The views, statements, and opinions expressed in the articles, editorials, and advertisements are those of the authors or advertisers. They do not necessarily represent the views and policies of CANN/ACIISN and the editors and publishers disclaim any responsibility or assumption of liability for these materials. AXON is indexed in the Cumulative Index to Nursing and Allied Health Literature, International Index (NI) and Nursing Citation index ISSN # 0834-7824.

MISSION STATEMENT
The Canadian Association of Neuroscience Nurses sets high standards of practice and promotes continuing professional education and research. Members collaborate with individuals, families, communities and health care professionals to promote wellness and injury prevention for clients at risk for, and/or experiencing alterations of the nervous system.

ÉNONCÉ DE MISSION
L’Association canadienne des infirmières et infirmiers en sciences neurologiques établit les plus hautes normes de compétence dans le domaine des soins infirmiers en sciences neurologiques, et fait la promotion de l’éducation professionnelle permanente et de la recherche. Les membres collaborent avec les individus, familles, communauté ainsi que les professionnelles de la santé dans le but de promouvoir le bien-être et la prévention des personnes à risques et/ou atteintes d’altérations du système nerveux.
January saw the dawn of a brand new year, but for the CANN executive and board of directors it was the mark of mid-year for this term. It was with great pride and respect that I chaired the mid-year meeting in Toronto. I was surrounded by a group of educated, dedicated and enthusiastic neuroscience nurses with a variety of backgrounds and scope of practice. Many times as I looked around the room, listening to the discussion and debate, I felt that this group truly was representing you, our members.

Several key people were a part of the meeting. We welcomed our new editor, Diane Duff and congratulated her on her creative and tireless efforts in making our journal a sought-after resource of information and communication. For those of you who may not be aware, Pappin Communications became our new publisher as of the September 2000 issue of AXON.

Evelyn Myles, our new communications and marketing chairperson, presented some new initiatives that fall directly in line with our strategic plan. Her portfolio is huge, simply because almost everything we do as an association is linked to communication. As Evelyn begins to work through some of her objectives, she may be calling on you for information or help on an ad hoc basis. Please be supportive if you can. I must acknowledge the work of Terry Myles, Evelyn’s husband, who quietly works behind the scene as our webmaster. Be sure to check out the website for interesting new items, links, and information. Feel free to send your own feedback and ideas to Terry or Evelyn.

Our newest voting board member is Carole White, professional practice. This position will serve as our link to CNA as well as the CCNS professional development committee. Her role will be instrumental in helping us in our mission to set high standards of practice and promote continuing education and research.

These are just a few of the new board members and their initiatives. I would encourage you to check our website for the entire list of the executive, councillors and portfolio chairpeople working for you. All of their contacts are listed and I know that any one of them would love to hear from you.

This week I was reading about the upcoming nursing leadership conference in Ottawa, and I was intrigued by the title: “Repair, Realign, Resource”. I am sure that each of you in your part of the country could use some of this right now in order to do your job of providing quality patient care to the citizens of our country. The key is that each and every one of you needs to acknowledge that tremendous changes have taken place in health care, not all of them good, and many of them have political overtones that we cannot change. However, if each of you makes the commitment to be a part of the solution, and let your nursing voice be heard, you can make a difference.

Darlene Schindel, President, CANN

Some scenes from the mid-year board meeting. Above, from left: Joan Hapgood, Nancy Thornton, Darlene Schindel and Judy Chisholm. Below, from left: Gail Green, Marlene Reimer, Debra Beveridge, Diane Pottie, Ann Huggard, Pam Bovan, Karen Waterhouse and Jill Kamensek. Bottom, from left: Lucy Wardell, Carole White, Janice Kenney, Evelyn Myles and Janet Brown.
Message de la présidente


Evelyn Myles, notre nouvelle représentante au comité des communications et de mise en marché, a présenté son plan pour appuyer notre stratégie. Son porte-feuille est très volumineux car plusieurs activités de l’association sont reliées au comité des communications. Pour développer ses objectifs, il se peut qu’Evelyn sollicite votre opinion, vos conseils ou votre support. S’il-vous-plaît, coopérez avec elle! Je dois souligner aussi le travail de Terry Myles, l’époux d’Evelyn, travailleur silencieux en tant que “webmaestro”. Vérifiez notre site “web” pour des nouvelles intéressantes! Vous pouvez même faire parvenir vos impressions et suggestions à Terry ou à Evelyn.

Carole White est la nouvelle membre votante du comité. Elle représente le comité de la pratique professionnelle. Ce poste servira de lien entre l’ACII et le comité de développement professionnel du CCSN. Le rôle principal de Carole est de nous aider à viser l’établissement de meilleurs standards de pratique et la promotion de l’éducation continue en plus de la recherche.

Ce ne sont que quelques-uns des nouveaux membres du comité exécutif et leur rôle. Je vous encourage à consulter notre site “web” pour la liste complète des membres de l’exécutif et des représentants des différents comités qui travaillent pour vous. Vous y trouverez toutes leurs coordonnées et je suis convaincue que toutes aimerait échanger avec vous commentaires ou questions.

Cet semaine, j’ai lu un article intitulé: « Nursing Leadership », une conférence qui aura lieu à Ottawa. Le titre a retenu mon attention: « Repair, Realign, Resource ». Je suis certaine que chacune de vous, dans votre coin de pays, pourrait utiliser immédiatement cette information afin de pourvoir les meilleurs soins possibles à tous les citoyens du pays.

La clé est que chacune de nous doit accepter les énormes changements dans le système de santé même si nous demeurons impuissantes devant certains, qui sont plutôt à odeur politique. Toutefois, si chacune de nous s’engage à faire partie de la solution et se fait entendre par la voix de l’ACIISN, nous avons le pouvoir de faire une différence.

Darlene R. Schindel
Présidente, ACIISN

CANN/ACIISN position statement on stroke

CANN/ACIISN promotes attitudinal changes through education and encourages the ongoing development and use of evidence-based best practice guidelines for patients and their families across the continuum of stroke care.

We participate in partnerships to strengthen networks that facilitate access to standardized stroke care throughout Canada.

CANN/ACIISN exposé complet concernant les maladies cérébrovasculaires

CANN/l’ACIISN encouragent un changement d’attitude et de perception par l’entremise de l’éducation et favorisent le développement et l’utilisation de meilleurs standards de soins pour les patients et leur famille durant le traitement des maladies cérébrovasculaires.

Nous travaillons en partenariat à renforcer les réseaux facilitant l’accès aux meilleurs traitements des patients atteints de maladies cérébrovasculaires dans tout le Canada.
Editorial: Maintaining professional competence in neuroscience nursing: CANN makes it simple!

In Canada, national, provincial, and territorial associations for registered nurses all support ongoing educational activities as one strategy for maintaining professional competence. Many RN associations, including those in Alberta, British Columbia, Manitoba, the Northwest Territories (including Nunavut), Nova Scotia, Ontario, and Quebec, have introduced, or are in the process of introducing, continuing education requirements to maintain registration. According to the provincial councillors, other provinces are also considering similar requirements. Therefore, in addition to initial registration exams and minimum practice hours, nurses must now generally engage in a reflective practice exercise. This includes self-assessment of one's own practice in comparison to provincial/territorial standards, peer feedback, and the development and implementation of professional objectives and a learning plan.

Membership in CANN provides several painless, dare I even say rewarding, opportunities to maintain and expand competence for nurses specializing in neuroscience. Local chapter meetings offer networking, educational, and social activities throughout the year. The annual CANN conference that is being held in Halifax this year, June 13-15, provides members with a chance to participate in educational, scientific, and social activities. The CANN website gives members a forum for seeking and sharing information and resources. AXON, the journal of the Canadian Association of Neuroscience Nurses, is published four times a year and it highlights professional papers on neuroscience nursing policy, practice, research, education, and administration, as well as CANN activities.

CANN encourages its members to consider CNA certification in neuroscience nursing. Certification is a tangible way of measuring excellence in neuroscience knowledge and practice. Neuroscience is one of 10 specialty areas in Canada that have certification exams. There are currently 8,820 certified specialty nurses. However, only 168 are specialized in neuroscience (www.cna-nurses.ca). This is unfortunate as there is some evidence that nurses who are specialty-certified in Canada and the United States express greater satisfaction personally and professionally than do non-certified nurses. Additionally, it is reported that certified nurses also had higher quality and patient safety outcomes than did non-specialized nurses (www.cna-nurses.ca).

Currently, neuroscience nurses make up only a fraction of certified specialty nurses in Canada, and CANN members make up only a fraction of neuroscience nurses in Canada. My challenge to all of you reading this issue is two-fold. First, to recruit new members to CANN, and second, to consider becoming a certified neuroscience nurse. I will undertake the same challenge, and over the next two years of my mandate as editor of AXON, I will endeavour to ensure AXON publishes peer-reviewed papers that are scholarly and relevant to the practice of neuroscience nurses. Starting in June, there will also be a continuing education column based on the core curriculum for neuroscience nurses who wish to prepare for certification. These study forums will be linked to the established neuroscience competencies. The current neuroscience competencies include: helping, teaching, diagnosing and monitoring, managing rapidly changing situations, therapeutic interventions, and utilizing collaborative and professional skills needed for nursing practice. So, consider joining me in this quest. I am sure we can double the number of CANN members and certified neuroscience nurses by 2002...or by 2003 at the latest!

By the way, in addition to competence objectives related to certification, I have also established a competence objective for 2001 that states I plan “to network with neuroscience and neurotrauma nurses from across Canada”. Feel free to use the same objective, and I will see you in Halifax!

Diane Duff, editor

Canadian Association of Neuroscience Nurses

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CANN reports…

CANN Secretary/V.P. report
It was energizing to attend the recent mid-year board of directors meeting in Toronto, Ontario and to meet with CANN colleagues from sea to sea. The breadth of educational offerings that councillors are coordinating is impressive, and the plans for the upcoming annual meeting in Halifax are exciting. I think we can all anticipate an exceptional meeting in June.

I was also struck by the great amount of CANN work accomplished by the committed group of elected and appointed members who make up your board of directors. We should all take pride in how well our association is functioning.

Nancy Thornton

Past-president’s report
As past-president I have enjoyed a more leisurely yet exciting seven months since the annual meeting in Ottawa. The board approved the appointment of several neuroscience nurses to board positions: professional practice (includes CCNS professional development committee): Carole White; translation: Suzanne Mandino; Think First: Nancy Krock. Welcome to all! These new members received an orientation at the mid-year meeting. At the same time it is necessary to look ahead to June 2001 and ensure positions are filled as members who have completed their term step down. You will find a list of available positions on this page of AXON along with a nomination form. Please give serious consideration to advancing the practice of neuroscience nursing in Canada by volunteering your time and talents to CANN. It’s worth it!

There was one nomination for honourary membership.

In addition to overseeing nominations, I have participated in regular conference calls with the executive. This was

Nominations

As a member of CANN, your participation is important in submitting names of nominees whom you feel will be beneficial to the effective running of the association. The nominating committee is requesting names for the positions of Vice-president/secretary and Councillors for Ontario (Central), Ontario (East), Saskatchewan, and Alberta. The positions will become available June 2001.

Councillors act as a liaison between the board of directors and the local chapters, coordinate activities at the chapter level, and conduct the business of the association as voting members of the board of directors. The term of office is three years.

The Vice-president/secretary is a member of the executive and a voting member of the board of directors. He/she must be willing to serve and observe a commitment of three years as vice-president/secretary, president, past-president/nominations chairperson. Suggested qualifications include:

1. Active member of CANN for at least four years.
2. Served on the board of directors of CANN and/or chaired a committee of CANN for at least two years.
3. Member in good standing in his/her provincial nurses association.
5. Computer skills including word processing and e-mail, an asset.

All nominations must include:
• signatures of two active members (nominator & seconder)
• written consent of the nominee
• curriculum vitae of nominee (typed)

Nominations must be received by May 15, 2001. Please forward all nominations to: Judy Chisholm, 48 Loggen Road, Lower Sackville, NS, B4E 1V7.

Nomination form

Date: __________________________ Position: ___________________________ CV enclosed: ☐

Name of Nominee: __________________________ Signature of Nominator: __________________________

Signature of Seconder: __________________________

1, __________________________ accept the nomination for the above named position.
particularly advantageous this year, as I could act as a liaison between the executive and the conference planners in Halifax. As outlined in the organizational chart, I supported the legislation and bylaws chairperson and WFNN representative as they enacted their responsibilities.

Last but not least, I continued to work towards a business plan for CANN. Depending on discussions at the mid-year meeting, you may hear more about this.

Judy Chisholm

Legislation and bylaws report

It has been a very quiet fall for this portfolio. No suggestions have been received for amendments to the legislation and bylaws and minor changes were received for the terms of reference. These changes were discussed at the mid-year meeting and the administrative manuals will be updated accordingly.

Reminders of legislation and bylaws portfolio deadlines:

1. Suggestions for proposed amendments to the organization’s legislation and bylaws must be submitted to the organization’s legislation and bylaws chairperson at least 90 days prior to the annual general meeting.

2. Board members are reminded to review their terms of reference in their administrative manual and send any suggestions for revisions to the legislation and bylaws chairperson by May 1.

Joanne Hapgood

Scientific committee report

The scientific committee was amazed at the response to the call for abstracts for Halifax, 2001. The call for abstracts was posted in national and local journals and newsletters as well as on the website. It was also sent to local health care agencies and universities. The deadline for receipt of abstracts was extended to December 1, as information was missing from the September AXON. A separate mail-out was sent to all board members via the president noting the deadline extension.

Think First report

In December, through a teleconference call across the nation, Think First members reflected on the successes of Think First in this new millennium.

Think First is creating a new Smart Hockey injury prevention program. The new video, to replace the Smart Hockey with Mike Bossey video, will hopefully be shown mid-winter on TSN. New Brunswick’s Dr. Simon Walling’s lecture on hockey concussion is being videoed. This video will be distributed to schools and hockey clubs in the region. Patti Gallagher reported that every hockey player in New Brunswick has a “Stop checking from behind” logo on the back of their shirts.

Karen Johnson of Montreal, a researcher on concussion, announced a new concussion website directed for kids. It is, www.concussionsafety.com and will link with the Think First website. In researching concussion, Karen is involved with the ski/snowboard ski patrol with Quebec’s Mt. Tremblant ski patrol and indicated Interwest is aware of the project and very supportive.

Dr. Michael Cusimano, Ontario, reported the research project evaluating the Think First For Kids program is going well with approval received from 11 school boards and another five in the wings. The study requires 46,000 children. Networking with the public health programs will be running in April and May 2001. Ontario Neurotrauma Foundation funding is for three years.

Mark Weisbarth, Think First executive member, has set up and will be maintaining the Think First website.

Congratulations to Nancy Thornton! She was recently recognized by the Registered Nurses Association of British Columbia (RNABC) with an award of excellence in nursing practice. Nancy was responsible for nursing quality management at the Children’s and Women’s Health Centre for British Columbia when she was nominated for this award. In this capacity, her achievements included accreditation and the creation of an online policy manual. Nancy is an expert clinician and researcher in pediatric neuroscience. She is currently vice-president of CANN.
Think First website is www.thinkfirst.com. Statistics were requested to be added to the new website.

Brain Waves, the official newsletter of Think First, was published in fall 2000. Brain Waves will be published three times a year.

Upgrading the Think First for Teens program involves a new half-day program: “Making Connections”. This project was created because schools indicated no follow-up after the 50-minute Think First for Teens presentation. This program, created by Eleanor Sam, executive director of Think First Canada, is designed to provide Grade 11 students with an awareness of neurotrauma injury prevention. Teens will get a neuroscience experience at the hospital to see what happens after an injury, and then go back to school and take the message to their peers. Making Connections has a research component and introduces students to careers in neurosciences. Pilot-testing scheduled at Toronto Western Hospital in winter/spring of 2001 involves the partnership with neuroscience professionals in various units of the hospital.

The new TD (Toronto Dominion) Think First for Kids curriculum for grades four, five, and six should be published and ready for distribution by next fall at the latest. The “Think for Families” program involving the parents’ assessment of how well their kids are learning safety will be out this spring. Joan Patterson, director of programs and curriculum development, who is responsible for the above programs, is acting as a liaison with the boards of education and ministries of education across the country.

Reflections of Think First at the provincial chapters level have demonstrated the success of the joint efforts of Think Firsters and the ministries of education in Newfoundland and New Brunswick in assisting in the distribution of the TD Think First manuals. Think First has distributed 140 programs in Newfoundland to date. Natalie AuClair of Think First Quebec reported their program is booked solid until May with presentations from kindergarten to high school.

CANN’s mission statement “promotes wellness and injury prevention for clients at risk for and/or experiencing alterations of the nervous system”. Making a poor choice, such as riding/driving your bicycle/car through a flashing yellow light, can occur without having experienced alterations of the CNS. Therefore, no matter what your situation, before proceeding, THINK FIRST.

Nancy Krock

World Federation of Neuroscience Nurses report

The World Federation of Neuroscience Nurses (WFNN) continues to grow. The Israeli neuroscience nurses have recently joined. Plans for a website and an electronic version of International Brain Waves, the official newsletter of WFNN, are being considered. The upcoming Eighth WFNN Quadrennial Congress is planned for September 16-20, 2001 in Sydney, Australia. CANN is part of this exciting worldwide neuroscience association.

There are opportunities to submit abstracts for this meeting (online application). There is also an opportunity to apply for the Agnes Marshall Research Award (amount $4,000.00). The deadline for both submissions is March 30, 2001. Further information is available at http://www.users.bigpond.com/annaexecutive/wfnn.htm.

I look forward to the Halifax meeting and plan to set up a display of WFNN newsletters and program packages regarding the meeting in Sydney. Consider submitting an abstract, attending the meeting, and developing your own personal international network of neuroscience nursing contacts.

Wilma Koopman

Research committee report

Towards a research agenda for neuroscience nursing

Establishing research priorities for Canadian neuroscience nursing is involving a large proportion of our membership through a modified Delphi process, initiated at a workshop at the CANN 2000 conference in Ottawa and circulated in the December AXON. Responses will be collated and circulated by e-mail and mailed to all respondents who provided their names and contact information, for further ranking and consolidation. CANN 2001 in Halifax will provide one further opportunity for attendees to indicate their priorities through an interactive poster presentation. The final results will be published in AXON in the fall. Besides being of value to our own members in planning research and related projects, these results will be sent also to the Neurosciences, Mental Health and Addictions Institute that is part of the new Canadian Institutes of Health Research. Special thanks go to Anne Wyness (BC), Darlene Schindel (Alberta), Carole White (Quebec) and Anne Choquette (Quebec) who took part in the panel presentation that kicked this project off last June, and to Diane Duff (Ontario) and the publishers for managing to get the survey into AXON in such a way that you did not need to tear your journal apart to respond. If there is anyone reading this report who has not yet returned the survey, please do and encourage others to do so as well. To be truly reflective of practice needs, it is important that we get as broad a representation as possible.

CANN Research Award

Last year’s recipient of the $1,000 CANN Research Award, Kathy Doerksen (Manitoba), reports excellent progress on her study, “A comparison of a standard neurological assessment tool to a stroke scale for detecting symptomatic cerebral vasospasm.” She looks forward to presenting her results at CANN 2001 in Halifax.

We are pleased to recommend to the board of directors that Diane Duff receive this year’s award for her
Increasing funding for neuroscience nursing research

In November I met with the development director of the Canadian Nurses Foundation (CNF) as part of an ongoing effort to generate increased funding that CANN could use to support more research. There is the possibility of working with CNF to access funding made available through the federally-funded nurse fund, but we would need to provide two-to-one matched funds. This opportunity continues to be explored, as do other funding possibilities. I look forward to discussing how we can coordinate fund-raising activities for the range of CANN initiatives during the mid-year board meetings.

Marlene Reimer

Guidelines for funding requests for neuroscience nursing research

1. Research funds will be allocated yearly based on numbers of requests;
2. Fundable projects will focus directly on neuroscience patient care issues;
3. Projects will focus on issues within the scope of nursing practice in Canada;
4. The primary investigator must be a nurse and an active member of CANN in the preceding year;
5. A written letter of request plus the proposal shall be sent to the chairperson of the research committee;
6. The research proposal shall include the following:
   a. Title of project
   b. Names and qualifications of the principal and co-investigators
   c. Purpose of the project
   d. Methodology (including sample, procedures and data analysis plan)
   e. Evidence of consent by the ethics committee of the institution/agency from which the research subjects will be selected
   f. Budget and timeframe
   g. Amount of money requested from CANN;
7. The research committee will review proposals and notify the board of directors on decisions about funding awards;
8. Those who receive funding shall provide progress reports to the research committee upon request;
9. Dates for competitions for research funds will be published in AXON;
10. Researchers will be required to publish their results in AXON and at the annual meeting.
11. Researchers must submit a report of their research to the research committee.

Application Deadline: September 1, 2001  Maximum Amount: $1,000.00

Submit to: Marlene Reimer, Chair, CANN Research Committee
c/o Faculty of Nursing, University of Calgary
2500 University Drive NW, Calgary, AB T2N 1N4
Telephone: (403)220-5839 Fax: (403) 284-4803
E-mail: mareimer@ucalgary.ca
Head on Down

The organizing committee of the thirty-second annual meeting of the CANN invites you to join us from June 13-15, 2001 in Halifax, Nova Scotia.

We have put together a memorable week of educational offerings during the day and evenings of play.

At the welcoming wine and cheese party on Tuesday, June 12, we promise you a chance to enjoy Nova Scotia taste treats.

Wednesday morning we will follow a piper to the World Trade Centre for our welcome breakfast and plenary sessions. Wednesday afternoon you will have your choice of five concurrent sessions, topics including pediatrics, neurology, neurosurgery and professional issues. These papers promise to stimulate you as the presenters are discussing current concepts in neuroscience nursing.

AXON Editor Diane Duff will also conduct a hands-on workshop on writing for publication. Then, prepare yourself for your first evening of dancing the night away at the congress welcome reception, followed by nurses’ night out at Triangles, featuring the music of Evans and Doherty. It is an evening of Irish fun.

Thursday morning we will begin with a continental breakfast and the CANN annual general meeting. Following the meeting there will be an opportunity to view the posters and exhibits at the Metro Centre. The annual lunch features Alan Cuvelier. In the afternoon, there is a choice of five concurrent sessions, including papers in all areas of nursing practice: neurology, neurosurgery and pediatrics. There are also three extended workshops on caring for the aggressive patient following a TBI, neuroassessment, and neuroanatomy. In the evening, plan to attend the congress fun night at Pier 21 on Halifax’s historic waterfront. It will include a lobster dinner and fine entertainment with one of our best bands, McGinty.

Friday morning there will be time to attend an early morning continental breakfast and to view the exhibits and poster sessions at the World Trade Centre. The final 12 concurrent sessions are offered in the morning, covering topics of interest to all participants. There are two sponsored lunches to choose from, on multiple sclerosis and Parkinson’s disease. This is followed by a discussion of ethical dilemmas in nursing with Dawn Potvin. The Codman award paper and closing remarks will bring the meeting to an end on Friday afternoon.

MORE DETAILS WILL COME TO YOU BY MAIL, and VISIT THE CANN WEBSITE: www.cann.ca

Destination: Halifax


Les organisateurs vous promettent une semaine éducative inoubliable, agrémentée de soirées très divertissantes.

Lors de notre Vin et Fromage du mardi 12 juin, vous pourrez déguster des amuse-gueules typiques à la Nouvelle-Écosse.

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The challenges of integration in health care research

By Wilma J. Koopman, Cathy-Lee Benbow and Nick Neary

Abstract
The team approach in neuroscience patient care results in health care professionals interacting on a daily basis. However, the collaboration of health care disciplines in research is limited. The barrier to research integration among disciplines may be related to the diverse views of the quantitative and qualitative paradigms. Health care research is challenged by both the variety of health professionals and differing research paradigms. Patients will benefit from integrated health care research with a coordinated research agenda and efficient use of resources.

There are many professionals conducting research with individuals who have health care concerns. These health care professionals come from a variety of medical and allied health backgrounds. Given the number of disciplines involved in health research, it is not surprising that many different research methodologies are used. Historically, physicians have come from a training that focuses upon the disease entity. Medical research rooted in the physical sciences is strongly anchored to quantitative methods. More recently, qualitative research approaches common to the social sciences have seen their acceptance and utilization increase among the health disciplines, including nursing.

The authors, a social worker and nurse practitioner in an outpatient neuroscience facility, conducted a needs assessment of patients with multiple sclerosis and their significant others. This article discusses the barriers between our disciplines and the challenges of diverse research methodologies that influenced our ability to complete this project.

Health care research has the opportunity to embrace the integration of research methodology across these disciplines. Methodological dichotomies do not need to exist between or within disciplines. The understanding and acceptance of both quantitative and qualitative methods by researchers may lead to integrative and complementary research.

Research paradigms, the quantitative and qualitative debate, and the position of nursing and social work in the current research environment are addressed in this paper. Integration of research methodologies and interdisciplinary collaboration will be discussed.

Quantitative paradigm
Disciplines at the core of health care, such as medicine, have traditionally used quantitative methods. The concept of statistical significance is of paramount importance in research based on this philosophy. Statistical significance refers to the importance of a relationship in a mathematical sense, as indicated by rejection of a null hypothesis at a particular level of significance. This testing relates to both the hypotheses made about the data and the actual data analysis (Lynn, 1990). Essentially, since there will always be different scores across groups, statistical measures are used to determine whether or not the differences between the groups occurred by chance. When a researcher reports that a difference found between groups is statistically significant to a particular level, he states the probability that the finding of a difference is a chance finding. Many researchers consider the 95% (or 5% likely to be a chance finding) significance level the consummate goal in research.

Qualitative paradigm
An alternate research approach is found in the qualitative paradigm. An example of this paradigm would be phenomenology. Phenomenology is inductive, and seeks to generate theory from insights obtained within the natural setting of the phenomenon being studied (van Mannen, 1990). Phenomenological research tries to grasp what people and their lives are all about, without including any preconceived ideas. A common understanding of the event under study is illuminated through a search for the structure or essence of lived experiences as perceived by individuals in their everyday lives. The perception of an individual’s experience is shaped...
by factors both internal and external to the person (Streubert & Carpenter, 1995). Phenomenology is concerned with reflectively analyzing thematic aspects of an experience, so that the experience is described and meaning is uncovered (van Mannen). Phenomenology assumes that human experience is unique and dynamic. This approach is one of discovery and revelation.

Qualitative-quantitative debate

When considering an integrated approach to research, it is important to understand the qualitative-quantitative debate. The debate has been a subject highlighted in the scientific literature by a series of papers (Pope & Mays 1993; 1995). This has mainly been a philosophical debate, occurring in many academic disciplines, though usually in fields where different methodologies may be appropriate, such as sociology, psychology, education, and nursing. Specific health care professionals often favour a qualitative or quantitative research approach.

Inductive researchers advocating qualitative methods have many concerns about quantitative approaches. Quantitative researchers are forced to commit to rigorous techniques at the expense of theoretical interests by emphasizing the aspects of research that can be numerically defined (Clarke, 1995). Statistical significance may imply that the difference is important, but may not indicate the cause for the observed trend. Statistically significant findings lacking reasonable causality may open new research questions. Statistical significance should be understood for what it is, a useful test of relationships between and within data sets. Statistical methods should be used as one of many indicators of importance. Statistical significance does not necessarily indicate clinical application.

Many critics of the quantitative paradigm refer to it as an approach that applies numbers to research questions that cannot always be answered by such means. This emphasis can lead researchers to a narrowly-defined set of problems that conform to the techniques being used. Though methodology is clearly important when deciding which research questions should be studied, it should not be the only factor, or a constraint on inquiry. Another important concern about the quantitative research approach is that it assumes the existence of what Holton terms an “objective reality” (Holton, 1993). Essentially, quantitative researchers assume that reality is independent of the observer. It is, therefore, essential that the researcher in quantitative inquiry be detached from the research process. The research can only be objective and free of bias if this separation is in place. This detachment imposed by methodology can be constraining in health care research, as researchers are often directly involved in the care of the individuals being studied. Employing and accepting qualitative methods removes this constraint and eliminates the need for a sharp division between the researcher and the data. Aiming to account for the subjective aspects of human experience (Mason, 1993), the qualitative approach to research augments the questions that can be addressed both within and between disciplines.

It would be limiting to dismiss quantitative methods. Qualitative researchers should understand the benefits of empirical methods, as well as their limitations. In fact, many qualitative methods are based on aspects of empiricism. A good example of this is content analysis, a rigorous methodology for interpreting verbal and written words. Clearly, there is a place for aspects of quantitative approaches in many different disciplines. The challenge seems to be finding and accepting that place. The integration of the quantitative and qualitative research methodologies may enhance the insight and understanding of clinical research problems.

Integration as an approach to research

In applied health research, integrative approaches are valuable in exploring how patients are cared for, and to what extent the health care sector meets their needs. This area of research is reflective of the trend toward patient-centred care, with the focus on how the patient can be served within the limits imposed by political and economic forces. Researchers become interested in defining needs of patients and examining whether or not the health care system is meeting them. Since the perceptions of patients are important, qualitative methods,
which take the feelings of patients into account, may be valuable. Stakeholders will also be interested in a cost-benefit analysis obtained through statistical quantification. Integrative approaches can, therefore, be very useful in applied health research and should be understood by all health care professionals. Porter (1989) called for a qualitative-quantitative “dualism,” which would replace the traditional “dichotomy” between the two paradigms.

The pursuit of integration in nursing and social work

Nursing and social work are professions where clinical intersections occur, thereby offering opportunities for integration in research. These two professions within the health care system have strongly advocated for patient-centred care and can serve as examples of the needs, benefits, and challenges of theoretical and research integration. The research questions of nursing and social work may be met through discipline-specific research efforts or through interdisciplinary collaboration. For example, the study of gradual versus fast titration of interferons in the treatment of multiple sclerosis patients is a nursing-specific research effort. The study of quality of life issues for patients on interferon treatments raises research questions common to both nursing and social work. While addressing a common research problem, integrative research may be cost-effective and require less time and resources.

Integration and nursing

Nursing is one discipline that has struggled with the perceived qualitative/quantitative dichotomy. The subject is debated in nursing journals with discussions focusing not only on questions of methodology, but also on the current state of research. Researchers on both “sides” of the debate often have very different perceptions about the current state of nursing research. Nursing literature suggests that quantitative methods are vastly under-used in nursing research and nurses need to develop their understanding of statistical methods. By contrast, others suggest that nursing research is limited by an adherence to a rigid research methodology founded in logical positivism. For example, a paper in the Advanced Journal of Nursing (Ratcliffe, 1998) stated that “quantitative methods are under-used in nursing research”, while another study found that 55% of doctoral-prepared nurses had primarily quantitative research training (Damrosch & Strasser, 1988). Though some nurses are still struggling with this debate of exclusion and polarization, there is a growing sense among nurse researchers that integration is the solution. Several papers, such as Clark (1998), Kirkevold (1997), and Porter (1989), call for nurses to move to integrative methods, and to embrace Porter’s qualitative-quantitative “dualism.” The same argument made for applied health research in general applies to nursing. Nurses often have a detailed scientific understanding of the medical conditions of their patients, and play a significant role in their psychosocial care. Nurses also interact with many different types of health care disciplines. Nursing is a discipline that is very wide in scope and requires an adaptable, fluid approach to research. These characteristics of nursing facilitate collaborative research with other health care disciplines.

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Integration and social work

The profession of social work must meet not only the challenge of the qualitative-quantitative dichotomy, but also establish a role for the profession within clinical research. Although social workers have always identified the need to employ patient-centred interventions, social workers have had difficulty evaluating the effectiveness of this philosophical approach. In fact, social workers have been seen as less active in areas of research, when compared to their colleagues in other health care professions. Research has occurred within the academic setting, but it is less apparent in the area of direct clinical practice. The literature challenges the social worker to engage in direct practice research (Sidell et al., 1996). Staudt (1997) challenges social workers to recognize the “pseudo issues” such as time constraints and practice complexities that are cited as barriers to direct practice evaluation and research. The emphasis of social work practice on the patient within the context of the individual, family, and society lends itself to the patient-centred philosophy and the practice of qualitative research (Falck, 1987). As a profession grounded in psychosocial theory, social work partners with allied health professionals in the psychosocial care of patients. Common clinical research questions may arise and their investigation would be strengthened by collaborative research.
The resolution of the debate

The debate may be expressed by the philosophical ideas of Niels Bohr, one of the founders of quantum theory:

[Such] quantitative analysis [is] characteristic of the exact sciences, whose task, according to the program of Galileo, is to base all description on well-defined mathematics. Notwithstanding the help which mathematics has always offered for such a task, it must be realized that the very definition of mathematical symbols and operations rests on the simple logical use of common language. Indeed, mathematics is not to be regarded as a special branch of knowledge based on the accumulation of experience, but rather as a refinement of general language, supplementing it with appropriate tools to represent relations for which ordinary verbal communication is too imprecise or cumbersome.

Niels Bohr, Rutherford Memorial Lecture, 1958 (French & Kennedy, 1986)

This idea is very powerful: if mathematics and languages are simply different ways of expressing common language, then every quantitative argument can theoretically be reduced to a qualitative one, and vice versa. In this sense, when researchers plan a study, their choice of methodology can be seen as a choice of communication. In effect, they are deciding how to communicate their results, not choosing one of two paradigms. This communication should be as precise and rigorous as possible, but words, numbers, or their combination, are all plausible. The essential idea is that irreconcilable views need not be contradictory. Two seemingly opposite views may be complementary and mutually illuminating.

References


Conclusion

This integrative approach to research is clearly valuable in the neurosciences, a specialty in which research collaboration between health disciplines has potential. The increasing specialization of neuroscience practice makes crossing disciplines challenging, yet important and rewarding. The neuroscience team that incorporates collaborative research within clinical practice promotes cost-effective, efficient resource allocation in the provision of patient-centred care.

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Psychological distress and family burden following spinal cord injury: Concurrent traumatic brain injury cannot be overlooked

By Karin M. Buchanan and Lorin J. Elias

Abstract
Although concurrent spinal cord injury (SCI) and traumatic brain injury (TBI) are recognized, there is little acknowledgement of SCI/TBI as a contributor to psychological distress and family burden. By mail-out questionnaire, we evaluated psychological distress and family burden in a married group (n=12) with traumatic SCI who had not been identified as having concurrent TBI on referral to the Canadian Paraplegic Association. Both the person with SCI and the partner completed the Brief Symptom Inventory (BSI), the Adjective Checklist, and a Likert strain scale to measure the perception of the partner’s strain. The partner also completed the Zarit Burden Interview. Despite screening criteria designed to selectively recruit individuals without TBI, seven individuals described post-traumatic amnesia (PTA) ≥ 3 days. Subsequently, participants’ reports were divided into two groups - “longer PTA” and “shorter PTA”. On the Brief Symptom Inventory, the two SCI groups did not differ, but the partners of individuals with “longer PTA” had significantly elevated Global Severity Index scores compared to the other partners. The “longer PTA” partner group demonstrated more strain and more burden (as measured by the Likert strain scale and the Zarit Burden Interview). Given the size of the groups (n = 7, n = 5), these findings are presented to illustrate trends and to stimulate further research.

Introduction
Although spinal cord injury (SCI) and traumatic brain injury (TBI) can be concurrent (Davidoff et al., 1988), with few exceptions (Richards et al., 1991), recent studies of SCI adjustment (Gerhart, Weitzenkamp, Kennedy, Glass, & Charlifue, 1999; Tate, Maynard, & Forchheimer, 1993; Widerstrom-Noga, Felipe-Cuervo, Broton, Duncan, & Yezierski, 1999), divorce (DeVivo, Hawkins, Richards, & Go, 1995), and caregiver distress (Weitzenkamp, Gerhart, Charlifue, Whiteneck, & Savic, 1997) may have overlooked concurrent TBI as a possible variable. While studying psychological distress and family burden in various neurological patient populations, the authors sought a group with a primarily physical disability (SCI). TBI was not forgotten, but it was perceived to have been eliminated as a variable. This brief report outlines for nurses the unexpected findings that reinforce that when overall SCI outcome is evaluated, possible SCI/TBI cannot be overlooked.

Methods
Twenty-six individuals (and their partners) who met the following criteria: traumatic SCI - complete lesion, injured ≥ 2 years ≤ 10 years, married or living common-law, and no co-existing TBI identified on referral to the local chapter of the Canadian Paraplegic Association (CPA), were mailed questionnaires to be completed separately and anonymously. They were asked the length of time following injury until the person “could ‘remember’ fairly well from hour to hour”. On receiving their replies, respondents were divided into two groups, which we refer to as “shorter post traumatic amnesia (PTA)” (≤ 2 days) and “longer PTA” (≥ 3 days).

There were usable responses (both the person with SCI and the partner responding, questionnaires fully completed) from 12 “matched pairs”. The mean time since injury was 5.8 years, mean present age (SCI individuals) 38.8 years, seven paraplegics, five quadriplegics, 11 males and 1 female.

All 24 participants completed the 53-item self-report Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982) to measure their individual levels of psychological distress at the time of assessment. The BSI has a Global Severity Index (GSI) and nine subscales. As Subscale I contains primarily somatic items, the GSI was calculated with and without this subscale. Subscale II includes cognitive complaints that are characteristic of mild brain injury. As there is a risk of these subscales being viewed as diagnostic when reported by name

| Table 1: Summary of differences between SCI individuals with “shorter PTA” versus those with “longer PTA”. Values are means with standard deviations in parentheses. All comparisons are 1-tailed. |
|---|---|---|---|
| | shorter PTA (n = 5) | longer PTA (n = 7) | t-score | p |
| Likert strain scale | | | | |
| SCI ind. view | 2.8 (1.1) | 4.7 (1.6) | 2.30 | .022* |
| partner view | 2.0 (1.2) | 4.5 (1.0) | 3.81 | .002* |
| Zarit Burden Interview | | | | |
| partner report | 16.2 (9.4) | 33.7 (13.7) | 2.46 | .017* |
| BSI (mean T-scores) | | | | |
| Global Severity Index (GSI) | 61.4 (9.8) | 68.1 (9.1) | 1.23 | .124 |
| † SCI ind. (without Subscale I) | 60.6 (12.5) | 68.1 (9.4) | 1.20 | .130 |
| ‡ Subscale II | 53.8 (8.9) | 62.1 (5.9) | 1.97 | .039* |
| SCI ind. partner | 56.2 (11.4) | 68.3 (9.9) | 1.96 | .040* |
| ‡ Subscale IV | 54.0 (12.3) | 59.4 (12.0) | 0.76 | .232 |
| SCI ind. partner | 61.4 (12.6) | 63.6 (12.6) | 0.29 | .388 |
| partner | 50.6 (9.0) | 62.4 (7.4) | 2.50 | .016* |

* significant at the p<.05 level
† without somatic complaints, BSI items #2, 7, 23, 29, 30, 33, 37
‡ cognitive complaints, items # 5, 15, 26, 27, 32, 36
§ depressive symptoms, items # 9, 16, 17, 18, 35, 50
(Kreutzer, Gervasio, & Camplair, 1994), in the present report they are referred to only by number.

Both the individual with SCI and the partner estimated the partner’s level of present strain from the SCI on a seven-point Likert scale and the partner also completed the Zarit Burden Interview (Zarit, Orr, & Zarit, 1985) as a measure of subjective family burden.

Participants also completed a measure of perceived personality and behaviour change after SCI, however only nine “pairs” knew each other prior to injury. These findings were previously reported in AXON (Buchanan & Elias, 1999).

Results

Surprisingly, seven injured persons reported “not remembering well” from hour to hour for three or more days (five individuals for two days or less). We have labelled these groups “longer PTA” and “shorter PTA” respectively. For the differences between the two groups, see Table 1.

“Longer PTA” individuals rated their partners’ strain on the Likert strain scale as higher than the “shorter” partners1 individuals rated their partners’ strain, t(10) = 2.30, p = .022. “Longer PTA” partners’ self-ratings of strain were higher, t(10) = 3.81, p = .002 and scores on the Zarit Burden Interview were higher, t(10) = 2.46, p = .017, compared to “shorter PTA” partners.

On the BSI, exclusion of Subscale I (somatic items) did not affect the Global Severity Index for either SCI group and the “shorter” and “longer PTA” groups’ GSI scores did not differ significantly. However, the “longer PTA” partners had significantly higher GSI scores, t(10) = 1.97, p = .039 than the “shorter PTA” partners. On Subscale II (“cognitive” complaints), injured persons with “longer PTA” had significantly higher scores, t(10) = 1.96, p = .040, compared to the other SCI group. On Subscale IV, which taps depressive symptoms, the “longer PTA” partners had significantly higher scores, t(10) = 2.50, p = .016, compared to the other partners.

Discussion

The limitations of splitting a group of 12 “pairs” into two subgroups are readily acknowledged. However, the results warrant report for they show a significant trend, albeit in a small group.

Married individuals with SCI who describe PTA ≥ 3 days reported more “cognitive” complaints but no more distress or depressive symptoms (as measured by the BSI), compared to injured persons who report PTA ≤ 2 days. On the other hand, partners of the “longer PTA” group reported more global distress and depressive symptoms (on the BSI) and more strain (Likert scale) and burden (Zarit Burden Interview) than partners of the “shorter PTA” SCI group.

None of the 12 injured persons were identified to the agency providing long-term services as SCI-TBI, yet 7 individuals reported PTA ≥ 3 days (confirmed by the partner). Five of these seven reported having been on a ventilator, which can make diagnosis of TBI more difficult. None of the SCI group received TBI rehabilitation (including service to partners to address family burden following SCI).

Conclusion

Are clinicians from all disciplines under-diagnosing TBI and subsequently minimizing its impact? Is profound physical disability after SCI assumed to be the cause of psychological distress? Are the most appropriate services provided in the community? Are investigators of SCI adjustment and caregiver distress adequately assessing the prevalence of TBI and its role as a moderating variable? This brief report is a reminder that the impact of possible TBI on psychological distress and family burden following SCI cannot be overlooked.

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References


Derogatis, L.R., & Spencer, P.M. (1982). The Brief Symptom Inventory (BSI): Administration and procedures manual-1. Baltimore: Johns Hopkins University School of Medicine, Clinical Psychometric Unit.


Daring men to be caring men: The dilemma of disability for male caregivers

By Marvin L. Anderson

Abstract

The presence of a chronic illness such as multiple sclerosis (MS) represents not only overwhelming demands on male caregivers, but ambivalence for men with respect to their masculinity. Men as sole caregivers for spouses with MS feel caught between a rock and a hard place, given their gender socialization and the pressing demands of caring for a dependent and vulnerable spouse. Regular chapter visits within the MS Society in Ontario confirmed the assumption that male caregivers have to contend with a predominant bias among professional female caregivers that men are really not capable of caring for someone with a chronic illness and subsequently cannot be trusted with such responsibility. This bias actually works to undermine men’s perceived capability and predisposition to caring for a vulnerable family member with a chronic illness or disability.

Introduction

Statistically, the ratio of women incurring multiple sclerosis (MS) is almost twice that of men (Siebert, 2000). In light of this ratio, it becomes incumbent on husbands or male spouses to take on the role of primary caregiver more often than the reverse. Furthermore, it is estimated that family members provide 80% of the informal care and support for adults with multiple sclerosis (MS). An increasing number of these caregivers are obviously male caregivers. One recent study suggested that as many as 28% of caregivers are men; family members account for much of that percentage, with husbands providing 13% of the care and sons, 7% (Siebert, p. 8).

We seldom question the presence and capacity of women as caregivers. With men in the primary role of caregiver, however, it does make us think more concretely about the role of gender in the critical task of caregiving. Recently, we have witnessed an unprecedented demographic shift in Canada and the United States in which more and more working- and middle-class mothers are working “outside the home”, or professionally from home. While more public scrutiny and mass media coverage have acknowledged the increasing role of fathers in tending to their own children, the novelty of fathers staying at home with their children is actually wearing off. Men who choose to stay at home are often underemployed or not employed to the same extent as their spouses.

Do we normally think men are as qualified and competent as women to look after all of the needs of someone diagnosed with MS? Traditionally, we assume that the man’s responsibility lies primarily in securing the necessary finances for his family (Siebert, 2000). However, when a female spouse diagnosed with MS is dependent on her partner, his need to take care of her takes priority over other obligations. Unfortunately, this priority for caregiving does not in any way rule out, or cancel, a husband’s other obligations and responsibilities. On the contrary, the dilemma of disability faced by male caregivers can be summarized in three succinct observations:

1. The expectation that they must be simultaneously a caregiver to the person with MS, raise children (if any), be the primary ‘breadwinner’ in terms of family income, and do all of the above without showing any signs of ‘weakness’ (i.e., visible symptoms of stress or emotion).

2. Moreover, they must deal with the consistent perception from others that they (as men) are incapable of providing such care in the role of primary caregiver.

3. They frequently have no familiar male role-models or mentors to show them how to be a good caregiver.

In the case of a family member diagnosed with a chronic illness, MS in particular, the support from immediate family and friends inevitably dries up as the MS progresses over the years. Despite this lack of alternative social support, male caregivers are still often not recognized as the primary caregiver. As Siebert (2000) has suggested, “[p]erhaps it’s because they don’t complain, keep a low profile, and are reluctant to ask for help” (p.8). While this observation is undoubtedly true, it begs for more information and warrants more gender-specific analysis.

Marvin Anderson
Review of the literature

Good, Bower, and Einsporn (1995) investigated gender differences in the social support of spousal caregivers of persons diagnosed with MS. They found that female caregivers scored significantly higher than males on the total number of resources available, including perceived social support and the perceived availability of friends and self-help groups. The data supported their findings that female caregivers received more social support (SS) resources and perceived social support (PSS) than males. This supports the prevailing social belief that women receive more social support than men. In addition, Good et al. found that female caregivers selected friends and self-help groups as resources more often than males. This research could be helpful to nurses in the assessment of caregivers, as well as the identification of SS needs and planning of interventions.

In their study of the various stresses on caregivers of spouses with MS, Miller, Crawford, and Kuenzel (1998) counter the common assumption that the pressures and stresses of living with and supporting someone with MS inevitably lead to a higher than normal divorce rate. Although there is no exact data on the number of MS marriages that end in divorce, the best available evidence indicates that the rate is actually lower than the 50% divorce rate of the general population in the United States. Apparently, some couples who might otherwise have separated still remain together after MS has been diagnosed. Well spouses may stay in a marriage because of a sense of commitment and obligation; meanwhile, MS spouses may remain in an unhappy marriage because of concerns about financial security or insurance benefits (Miller et al., p. 94). However, Miller et al. found that some well spouses who feel obliged to honour the marriage commitment may in fact gradually distance themselves from the relationship emotionally, physically, and financially. This ‘pseudo-divorce’ may actually be more painful and detrimental to the MS spouse than a legal divorce, especially if it is characterized by an emotional withdrawal from the marital relationship. As long as the couple remains together, it may be more difficult or awkward for family and friends to offer or provide help to the MS spouse. To make matters worse, the MS spouse remains ineligible for certain kinds of resources and perceived social support (PSS) than males.

The pedagogical use of myth

The myth that speaks to most men of their lot in life and their attempt to deal with pain is that of Heracles, in the form he took in the classical Greek myths (Mazis, 1993). [Since Heracles has become known in popular culture as “Hercules” – the later Roman form of his name – we will refer to him by that name.] As a fertility god, Hercules had been a consort to the goddess. He was later transformed by the Greek warrior Ethos into the paradigm of the new masculine hero. According to Mazis, Hercules’ notorious struggles to achieve glory and carry the burdens he had to bear, still speak poignantly to most men in our own culture. In the penetrating psychological interpretation offered by Mazis, Hercules’ need to inflict pain on others allows him to distance himself from any visceral connection or empathy with others—as well as from his own pain. This is the unacknowledged shadow side of Hercules’ archetypal quest for glory, in effect, “rising above it all” (p.21). It is instructive, therefore, to look at some of the more pertinent details of Hercules’ story as a mythological framework or metaphor for how men often deal with their own pain (their emotional pain, in particular), and that of their loved ones. Contrary to the ‘heroic’ exploits of Hercules in slaughtering the nine-headed hydra, killing the Amazons and committing other violent acts, the most humbling of Hercules’ “great labours” was also the most unthinkable. He had to clean 30 years of excrement from the Augean stable (Mazis, p.26). Surely, a hero of his stature is not going to be caught cleaning out the stables. In order to keep his distance from any excremental association, Hercules changes the flow of the rivers Alpheus and Peneus to wash away the accumulated faeces. Thus, he cleverly manages to get rid of it all and avoids “soiling so much as his little finger”(Mazis, p.21).

When Hercules steals the oxen of Geryon, he slays the giant and two-headed dog and then – true to his legendary character – he raises the mountains as monuments to his triumph. Hercules “is always monumentalizing his ego”(Mazis, p.27). When Hercules commands Atlas to get the golden apples from his daughters, the Hesperides, he offers to hold up the world while Atlas retrieves the apples. Recall that Atlas was condemned by the gods to support the weight of the heavens by means of a pillar on his shoulders. Atlas will do anything to be momentarily relieved of this duty—who wouldn’t? Hercules then persuades Atlas to take back the pillar just long enough for Hercules to get a cushion for his shoulder, and leaves the Titan “holding the bag”, so to speak. Yet psychologically speaking, Hercules’ willingness to take on Atlas’ burden of holding up the world underscores the archetypal and heroic male temptation to be

Rationale for educational workshop

As boys, generations of Canadian men have been socialized to aspire to the masculine heroic ideal of autonomy and independence. Vulnerability, on the contrary, is considered taboo. It is, after all, the unspoken and formidable foe of the Stoic male ideal, or, in modern terms, the self-reliant (Marlboro) man. The word “vulnerability” comes from the Latin word, vulnus, which literally translates as “wound”. No wonder men are invariably uncomfortable with, if not repelled by, the demands of attending to a wound—particularly if it occurs in the form of a chronic illness like MS afflicting your spouse.
Duff's observation, it is now wonder that spouses with chronic the daily and dependent recipients of caregiving. In light of both male and female caregivers, but among those who are and Stoic posture vis-à-vis pain is not only present among those who are sick or disabled. The shadow side of the heroic many well and able-bodied people feel in the presence of herself has been diagnosed with what is now called chronic chronically sick or have a disability is the discomfort that professional gender role of being the primary caregivers, should they take on this traditional-turned-expectation, so it seems out of character for the scripted male identity to truly and ineluctably be the main caregiver. This results in leaving male caregivers between a rock and a hard place. The Herculean myth is not solely borne by men who become the primary caregivers for their spouses and female partners. Female spouses, as well as professional female caregivers such as MS Society staff or nurses, undoubtedly face similar challenges and typically respond in the way that we would want and expect them as women to respond – responsibly and heroically. Given the demands of their work, or the caseload or number of patients for which they are responsible, the prevailing socialization of women and heroically. Given the demands of their work, or the caseload or number of patients for which they are responsible, the prevailing socialization of women predisposes them to be proficient and conscientious caregivers, should they take on this traditional-turned-professional gender role of being the primary nurturer. For men, this is not the prevalent gender or peer role, or expectation, so it seems out of character for the scripted male identity to truly and ineluctably be the main caregiver. This results in leaving male caregivers between a rock and a hard place.

The moralistic agenda of medicine
As further background to the theoretical context, it is instructive to explore the writings of Duff (1993). Duff herself has been diagnosed with what is now called chronic fatigue and immune dysfunction syndrome, or CFIDS, which she describes symptomatically “as a bad flu that never goes away” (Duff, p.xi). She states that one of the most difficult things that people have to deal with when they are chronically sick or have a disability is the discomfort that many well and able-bodied people feel in the presence of those who are sick or disabled. The shadow side of the heroic and Stoic posture vis-à-vis pain is not only present among both male and female caregivers, but among those who are the daily and dependent recipients of caregiving. In light of Duff’s observation, it is no wonder that spouses with chronic fatigue or MS try their best to present a healthy face; not to do so incurs further blame for being sick. Our culturally-defined concepts of physical and psychological health have become one-sidedly identified with the heroic qualities most valued in our culture: youth, activity, productivity, independence, strength, confidence, optimism (Duff, p. 40). Advertisements reflect this idealized picture of health as young, white, slim, athletic, and beaming with “the cheerful effervescence of a Bernie Siegel or a Louise Hay,” (Daniel Harris cited in Duff, p. 40). This kind of rosy optimism is most evident when even sick people are encouraged to cheer up and be brave. In fact, those who can joke in the midst of experiencing intense pain are revered by all. As Jungian analyst Adolf Guggenbuhl-Craig has observed, “Once a person went through life with a melancholic temperament; today the same person has to swallow strong medication until he becomes relaxed and stupidly happy”(cited in Duff, p.41).

Sickness, by the above definitions, is not only seen as a breakdown of normal health, but as a personal failure, which may explain why many sick people feel so guilty and ashamed—or angry at anyone who intimates they have done something. It is as if they have brought it on themselves. Trautmann (cited in Duff, 1993) made this astute observation during her daughter’s struggle with leukemia:

“\textit{As long as the blood counts are good or within the acceptable range, she will be praised; if they deteriorate, she can expect disapproval from both nurses and doctors; relapse must mean the height of failure then.}\n
“When symptoms persist and illness becomes chronic,” Duff comments,

we often find fault with the victim...[adding that] we call it a lack of will power, a desire for attention, an unwillingness to work or change, rather than question the hidden assumption that it is within our power as human beings to overcome sickness and, in fact, it is our job to do so (Duff, p. 41).

Guggenbuhl-Craig coined the term “wholeness moralism” for the tendency to accept people only when they get better, heal, or want to (Duff, p. 41).

In our infatuation with health and wholeness, illness is one-sidedly identified with the culturally devalued qualities of silence, introspection, weakness, withdrawal, vulnerability, dependence, self-doubt, and depression. When somebody does display any of these qualities to a great extent, he or she is likely to be considered ill and encouraged to see a doctor or therapist. Meanwhile, a multitude of self-help books now proliferate in bookstores encourage sick people to cultivate positive attitudes – faith, hope, laughter, self-love, and a fighting spirit – to overcome their diseases (Duff, 1993). As a result, many sick people are shamed by friends, family, or even their doctors or healers into thinking they are sick because they lack these “healthy” attitudes. Yet illnesses often accompany critical turning points in our lives, especially when it is necessary to withdraw and reflect on making needed changes in our lives.
The experience of male caregivers

Two men who attended the workshop were invited to speak about their own experiences of being male caregivers to their wives with MS for over 30 years. The first one expressed regret at not having asked for more help, and admitted he was resigned to doing everything himself. His talk underscored the social isolation and stigmatization of MS couples and, in particular, the ‘raw deal’ for men in this situation. Interestingly enough, his implicit mythical perspective was biblical, not Greek: he admitted he needed “the patience of Job” in looking after his wife. The second speaker corroborated the first one’s testimony that his single-handed caregiving was necessary for his wife’s survival, and there was simply “no alternative”. His candid and thorough account of the manual work required in attending to his wife’s needs was moving. Moreover, his reference to the daily ritual of changing and rinsing out her catheter evoked the antithesis of Hercules’ notorious revulsion at dealing with excretions, and further demonstrated the genuine and loving commitment that no doubt many male caregivers have. His poignant story echoed the first speaker’s lament in terms of the social limitations imposed by MS: “we don’t hear from anyone”. Fortunately, though, the second man was able to secure the “indispensable” help from home care (a governmental service in Ontario) at least one day a week, so that he could do the long distance travelling necessary for his work. Not surprisingly, both stories corroborated the previously cited findings of Miller, Crawford, and Kuenzel (1998). Couples who are already relatively happy will continue to stay together, and the spouse (in this case the husband) not only stays in the marriage, but takes on the primary role of caregiver.

Conclusions

The explicit literary and psychological use of the Greek myth of Hercules provided a nonliteral and metaphorical framework by which participants of the workshop could see the relevance of myth to their intimate lives, in particular, the gender roles they take on in caregiving. While a handful of participants complained about the abstract nature of this intellectual presentation, it proved stimulating for most of them. This methodology enabled participants to critically identify the onerous and incessant demands of caregiving for a MS spouse, with subsequent recognition of the concomitant need for additional support than that offered solely by the well spouse (in this case the male spouse). The psychological explication of the Herculean myth as a hero archetype allowed participants to reflect on their own professional and familiar gender roles in caregiving. It subsequently helped them to differentiate the mixed messages which both men and women receive in this culture regarding who takes care of whom, when a spouse is diagnosed with MS.

About the author

Marvin L. Anderson is a consultant to Individual and Family Services of the MS Society of Canada, Toronto, Ontario. He also serves as a consultant to the Ontario Federation for Cerebral Palsy, and is currently managing the Fathers’ Project for The Macaulay Child Development Centre in Toronto. In addition, he serves as an adjunct faculty member of the Toronto School of Theology, as well as an instructor at Queen’s Theological College, Kingston. He is completing a PhD in theology at the University of St. Michael’s College in Toronto.

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This paper is based on a one-day educational workshop that was designed to better inform MS caseworkers and staff of the dilemma of disability for male caregivers. It was initially held on November 17, 1999 in Toronto. This workshop was selected as a poster presentation for the International Consortium of Multiple Sclerosis Centers in Halifax, Nova Scotia, Canada, June 22-25, 2000.

The author of this paper wishes to thank Debra Orton, Regional Manager, Individual and Family Services, MS Society of Canada, Ontario Division, for her support and vision in seeing this workshop to completion. The author also wants to gratefully acknowledge the above two male caregivers whose anonymity I wish to respect, and whose model as ‘heroic’ caregivers I heartily commend. On a personal note, the faithful caregiving of these two men reminds me of my own father, Dell R. Anderson, to whom I dedicate this article. In taking care of my mother who incurred a stroke three years ago, my father has exemplified the kind of ‘heroism’ profiled above, and continues to inspire me and my two sons.

References


## Membership application

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