CILT'S Volunteer Vibes

Volume 8, Issue 3
December 2006

Anne Brown….Whatever Will We Do Without Her?

By Nancy Barry

This article is one of the most difficult that I have ever had to write because it has taken me some time to find the words to convey how much Anne has meant to all of us at the Centre, and to me as a friend. One of our dearest and most cherished volunteers, Anne Brown, passed away on September 12, 2006 at Sunnybrook Hospital. She was 91 years old and up until a month before, came in every Thursday, for the past nine years to help us out in our resource library.

I have been working at the Centre for Independent Living in Toronto for about nine and a half years, originally hired as the Peer Support Coordinator. Shortly after that, I was asked to start up a formal Volunteer Program for the Centre. Anne was my first recruit, and she made my job enormously easy.

Over the years we became very good friends, sharing memories and stories about the past. At times, I found myself talking to Anne about things that I was unable to talk about with anyone else.

CILT will not be the same without Anne's smile, warmth and true dedication. Winter cold, snow, sleet or rain, Anne rarely missed a day at the salt mines. Every Thursday afternoon, without fail, Anne would come in ready to dive in to her work. She was the walking definition of the words "volunteer", and "friend", a woman who took pride in everything that she did.

Aside from her contribution to CILT, Anne also volunteered for many other groups and organizations. She read to children, she spoke at librarians' conferences and shared her experiences and her wisdom with many. I will always remember Anne as an independent woman who was never afraid to speak her mind. If there was a book missing from the library, she would make a special visit to every staff member's office until she found it and placed it back in its rightful place.

At our last annual Volunteer Appreciation event, I had the privilege of presenting Anne with the City of Toronto's "Volunteer of the Year" Award, signed by Mayor David Miller, and I am so grateful that I was able to do that. I can think of no one else more deserving of that award than Anne. She will be missed beyond our imaginations, but will live on in our hearts forever.

Flu Myths

There are many reasons why some people are unlikely to get the flu vaccination. Some people are allergic to eggs and really shouldn't get a flu shot. Others admit they're afraid of needles and don't like getting shots of any kind. Still others claim that they had intended to get a flu shot but couldn't find the time to do so.

Outside of an allergy to eggs, there is no good reason to avoid getting a flu shot – especially when it can help you avoid a serious and potentially life-threatening illness. Complications from the flu can be very serious and the flu shot dramatically reduces the risk of contracting this disease. Through the Universal Influenza Immunization Program, Ontario's health ministry makes flu shots available to all Ontarians free of charge.

Let's dispel some common myths about getting a flu shot:

Myth #1:
I didn't get a flu shot last year and I didn't get sick. Obviously I don't need the flu vaccination.

Fact:
Every flu season brings a new and different strain of the disease. While some flu seasons turn out to be "lighter" than others, no one can predict when a really bad flu season will occur.

Myth #2:
I'm young and healthy. I don't need a flu shot.

Fact:
Influenza is much worse than a cold. Even healthy young adults can become seriously ill. On average, people who become sick from the flu are bed-ridden for up to five days, causing them to lose time from work or vacation.

Besides, if you develop the flu, there's a chance you might infect others who are at much higher risk than you: young children, elderly people, or someone with a medical condition who could end up with serious complications from the flu and end up in the hospital.

Myth #3:
Getting a flu shot will give me the flu.

Fact:
This is simply not true. The vaccine does not contain any live virus so you cannot get the flu from the vaccine. Many people confuse the flu with a cold or other

respiratory infections. The vaccine will not protect you against these.

Myth #4:
The flu is just a bad cold.

Fact:
A cold is not the flu. The flu is much worse. The flu is caused by the influenza virus. A cold is caused by several different viruses.

Myth #5:
Flu shots aren't worth getting because they're not very effective anyway.

Fact:
A flu shot is about 70% to 90% effective in preventing illness in healthy adults. In children, it's about 62% to 73% effective in preventing illness with fever. Among the elderly, the vaccine can prevent pneumonia and hospitalization in about six out of ten people. Protection from the vaccine develops about one to two weeks after the shot, and may last for up to one year. Vaccine effectiveness varies from one person to another, depending on their general state of health. Some individuals who get a flu shot can still get the flu. But if they do, it is usually a milder case than it would have been without the flu shot.

Myth #6:
I don't need another shot. I've already been vaccinated.

Fact:
A flu shot is needed every year. There are many different strains of the flu virus with slightly different characteristics. The strains change yearly and each year a new vaccine is produced that provides protection against the three most common strains predicted for the coming season. Protect yourself and the people around you by getting a free flu shot. And this year, it's never been easier. See your doctor or pharmacist, or call to find a clinic near you.

Managing Workplace Conflict © *Malaspina College, www.mala.ca*

Disagreement and conflict is normal in any workplace. As diverse human beings with different roles, goals and personal perspectives we will necessarily have differences of opinion. The goal is to resolve these differences is positive ways – in ways that:

- respect the other person,
- consider multiple perspectives and possibilities, and
- value the legitimate needs of everyone involved.

Such a process can result in solutions or decisions that are creative and innovative. Decision-making and problem-solving is enhanced when differences are used to generate and expand the possible avenues for action.

When instead disagreements worsen and become unmanaged conflict there are often negative results for an employee. People may feel threatened – this feeling of threat can be physical but is often emotional, such as a threat to goals, status, job security, values or preferred outcome. Ineffectively managed conflict can impact the parties in many ways, such as:

- loss of sleep,
- anxiety,
- lowered morale
- decreased job satisfaction.

It can, on occasion, also take on a life of its own, drawing in other people or departments. If the conflict grows - people, departments and the institution - all pay the price of deteriorating work performance. In very extreme circumstances it can lead to workplace violence.

It is important for conflict to be addressed in productive ways. Conflict that is well managed can produce positive effects in working relationships and eliminate the negative effects of escalated conflict.

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Tips for Managing Workplace Conflict:

What should I do if I'm concerned about the working relationship with a co-worker?

People often respond with whatever behaviour they have used in the past in conflict situations, such as:

- arguing, with loud voices and aggressive body language,
- avoiding contact with the other person as much as possible,
- excusing the conflict as resulting from the other person being under stress, or as an isolated incident that will not be repeated,
- not wanting to "make a big deal out of it" and pretending that it never happened.

These responses can set the stage for this colleague's future actions to be viewed in a negative light – e.g. "there s/he goes again".

When the issue is important to you or the working relationship is important to you, it is recommended that you talk about the problem with the other person as quickly as possible. This practice is not "making a big deal" of the issue but effective conflict management.

Talking to the other person is respectful, as it:

- gives the other person a chance to explain themselves, or
- gives the other person a chance to apologize,
- gives both of you an opportunity to better understand each other's views on the working relationship, and
- allows you to negotiate ways of working together that work for both of you.

What if the conflict is with my supervisor?

When the conflict is with a supervisor there is a power differential that may influence how a conflict can be approached. If you are in a subordinate position within the institutional structure you may fear retribution or mistreatment if the discussion does not go well. If issues cannot be resolved through direct and open discussion then it is recommended that you request assistance from a supervisor at a higher administrative level within your faculty, the Human Resources Office, the Human Rights Office or your union (where applicable).

You may be able to reduce conflict by making sure that you communicate effectively with him or her about your work. Make sure that you keep your supervisor informed about your work activities and any issues that may arise. In addition, you should feel free to make sure you understand the expectations of your supervisor. Ask if things do not seem clear, and review expectations to make sure both you and your supervisor are in agreement.

What if I lack confidence in my ability to approach the other person directly?

Approaching a person sincerely, with a real willingness to hear what the problems are from their perspective, are the key ingredients. If you can do that – you can begin to address the situation yourself. While your first attempts may feel awkward and difficult, with practice, like with any new skill, you will gain confidence and expertise.

Coaching from others can also be helpful. Coaching can be requested from a number of resources:

- the Employee and Family Assistance Program,

- the Human Rights Advisor,
- a supervisor,
- a trusted friend or colleague who you think handles conflict well.

A proactive approach would be to enroll in a basic conflict resolution course before the need arises as part of your professional development plan.

When necessary, a meeting with a co-worker and a neutral third person to assist can be requested. A neutral, third party can assist both of you in having a productive discussion. A supervisor, a colleague or co-worker that you both trust, a union steward (when you are both members of the same union), a Human Resources Assistant or the Human Rights Advisor may be able to serve as a neutral third party to assist in the resolution of the concern.

What if the direct approach is unsuccessful or the situation is already escalated?

As out-of-control conflict has a negative impact on individuals and on the workplace it is important to ask for assistance. Assistance from a supervisor, department chair or dean may be appropriate as well as a union steward. The Human Rights Advisor will also work with employees and supervisors to resolve workplace disputes. In very serious situations a conflict resolution specialist external to the institution can be brought in to assist in restoring working relationships. Consult the Institutional Resources section for more information.

What if the conflict leads to angry, threatening behaviour?

Yelling, name-calling or threatening outbursts should not be tolerated in any workplace. If a co-worker displays this kind of behaviour a report to a supervisor and to the Environmental Health and Safety Office should be made immediately so that a quick response can occur. While we encourage employees to address workplace conflict on their own whenever possible, the behaviours described above are symptoms of conflict that has become dangerously escalated and that require direct intervention.

Stay tuned for the continuation of this educational series of "Conflict Management in the Workplace" in the next issue of Volunteer Vibes.

Disability Awareness Corner – Charcot-Marie-Tooth ©

www.charcotmarietooth.com

An Overview of Charcot-Marie-Tooth Disorders

Charcot-Marie-Tooth, or CMT, is the most commonly inherited neurological disorder, affecting approximately 150,000 Americans. CMT is found world-wide in

all races and ethnic groups. It was discovered in 1886 by three physicians, Jean-Martin-Charcot, Pierre Marie, and Howard Henry Tooth.

CMT patients slowly lose normal use of their feet/legs and hands/arms as nerves to the extremities degenerate and the muscles in the extremities become weakened because of the loss of stimulation by the affected nerves. Many patients also have some loss of sensory nerve function.

CMT is one of the 40 diseases covered by the MDA, but unlike muscular dystrophy, in which the defect is in the muscles, CMT is a disorder in which the defect is in the nerves that control the muscles.

CMT usually isn't life-threatening and almost never affects brain function. It is not contagious, but it is hereditary and can be passed down from one generation to the next.

Characteristics and Symptoms of CMT

Although there are many different genetic causes of CMT, all types tend to have remarkably similar symptoms. What follows is a general description of these symptoms. Individual patients may not experience all of these symptoms, and the severity of the symptoms may vary greatly from one person to the next.

A high arched foot is usually one of the first signs of this disorder, although in some instances extremely flat feet are also typical of CMT. As the disease progresses, structural foot deformities take place. The patient may develop a pes cavus (high-arched) foot and hammer toes.

The progressive muscle wasting of CMT also leads to problems with walking, running, and balance. Ankle weakness and sprains are common, and many patients develop foot drop. To avoid tripping, patients with foot drop raise their knees unusually high, resulting in the high "steppage" gait associated with CMT. In some patients, muscle weakness may also occur in the upper legs.

Later in the course of the disease, hand function may become affected. Progressive atrophy of the thenar muscle and the small muscles in the hand results in weakening or loss of the opposable pinch, and tasks requiring manual dexterity become difficult. Patients have problems holding writing utensils, buttoning clothing, grasping zipper pulls and turning doorknobs. Many people benefit from occupational therapy which helps people accomplish the tasks of daily living with the use of assistive devices.

The loss of nerve function is often accompanied by tingling and burning sensations in the hands and feet. This usually causes little more than mild discomfort, but some people experience severe neuropathic pain and require

medication to control it.

At the same time, loss of nerve function in the extremities can also result in sensory loss. The sense of touch is diminished, as is the ability to perceive changes in temperature, and patients may unknowingly injure themselves. They can be unaware of having developed ulcers of the feet or of cuts or burns on the hands. Sensory loss in CMT patients may also be associated with dry skin and hair loss in the affected areas. In rare cases, sensory loss can lead to gradual hearing impairment and, sometimes, deafness.

Sensory loss notwithstanding, many patients are extremely sensitive to the cold or even to temperatures a few degrees lower than normal. The “stocking-glove” pattern of atrophy results in the loss of insulating muscle mass, which, combined with reduced muscular activity and circulation, can leave patients with chronically cold hands and feet. Impairment of the normal circulatory process can also result in swelling (edema) of the feet and ankles.

In many patients, deep-tendon reflexes, such as the knee jerk reaction, are lost. This does not cause any particular problem but is often noted on physical exams. Some people with CMT also have tremor (usually of the hands) and the combination of tremor and CMT is sometimes referred to as Roussy-Levy Syndrome.

Weakness of the respiratory muscles is in rare in people with CMT, but when present, it can cause life-threatening problems. If shortness of breath is an issue, a patient should be checked by a respiratory specialist to see if the use of a ventilator is recommended.

Another problem related to CMT can be scoliosis or mild curvature of the spine. This often occurs in puberty and tends to be most common in people with early onset of gait abnormalities. Hip dysplasia also affects a small number of CMT patients at an early age.

As noted, the severity of symptoms can vary greatly from patient to patient, even within the same family. A child may or may not be more severely disabled than his/her parent. Some family members may experience significant impairment and require bracing while others have no noticeable symptoms but are found to have CMT upon examination by EMG or nerve conduction studies.

Treatment and Management of CMT

Treatment of CMT is done in conjunction with medical professionals of various specialties. After diagnosis by a neurologist, CMT patients are usually directed to either a podiatrist for care of their foot problems, an orthotist for the manufactureand fitting of braces, an orthopaedic surgeon for surgeries to

straighten toes, lengthen heel cords or lower arches, or a physical therapist or occupational therapist to design exercise programs to strengthen muscles or learn energy conservation.

Although there is no cure for CMT at the present time, there are many therapies that can greatly improve life and function for CMT patients. The general advice for patients seeking assistance is to look first for the least invasive way to correct their problems.

In general, it is important for people with CMT to maintain what movement, muscle strength and flexibility they have. Hence, physical therapy and moderate activity are recommended. Overexertion, however, should be avoided. Swimming or water therapy is an excellent form of exercise since it does not put undue stress on the joints. A physical therapist can design an exercise program that fits a patient's personal strengths and flexibility. It is impossible to build up muscles already atrophied by CMT, so the best program works on strengthening unaffected muscles that can help do the work of those that have atrophied because of CMT.

Bracing is another non-invasive form of correcting problems caused by CMT. Often gait abnormalities can be corrected by the use of either articulated (hinged) or unarticulated, molded braces called AFOs (ankle-foot orthoses). These braces help control foot drop and ankle instability and often provide a better sense of balance for patients. There are many new forms of bracing available for CMT patients, depending, of course, on the severity of their foot deformities and muscle weaknesses.

Because of lack of good sensory reception in the feet, CMT patients may also need to see a podiatrist for help in trimming nails or removing calluses that develop on the pads of the feet. It is important to consult a medical professional so that the patient does not injure himself/herself doing these procedures.

The final decision a patient might make in caring for his/her foot or leg deformities is to have surgery. Many patients choose to stabilize their feet or correct progressive problems. These procedures include straightening and pinning the toes, lowering the arch, and sometimes, fusing the ankle joint to provide stability. Recovery from these surgeries can be long and sometimes difficult. Before considering surgery, a patient should always ask what the benefits may reasonably be considered to be and that must be weighed against the problems that might be incurred.

There is no magic nutritional diet to treat CMT, but it is important for CMT patients to control their weight. Not only does extra weight make physical activity more difficult, but it also increases the stress on already compromised joints and muscles.

It is also important for patients to maintain as much strength and flexibility as possible. Generally, patients should consult a physical therapist or physician before beginning an exercise program, and avoid strenuous activity and overwork. Moderate activity and physical exercise can be beneficial, but patients must be conscious of their physical limitations. Patients must learn to say no to tasks that overwhelm them and to delegate tasks to other members of their family when possible.

Finally, stress management is important in maintaining a healthy body. Any disabling condition can affect the way people think and feel about themselves, but having a chronic illness like CMT, which is often unseen, places stress on individuals and often causes depression. People with CMT can suffer from low self-esteem and relationships with others can be affected. Even when a person has learned to live with CMT, the progressive nature of the disorder may bring about more loss and the grieving process can begin again.

Some patients cope successfully on their own or with the support of family and friends; others find it therapeutic to talk to a professional counsellor or to participate in a support group.

CILT News

United Way Fundraising Campaign 2006

Every year CILT participates in the United Way of Greater Toronto's annual fundraising campaign. CILT tries its best to play a role in helping United Way fulfill its mission to attain an achievement of $100 million.

This year's campaign chair is Judy Lu, who was accompanied by her committee comprised of Nancy Barry, Leisa DeBono and John Mossa. On October 3rd, CILT raised $387.72 from our first Bake Sale. Our second Bake Sale was held on October 26th, CILT raised a total of $453.66. The staff's involvement was vital for the success of our campaign. The amount of $2082.00 contributed by our staff and countless hours of hard work go towards making CILT stand out in the crowd. In total, CILT raised $2947.88 for this year's United Way Fundraising Campaign.

Staff Changes

Please welcome Katrin Berkehake to CILT. She joins us as our Disability Accommodation/Office Support Worker.

Katrin is originally from Germany where, among other things, she worked as a supervisor/accountant in a trucking company there. She has primarily been

working as an attendant since coming to Canada. She is highly competent and a quick learner with lots of computer experience on spreadsheets, data-bases etc.

Elena Petrescu will be working with us again for a while in continuing on with the Direct Funding auditing work where Blair Humphrey left off. Several years ago, Elena was a full time staff member in the DF Program as the accountant. Please join us in welcoming back Elena.

CILT's Board of Directors
2006-2007

It is CILT's pleasure to introduce this year's newest Board members: please welcome Sheila Keogh, Treasurer, Nancy Christie and Alessia Di Virgilio; and congratulations to Ron McInnes on his new position as President of the Board.

At the same time we must bid farewell to Steve Kean, former President, Kevin Humphrey and Heather Willis and thank them all for their dedication and hard work they have contributed towards CILT's interests. We wish them both good fortune in their future endeavors.

The current members of the Board of Directors for 2006-2007 are:

Ron McInnes, President
Audrey King, Vice President
Sheila Keogh, Treasurer
Shannon Hill, Secretary
Nancy Christie
Alessia Di Virgilio
Mary Louise Dickson
Beverley Elliott
Kevin Rogers
Jane Staub
John Suchon
David Wallace

<u>Holiday Hours:</u>

CILT will be closed for the holidays from 5:00 p.m. on December 22nd, 2006 and will re-open Tuesday January 2nd, 2007.

Happy Holidays to all of our volunteers! Many good wishes for the coming New Year.