This issue is all about making connections and the importance and relevance of this concept after a spinal cord injury (SCI). For many people, a SCI causes a sense of disconnection as you are taken out of the life you were living and thrown somewhere else – typically a new world with new rules. Some people feel disconnected from their body as it no longer does the things they want and expect. Others feel disconnected from their lives, as they don’t know where they are now fits in with previous work, relationships or even living environment.

Establishing points of connection with your old life, your strengths, and your supports is of critical importance. You are the same person you were – but now you have new challenges to deal with. The journey ahead requires that you get in touch with the best and strongest aspects of yourself – be they your determination or your faith and religious affiliation or the support your family provides – and use them to forge ahead.

Making connections starts in the hospital and rehabilitation center, as you connect with the physicians, therapists, and other patients on the unit. Here you form relationships that take you through rehab and may last for the rest of your life. The connections continue as you allow your family and friends into the rehabilitation process – recognizing how the SCI may change their lives as well as your own and sharing your feelings, hopes, and concerns.

From the medical perspective, inpatient rehab is about teaching you the information and the skills that you need to regain strength and independence and to learn to manage your health given your impairment. You spend hours each day in physical and occupational therapy and learn how to accomplish things – from transferring to toileting to cooking – in new ways. You talk with social workers, psychologists and recreational therapists about how to integrate your old life and new realities. And if you go (or went) through inpatient rehab at the University of Michigan, you will likely attend Independent Living classes (described later in this issue) and learn about the challenges, rules and possibilities of life with a SCI.

The time immediately after injury is also a time when many consider their connections with their religious beliefs and a higher power. The sense of faith and comfort that those can provide often connect people to supportive communities and become a touchstone and well of strength. For the Benedictines, who you’ll hear from later in this issue, it is the Presbyterian Church that offers a continuing resource for practice, emotional and spiritual support.

Peers – individuals with SCI or other disabilities – can serve as an important point of connection, as they can provide the “been there, done that” perspective. As described by Tom Hoatlin, peers can provide a powerful resource as they demonstrate not only that life can go on after a SCI, but that it can be good and you can be happy. As articulated by Michelle Meade, Ph.D.

Continued on page 3


**Director’s Corner**

**Spinal Cord Injury Research: Funding and Priorities**

By: Denise G. Tate, Ph.D., ABPP

With the elections now behind us, researchers across the country continue to worry about opportunities for funding spinal cord injury research. At best, budgets for many of the federal agencies will remain flat - meaning that there will not be much room for growth and innovation in the years to come.

Still, some very exciting progress in SCI research was noted at the last Neuroscience’s conference, held in October of 2012. Examples of innovative projects included studies on deep brain stimulation which are attempting to restore locomotion in rats with partial spinal cord injuries; underwear wired to deliver tiny electrical currents so as to prevent pressure sores; and the use of stem cells to treat autonomic dysreflexia associated with SCI.

So what is the next step in closing the gap between the availability of funds and the development of research that can help people with SCI live better lives? Get personally involved by advocating for these funds. This advocacy may include calling your congressman and senators in Washington DC to stress the importance of funding such research or joining with local and community-based agencies such as Centers for Independent Living to advocate for the needs of people with SCI. Our voices need to be heard - both individually and jointly - to ensure that SCI research can go on apart from politics.

At our center, we continue to work hard on our National Institute on Disability and Rehabilitation Research (NIDRR) funded projects related to SCI bladder and bowel complications and quality of life, self-management and health behaviors. Our investigators and staff have been recognized for their expertise in this area and commitment to SCI research. Dr. Chiodo, SCI Medical Director here at the University of Michigan, was invited to deliver the Walter J. Zeiter lecture at the annual meeting of the American Academy of Physical Medicine and Rehabilitation (AAPMR). Dr. David Tulsky delivered the keynote lecture at the International Spinal Cord Society (IS-CoS) meeting in September this year. Working with the Ann Arbor Department of Veterans Affairs Health System, Drs. Meade and Tate received grants from the Department of Defense to study problems related to bowel and bladder, and positive coping and adjustment among civilians and veterans with SCI. In addition, international collaborations on SCI are being forged with Brazil and possibly India that will continue to develop in the years to come.

This is an exciting time for all of us and we want you to be part of it too. Please send us your thoughts, questions and comments about the work we do at our center.

In addition to serving as Principal investigator for the University of Michigan SCI Model System, Dr. Tate is the Associate Chair for Research and a Professor in the Department of Physical Medicine & Rehabilitation at the University of Michigan.

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**UM SCI Model System: Alumni News**

By: Constance Pines, RN

We enjoy hearing from our Alumni! The SCI Access Newsletter would like to include news and advice from you, our alumni, in future newsletters. It is important to us to highlight your experiences and triumphs and look forward to hearing from you. You may contact us online at our website www.med.umich.edu/pmr/modelsci or call our office at 734-763-0971 for information.

David Nickelson (in his own words):

**Age:** 33

**Date of Injury:** April 2002

**Level of Injury:** T-11 (Incomplete)

SCI Access: Tell us about yourself! Have any significant events taken place since your injury? Do you have any hobbies? What have you accomplished?

David Nickelson:

It took about a year and a half after my injury to get back into a more normal life but I worked briefly near Philadelphia before starting law school at the University of Miami (FL) in the Fall of 2004. I graduated in May of 2007 and passed the Florida bar exam that summer. I now work analyzing and researching patents and I’m able to do all the work from home through my laptop so I take advantage of that and live in Florida most of the year while also going to Montana during the summers. A snowbird at just 33! The job is great and keeps me busy but I was also able to purchase a townhome in Florida in 2011.

I took up hand-cycling in 2008 and that’s been an incredible experience. Being able to get out and about at a decent speed opens so many doors. I’ve competed in a number of races including the Disney World ‘Goofy Challenge’ that consists of a half marathon on Saturday and then a full marathon on Sunday in both 2011 and 2012, finishing second overall in the half marathon both years and finishing second in the full in 2011 and first overall in 2012. I’m signed up for my third one in January 2013. During the summer I use my handcycle on the Going to the Sun road in Glacier National Park which is an arm-burning 3000 foot vertical climb from the valley floor to the pass.

SCI Access: Share your thoughts and advice! What has kept you motivated since your injury? What have you done to overcome any challenges you have met along the way?

Nickelson: My advice would be to stay active if at all possible. Look into hand-cycling if you’ve never tried it. It was a life changer for me. You get great exercise, people are fascinated by the bike so you’re constantly meeting new people and making new friends. You don’t have to be racing, it’s a great way to just get out and go around the block.
Proving a Framework to Support Living Independently

By: Patty Zuba, O.T.R. and Cindy Douglas, P.T

Independent living is a philosophy that is important to learn and practice every day. Its aim is to encourage all persons with disabilities to control all aspects of their lives. Opportunities in life should not be restricted by disability. Life doesn’t have to be defined or limited by a disability. Individuals with SCI and other disabilities are entitled to the same rights and choices in life that they had before their impairments or injuries. Although there are many challenges in learning to live independently, there are also a myriad of skills, tools and laws that have been developed to provide information, assistance and support. Individuals with SCI do not need to face the learning curve alone; many facilities teach independent living classes.

On the Inpatient Rehabilitation Unit of the University of Michigan Health System, Independent Living classes teach participants skills that will help them manage not only their disabilities, but will also assist them with their daily living activities and their lives as a whole. Generally, the classes teach strategies and skills that will allow individuals with SCI to take control of all aspects of their lives. These classes are designed to empower participants with helpful skills and strategies discussed in a friendly, open, and encouraging environment. More specifically, Independent Living classes cover topics such as health and wellness, assistance management, recreation and assistive technology, housing, transportation, sexuality, communication, and rights and benefits.

The classes are led through a collaboration of professional staff including occupational therapists, physical therapists, medical doctors, social workers, and therapeutic recreational specialists. Also included in the group setting are former patients and peers from our local Center for Independent Living who have SCI. The group allows participants to ask questions based on individual needs and provides the opportunity for other patients to share their experiences.

As individuals participate in group classes together, it becomes a valuable way for them to support one another, both in their learning and their rehabilitation. Not only do patients learn from the professionals, but they can learn from the people who have experienced similar events, who use the techniques that are being taught every day, and who can provide useful tips for daily life. These tips are not aimed at household activities, but include the knowledge and skills which will serve those with SCI while they are out, enjoying life. No matter if someone with SCI is having a night on the town, a quiet dinner with close friends, or keeping up with children, the skills learned in independent living classes make life easier and more enjoyable.

The University of Michigan is committed to helping those with disabilities live full, independent lives. In a demonstration of these values, Independent Living classes are held for inpatients every Wednesday afternoon on the rehabilitation floor. Classes are facilitated by Patty Zuba, O.T.R. and Cindy Douglas, P.T. and teach valuable skills which allow people with new disabilities to be independent, active and mobile. Therapists, medical staff and mentors are there to support patients with their new adventures as they learn that many of their old interests can still be pursued, that their lives can still be active, and that they can be independent.

The Importance of Connections
Continued from page 1

Marva Ways in one of her articles, “identifying and associating with peers with disabilities can provide a sense of identity, motivation and inspiration.”

Of course, connections are what the Spinal Cord Injury Model Systems is about. It is about the University of Michigan Health System connecting with other centers across the United States in order to improve research and knowledge about SCI. It is about staff at the various centers and health systems connecting and sharing what we learn in order to improve clinical care, education, and outreach for individuals with SCI and their families. It is about those with SCI reaching back and sharing their experiences to help both inform research (though participation in studies and advisory boards) and to support others going through the rehab and adjustment processes after them. In addition, here at U-M, the Model Systems is in a large part based on our connection with the Ann Arbor Center for Independent Living and with the commitment to help people get back to their lives.

I hope that you enjoy this issue and how it highlights the connections that support and strengthen all of us.
The Power of a Peer Mentor

By: Tom Hoatlin

Whether they know it or not, everyone has been a peer mentor. Some have had formal training but many aren’t aware of just how powerful sharing their personal story with someone else has been. Either way, sharing life experiences can be very powerful and meaningful, especially for someone who is in need.

The idea that mentoring makes a difference is simple — you honestly share an experience that you have been through and have successfully overcome in a way that is relevant to the experience that your mentee is struggling with. In some cases, it might be as easy as identifying a valuable resource; in others it may be as complex as sharing your experience with losing someone or something that is very close and personal to you. Similarly, a mentoring relationship can be as informal as listening to a friend that has a difficult problem and offering your support. In any case, who better to share a conversation with than someone who has been through the same experience?

Merriam Webster defines mentoring as a “trusted counselor or guide.” Synonyms include coach, counsel, lead, pilot and tutor. All of these make sense and each word fits in its own way. Coaches are definitely mentors; guides and pilots lead you in the right direction; and a tutor teaches you what you don’t know or are struggling with. These are all great characteristics and roles that make for an excellent peer mentor.

Peer mentoring has been around for a very long time. For example, take Alcoholics Anonymous. In that model, someone who has “been there, done that” gets assigned as a sponsor so that someone new to the program has a trusted friend to call or meet with when they are feeling down or vulnerable. The sponsor talks about when they were in the beginning stages of recovery or rehabilitation and can be very effective in making their mentee feel better and maintain their commitment to sobriety.

There is one common word that shows up in researching mentors of any capacity and that is “trust.” A peer mentor must establish trust right away and try to make their mentee feel as comfortable as possible.

Beyond that, every peer mentoring relationship is different. They are not always conducted in person. In fact, many interactions occur by phone, e-mail or Skype. It’s up to the individuals involved to decide how to develop and make good use of the relationship. In order for the relationship to work, participants must be active and invested with each other. Learning how to set goals and to find ways to achieve them is an important part of the rehabilitation process and relevant characteristics, such as race, gender, age and disability characteristics. It is very hard to be an effective peer mentor if you have paraplegia and your client has quadriplegia. Although there are common threads, most times the level of independence is so different that the person with quadriplegia can tune out when they see the obvious differences. The same goes for a young man trying to mentor a woman of retirement age or even a woman his own age.

As a mentee, or someone considering using a mentor, developing or maintaining a positive, beneficial peer mentoring relationship involves:

• Taking active steps to get started. Talk with the staff of your rehabilitation hospital’s SCI program or contact other organizations (such as the National Spinal Cord Injury Association) to find out if they are connected to a local program.

• Clearly communicating your needs and interests. Let the peer mentoring program team and peer mentor(s) know what your expectations are.

• Being realistic. A peer mentor can provide a lot of support and information, but can’t be expected to solve all of the mentee’s problems. Mentors won’t be available around-the-clock and can’t take the place of a doctor or other trained professionals.

• Setting personal goals. Actively set and write down reasonable goals from the
beginning for what you want to gain from the relationship and each meeting.

• Being flexible. Remember that a peer mentor has other responsibilities, such as work, family, and social activities. Be flexible with your schedule as well.

• Being respectful. Treat a peer mentor respectfully and courteously — if you can’t make an appointment or a call, advance notice should always be the policy.

As a peer mentor or someone who is willing to share your life experience with someone in need, developing or maintaining a positive mentoring relationship involves:

• Listening. Mentors are there to learn more about the mentee and what is on their mind. The purpose is not really about the mentor until or unless the mentee asks specific questions. The mentor should make the sessions all about the mentee.

• Establishing trust. It’s important to inform a mentee that anything that is discussed is confidential even from family members. The only exception is if a mentee discusses harming themselves or others. This should be reported to a professional immediately.

• Being ethical. It is the mentor’s responsibility to make sure that the relationship remains professional by not benefiting financially from a product they may represent or entering into a personal relationship with the mentee or a close acquaintance of theirs.

• Not offering medical advice. Mentors are there to share their life experience but not to recommend treatment or products. The mentee should always be referred to their doctor or therapist for specific health related questions.

• Providing information about resources. Mentors should be knowledgeable on local, regional and national resources that will help their mentee gain independence and experience as many opportunities that are available.

I am a direct recipient of peer mentorship and can definitively attest to how powerful it can be. In 1991, I sustained a gunshot wound in an armed robbery at the suburban hotel where I worked as the general manager. In a matter of five minutes I was propelled into a whole different world - one far different than the one I had lived for 28 years. The bullet lodged in my 2nd and 3rd thoracic vertebrae, crushing my spinal cord and leaving me with high level paraplegia.

When my health finally stabilized, I found myself on the rehabilitation unit. Although I was surrounded by a great medical team as well as others in rehab and the many friends and family members who made themselves at my disposal, I felt incredibly lonely. It was a loneliness I had never felt before. No one could understand the depth of my loss and grief. At least that’s how I felt.

I remember the day a man rolled into my room using a wheelchair. He introduced himself and broke the ice by joking around and poking light hearted fun at the hospital experience. He began to speak of his experience with a SCI. At first, I remember thinking to myself that regardless of what he was saying I did not need to know it; my situation was temporary. I would not be a part of his disability population. I couldn’t imagine that I would use a wheelchair like he did or for as long as he had. I instinctively tuned out but he kept coming week after week and I began to realize that I might need to use his advice in the future and that the resources he shared were invaluable.

One resource he mentioned several times was the Ann Arbor Center for Independent Living (CIL) - a nonprofit organization dedicated to the success of people with disabilities. Because of his recommendation and my rehab social worker’s referral, I visited the Center. That visit had a lasting effect on my new life with a disability. I learned that they had an extensive training program for people interested in becoming peer mentors.

Just months after leaving the hospital I took the training program, where I would sit amongst others with disabilities and share stories of success and failure. Participants had to first come to terms with our own disability experience before they could focus on being effective at offering resources and personal support to others with, in my case, spinal cord injuries. I would someday roll into someone’s room and share my disability experience like my mentor did during my hospitalization.

Who better to share with than someone who has been through the same experience?

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New National Peer Mentoring Support Program
Offered by the Christopher & Dana Reeve Foundation

By: Tom Hoatlin

In 2011, the Christopher & Dana Reeve Foundation launched a new national peer mentoring initiative – the Peer & Family Support Program (PFSP) – to fill support gaps. They saw the need to develop programs where they do not exist, to network with existing programs, and most importantly to introduce a standardized training curriculum to certify mentors nationwide.

PFSP empowers people living with paralysis, their families, and caregivers by helping them to go forward living happy, healthy, full lives. Peers provide emotional support and guidance, and share real-world experiences with people seeking advice. The peers can help to answer questions, and find solutions to life’s common challenges through confidential discussions and demonstrations.

Why a national program?
The need has never been greater for a family living with paralysis to learn the importance of health and wellness, and how to avoid developing secondary conditions which can prevent employment, education, and re-integration into society. In addition, the length of rehabilitation stays for the newly injured have been dramatically reduced in the past decade. Services for those living with paralysis have also been reduced or, in some cases, have nearly vanished at the local and state levels. However, it is our hope that these situations will improve as the peer and family support program and associated advocacy efforts gain more traction.

There are nine Regional Coordinators of the PFSP across the country, each with a territory of multiple states. I (Tom Hoatlin) serve as the Midwest Regional Coordinator and have a territory that includes Michigan, Ohio, Indiana, Illinois and Wisconsin. This means that I am responsible for finding people living with paralysis who are successful and thriving and would like to become certified peer mentors. Once a number of individuals express interest, I schedule a hybrid training approach and the certification process begins.

The primary prerequisites to be considered for the certified peer mentor program include having paralysis (or being a family or caregiver of an individual with paralysis). In addition, candidates must also be at least one year post-injury, and be living successfully and thriving. After the application is approved, candidates take a series of online modules and a competency assessment to prepare them for the onsite training. In particular, the training has candidates engage in discussion, role-playing and exercises associated with:

• How to become an effective peer mentor
• Ethics, values and peer support
• Interpersonal communication skills and;
• Resources for peer mentors and their clients

The newly trained and certified Peer Mentor is then a part of the most diversified pool of mentors in the country. They are a part of a network, connecting them with other individual mentors and existing programs across the country that are already doing great work in their communities. This nationwide reach not only allows mentors to work with clients from their local communities but also has the potential to connect them with clients from all over the country. The PFSP is utilizing technology to facilitate real-time communication between clients and mentors to ensure that clients in remote areas and with special needs can also receive mentoring.

One of the goals of the PFSP is to match clients with a Reeve Certified Mentor who will be of similar age, gender, level of paralysis, ethnicity, veteran status and location. Matching on these criteria should help address the unique needs of each client, further enhancing the client/mentor match and ultimately making the mentoring experience as beneficial as possible.

The Reeve Foundation also offers MentorNet, another unique and interactive way for Regional Coordinators, Peer Mentors, Coaches, Trainers and PFSP staff to stay connected and be of support to one another. This online community provides a forum for staff and mentors to chat, network, share resources, ask questions, pose topics and find tough matches.

The Peer and Family Support Program is empowering people through experience and the program believes no one should be alone. Reeve Foundation mentors don’t have answers to all of the questions but they will listen and provide a perspective that only someone who has been there can. They understand what their clients are experiencing better than anyone. The Foundation believes in the power of “we” not “me.”

Would you or someone you know make a great peer mentor? Do you think that you or someone close to you might benefit from a mentor relationship? Would you just like more information on the PFSP or a free copy of the Reeve Foundation’s Paralysis Resource Guide? For any or all of these, please contact me at: midwestrc@christopherreeve.org.

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Lifes Lessons Learned: Don’t Dis Our Ability! 
Identifying and Connecting with the Disability Community

By: Marva Ways

On October 28th, I was fortunate enough to celebrate my 63rd birthday. For 36 of those years I have been loving and living my life with a disability. I acquired my disability – a C 6/7 cervical fracture with resulting tetraplegia - in 1976 as the result of a car accident. Doctors informed my parents that they should put me in a nursing home because I would never be able to do anything for myself. Wow! If they could see me now! Please indulge me as I stroll/roll down memory lane and recall the past 36 years.

I received an anterior fusion and initial hospitalization at the University of Nebraska. After three months, I returned home to Detroit to receive physical therapy from the Rehabilitation Institute of Michigan (RIM). Prior to my accident, I rarely saw someone using a wheelchair and on those few occasions when I did, it was usually an older person. Upon entering rehab, there were only few younger females with disabilities. My therapist became my best friend because - back then - there was no such thing as mentors or peer support. I was like a sponge, soaking up everything they were teaching, and all my free time was used to perfect what I had learned.

In those days, a normal stay in rehab was six months - but I was discharged by the end of three months. My therapist thought I was ready to test the waters and put what I had learned to practice in the real world. I was excited but nervous at the same time.

This whole idea of living with a disability was very new to me. I couldn’t wait to connect with others to swap stories and share experiences - people with whom I could associate to learn coping skills and gather resources. I thank my doctors, nurses and therapists for my recovery and teaching me the skills I learned during rehab. No disrespect to them, but they were all able bodied people and I wanted to see and talk to someone who was like me. I wanted someone whom I could identify with because we had something in common - someone who had “been there, done that” as the saying goes.

After leaving RIM, my main focus was raising my six year old daughter. We became avid fans of wheelchair basketball. I even joined the basketball team and began participating in other wheelchair sports. I joined clubs and organizations that were connected to people with disabilities. I was among my people living, and loving my new life. I felt comfortable and accepted and had a sense of belonging. We talked about anything and could share our inner-most feelings.

I learned early on, while working at the Great Lakes Center for Independent Living, the importance of identifying and associating with peers with disabilities. Consumers who came in for services saw that 95% of the employees were people with disabilities themselves. They could see people with physical, visual and hidden disabilities. They felt connected and gained a sense of identity, motivation and inspiration.

Along the way, I also joined ADAPT - a national, grass-roots community that organizes disability rights activists to engage in nonviolent direct action, including civil disobedience, to assure the civil and human right of people with disabilities to live in freedom. I attended conferences and “actions” where over 500 people with disabilities came together to talk and make their voices heard. There were people with cognitive and physical disabilities, hearing and vision impairments, and even some with hidden disabilities. Some were ambulatory while others used canes, manual wheel chairs, or power wheelchairs. In spite of the differences that others might have perceived, we felt like one big, happy family. Each person was respected, celebrated, and appreciated for who they were. We all felt empowered.

What I’ve learned is that it is very important for the newly injured person to recognize, relate, and connect to people with disabilities and the disability community and culture. Identifying with someone who has a disability can help them make the adjustment to their new way of life. This association can provide valuable information and resources that will help them on their journey to independence. The relationships and connection that we share make us a stronger and better community. Even though we are different, there is a common theme that brings us together.

Things certainly have changed for the better since I was injured. Not only have there been new medical and technological advances, but peer mentorship and support is usually available someplace within your home or extended community. As a result, people with SCI and other disabilities are more visible than ever. We are employers as well as employees, athletes, husbands, wives, mothers and fathers. On any given day, you may see us out and about, enjoying a movie, shopping, enjoying dinner or just socializing with friends.

I am the person whom I am today in part because of my association with our disability community and because of 36 years of interacting with and being a part of the disability culture. I am empowered and have the power of one, but when I connect to my brothers and sisters we become united in strength and deeds. So a shout out to all - don’t dis our ability!
Drew Clayborn, a very active 15 year old sophomore at Walled Lake (Michigan) Central High School, was on the football and basketball teams and played tuba in the marching band. But on March 26, 2010, while with friends in a school hallway, he tried to show them the back flip he would be doing in the school’s spring musical. He unfortunately landed on his head and suffered a devastating C-1, complete, spinal cord injury.

A helicopter ride took him to the University of Michigan hospital, where he resided for the next three months while receiving initial rehabilitation therapy. Continuing rehab has been at the Novi extension facility of the Detroit Medical Center (DMC).

When he returned home, Drew, a very well-liked person in the community, benefited from an outpouring of inquiries regarding his status and offers to help. To keep the community informed, Drew’s father, LeDon set up a website, www.theDrewCrew.org. The site recounts what happened, provides Drew’s current and continuing status, reveals what is planned as well as what is hoped for in the future and organizes community involvement.

The many special needs of an individual with high-level tetraplegia are complicated, involving a lot of sophisticated equipment and many people— and it must all be well coordinated. Fortunately, Drew’s father is a master organizer/doer. And also fortunately, people from the family’s church, the Orchard Grove Community Church, as well as the area community have come forth in various ways, either in direct help or by substantially supporting fundraisers that help with the major expenses involved. On the DrewCrew website a section recognizing Supporters, gives a listing of over 50 individuals and area businesses/organizations that have helped.

Amongst the major costs were: a fully equipped van, a motorized wheelchair with controls that Drew could use via the “sip & puff” method (he has no use of his hands), a mechanical ventilator, with automatic back-up systems (Drew cannot breathe on his own, so reliability is essential), a ceiling hung lift to go from his bed area to the bathroom, and a great deal of complicated electronics and a lot of medical care. Professional nursing help is needed most of the time, which the family’s insurance doesn’t cover, leaving them to pick up these costs or supply the help themselves.

Having family members personally providing care for Drew has been/is an essential element. His father, besides being the principal organizer, is also the trainer of others and the fall-back provider when someone else must cancel their shift (e.g., to be with Drew during the night). Drew’s mother, Carolyn, who has lived in Illinois since the divorce with LeDon, provides the time and support that she can to help Drew, but has unfortunately been unable to permanently move back to Michigan due to finances. Drew’s sister, Desirae, has become a dedicated care giver, performing important personal care that must regularly be done. And Drew’s step-mother, Tracie, lovingly helps with Drew’s care.

All the people attending Drew are not there merely to keep him alive; they are also on a mission to help him become an active and productive person in our society. Their vision even includes Drew eventually walking again. They know this would be a long road, and that it may not be accomplished. But, amazing developments have happened in the past, and may again in the future — so, they don’t want to neglect something now that may be needed for participation in such a great development later.

Thus, every day, Drew’s family and attendants put him in his “Wearable Therapy,” a development of Axio Bionics. It consists of special cloth pants that are wrapped around his lower torso and legs, and which place electrodes against his skin to stimulate muscle activity. When used on a twice daily basis, the family feels these garments prevent muscle “disuse atrophy” and can even rebuild muscle bulk/strength that had previously been lost. Drew reported that, by measurement, his thighs regained four inches in circumference from when they started this therapy. Drew also noted that he can “feel”/sense when the stimulating electrodes are “on.” Electrode containing garments for his arms have now also been acquired for stimulation of those muscles too.

By: Eric A. Appleberry, DDS, MS

Drew Clayborn & Family: Perseverance after C-1 SCI Injury

And not to be forgotten is the positive mental attitude of Drew (and his father). It helps Drew’s healing and encourages that love and support of family and community which round out the values of living.
Bone strength will also be needed for that hoped for ability to walk again. Stimulation of the muscles, which connect one bone to another, puts compression forces on the bones, which helps to maintain them. Drew is also regularly put into a “standing frame” which gives a weight bearing stimulus to his bones.

Another essential element for Drew’s future is an education and training in a profession that he will enjoy and is good at, one in which he can feel he is being of use in the world—and one that will allow him to financially support himself.

This though is not something based just on hope. Drew says he has been a “math and computer type” guy since he was very young. In combination with the explosion in electronics and touch screen technology (he’s adept with a mouth-stick), he will do well in computer programming, a field that needs talented people.

Drew (who finished high school this past spring) is now enrolled at the University of Michigan in their “Informatics” program, where his skills will be appreciated. He will still be living at home, having arranged to have all his classes in just three days of the week. However, he has been assigned a dorm room, which he will use for between class breaks. In addition, one of his nurse attendants will be with him at all times.

A spinal cord injury such as Drew had is about as bad as it gets. That he is alive at all is testament to the scientific discovery, research, technology and skills development done by many scientists, physicians and therapists over time. Practically speaking though, the actual delivery of all this is not possible without a whole host of support personnel in our complex health system.

A spinal cord injury such as Drew had is about as bad as it gets. That he is alive at all is testament to the scientific discovery, research, technology and skills development done by many scientists, physicians and therapists over time. Practically speaking though, the actual delivery of all this is not possible without a whole host of support personnel in our complex health system.

Drew and his father, LeDon, thank a business for sponsoring a recent fund-raising event from the 911 call operator to the assistant who (with pleasant greetings) empties one’s urine drain bag. They are all important.

Possibly more important, though, is the positive mental attitude of Drew (and his father). It helps Drew’s healing and encourages that love and support of family and community which round out the values of living.

It’s all connected and it’s all important. It’s all connected and it’s all important.

The Power of Peer Mentor
Continued from page 5

Ann Arbor CIL staff and volunteer peer mentors who have SCIs meet new patients from the University of Michigan and other health systems and forge friendships with them just like I had experienced. We offer valuable information on communication, health and wellness, sexuality, employment, sports and recreation, travel, and benefits; but the most important resource is the emotional support. We remember the catastrophic grief and anger associated with this life-altering event. We can actually say, “I know some of what you are going through.” We never want to tell someone, “I know how you feel,” because we really don’t; everyone processes their emotions differently.

While the treatment team of doctors, nurses and therapists are critically important, when someone rolls into a room and the patient sees a healthy person using a wheelchair who is happy, healthy, working, has a family and has had a successful rehabilitation, the “patient” immediately makes a connection. They are like human sponges, absorbing every bit of information that the mentor has to share. This shows them promise and offers hope.

Everyone has an opportunity to make a difference in someone’s life by acting as a peer mentor to someone that is in need of a role model, teacher, coach and friend. By sharing our experiences, both successes and failures, we are opening ourselves up for a very honest and meaningful relationship. The power of a peer mentor and their mentee can be transformative. It can make a difference between being depressed and not progressing past the initial stages of grief and anger to moving forward and exploring new opportunities and hopefully becoming a positive role model for those that will follow.

For more information on Peer Mentoring or obtaining this article in alternative formats, please contact Tom Hoatlin at the Ann Arbor CIL at tom@aacil.org or 734-971-0277 ext. 18.

Information in this article is based on: Effective Peer Mentoring, Christopher & Dana Reeve Foundation’s Peer & Family Support Program
Planned Spontaneity

By: Michelle A. Meade, Ph.D.

Spon-ta-ne-i-ty [spon-tuh-nee-i-tee, -ney-] Noun
(1) the quality or state of being spontaneous;
(2) voluntary or undetermined action or movement.
(Miriam-Webster Online Dictionary)

One of the more frequent complaints of folks who have been living with Spinal Cord Injury (SCI) for a while is not that they can’t do anything. Most individuals with SCI and other disabilities learn that while there are some limitations, there are many things that they CAN do with enough time and creativity. However, needing to be creative and problem-solve all the time gets tiring and people begin to lament the lack of spontaneity.

Spontaneity is the ability to do things when you want to do them – whether it is to go on a date or enjoy a beautiful fall day, or grab a cup of coffee after class. As we get older, our sense of spontaneity is often limited by increasing responsibilities. We can’t just take off and go to the lunch-time concert in town because of the responsibilities that we have as employees, parents, caregivers, or volunteers.

However, beyond those, there is something freeing about being able to say – yes, I can rearrange things and go. This concept of being able to be spontaneous is in some ways a right and in other ways a responsibility. As a right, it is about being able to access the environments and resources that are available to individuals without disabilities at a similar cost and within similar boundaries. As a responsibility, being spontaneous requires that you know how your actions may impact both yourself and others, and then make an informed choice to prevent, limit or deal with potential negative consequences.

Of course, the whole point of being able to be spontaneous is being able to enjoy and appreciate the opportunities that present themselves at that moment. Notice the key words here are enjoy and appreciate. These things are difficult to do if you wind up stuck with a flat tire on your wheelchair or, left outside of a concert hall that is inaccessible.

So – whatever rights may be recognized and enforced – the reality is that you are the one who needs to be prepared and able to handle whatever comes at you – and to do so in a way that will still allow you to enjoy and appreciate the moment.

It is for this reason that the concept of planned spontaneity has become increasingly common. Planned spontaneity involves being armed with the knowledge, skills, systems and equipment to be able to handle whatever comes up and being able to make – or change – plans with little forewarning.

Knowledge

As the saying goes, Knowledge is Power. The more you know about yourself, your rights, available resources, or the situation that you may find yourself in, the better prepared you will be to make informed choices and to deal with whatever occurs.

• Know thyself: Be knowledgeable about exactly what it takes to stay healthy and get the needed care done. Know the primary goals of managing your health as well as several possible ways to accomplish them. For example - you need to avoid overstretching your bladder? If you are going to be able to cath or empty it, drink as normal. If it may be half a day before you get to a place or situation where you can cath, consider adjusting your fluid intake accordingly.

• Be aware of supports and resources that may be available to you. There are many organizations and programs out there that can provide you with access to information or resources. Check with your local Center for Independent Living to see if they have a list or guide of what may be available in your area. If they don’t have anything specific, connect with others with disabilities in your area – they are generally a wealth of information. If you don’t have car, get to know bus routes, or at least where to find that information. Know the rules of Para transit and get registered and approved by their system.

• Become familiar with technology that can help you find information. Whether websites, apps, or blogs, information about places and services is increasingly available for individuals with physical
disabilities. For example, I recently saw an app to help locate accessible bathrooms in the local area. Other apps and technology can help you schedule your bowel program, remind you to take medication, get to a location using public transportation, or allow you to get feedback and advice from others living with SCI. While not all information provided online is accurate, it is often a place to start.

Skills
If you want to be able to be spontaneous, you really need to be able to problem-solve. Those with SCI and other disabilities regularly encounter situations and environments that present a multitude of challenges and potential barriers. Problem-solving is about figuring ways to handle new situations or to handle familiar situations (particularly those you want to get a new outcome with) in new ways. Basic steps include identifying and detailing a problem, brainstorming possible solutions, evaluating the pros and cons of each solution, picking the one that works best for you, and finally determining how well that solution did. If you’re not happy with the outcome, consider repeating the previous steps, adding in the information and results that you just learned.

Communication and organization can be seen as two specialized forms for problem-solving that are particularly useful to practice. When communicating strategically, you are trying to figure out how to use this interaction with someone else to accomplish your objective. Do need help in getting a prescription filled when you are out of state? Consider who may be able to help you and what the best approach will be to ask.

Organization, on the other hand, is the skill that allows you to use your time and other resources most efficiently. You can organize your environment, your schedule, your insurance paperwork or your CD collection. To allow more spontaneity in your life, organize so that you are able to locate what you need in a hurry and be able to go.

Equipment and Supplies
Having equipment and supplies that you can pack up and bring with you definitely makes it easier to be spontaneous. A van or car of your own is particularly useful, as it not only provides a flexible form of transportation, but also allows you to store the supplies (and spares) that you will need for this (and future) adventures. Increasingly, I’ve heard of folks carrying around portable ramps in their vans, so they can get into friends’ houses or other otherwise inaccessible locations.

Beyond that, though, it makes sense to have a “go bag” packed with supplies and equipment that you would use in a single day – possibly including 1 or 2 days’ worth of medication, catheters, baby wipes / sanitizers, and a change of clothes. Whether you want to take advantage of a last minute invitation to attend an event or need to respond to an emergency, having supplies and equipment available and in good condition will make all the difference.

Systems
Develop systems that are transportable. This concept was recently articulated for me by a world-traveler with paraplegia. When asked about the key things that allow him to be spontaneous and to travel the world, he mentioned the importance of having systems for managing his health that he could bring from Indiana to India. These ranged from basics for washing up (i.e., bucket showers) to ways of cleaning catheters.

Attitude and Expectations
As an individual with a disability, you have the right to expect accessibility in the built environment. However, the unfortunate reality is that it may or may not be there. It makes for a more enjoyable day if you know what to expect and are able to roll with that. When you are trying to be spontaneous and enjoy the day, I would suggest that this is NOT the time to do heavy-duty education and advocacy. Instead, change plans to find some place that is more accessible or work with what you have. You can always go back later to educate and advocate.

A word about responsibility, you are still responsible for the commitments that you make. If someone is expecting to meet you or to assist you, it is only responsible – and respectful – to let them know about any change of plans. To the extent that your plans change, also involves a change in their plans – such as with as with caregivers – it is important to pre-plan for how you will handle that situation. If you require other people’s assistance – whether paid or unpaid – you are required to deal with their perceptions of what their responsibilities and limitations are. Are they able to flex their hours to extend a shift or provide additional assistance?

Finally – about attitude. Once again, go back to the enjoy and appreciate rule. In that moment, give up the “but they should have’s” and the “but they are supposed to’s” and figure out how to make the most of the moment and enjoy the place you are and the people you are with. Remember – that is the whole point of being spontaneous.
Making Connections and Accessing Supports through faith-based organizations

By: Daniel and Rebecca Benedict

The Ann Arbor area provides many resources for those with a spinal cord injury (SCI) to find connections and access supports. Most people are familiar with the Ann Arbor Center for Independent Living. This is a strong resource in the community, providing education, activities, and information. Other resources that may not be as familiar or well-known are those available through local churches.

In particular, the First Presbyterian Church is a stellar example of an organization that can provide numerous services and supports to you. During hospital stays, if you notify the staff that you are involved with the Presbyterian Church, they will provide their congregations and committees with information so members or representatives from the church can freely and regularly visit with you. Whether you are dealing with the initial impact of your injury, or revisiting the hospital for a secondary problem, the support and guidance provided by the church is invaluable.

The church further offers various programs designed to reach out personally to families. The first is the Helping Hands program. In this program, members of the church volunteer to assist families with whatever they may need. The simplest of tasks can easily be taken for granted within our daily lives, and can become the heaviest of burdens after an injury. From cutting the grass, to fixing a broken table leg, to supplying and helping with a nightly meal, these are the kinds of services the program focuses on providing.

A second program is the Stephen Ministry. In this ministry of listening, as the church itself describes it, a trained layperson becomes a caregiver to a care-receiver who is dealing with needs, concerns, or struggles that would be made easier with support and prayer. A Stephen Minister adheres to very clear guidelines on confidentiality. The minister will be there for his or her care receiver, meeting faithfully on a weekly basis for as long as there is need, while providing emotional and spiritual support. Stephen Ministers are proud of their rewarding work, and convey that they get as much out of the experience as those receiving the support.

These services are not solely limited to members of the church, nor are these services solely provided only by the First Presbyterian Church. A church in your community or of your own faith may provide the same services or similar resources. These programs, as well as many other organizations, are always looking for volunteers. Check within your local community to find the service that best fits you.

A spinal cord injury is a life-altering event, involving not just those injured but their families and those around them. Through the support and giving of others, the healing process can begin in an effort to rebuild and re-establish one’s life.

Welcome Dr. Nancy Merbitz!

Nancy Merbitz, PhD joined the Department of Physical Medicine and Rehabilitation here at the University of Michigan in June of this year to provide psychological services to inpatients with spinal cord injury or other spinal disorders.

“Dr. Nancy” came here from a private practice in rural Illinois where she worked with clients and their families dealing with almost every kind of issue, including health and disability but also marital, school, and work-related difficulties. Twenty years ago, she did her postdoctoral fellowship right here in this department and on the same rehabilitation inpatient unit. It was here that she learned about working in collaboration with people with disabilities - getting input and guidance from the inpatients, the staff of the Ann Arbor CIL, and Drs. Denise Tate and Ned Kirsch.

Prior to that, Dr. Merbitz had trained for two years at a Veterans hospital and outpatient clinic in California, spent two years at a medical rehabilitation unit in South Bend, IN, and graduated with her PhD from the University of Notre Dame. Activities since completing her fellowship include teaching at the University undergraduate and graduate levels, conducting research, and writing and speaking about improving the process of medical rehabilitation.

Dr. Merbitz says that she looks forward to providing supportive psychotherapy for inpatients that are in rehabilitation for spinal disorders and to working together with their team to provide the best possible rehabilitation experience.
Community Profile: Think Beyond The Chair

By: Marva L. Ways

Hello, I am Marva Ways, and I am an African-American woman with a spinal cord injury. The disability community and culture has changed much since I acquired my disability in 1976. There have been many medical advances to help improve the lives of people with disabilities. Research is investigating how to make our lives better. New technology is being created to make our lives more accessible and convenient. Legislation has been passed to make the world and the workplace more accommodating and accessible than ever.

There are also new groups to help us adapt and live successfully. Think Beyond the Chair is one of these. It is a new, non-profit organization with the vision of helping of persons with a disability achieve a life of independence and productivity as he or she sees fit. The organization was formed to allow us to MAKE CHOICES FOR OUR LIVES instead of taking chances with our life. It celebrates disability community and its culture.

Our website is located at www.thinkbeyon-dthechair.org and is easy to navigate. Some of its key features include the following:

- The ability to chat one-on-one with peers and friends or to have a conversation with the entire community about a subject or concern of your choice.
- Postings and calendars to allow you to keep up-to-date with events in the community.
- Be sure to visit the Empowerment Zone where our specialty programs - such as anti-bullying, violence prevention, and mentoring to empower - are housed.
- The Featured tab is another must-see as it shares recent stories and messages pertaining to the disability community. In particular, it this section highlights new technologies, companies and people all striving to better the disability community.

Think Beyond the Chair is a group dedicated to making a difference in peoples’ lives. The need for such an organization was highlighted for me during a recent conversation that I had. At Party in the Park, a recreational and outreach event hosted by our organization, a mother of a child with a disability was recounting the complications and frustrations that she and her family had experienced while trying to choose a wheelchair for her son. She told me how she wished she had heard about us months ago, stating that she had no idea where to start and how it would have made the whole process much easier if she had known about our organization. Our website, in particular could have provided her with a single location where she would have been able to network with other parents and get expert advice regarding wheelchairs and home modifications. It also would have provided her with the opportunity to get support from and to hear about the experiences of other community members. This example perfectly illustrates what Think Beyond the Chair is striving for - to create a place where people can get together and learn, explore, grow and promote the betterment of the disability community.

Please check out Think Beyond the Chair’s website and help us grow this site into the dream and expectation we envision for us and for you. Once again, our website can be found at www.thinkbeyondthechair.org.
Keeping up with the SCI Model Systems Team

We’ve been busy here at the SCI Model Systems. Our team members have been around the country conducting presentations, in addition to performing research and outreach in Ann Arbor and other areas of Michigan. Below are some of the details of what we have been doing since the last newsletter!

AROUND ANN ARBOR

While we tend to travel a lot to present our research at national and international conferences, it is important for us to keep connected with consumers and supporters here in Michigan.

UM-SCI Model Systems says “Thank You” to the Fraternal Order of Eagles

Throughout the years, funds and support provided by the Fraternal Order of the Eagles has allowed us at the UM SCIMS to expand and enhance the research that we conduct on and for individuals with SCI. In particular, the hard work and fund-raising efforts of their past president, Carl (Pete) Hypio, and his wife, Shirley Hypio, have allowed them to continue to support spinal cord injury research at the University of Michigan Model System. This year, funding and support from the Fraternal Order of the Eagles is being used to expand a study on aging with SCI. Most recently, Dr. Tate had the pleasure of hosting Mr. Hypio and his two sons, Craig and Brian, at the U-M versus MSU football game.

Congratulations to Dr. Chiodo

Please join us in congratulating Dr. Tony Chiodo for being selected by the Academy of Physical Medicine and Rehabilitation to deliver the next Walter J. Zeiter Lecture at the Academy’s annual meeting. It is an honor to be selected for this event, which provides the presenter an opportunity to explore and discuss major issues affecting medical rehabilitation care and policy in the United States. We here at the University of Michigan feel privledged to have Dr. Chiodo as part of our leadership team, conducting and promoting SCI clinical and research activities. Congratulations Dr. Chiodo!

Research Registry Presentation

Dr. Claire Kalpakjian, Co-investigator of the UM SCIMS and Assistant Professor in the UM Department of PM&R Investigator, and Rachel Hartwig, Registry Coordinator, were invited to speak at the “Registries for Research” workshop held September 21st, 2012. The workshop was hosted by the Registries and Cohorts Program of the Michigan Institute for Clinical and Health Research. Dr. Kalpakjian and Ms. Hartwig reached out to other Registries across the University and shared their expertise regarding the use of a registry for recruitment. The presentation provided practical strategies for successful recruitment and retention, as well as lessons learned from the recent growth in the registry.

Informative Lecture on Neurogenic Bladder Management Strategies and Options presented at the AACIL

On November 14th, Dr. Anne Pelletier Cameron, from the UM Department of Urology, and Dr. Ed Chadd, from the UM Department of PM&R provided answers to the most frequently asked questions on bladder management for persons with SCI. The presentation was held at the Ann Arbor Center for Independent Living as part of the SCI Lecture Series. Funding for this event is provided by the SCI Model Systems grant and donations from the Eagles and the Michigan PVA. If you were unable to attend this excellent presentation, keep an eye on the SCI Model Systems website – it should be posted there soon!

OUT-AND-ABOUT

As mentioned, faculty and staff from the SCI Model Systems team spend a significant amount of time on the road! Presenting at conferences is one of the most effective ways to disseminate our research to colleagues around the country and around the world!

University of Michigan Researchers present findings at International Meeting

Among the highlights of recent conferences were those presentations at the 51st Annual Scientific Meeting of the International Spinal Cord Society (ISCoS) in London, held between September 3th and 5th, 2012. UM Investigators presented the studies that they conducted in collaboration with the University of Washington in Seattle and the University of Sao Paulo, Brazil.

Dr. David Tulsky, Director of ROAR and Co-Investigator of the UM-SCIMS, delivered a keynote speech on the importance of measuring patient reported outcomes. Dr. Tulsky has extensive experience on patient-reported outcomes measures. He is the study director for two modular research studies currently being conducted by USCIMS.

Dr. Denise Tate, UMSCI Model Systems PI, discussed findings about secondary conditions, quality of life and depression for those aging with SCI. Not surprisingly, life satisfaction is associated with the presence of secondary conditions such as urinary tract infections, pain and pressure ulcers. Dr. Tate co-chairs the quality of life interest group of ISCoS.

From an international perspective, researchers at the UMSCIMS are interested in comparing outcomes of neurogenic bowel and bladder issues with their colleagues at the University Sao Paulo Hospitals, Brazil. As a first step, researchers from both sites collaborated in translating the international datasets for neurogenic bowel into Portuguese. Results of a brief validation study were then presented at ISCoS. This project is part of the University of Michigan Global Reach initiative which links UM to USP. Dr. Julia Greve leads this effort in Brazil.
U-M SCIMS Researchers Present at the American Congress of Rehabilitation Medicine (ACRM) Meeting

The 2012 ACRM annual conference was held in Vancouver, Canada, from October 9th to the 13th. ACRM Every year, ACRM presents cutting edge research on topics involving spinal cord injury, brain injury, stroke and neurorehabilitation. This meeting offered a nice opportunity for U-M SCIMS investigators to present their research.

Dr. Tate presented results from the study on depression conducted during the past grant cycle. The study, developed to honor the life of Ms. Julie Harrison, a former colleague and research assistant at the UM SCIMS office who battled depression, examined the effectiveness of venlafaxine XR, a serotonin-norepinephrine re-uptake inhibitor- SNRI antidepressant, to reduce symptoms of depression and pain following SCI among people with mild to moderate symptoms. The presentation described the study, characteristics of participants, and changes over time. Results showed that both the treatment and placebo-control groups experienced a decrease in depressive symptoms over time. It is thought that this lack of differences between the intervention and the control group might be explained by a large placebo effect, but this is currently being explored.

Dr. Kalpakjian also presented at ACRM with Dr. Tulsky and Dr. Stephanie Kolakowsky-Hayner from Santa Clara Valley Medical Center. The presentation, entitled Validation of New Measures of PatientReported Outcomes for Rehabilitation Medicine, explained how new outcome measures show potential to enhance research and practice in rehabilitation medicine. A new way of assessing patient reported health and quality of life was developed. Several related projects which all used similar methodologies and pursued similar goals of assessing patient reported health and quality of life have been conducted, targeted to individuals with spinal cord injury (SCI), traumatic brain injury (TBI), and other neurologic diseases or impairments (e.g., stroke, epilepsy, multiple sclerosis).

The measurement systems were developed through multisite projects utilizing advanced qualitative and quantitative research methods, involving over 1400 individuals with SCI and TBI. Participants completed the newly developed instruments along with several criterion measures. Efforts have been undertaken to equate several measures of depression and anxiety with the traditional instruments. All of these efforts mark the first steps toward marshaling evidence of construct validity to support the use of these scales in rehabilitation research and clinical practice.

Mr. Martin Forchheimer, M.P.P., U-M SCIMS Co-investigator and Senior Research Associate, presented a poster at the ACRM conference entitled Spiritual Well-Being After Spinal Cord Injury: Opportunities for Treatment. The analyses presented came from data from the NIDRR-funded multi-center PRISMS study, led by the University of Washington. Marty conducted this work with Dr. Catherine Wilson, a psychologist at the Rehabilitation Institute of Chicago and the VA Hospital in Tampa, FL. They found that spirituality was strongly associated with quality of life, mood, and lower levels of depression. This was true when spirituality was assessed in terms of sense of meaning and peace, as well as faith. They concluded that clinicians can profitably discuss spiritual beliefs in assisting patients with SCI with adjustment issues and that this does not require a religious focus.

U-M SCIMS Researchers Present at the Academy of Spinal Cord Injury Professionals (ASCIP) Meeting

The 2012 ASCIP annual conference was held from September 3rd to the 5th in Las Vegas, NV. This meeting brings together SCI clinicians and researchers from across many disciplines to present findings from their work that have implications for clinical practice.

The 2012 ASCIP annual conference took place in Las Vegas, Nevada from September 3rd to the 5th, bringing together SCI clinicians and researchers from across many disciplines in order to present research and discuss implications for clinical practice.

Mr. Forchheimer presented some results from a SCI Model Systems multi-center collaborative study called the Project to Improve Symptoms and Mood after SCI (aka PRISMS), which was led by the University of Washington. His talk was entitled, Comorbidities & Secondary Health Conditions: Their Prevalence and Associations with Levels of Depression among Depressed Persons with SCI. He began by defining the terms comorbidities and secondary health conditions, which are not used consistently. Comorbidities are significant health conditions not related to SCI but which may be more prevalent in this population and that may occur earlier in life. Secondary health conditions are conditions that occur in the general population but are directly associated with SCI and occur with higher frequency. He then reported that, contrary to expectations, levels of depression were not associated with either extent of comorbidities or number of secondary health conditions. In addition, it had been expected that both comorbidities and secondary health conditions would be associated with two aspects of aging: age and time since injury (TSI); however, while comorbidities were associated with age, they were not associated with TSI. Conversely, secondary health conditions were associated with TSI but not with age. Since all study subjects expressed interest in participating in a clinical trial to address depression, the findings about the relationship of depression to health may not hold in the SCI population at large.

Dr. Michelle Meade, Co-investigator and Director of Dissemination for the UM SCI Model Systems, presented the symposium Proactive What??!! Concepts and Controversies in Quality of Life after SCI/D in Legal, Health Care and Community Settings in collaboration with Drs. Perkel, Goldberg and Budd. This panel presentation discussed various issues associated with the assessment quality of life for individuals with SCI and how this information is considered and applied in various settings.

In addition, she presented on the serious game that she is developing with funding from the National Institute of Disability and Rehabilitation Research. Her presentation, Psychological and Behavioral Considerations in the Development of a Health Game to Promote Self-Management Skills Among Adolescents and Young Adult Males with Spinal Cord Injury (SCI), generated significant interest among clinicians from various settings who were interested in finding out when this application would be available for their patients.
The University of Michigan Spinal Cord Injury Model System publishes SCI Access. This newsletter is designed to provide information on research, treatment, and social issues related to rehabilitative care, spinal cord injury and disability. Established in 1985, the University of Michigan Spinal Cord Injury Model System is supported by grant #H133N110002 from the National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services, U.S. Department of Education, Washington, DC

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Best wishes for a Happy and Healthy Holiday Season!
From the University of Michigan SCI Model Systems team

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