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Chapter 1 : Cardiomyopathy | National Heart, Lung, and Blood Institute (NHLBI)

Meet own needs through nutrition, fitness, hygiene, rest and relaxation, interpersonal relationships, meaningful work, spiritual practices, prevention and health promotion practices A requirement for nursing exists when a person is unable to maintain for him/herself self-care action which is therapeutic in sustaining life and health, recovering.

It can have the following impact: Not getting enough sleep prevents the body from strengthening the immune system and producing more cytokines to fight infection. This can mean a person can take longer to recover from illness as well as having an increased risk of chronic illness. Sleep deprivation can also result in an increased risk of new and advanced respiratory diseases. A lack of sleep can affect body weight. Two hormones in the body, leptin and ghrelin, control feelings of hunger and satiety, or fullness. The levels of these hormones are affected by sleep. Sleep deprivation also causes the release of insulin, which leads to increased fat storage and a higher risk of type 2 diabetes. Sleep helps the heart vessels to heal and rebuild as well as affecting processes that maintain blood pressure and sugar levels as well as inflammation control. Not sleeping enough increases the risk of cardiovascular disease. Insufficient sleep can affect hormone production, including growth hormones and testosterone in men. Causes Sleep deprivation occurs when someone does not get a healthy amount of sleep. Newborns 0 to 3 months: This intentional sleep deprivation is most likely to be seen in teenagers and young adults. Others may unintentionally not get enough sleep because of shift work, family obligations, or demanding jobs. Consistent sleep-wake patterns of going to bed late, frequent nighttime arousals, or waking up early can lead to sleep deprivation and the accumulation of sleep debt. Additional causes of sleep deprivation include medical problems such as depression, obstructive sleep apnea, hormone imbalances, and other chronic illnesses. Treatment Treatment is only required when a person physically cannot get to sleep, due to either physical or psychological difficulties. A therapist or sleep specialist will be able to offer guidance and coping techniques for reaching a restful state and sleeping. There are two main avenues of treatment for sleep deprivation: Behavioral and cognitive measures and medications. Behavioral and cognitive treatments There are a number of effective methods to enhance sleep that do not require medication, including: Progressive muscle relaxation involving tensing and untensing different muscles in the body to help calm the body. Meditation techniques, mindfulness training, breathing exercises, and guided imagery can also help in this area. Audio recordings are available that can help a person fall asleep at night. This involves controlling pre-bedtime activities and surroundings to moderate the sleeping pattern. For example, a person controlling their stimulus would spend time in bed only when they feel sleepy, which controls the association between being in bed and feeling ready to sleep. Cognitive behavioral therapy CBT: This is a type of therapy designed to help people understand and change the thought patterns behind certain behaviors. It can challenge beliefs that may not be healthy and promote rational, positive thought. CBT can help a person to develop a healthier sleeping pattern. Medications When non-medicinal treatment is not effective, drugs are available that can help induce sleep. Some are available over-the-counter OTC, and some are only available with a valid prescription. There is a wide range of available options, including benzodiazepines, non-benzodiazepine hypnotics, and melatonin receptor antagonists. However, some people form a dependency on sleeping medications. It is important to limit the dosage and try to use non-medicinal measures where possible. Home management The good news is that most of the negative effects of sleep deprivation reverse when sufficient sleep is obtained. The treatment for sleep deprivation is to satisfy the biological sleep need, prevent deprivation and "pay back" accumulated sleep debt. If you cannot get to sleep, experts recommend carrying out an activity such as reading until you feel sleepy. Some suggestions for good sleep habits include: For example, if you need 7 hours of sleep nightly to feel awake and alert and only get 5 hours, you have a sleep debt of 2 hours. If you continue that pattern for five nights, you have an accumulated sleep debt of 10 hours. The only way to erase a sleep debt is to get more sleep. Depending on the scale of the sleep debt, it may take some time to recover fully. However, the positive effects of paying this debt off will be

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felt quickly. To pay back a sleep debt, it is necessary to start getting the sleep you need, plus an additional hour or so per night, until the debt is paid. Afterwards, the required amount of sleep can be resumed without the additional hour. Even if the sleep debt is hundreds or even thousands of hours, it can still be successfully reconciled with a conscious effort to restructure obligations, and allowing sufficient time off to recover. You will know you have paid back your sleep debt when you wake up feeling refreshed, and you do not feel excessively drowsy during the day. If sleep deprivation is ongoing, and negative symptoms persist despite practicing good sleep hygiene measures, consultation with a healthcare provider is recommended.

Diagnosis It is important when diagnosing sleep deprivation to identify an ongoing cycle of poor sleep. The first step for recognizing a sleep problem is to keep a written sleep history in a sleep log. Write down each day how many hours sleep you have, how many times per night you wake up, how rested you feel after waking up, and any feelings of sleepiness you experience during the day. If you have a partner, it may be worth asking them to note any snoring, gasping, or limb-jerking, as a doctor may also ask about this. It will then be possible to present this information to any doctor you visit in a meaningful way. Sleep specialists can also identify a pattern using a polysomnogram, or sleep study. This is carried out in a sleep laboratory. Electrodes are placed at various points on the body, including the scalp and face. The person with suspected sleep deprivation will sleep overnight at a sleep clinic, and these monitors will measure breathing, blood, heart rate and rhythm, muscle activity, and brain and eye movements during sleep. Especially in those who wilfully sleep too little, diagnosis can be as simple as recognizing that you do not get enough sleep and deciding to make changes.

Complications Shift work and demanding jobs can lead to sleep deprivation over time. Sleep deprivation weakens the ability of the part of the brain that handles reasoning, known as the prefrontal cortex, to control the emotional part, the amygdala. This leads to the abnormal processing of emotions. Sleep also appears to be necessary to prepare the brain for learning. When the brain is deprived of sleep, it is difficult to concentrate and form new memories. When we stay awake all night or significantly cut sleep short, the body does not release the hormones necessary to regulate growth and appetite, and instead forms an overabundance of stress chemicals, such as norepinephrine and cortisol. Research suggests shorter sleep durations may be a predictor of weight gain in adults and children. Each 1 hour reduction in sleep time per day is associated with an increase of 0. These changes result in an increased risk for hypertension, diabetes, obesity, heart attack, and stroke in the sleep-deprived individual. Sleep loss can have a profound impact on both emotional function and normal thinking abilities in healthy individuals, resulting in: Many of these deficits remain even when alertness is sustained with stimulants such as caffeine. Finally, sleep-deprived individuals score higher on clinical scales measuring depression, anxiety, and paranoia. Increased risk of accidents After around 16 hours of staying awake, the body attempts to balance the need for sleep. If a person does not get enough sleep, the brain obtains sleep through short sleep attacks called microsleeps. This is an uncontrollable brain response that renders a person unable to process environmental stimulation and sensory information for a brief amount of time.

Prevention Sleep deprivation can be linked to serious accidents and poor job or school performances. There is no substitute for restorative sleep. A certain amount of care should be taken to prevent ongoing sleep deprivation in individuals of all ages.

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Chapter 2 : Brain Basics: Understanding Sleep | National Institute of Neurological Disorders and Stroke

Brush up on your chess strategy skill while you recover from surgery. See Practical Advice for Recovering from Back Surgery. Subscribe to Netflix, Amazon Videos, or Hulu to watch a season of a TV series that you've always wanted to see.

Received Nov 26; Accepted Dec This article has been cited by other articles in PMC. Abstract Virtual Reality VR provides a unique medium suited to the achievement of several requirements for effective rehabilitation intervention. Specifically, therapy can be provided within a functional, purposeful and motivating context. Many VR applications present opportunities for individuals to participate in experiences, which are engaging and rewarding. In addition to the value of the rehabilitation experience for the user, both therapists and users benefit from the ability to readily grade and document the therapeutic intervention using various systems. In VR, advanced technologies are used to produce simulated, interactive and multi-dimensional environments. Visual interfaces including desktop monitors and head-mounted displays HMDs , haptic interfaces, and real-time motion tracking devices are used to create environments allowing users to interact with images and virtual objects in real-time through multiple sensory modalities. Opportunities for object manipulation and body movement through virtual space provide frameworks that, in varying degrees, are perceived as comparable to similar opportunities in the real world. This paper reviews current work on motor rehabilitation using virtual environments and virtual reality and where possible, compares outcomes with those achieved in real-world applications. Introduction One of the major goals of rehabilitation is to make quantitative and qualitative improvements in daily activities in order to improve the quality of independent living. Three determinants of motor recovery are early intervention, task-oriented training, and repetition intensity [1] while a major objective of rehabilitation is to identify the means to provide repeated opportunities for tasks that involve multimodal processes different sensory modalities including vision, haptics, proprioception, audition and that further enable increases in function. Carr and Shepherd [2] focus on motor relearning where relearned movements are structured to be task specific. They suggest that the practice of specific motor skills leads to the ability to perform the task and that motor tasks should be practiced in the appropriate environments where sensory inputs modulate their performance. The functional relevance of the specific environmental context has been specifically addressed by Keshner and colleagues [3 - 5] as it relates to posture control. These authors have shown that specific postural responses differ between paradigms where isolated individual control pathways are manipulated i. The successful integration of virtual reality into multiple aspects of medicine, psychology, and rehabilitation has demonstrated the potential for the technology to present opportunities to engage in behaviors in challenging but safe, ecologically valid environments while maintaining experimental control over stimulus delivery and measurement [for review see [6 , 7]]. Moreover, in VR, the user patient, therapist interacts with a multidimensional, multisensory computer generated environment, a virtual environment, which can be explored in real time [8]. Virtual reality also offers the capacity to individualize treatment needs while providing increased standardization of assessment and training protocols. In fact, preliminary evidence [9 - 11] indicates that VR provides a unique medium where therapy can be provided within a functional, purposeful and motivating context and can be readily graded and documented. Several features distinguish virtual environments from other forms of visual imaging such as video and television. A key feature of all VR applications is interaction. Virtual environments VE are created that allow the user to interact with not only the VE but also with virtual objects within the environment. In some systems, the interaction may be achieved via a pointer operated by a mouse or joystick button. Finally, while many applications of VR allow the user to control the viewpoint on the screen, third-person views or images of the users themselves that appear as players in the environment also provide the opportunity for interaction with the VE. A broad range of visual interfaces are used to create varying degrees of immersion in a VE ranging from conventional desktop monitors to head mounted displays. Increasingly complex, fully

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immersive VR systems, such as the Cave Automatic Virtual Environment CAVE developed at the University of Illinois at Chicago, provide the illusion of immersion by projecting stereo images on the walls and floor of a room-sized cube. Several persons wearing lightweight stereo glasses can enter and walk freely inside the CAVE. A head tracking system continuously adjusts the stereo projection to the current position of the leading viewer. In order to integrate the movement of the user with that of the VE and virtual objects, user position and motion must be tracked so that virtual images can be updated in real-time. Motion tracking approaches include color subtraction technology, video frame subtraction as well as magnetic and infrared tracking devices. Technical advances in the development of these interfaces have minimized the once lengthy lag times responsible for some of the earlier reports of cybersickness. To date, rehabilitation applications have primarily used visual and auditory sensory input while the addition of haptics is less developed. Haptic interface devices including gloves, pens, joysticks and exoskeletons provide users with a sense of touch and allow the user to feel a variety of textures as well as changes in texture. There is increasing evidence that haptic information is an effective addition towards the accomplishment of certain treatment objectives such as increasing joint range of motion and force [12]. For example, Shing and colleagues [13] report a specific benefit of adding haptic information to an upper extremity movement when the difficulty of the task, in this case a 3D pick and place task, was high. Integration of visual and haptic interfaces with motion tracking allows the user to become immersed in three dimensional virtual environments, including three dimensional sound, and virtual objects that can be picked up, manipulated, and even felt with the fingers and hands [14]. Another cardinal feature of virtual reality is the provision of a sense of actual presence in, and control over, the simulated environment [15]. Early studies relied on questionnaires to characterize presence within a virtual environment [15] with more recent work suggesting that physiological measures including heart rate and galvanic skin response provide important information about user immersion [17]. Movement elicited and generated in virtual reality applications One important consideration with the application of virtual reality and movement in virtual environments is the behavior or movement characteristics of subjects in virtual environments [8]. Recent work by Feldman and colleagues [18] specifically compared movements made with or to virtual objects in a VE to movements made with or to real objects in real environments. Virtual representations of the hand were obtained by combining a fiber optic glove with a prehension force feedback device. Orientation of the hand in the VE was achieved using an electromagnetic tracker while kinematic data of the arm and trunk were recorded as the participant reached separately to real and virtual targets. Minimal movement differences in spatial and temporal kinematics of reaching in healthy adults were identified and included the amount of terminal wrist and elbow extension as well as timing of maximal grip aperture. There were no differences in movement characteristics between the real and virtual task in participants with hemiparesis. The authors suggest that VR is similar enough to reality to provide an effective training environment for rehabilitation. In contrast, we have demonstrated significant differences between functional lateral reach performances when performed in the real environment versus in a virtual environment delivered on a flatscreen [19]. Both young and old adults reached significantly further when virtual objects were presented in the VE compared to when reaches were made to real objects presented in the periphery. Lateral stability is crucial for performance of many weight-bearing tasks including turning, transferring, and stepping onto a stool while controlling a reach made as far as possible to the side requires regulation of the position of the center of mass within the limits of stability. We proposed that embedding the reaching task within a VR application may have resulted in shifting attention away from the potential for loss of balance, whereas focusing attention on balance, such as in the real-environment, may have resulted in increased fear of destabilization and underestimation of true ability. Thus, integrating the means to modulate the level of difficulty within a VR task is of crucial importance. A virtual reality system VIVID GX was used to provide independent leisure opportunities to adults with cerebral palsy and severe intellectual disabilities who were non-speaking and who used wheelchairs for mobility [15]. The participants demonstrated an exceptional degree of enthusiasm during the VR experiences reacting with appropriate, goal-oriented responses. However, a small number of participants clearly displayed involuntary

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movement synergies, increased reflexes and maladaptive postures, which were attributed to the level of task difficulty. Does the technology work? Transfer of training Central to the issue of virtual environments as a training medium is the issue of transfer of training; does task improvement or learning transfer reliably from a VE to a real environment? Virtual environments and VR interventions should not only be used to augment current ability or to provide exposure to "other" therapeutic possibilities, but importantly to demonstrate distinct carryover to real-life functional tasks. One major challenge is identifying effective and motivating intervention tools that enable transfer of the skills and abilities achieved during rehabilitation to function in the "real" world. For example, recent studies stress that simple repetitive movements of an affected limb are not productive for the reorganization process but that it is action related to skill acquisition which contribute to the desired effect [21]. Rose and colleagues studied the transfer of training of a simple sensorimotor virtual task to performance on the "real world" equivalent [22]. The real-world equivalent consisted of a curved wire suspended between two vertical supports. With the non-preferred hand, the subject held a rod with a wire loop at the end and guided the loop along the wire without touching it. Contact between loop and wire, defined as an error, produced feedback. Errors and time to complete task were recorded. The group provided with no practice did significantly worse than the two practice groups, one practicing with the virtual task and one practicing with the real task, although with no difference between the type of practice performed. In other words, within the constraints of this task, final real-world performance benefited as much from real as virtual practice. Thus, it is not sufficient simply to demonstrate that training does transfer in a given situation. It is crucial to identify whether a specific skill or a general familiarity with the training context is being transferred. If specific skills are transferred, it is important to determine whether the transferred training lasts as long and as reliably as an equivalent amount of real world training [22]. In addition, the conditions such as degree of immersiveness, overlap between real and virtual tasks, must be understood if we are to optimize or facilitate transfer.

Balance and Posture Several systems have been used in studies of balance including a combined HMD display system combined with a fixed bicycle, a flatscreen VR system providing primarily 2D visual information and more recently an immersive dynamic virtual environment combined with a posture platform. Kim et al [23] reported preliminary data from healthy adults using a bicycle linked to a virtual visual environment and suggested that this training system would be beneficial for postural balance control. They described decreases in cycling path deviation and increases in cycling velocity following a short training period and suggested that these variables, in conjunction with additional parameters, may be relevant for determining a training effect on balance rehabilitation. Several problems remain to be resolved including the limited integration of bicycle motion and auditory cues. A specific concern is that a fixed bike was used which could provide the degree of safety necessary for an individual with a significant amount of balance impairment. The systems take a video image of the user and use color subtraction software to remove a monochrome background and insert the user into a virtual environment. Proprietary software is used to allow the user to interact with virtual objects within the VE. Applications that have been used in various studies include: The applications are modifiable allowing the task difficulty to be modified by increasing the number of virtual objects to contact, increasing the speed at which the objects or environment moves, or increasing and decreasing the height of the objects requiring users to reach to the ground or to step up onto a stool. One of the earliest reports of use of the technology in rehabilitation compared therapy delivered through VR to a conventional approach in a sample of frail, older adults [25]. We have used a similar approach with a significantly larger study population of community-living individuals with traumatic brain injury [see [9 , 10 , 26] for preliminary data]. Although not all participants involved in the exercise programs improved on their balance measures, 10 out of 14 individuals in the VRE group and 4 out of 10 individuals in the ABE group had clinically significant improvements. Most recently, we have demonstrated significant improvements in balance and functional mobility in community-living older adults following a VR exercise program. The comparison group completed a biofeedback exercise program and also demonstrated significant balance improvement [24]. Although these two studies did not demonstrate significantly greater improvements in

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balance outcome with the VR exercise program relative to the comparison intervention, other benefits of VR were identified. Specifically, the participants in the VR programs indicated greater enthusiasm about the exercise programs and reported greater enjoyment and improved confidence. The implications of these psychosocial benefits for long-term exercise compliance and participation have yet to be determined. More recently, Keshner and colleagues [4] have united an immersive dynamic virtual environment projected onto a wall with a linear accelerator sled that is translated in the anterior-posterior direction. Study participants stand on the sled in front of a screen on which a virtual image is projected. Various combinations of inputs i. The results of initial experiments clearly demonstrate the non-linear effect in the postural response from single versus different combinations of inputs. These findings suggest that using this or similar complex, multimodal environments for rehabilitation intervention would promote ongoing recalculation of sensory inputs that would result in appropriate updates of posture within realistic environmental contexts. Reiss and colleagues [28] reported that a stable cue appearing about six inches in front of the toes was required to initiate the first step, while cues scrolling toward the feet, as if stable on the ground as the person moves, were needed to sustain walking. The effectiveness of the visual cue was dependent on the degree and type of akinesia with, as a general rule, more realistic cues needed as the severity of akinesia increases. The footpads in the GM2 follow the trajectory of a healthy individual when walking. The user thus experiences a corrected foot trajectory for each step. Modifications in gait patterns of two hemiplegic patients following gait training with the GM2 included moderate improvements in gait speed, improvements in leg muscle activity, increased symmetry during gait and improvement in QOL. A VR-enhanced orthopedic appliance for use with individuals with spinal cord injuries has also been developed and links a gait-inducing exoskeleton to a HMD providing binocular visual displays [30]. Briefly, the exoskeleton consists of a semi-rigid sling that supports the bust and lower limbs of the user.

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Chapter 3 : 1A by NPR on Apple Podcasts

Every individual carries an idea for life, and if your idea of life doesn't allow you to slow down for rest, relaxation and rejuvenate yourself, you happen to be the driver of a car, that doesn't have a break.

What will my day look like as a patient on rehab? You will spend a minimum of 3 hours per day for at least 5 days per week in therapy, including Saturday. Sunday is a day of rest and relaxation. Therapies may be in 30, 45, or 60 minute sessions. Rest periods will be provided at intervals during the day as needed. What about my meals? A dining room is available and patients are encouraged to eat together in a group-like setting. When are visiting hours? Patients are usually busy in therapy from early morning until late afternoon Monday through Saturday, and visiting is encouraged after the therapy day. What should I bring? We usually encourage patients to bring comfortable and casual clothes to wear during the day and pajamas for sleep. It is vital that you have shoes with no-slip soles to avoid falls. What safety measures might I expect? Alarms are used on the beds and wheelchairs as needed, to keep you or your loved one safe. Gait belts are used when ambulating. To assure your safety, all activities on the unit such as walking, showering, and bathroom use, should be performed with nursing or therapist supervision. As you improve, you and your team will decide when you no longer need supervision and can be more independent. What will my room be like? There is a central station with a call light system. Call lights are available at bedside and in bathrooms. Free WiFi is available in the facility and your room has a flat screen t. The temperature in your room can be set for your comfort. TrustPoint Hospital is a smoke free facility.

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Chapter 4 : Latest News, Diets, Workouts, Healthy Recipes | MSN Health & Fitness

The value of rest for a cancer survivor is paramount. Bonnie Annis is a breast cancer survivor, diagnosed in with stage 2b invasive ductal carcinoma with metastasis to the lymph nodes.

Where can I get more information? Introduction Sleep is an important part of your daily routine—you spend about one-third of your time doing it. Quality sleep and getting enough of it at the right times -- is essential to survival as food and water. Sleep is important to a number of brain functions, including how nerve cells neurons communicate with each other. In fact, your brain and body stay remarkably active while you sleep. Recent findings suggest that sleep plays a housekeeping role that removes toxins in your brain that build up while you are awake. Everyone needs sleep, but its biological purpose remains a mystery. Sleep affects almost every type of tissue and system in the body -- from the brain, heart, and lungs to metabolism, immune function, mood, and disease resistance. Research shows that a chronic lack of sleep, or getting poor quality sleep, increases the risk of disorders including high blood pressure, cardiovascular disease, diabetes, depression, and obesity. Sleep is a complex and dynamic process that affects how you function in ways scientists are now beginning to understand. This booklet describes how your need for sleep is regulated and what happens in the brain during sleep.

Anatomy of Sleep Several structures within the brain are involved with sleep. The hypothalamus, a peanut-sized structure deep inside the brain, contains groups of nerve cells that act as control centers affecting sleep and arousal. Within the hypothalamus is the suprachiasmatic nucleus SCN -- clusters of thousands of cells that receive information about light exposure directly from the eyes and control your behavioral rhythm. Some people with damage to the SCN sleep erratically throughout the day because they are not able to match their circadian rhythms with the light-dark cycle. The brain stem, at the base of the brain, communicates with the hypothalamus to control the transitions between wake and sleep. The brain stem includes structures called the pons, medulla, and midbrain. Sleep-promoting cells within the hypothalamus and the brain stem produce a brain chemical called GABA, which acts to reduce the activity of arousal centers in the hypothalamus and the brain stem. The thalamus acts as a relay for information from the senses to the cerebral cortex the covering of the brain that interprets and processes information from short- to long-term memory. During most stages of sleep, the thalamus becomes quiet, letting you tune out the external world. But during REM sleep, the thalamus is active, sending the cortex images, sounds, and other sensations that fill our dreams. People who have lost their sight and cannot coordinate their natural wake-sleep cycle using natural light can stabilize their sleep patterns by taking small amounts of melatonin at the same time each day. The basal forebrain, near the front and bottom of the brain, also promotes sleep and wakefulness, while part of the midbrain acts as an arousal system. Release of adenosine a chemical by-product of cellular energy consumption from cells in the basal forebrain and probably other regions supports your sleep drive. Caffeine counteracts sleepiness by blocking the actions of adenosine. The amygdala, an almond-shaped structure involved in processing emotions, becomes increasingly active during REM sleep. Each is linked to specific brain waves and neuronal activity.

Stage 1 non-REM sleep is the changeover from wakefulness to sleep. During this short period lasting several minutes of relatively light sleep, your heartbeat, breathing, and eye movements slow, and your muscles relax with occasional twitches. Your brain waves begin to slow from their daytime wakefulness patterns. Stage 2 non-REM sleep is a period of light sleep before you enter deeper sleep. Your heartbeat and breathing slow, and muscles relax even further. Your body temperature drops and eye movements stop. Brain wave activity slows but is marked by brief bursts of electrical activity. You spend more of your repeated sleep cycles in stage 2 sleep than in other sleep stages. Stage 3 non-REM sleep is the period of deep sleep that you need to feel refreshed in the morning. It occurs in longer periods during the first half of the night. Your heartbeat and breathing slow to their lowest levels during sleep. Your muscles are relaxed and it may be difficult to awaken you. Brain waves become even slower. REM sleep first occurs about 90 minutes after falling asleep. Your eyes move rapidly from side to side behind closed eyelids. Mixed

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frequency brain wave activity becomes closer to that seen in wakefulness. Your breathing becomes faster and irregular, and your heart rate and blood pressure increase to near waking levels. Your arm and leg muscles become temporarily paralyzed, which prevents you from acting out your dreams. As you age, you sleep less of your time in REM sleep. Sleep mechanisms Two internal biological mechanisms—circadian rhythm and homeostasis—work together to regulate when you are awake and sleep. Circadian rhythms direct a wide variety of functions from daily fluctuations in wakefulness to body temperature, metabolism, and the release of hormones. They control your timing of sleep and cause you to be sleepy at night and your tendency to wake in the morning without an alarm. Circadian rhythms synchronize with environmental cues light, temperature about the actual time of day, but they continue even in the absence of cues. Sleep-wake homeostasis keeps track of your need for sleep. The homeostatic sleep drive reminds the body to sleep after a certain time and regulates sleep intensity. This sleep drive gets stronger every hour you are awake and causes you to sleep longer and more deeply after a period of sleep deprivation. Factors that influence your sleep-wake needs include medical conditions, medications, stress, sleep environment, and what you eat and drink. Perhaps the greatest influence is the exposure to light. Specialized cells in the retinas of your eyes process light and tell the brain whether it is day or night and can advance or delay our sleep-wake cycle. Exposure to light can make it difficult to fall asleep and return to sleep when awakened. Night shift workers often have trouble falling asleep when they go to bed, and also have trouble staying awake at work because their natural circadian rhythm and sleep-wake cycle is disrupted. In the case of jet lag, circadian rhythms become out of sync with the time of day when people fly to a different time zone, creating a mismatch between their internal clock and the actual clock. Your need for sleep and your sleep patterns change as you age, but this varies significantly across individuals of the same age. Babies initially sleep as much as 16 to 18 hours per day, which may boost growth and development especially of the brain. School-age children and teens on average need about 9. Most adults need hours of sleep a night, but after age 60, nighttime sleep tends to be shorter, lighter, and interrupted by multiple awakenings. Elderly people are also more likely to take medications that interfere with sleep. In general, people are getting less sleep than they need due to longer work hours and the availability of round-the-clock entertainment and other activities. Many people feel they can "catch up" on missed sleep during the weekend but, depending on how sleep-deprived they are, sleeping longer on the weekends may not be adequate. You spend about 2 hours each night dreaming but may not remember most of your dreams. Events from the day often invade your thoughts during sleep, and people suffering from stress or anxiety are more likely to have frightening dreams. Dreams can be experienced in all stages of sleep but usually are most vivid in REM sleep. Some people dream in color, while others only recall dreams in black and white. The Role of Genes and Neurotransmitters Chemical signals to sleep Clusters of sleep-promoting neurons in many parts of the brain become more active as we get ready for bed. GABA is associated with sleep, muscle relaxation, and sedation. Norepinephrine and orexin also called hypocretin keep some parts of the brain active while we are awake. Other neurotransmitters that shape sleep and wakefulness include acetylcholine, histamine, adrenaline, cortisol, and serotonin. Genes and sleep Genes may play a significant role in how much sleep we need. Scientists have identified several genes involved with sleep and sleep disorders, including genes that control the excitability of neurons, and "clock" genes such as *Per*, *tim*, and *Cry* that influence our circadian rhythms and the timing of sleep. Genome-wide association studies have identified sites on various chromosomes that increase our susceptibility to sleep disorders. Also, different genes have been identified with such sleep disorders as familial advanced sleep-phase disorder, narcolepsy, and restless legs syndrome. Some of the genes expressed in the cerebral cortex and other brain areas change their level of expression between sleep and wake. Several genetic models—including the worm, fruit fly, and zebrafish—are helping scientists to identify molecular mechanisms and genetic variants involved in normal sleep and sleep disorders. Additional research will provide better understand of inherited sleep patterns and risks of circadian and sleep disorders. Sleep studies Your health care provider may recommend a polysomnogram or other test to diagnose a sleep disorder. A polysomnogram typically involves spending the night at a sleep lab or sleep center. It

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records your breathing, oxygen levels, eye and limb movements, heart rate, and brain waves throughout the night. Your sleep is also video and audio recorded. The data can help a sleep specialist determine if you are reaching and proceeding properly through the various sleep stages. Results may be used to develop a treatment plan or determine if further tests are needed. Smart technology can record sounds and movement during sleep, journal hours slept, and monitor heart beat and respiration. Using a companion app, data from some devices can be synced to a smartphone or tablet, or uploaded to a PC. Other apps and devices make white noise, produce light that stimulates melatonin production, and use gentle vibrations to help us sleep and wake. Here are a few tips to improve your sleep: Set a schedule â€” go to bed and wake up at the same time each day. Exercise 20 to 30 minutes a day but no later than a few hours before going to bed. Avoid caffeine and nicotine late in the day and alcoholic drinks before bed. Relax before bed â€” try a warm bath, reading, or another relaxing routine. See a doctor if you have a problem sleeping or if you feel unusually tired during the day. Most sleep disorders can be treated effectively. A key focus of research is to understand the risks involved with being chronically sleep deprived and the relationship between sleep and disease. People who are chronically sleep deprived are more likely to be overweight, have strokes and cardiovascular disease, infections, and certain types of cancer than those who get enough sleep.

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Chapter 5 : Motor rehabilitation using virtual reality

dizziness, tension headaches, sleep disturbance, inability to relax, or irritability; the patient is unable to recover from the symptoms by means of rest, relaxation or entertainment;.

Also known as chronic obstructive pulmonary disease; chronic bronchitis; or emphysema. COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. Cigarette smoking is the leading cause of COPD. Most people who have COPD smoke or used to smoke. However, up to 25 percent of people with COPD never smoked. Long-term exposure to other lung irritants—such as air pollution, chemical fumes, or dusts—also may contribute to COPD. A rare genetic condition called alpha-1 antitrypsin AAT deficiency can also cause the disease. Within the lungs, your bronchial tubes branch many times into thousands of smaller, thinner tubes called bronchioles. These tubes end in bunches of tiny round air sacs called alveoli. Small blood vessels called capillaries run along the walls of the air sacs. When air reaches the air sacs, oxygen passes through the air sac walls into the blood in the capillaries. At the same time, a waste product, called carbon dioxide CO₂ gas, moves from the capillaries into the air sacs. This process, called gas exchange, brings in oxygen for the body to use for vital functions and removes the CO₂. The airways and air sacs are elastic or stretchy. When you breathe in, each air sac fills up with air, like a small balloon. When you breathe out, the air sacs deflate and the air goes out. In COPD, less air flows in and out of the airways because of one or more of the following: The airways and air sacs lose their elastic quality. The walls between many of the air sacs are destroyed. The walls of the airways become thick and inflamed. The airways make more mucus than usual and can become clogged. The inset image shows a detailed cross-section of the bronchioles and alveoli. The inset image shows a detailed cross-section of the damaged bronchioles and alveolar walls. In emphysema, the walls between many of the air sacs are damaged. As a result, the air sacs lose their shape and become floppy. This damage also can destroy the walls of the air sacs, leading to fewer and larger air sacs instead of many tiny ones. If this happens, the amount of gas exchange in the lungs is reduced. In chronic bronchitis, the lining of the airways stays constantly irritated and inflamed, and this causes the lining to swell. Lots of thick mucus forms in the airways, making it hard to breathe. Most people who have COPD have both emphysema and chronic bronchitis, but the severity of each condition varies from person to person. Thus, the general term COPD is more accurate. Currently, 16 million people are diagnosed with COPD. Many more people may have the disease and not even know it. Symptoms often worsen over time and can limit your ability to do routine activities. Severe COPD may prevent you from doing even basic activities like walking, cooking, or taking care of yourself. Most of the time, COPD is diagnosed in middle-aged or older adults. The disease is not contagious, meaning it cannot be passed from person to person. COPD has no cure yet, and doctors do not know how to reverse the damage to the lungs. However, treatments and lifestyle changes can help you feel better, stay more active, and slow the progress of the disease. Causes Long-term exposure to lung irritants that damage the lungs and the airways usually is the cause of COPD. Pipe, cigar, and other types of tobacco smoke also can cause COPD, especially if the smoke is inhaled. Breathing in secondhand smoke, which is in the air from other people smoking; air pollution; or chemical fumes or dusts from the environment or workplace also can contribute to COPD. People who have this condition have low blood levels of alpha-1 antitrypsin AAT—a protein made in the liver. If you have alpha-1 antitrypsin deficiency and also smoke, COPD can worsen very quickly. Asthma is a chronic lung disease that inflames and narrows the airways. Up to 75 percent of people who have COPD smoke or used to smoke. People who have a family history of COPD are more likely to develop the disease if they smoke. Long-term exposure to other lung irritants also is a risk factor for COPD. Examples of other lung irritants include air pollution, chemical fumes and dusts from the environment or workplace, and secondhand smoke, which is smoke in the air from other people smoking. Most people who have COPD are at least 40 years old when symptoms begin. Although uncommon, people younger than 40 can have COPD. If you already have

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COPD, you can take steps to prevent complications and slow the progression of the disease. Smoking is the leading cause of COPD. If you smoke, talk with your doctor about programs and products that can help you quit. If you have trouble quitting smoking on your own, consider joining a support group. Many hospitals, workplaces, and community groups offer classes to help people quit smoking. Ask your family members and friends to support you in your efforts to quit. Also, try to avoid lung irritants that can contribute to COPD, such as air pollution, chemical fumes, dusts, and secondhand smoke, which is smoke in the air from other people smoking. Although these resources focus on heart health, they include basic information about how to quit smoking. Quitting can help prevent complications and slow the progression of the disease. You also should avoid exposure to the lung irritants mentioned above. Follow your treatments for COPD exactly as your doctor prescribes. They can help you breathe easier, stay more active, and avoid or manage severe symptoms. These vaccines can lower your chances of getting these illnesses, which are major health risks for people who have COPD. As the disease gets worse, symptoms usually become more severe. Shortness of breath, especially with physical activity Wheezing or a whistling or squeaky sound when you breathe Chest tightness If you have COPD, you also may often have colds or other respiratory infections such as the flu, or influenza. Not everyone who has the symptoms described above has COPD. Likewise, not everyone who has COPD has these symptoms. Some of the symptoms of COPD are similar to the symptoms of other diseases and conditions. Your doctor can determine if you have COPD. If your symptoms are mild, you may not notice them, or you may adjust your lifestyle to make breathing easier. For example, you may take the elevator instead of the stairs. Over time, symptoms may become severe enough to cause you to see a doctor. For example, you may become short of breath during physical exertion. The severity of your symptoms will depend on how much lung damage you have. If you keep smoking, the damage will occur faster than if you stop smoking. Severe COPD can cause other symptoms, such as swelling in your ankles, feet, or legs; weight loss; and lower muscle endurance. Some severe symptoms may require treatment in a hospital. Youâ€™or, if you are unable, family members or friendsâ€™should seek emergency care if you are experiencing the following: You are having a hard time catching your breath or talking. Your lips or fingernails turn blue or gray, a sign of a low oxygen level in your blood. People around you notice that you are not mentally alert. Your heartbeat is very fast. The recommended treatment for symptoms that are getting worse is not working.

Diagnosis Your doctor will diagnose COPD based on your signs and symptoms, your medical and family histories, and test results. Your doctor may ask whether you smoke or have had contact with lung irritants, such as secondhand smoke, air pollution, chemical fumes, or dusts. Also, let your doctor know whether you have a family history of COPD. Your doctor will examine you and use a stethoscope to listen for wheezing or other abnormal chest sounds. He or she also may recommend one or more tests to diagnose COPD.

Pulmonary Function Tests Pulmonary function tests measure how much air you can breathe in and out, how fast you can breathe air out, and how well your lungs deliver oxygen to your blood. The main test for COPD is spirometry. Other lung function tests, such as a lung diffusion capacity test, also might be used.

Spirometry During this painless test, a technician will ask you to take a deep breath in. The machine is called a spirometer. The machine measures how much air you breathe out. It also measures how fast you can blow air out. Spirometry The image shows how spirometry is done. The patient takes a deep breath and blows as hard as possible into a tube connected to a spirometer.

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Chapter 6 : Hillsborough disaster - Wikipedia

The ability to accept yourself and others, express and manage emotions, and deal with demands and challenges you meet in your life.

Your cardiomyopathy may be due to an underlying disease or condition. If you treat that condition early enough, you may be able to prevent cardiomyopathy complications. Get regular checkups with your doctor. Take all of your medicines as your doctor prescribes. Signs, Symptoms, and Complications Some people who have cardiomyopathy never have signs or symptoms. As cardiomyopathy worsens and the heart weakens, signs and symptoms of heart failure usually occur. These signs and symptoms include: Shortness of breath or trouble breathing, especially with physical exertion Fatigue tiredness Swelling in the ankles, feet, legs, abdomen, and veins in the neck Other signs and symptoms may include dizziness; light-headedness; fainting during physical activity; arrhythmias irregular heartbeats ; chest pain, especially after physical exertion or heavy meals; and heart murmurs. Heart murmurs are extra or unusual sounds heard during a heartbeat. Diagnosis Your doctor will diagnose cardiomyopathy based on your medical and family histories, a physical exam, and the results from tests and procedures. Specialists Involved Often, a cardiologist or pediatric cardiologist diagnoses and treats cardiomyopathy. A cardiologist specializes in diagnosing and treating heart diseases. A pediatric cardiologist is a cardiologist who treats children. Medical and Family Histories Your doctor will want to learn about your medical history. Your doctor also will want to know whether anyone in your family has had cardiomyopathy, heart failure , or sudden cardiac arrest. Physical Exam Your doctor will use a stethoscope to listen to your heart and lungs for sounds that may suggest cardiomyopathy. These sounds may even suggest a certain type of the disease. For example, the loudness, timing, and location of a heart murmur may suggest obstructive hypertrophic cardiomyopathy. A "crackling" sound in the lungs may be a sign of heart failure. Heart failure often develops in the later stages of cardiomyopathy. Physical signs also help your doctor diagnose cardiomyopathy. Swelling of the ankles, feet, legs, abdomen, or veins in your neck suggests fluid buildup, a sign of heart failure. Your doctor may notice signs and symptoms of cardiomyopathy during a routine exam. For example, he or she may hear a heart murmur, or you may have abnormal test results. Diagnostic Tests Your doctor may recommend one or more of the following tests to diagnose cardiomyopathy. Blood Tests During a blood test , a small amount of blood is taken from your body. The procedure usually is quick and easy, although it may cause some short-term discomfort. Blood tests give your doctor information about your heart and help rule out other conditions. Chest X Ray A chest x ray takes pictures of the organs and structures inside your chest, such as your heart, lungs, and blood vessels. This test can show whether your heart is enlarged. A chest x ray also can show whether fluid is building up in your lungs. The test shows how fast the heart is beating and its rhythm steady or irregular. An EKG also records the strength and timing of electrical signals as they pass through each part of the heart. This test is used to detect and study many heart problems, such as heart attacks , arrhythmias irregular heartbeats , and heart failure. EKG results also can suggest other disorders that affect heart function. A standard EKG only records the heartbeat for a few seconds. To diagnose heart problems that come and go, your doctor may have you wear a portable EKG monitor. The two most common types of portable EKGs are Holter and event monitors. Holter and Event Monitors Holter and event monitors are small, portable devices. For many event monitors, you push a button to start the monitor when you feel symptoms. Other event monitors start automatically when they sense abnormal heart rhythms. Echocardiography Echocardiography echo is a test that uses sound waves to create a moving picture of your heart. The picture shows how well your heart is working and its size and shape. There are several types of echo, including stress echo. This test is done as part of a stress test see below. Stress echo can show whether you have decreased blood flow to your heart, a sign of coronary heart disease. TEE provides a view of the back of the heart. For this test, a sound wave wand is put on the end of a special tube. The tube is gently passed down your throat and into your esophagus the passage leading from your

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mouth to your stomach. **Stress Test** Some heart problems are easier to diagnose when your heart is working hard and beating fast. These tests may include nuclear heart scanning , echo, and positron emission tomography PET scanning of the heart. **Diagnostic Procedures** You may have one or more medical procedures to confirm a diagnosis or to prepare for surgery if surgery is planned. During cardiac catheterization, a long, thin, flexible tube called a catheter is put into a blood vessel in your arm, groin upper thigh , or neck and threaded to your heart. This allows your doctor to study the inside of your arteries for blockages. **Coronary Angiography** This procedure often is done with cardiac catheterization. During the procedure, dye that can be seen on an x ray is injected into your coronary arteries. The dye lets your doctor study blood flow through your heart and blood vessels. Dye also may be injected into your heart chambers. This allows your doctor to study the pumping function of your heart. **Myocardial Biopsy** For this procedure, your doctor removes a piece of your heart muscle. This can be done during cardiac catheterization. The heart muscle is studied under a microscope to see whether changes in cells have occurred. These changes may suggest cardiomyopathy. Myocardial biopsy is useful for diagnosing some types of cardiomyopathy. **Genetic Testing** Some types of cardiomyopathy run in families. Thus, your doctor may suggest genetic testing to look for the disease in your parents, brothers and sisters, or other family members. Genetic testing can show how the disease runs in families. It also can find out the chances of parents passing the genes for the disease on to their children. If the test shows you have the disease, your doctor can start treatment early, when it may work best. **Treatment** People who have cardiomyopathy but no signs or symptoms may not need treatment. Sometimes, dilated cardiomyopathy that comes on suddenly may go away on its own. For other people who have cardiomyopathy, treatment is needed. Treatment depends on the type of cardiomyopathy you have, the severity of your symptoms and complications, and your age and overall health.

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Chapter 7 : Walt Disney - Wikipedia

Sunday is a day of rest and relaxation. Therapies may be in 30, 45, or 60 minute sessions. Rest periods will be provided at intervals during the day as needed.

In Marceline, Disney developed his interest in drawing when he was paid to draw the horse of a retired neighborhood doctor. Disney and his brother Roy woke up at 4: The schedule was exhausting, and Disney often received poor grades after falling asleep in class, but he continued his paper route for more than six years. After forging the date of birth on his birth certificate, he joined the Red Cross in September as an ambulance driver. He was shipped to France but arrived in November, after the armistice. There, he drew commercial illustrations for advertising, theater programs and catalogs. He also befriended fellow artist Ub Iwerks. They started their own business, the short-lived Iwerks-Disney Commercial Artists. Cauger; the following month Iwerks, who was not able to run their business alone, also joined. With the assistance of a borrowed book on animation and a camera, he began experimenting at home. Although New York was the center of the cartoon industry, he was attracted to Los Angeles because his brother Roy was convalescing from tuberculosis there. She was losing the rights to both the Out of the Inkwell and Felix the Cat cartoons, and needed a new series. In October they signed a contract for six Alice comedies , with an option for two further series of six episodes each. Mintz had also persuaded many of the artists involved to work directly for him, including Harman, Ising, Carman Maxwell and Friz Freleng. Disney also found out that Universal owned the intellectual property rights to Oswald. Mintz threatened to start his own studio and produce the series himself if Disney refused to accept the reductions. Also hired at this time were several local artists, some of whom stayed with the company as core animators; the group later became known as the Nine Old Men. In , Disney tried to trim costs from the process by urging Iwerks to abandon the practice of animating every separate cel in favor of the more efficient technique of drawing key poses and letting lower-paid assistants sketch the in-between poses. Disney asked Powers for an increase in payments for the cartoons. Powers refused and signed Iwerks to work for him; Stalling resigned shortly afterwards, thinking that without Iwerks, the Disney Studio would close. By , Disney had become dissatisfied with producing formulaic cartoon shorts, [74] and began a four-year production of a feature-length cartoon, Snow White and the Seven Dwarfs , based on the fairy tale. The glass could be moved to create the impression of a camera passing through the scene. Although Snow White had been largely finished by the time the multiplane camera had been completed, Disney ordered some scenes be re-drawn to use the new effects. The studio made a loss on both pictures and was deeply in debt by the end of February You have to relax and give them time to market their product. Roy Disney, for financial reasons, suggested more combined animation and live-action productions. With the help of his friends Ward and Betty Kimball , who already had their own backyard railroad , Disney developed blueprints and immediately set to work on creating a miniature live steam railroad for his backyard. The miniature working steam locomotive was built by Disney Studios engineer Roger E. Broggie , and Disney named it Lilly Belle after his wife; [] after three years Disney ordered it into storage due to a series of accidents involving his guests. It was popular with critics and theater audiences. From the early to mids, Disney began to devote less attention to the animation department, entrusting most of its operations to his key animators, the Nine Old Men, although he was always present at story meetings. Instead, he started concentrating on other ventures. When he visited Griffith Park in Los Angeles with his daughters, he wanted to be in a clean, unspoiled park, where both children and their parents could have fun. The connected themed areas were Adventureland , Frontierland , Fantasyland and Tomorrowland. The park also contained the narrow gauge Disneyland Railroad that linked the lands; around the outside of the park was a high berm to separate the park from the outside world. Roy believed the program added millions to the box office takings. In a March letter to shareholders, he wrote that "television can be a most powerful selling aid for us, as well as a source of revenue. It will probably be on this premise that we enter television when we do". Travers ; he had been trying to acquire the rights to

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the story since the s. He hired experts such as the renowned Olympic ski coach and ski-area designer Willy Schaeffler. In late , he announced plans to develop another theme park to be called "Disney World" now Walt Disney World , a few miles southwest of Orlando, Florida. It will be a community of tomorrow that will never be completed, but will always be introducing and testing and demonstrating new materials and systems. He did not use cigarettes with filters , and had smoked a pipe as a young man. In November , he was diagnosed with lung cancer and was treated with cobalt therapy. On November 30 he felt unwell and was taken to St. Joseph Hospital where, on December 15, ten days after his 65th birthday, he died of circulatory collapse caused by lung cancer. The university moved there in November He changed the focus of the project from a town to an attraction. Miller, opened in the Presidio of San Francisco.

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Chapter 8 : Physical Medicine & Rehabilitation FAQ | TrustPoint Rehab Hospital

In this way, the individual is learning to relax through deep breathing. Sensory Grounding & Containment This technique assists the trauma survivor in developing the capacity to "self-rescue" from the obsessive, hypnotic and numinous power of the traumatic intrusions/flashbacks.

Kick-off was scheduled for 3: Hooliganism had affected the sport for some years, and was particularly virulent in England. It emphasised the general situation at Hillsborough was satisfactory compared with most grounds. It made recommendations on the safety of crowds penned within fences, [17] including that "all exit gates should be manned at all times A crush occurred at the Leppings Lane end of the ground during the semi-final between Tottenham Hotspur and Wolverhampton Wanderers after hundreds more spectators were permitted to enter the terrace than could safely be accommodated, resulting in 38 injuries, including broken arms, legs and ribs. The safety certificate was never renewed and the stated capacity of the stadium was never changed. After the crush in , Hillsborough was not chosen to host an FA Cup semi-final for six years until A Leeds fan described disorganisation at the turnstiles and no steward or police direction inside the stadium, resulting in the crowd in one enclosure becoming so compressed he was at times unable to raise and clap his hands. Liverpool lodged a complaint before the match in One supporter wrote to the Football Association and Minister for Sport complaining, "The whole area was packed solid to the point where it was impossible to move and where I, and others around me, felt considerable concern for personal safety". Four officers resigned and seven were disciplined over the incident. Chief Superintendent Mole himself was to be transferred to the Barnsley division for "career development reasons". The transfer was to be done with immediate effect on 27 March No known minutes exist of this meeting. This left planning for the semi-final match to Duckenfield, who had never commanded a sell-out football match before, and who had "very little, if any" training or personal experience in how to do so. The approach has been described as a "bottleneck" in which attendees had to fill two sides of the stadium. Nottingham Forest supporters were allocated the South Stands and Spion Kop [a] on the east end, with a combined capacity of 29,, reached by 60 turnstiles spaced along two sides of the ground. Liverpool supporters were allocated the North and West ends Leppings Lane , holding 24, fans, reached by 23 turnstiles from a narrow concourse. Turnstiles numbered 1 to 10, 10 in all, provided access to 9, seats in the North Stand; a further 6 turnstiles numbered 11 to 16 provided access to 4, seats in the upper tier of the West Stand. Finally, 7 turnstiles lettered A to G provided access to 10, standing places in the lower tier of the West Stand. Although Liverpool had more supporters, Nottingham Forest was allocated the larger area, to avoid the approach routes of rival fans crossing. As a result of the stadium layout and segregation policy, turnstiles that would normally have been used to enter the North Stand from the east were off-limits and all Liverpool supporters had to converge on a single entrance at Leppings Lane. On match day, radio and television advised fans without tickets not to attend. The passengers arrived on the grounds about 2: Some supporters were delayed by roadworks while crossing the Pennines on the M62 motorway which resulted in minor traffic congestion. While rehearsing for the match off-air, he suggested a nearby cameraman look as well. People presenting tickets at the wrong turnstiles and those who had been refused entry could not leave because of the crowd behind them but remained as an obstruction. Fans outside could hear cheering as the teams came on the pitch ten minutes before the match started, and as the match kicked off, but could not gain entrance. A police constable radioed control requesting that the game be delayed, as it had been two years before, to ensure the safe passage of supporters into the ground. The request to delay the start of the match by 20 minutes [34] was declined. Two further gates A and B were subsequently opened to relieve pressure. After an initial rush, thousands of supporters entered the stadium "steadily at a fast walk". As the disaster unfolded, the events were relayed live to the Saturday sports show, Grandstand. When the gates were opened, thousands of fans entered a narrow tunnel leading to the rear of the terrace into two overcrowded central pens pens 3 and 4 , creating pressure at the front. Hundreds of people were pressed against one another and the fencing by the

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weight of the crowd behind them. People entering were unaware of the problems at the fence; police or stewards usually stood at the entrance to the tunnel and, when the central pens reached capacity, directed fans to the side pens, but on this occasion, for reasons not fully explained, they did not. The match between Liverpool and Nottingham Forest began as scheduled at 3: Fans were still streaming into pens 3 and 4 from the rear entrance tunnel as the match began. For some time, problems at the front of the Liverpool central goal pens went largely unnoticed except by those inside it, and by a few police at that end of the pitch. Lewis stopped the match at 3: By this time, a small gate in the fence had been forced open and some fans escaped via this route, as others continued to climb over the fencing. Other fans were pulled to safety by fans in the West Stand above the Leppings Lane terrace. The intensity of the crush broke more crush barriers on the terraces. Holes in the perimeter fencing were made by fans desperately attempting to rescue others. Meanwhile, on the pitch, police, stewards and members of the St John Ambulance service were overwhelmed. Many uninjured fans assisted the injured; several attempted CPR and others tore down advertising hoardings to use as stretchers. As events unfolded, some police officers were still deployed making a cordon three-quarters of the way down the pitch to prevent Liverpool supporters reaching the opposing supporters. Without public address announcements to explain the situation, many Nottingham Forest fans on the other end were chanting for their team and whistled their anger at what they saw as a pitch invasion, incensing some of the Liverpool supporters. Some fans tried to break through the cordon simply to ferry injured fans to waiting ambulances on the Nottingham Forest end but were forcibly turned back. This confusion migrated to the first responders waiting in ambulances at the CRP, a location which quickly deteriorated into an ambulance parking lot. As the Panel explained in their report: Some ambulance crew did take equipment when they left their vehicle, but there was no systematic direction to do so, not all did, and none initially had been given any information about the situation inside the stadium. Bush , and the chief executive of Juventus fans of Liverpool and Juventus were involved in the Heysel Stadium disaster amongst many others. Thousands of fans visited and the stadium filled with flowers, scarves and other tributes. The first reading was read by Liverpool goalkeeper Bruce Grobbelaar. The FA chief executive Graham Kelly , who had attended the match, said the FA would conduct an inquiry into what had happened. Speaking after the disaster, Kelly backed all-seater stadiums, saying "We must move fans away from the ritual of standing on terraces". His remarks led to Liverpool F. During the final match of the 1989 English Football League season, contested on 26 May between Liverpool and second-place Arsenal , the Arsenal players presented flowers to fans in different parts of Anfield in memory of those who had died in the Hillsborough disaster. It entered the UK Singles Chart at number 1 on 20 May, remaining at the top for a total of three weeks. Another survivor had spent eight years in psychiatric care. There were cases of alcoholism, drug abuse, and collapsed marriages involving people who had witnessed the events. The lingering effects of the disaster were seen as a cause, or contributory factor, in all of these. The less seriously injured survivors who did not live in the Sheffield area were advised to seek treatment for their injuries at hospitals nearer to their homes. This followed a legal challenge in the High Court by his family to have his treatment withdrawn, a landmark challenge which succeeded in November Andrew Devine, aged 22 at the time of the disaster, suffered similar injuries to Tony Bland and was also diagnosed as being in a persistent vegetative state. In March 1990 "just before the eighth anniversary of the disaster" it was reported he had emerged from the condition and was able to communicate using a touch-sensitive pad, and he had been showing signs of awareness of his surroundings for up to three years before. He is still alive as of His cousin, Steven Gerrard , then aged 8, went on to become Liverpool F. Gerrard has said the disaster inspired him to lead the team he supported as a boy and become a top professional football player. Stephen Whittle is considered by some to be the 97th victim of Hillsborough, as due to work commitments, he had sold his ticket to a friend whom he and his family chose not to identify , who then died in the disaster; the resulting feeling of survivor guilt is believed to be the main reason for his suicide in February A further 20 were from counties adjacent to Merseyside. An additional 3 victims came from Sheffield with 2 more living in counties adjacent to South Yorkshire. The remaining 14 victims lived in other parts of England. Ages Of those who died, 78

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were aged under 30, 38 of whom were under 20, and all but three of the victims were aged under

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Chapter 9 : COPD | National Heart, Lung, and Blood Institute (NHLBI)

My therapists and I work together to customize each client's massage to help them meet their personal goals whether it is pain management, rest and relaxation, or getting ready for their next Iron Man.

So, how safe do you have to be and how do you get there? Destabilization tends to be precipitated by client behaviors and thoughts in response to the bombardment of intrusive symptoms nightmares, flashbacks, psychological and physiological reactivity. Therefore, being able to manage these symptoms safely is imperative. There are no hard and fast criteria for safety, but we will discuss various techniques to help establish safety and stabilization and discuss reference points that can be useful to help you decide. Firemen who only stay in the firehouse practicing what to do in the event of a fire never gain mastery over fighting fires. Clients should develop the minimum "good enough" level of safety and stabilization and then address and resolve the intrusive symptoms by enabling a narrative of the traumatic experience. This is often counter-intuitive and usually anxiety producing for the clinician. Level One of Safety includes the resolution of environmental danger. When treating an addicted survivor, environmental danger may manifest itself in unsafe situations such as those of domestic violence, living with an active addict or self-destructive behaviors. Traumatic memories will not resolve if the client is in active danger. Active addiction IS active danger. The addicted survivor must arrest active addiction before treatment for recovery to be effective. This needs be clearly communicated to the addicted survivor and may be articulated as: This safety will require that you bring your using behavior under control i. In fact, the symptom cluster of "Arousal" is mostly about this phenomenon. It is important for the clinician to confront this distortion and help the client to distinguish, objectively, between "outside danger" and "inside danger. Inside danger, or the fear resultant from intrusive symptoms of past traumatic experiences, must be met with interventions designed to lower arousal and develop awareness and insight into the source memory of the fear. Addicted survivors of trauma are used to resolving internal danger with mood altering substances. Not feeling safe is often a precursor to impulsive behavior. As noted above, Dayton discusses the phenomenon of emotional literacy. It is not necessary that a trauma survivor be fluid in their emotional literacy in order to resolve traumatic material yet they do need to be able to distinguish when they are not feeling safe. With addicts, it may be useful to develop a few words for the feelings of discontent that predispose the individual to turning to mood altering substances and behaviors. For instance, a client may not be able to articulate feelings of powerlessness or vulnerability but they may be able to distinguish an internal cue that tells them that things are "not right. Addicted survivors of trauma are accustomed to using mood altering substances and behaviors to self-soothe. The ability to use alternative methods of self-soothing is often a turning point for the survivor as they move from engulfment by the traumatic material to feeling a sense of empowerment over it. When dealing with the traumatic material, the client must be able to identify to what extent they may explore the material before needing to retreat and return to the safety of the present. This is a scale from zero to ten that indicates what level of discomfort a client is experiencing. Traumatic material will inevitably produce discomfort, but the trauma survivor must practice leaning into the resistance without being overwhelmed. With a SUDS scale, the client can identify their own limits and when self-rescue is necessary. A SUDS rating of 10 would indicate the most discomfort a survivor could imagine feeling. This may be indicated during a flashback. A SUDS rating of 0 or 1 would indicate no discomfort. By using this scale, the client is then able to gain a sense of awareness as to what extent they may safely explore the traumatic material, without becoming overwhelmed. It is useful to ask the client to begin to narrate the traumatic experience s and as their emotions intensify, the clinician may challenge the client to rescue themselves from these overwhelming feelings by implementing the skills above. It is also a testament to the client now being empowered with choice to continue treatment and confront trauma memories. The final important ingredient of the Safety Phase of treatment is negotiating the contract with the client to move forward to Phase II Trauma Resolution. Remember the importance of mutual goals in the creation and

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maintenance of the therapeutic alliance. Judging from how well you have done this, I expect the same kind of success as we begin to work toward resolving these traumatic memories. What do you need before we begin to resolve these memories? These skills are meant to be suggestive and may not work for every survivor. It is important that the client be able to identify what works for them. Some clients experience a feeling of failure if they attempt to lower their SUDS scale and it does not work. It is important that we as clinicians normalize trial and error and instill hope in the trauma survivor. Remember that the goal of these skills is to take the client out of the fight or flight option and back into intentionality where they control their internal and external world. It is helpful to use the term staying "intentional" vs. When we are in a reactive state of mind, we react to situations without thought or insight. A reactive state is fear driven and impulsive. In her excellent book, "The Body Remembers" Rothschild encourages clinicians to teach clients how to put the "brakes" on when beginning trauma therapy. She uses the analogy of teaching a new driver to be really comfortable with the braking system in a car before "accelerating". In this way, the client moderates the trauma work. A client can begin to work beyond the fear once they have learned that they need not be stuck in fear forever. Once an individual learns that they can touch just the surface of their experience and then return to a safe or neutral ground it is empowering and affords them the knowledge that they can master their own discomfort. Progressive Relaxation Ehrenreich provides a simple script for Progressive Relaxation that can be expanded or contracted with just a minimum of effort. Begin this exercise by instructing the individual to focus on lengthening and deepening the breath. Focus on the inhalation and exhalation making the breath smooth and deep. Now tighten both fists, and tighten your forearms and biceps Hold the tension for five or six seconds Now relax the muscles. When you relax the tension, do it suddenly, as if you are turning off a light Concentrate on the feelings of relaxation in your arms for 15 or 20 seconds Now tense the muscles of your face and tense your jaw Hold it for five or six seconds Now arch your back and press out your stomach as you take a deep breath Now tense your thighs and calves and buttocks Concentrate on the feelings of relaxation throughout your body, breathing slowly and deeply Ehrenreich, , Appendix B. Although written for a different audience, it is applicable to the addicted survivor. Autogenics is a process of using internal dialogue to self-soothe. It is NOT hypnosis. The client is in control the entire time. It begins by encouraging the client to find a relaxing place and position. Focusing on their breath allows it to soften, lengthen, and deepen. The internal dialogue can then begin. Jamieson begins with: Focus on each phrase as you repeat it to yourself" p. I am beginning to feel calm and quiet. I am beginning to feel quite relaxed. My right foot feels heavy and relaxed. My left foot feels heavy and relaxed. My ankles, knees, and hips feel heavy, relaxed, and comfortable. My stomach, chest, and back feel heavy and relaxed. My neck, jaw, and forehead feel completely relaxed. All of my muscles feel comfortable and smooth. My right arm feels heavy and relaxed. My left arm feels heavy and relaxed. My right hand feels heavy and relaxed. My left hand feels heavy and relaxed. Both my hands feel heavy and relaxed. My breathing is slow and regular. I feel very quiet. My whole body is relaxed and comfortable. My heartbeat is calm and regular. I can feel warmth going down into my right hand. It is warm and relaxed. My hands are warm and heavy. It would be very difficult to raise my hands at this moment. I feel very heavy. My breathing is slow and deep. My breathing is getting deeper and deeper. I am feeling calm.