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Songs of Innocence and of Experience is an collection of poems by William Blake. It appeared in two phases. A few first copies were printed and illuminated by William Blake himself in 1789; five years later he bound these poems with a set of new poems in a volume titled Songs of Innocence and of Experience Shewing the Two Contrary States of the Human Soul. William Blake was also a painter before the songs of innocence and experience and made paintings such as Oberon, Titania, and Puck dancing with fairies. "Innocence" and "Experience" are definitions of consciousness that rethink Milton's existential-mythic states of "Paradise" and "Fall". Often, interpretations of this collection centre around a mythical dualism, where "Innocence" represents the "unfallen world" and "Experience" represents the "fallen world". Blake categorizes our modes of perception that tend to coordinate with a chronology that would become standard in Romanticism: childhood is a state of protected innocence rather than original sin, but not immune to the fallen world and its institutions. This world sometimes impinges on childhood itself, and in any event becomes known through "experience", a state of being marked by the loss of childhood vitality, by fear and inhibition, by social and political corruption, and by the manifold oppression of Church, State, and the ruling classes. The volume's "Contrary States" are sometimes signalled by patently repeated or contrasted titles: in Innocence, Infant Joy, in Experience, Infant Sorrow; in Innocence, The Lamb, in Experience, The Fly and The Tyger. The stark simplicity of poems such as The Chimney Sweeper and The Little Black Boy display Blake's acute sensibility to the realities of poverty and exploitation that accompanied the "Dark Satanic Mills" of the Industrial Revolution.

Peter Skrzynecki is a poet and fiction writer of Polish-Ukrainian descent. His poems are largely poems of reflection and observation, but in the course of their 'meditations' on experience they touch on the special pathos of immigrant families as they come to terms with a new and very foreign country.

This is the story of Amelia and Riley, bad kids from bad Brookfield High who have transferred to Ashbury High for their final year. They've been in love since they were fourteen, they go out dancing every night, and sleep through school all day. And Ashbury can't get enough of them. Everyone's trying to get their attention; even teachers are dressing differently, trying to make their classes more interesting. Everyone wants to be cooler, tougher, funnier, hoping to be invited into their cool, self-contained world.

In this free-verse novel, sixteen-year-old Billy leaves behind his drunken, abusive father, takes refuge in an abandoned freight train, falls in with the wealthy, restless Caitlin, and discovers the true meaning of friendship and family.

The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although life expectancy and survival rates in the United States have improved dramatically over the past century, Americans live shorter lives and experience more injuries and illnesses than people in other high-income countries. The U.S. health disadvantage cannot be attributed solely to the adverse health status of racial or ethnic minorities or poor people: even highly advantaged Americans are in worse health than their counterparts in other, "peer" countries. In light of the new and growing evidence about the U.S. health disadvantage, the National Institutes of Health asked the National Research Council (NRC) and the Institute of Medicine (IOM) to convene a panel of experts to study the issue. The Panel on Understanding Cross-National Health Differences Among High-Income Countries examined whether the U.S. health disadvantage exists across the life span, considered potential explanations, and assessed the larger implications of the findings. U.S. Health in International Perspective presents detailed evidence on the issue, explores the possible explanations for the shorter and less healthy lives of Americans than those of people in comparable countries, and recommends actions by both government and nongovernment agencies and organizations to address the U.S. health disadvantage.

Weaving outwards from a centripetal force of biographical stances, this book presents the collective perspectives of literacy researchers from Brunei, China, Hong Kong, Malaysia, Singapore, the Philippines and Taiwan. It represents the first all-Asian initiative to showcase the region ’ s post-colonial, multilingual and multicultural narratives of literacy education. This book provides a much-needed platform that initiates important conversations about literacy as a sociocultural practice in a region that is both challenged and shaped by sociocultural influence unique to Asia ’ s historical and geopolitical trajectory. Driven by the authors ’ lived experiences of becoming literate as well as their empirical research work in later years, each chapter brings decades of biographical narratives and collective empirical research findings to bear. Within the book are negotiations about literacy across and within home and school contexts; transactions of literature, text and reader; and considerations of the literacy policy-practice nexus. These trajectories, while divergent in their issues, come together as shared lived experience located in local contexts considered through global perspectives. As Asia looks set to become the 21st century ’ s new economic and labour force, the need to understand the sociocultural milieu of this region cannot be understated. This book on literacy education in Asia contributes to the larger narrative.

There are at least four reasons why a sleep clinician should be familiar with rating scales that evaluate different facets of sleep. First, the use of scales facilitates a quick and accurate assessment of a complex clinical problem. In three or four minutes (the time to review ten standard scales), a clinician can come to a broad understanding of the patient in question. For example, a selection of scales might indicate that an individual is sleepy but not fatigued; lacking alertness with no insomnia; presenting with no symptoms of narcolepsy or restless legs but showing clear features of apnea; exhibiting depression and a history of significant alcohol problems. This information can be used to direct the consultation to those issues perceived as most relevant, and can even provide a springboard for explaining the benefits of certain treatment approaches or the potential corollaries of allowing the status quo to continue. Second, rating scales can provide a clinician with an enhanced vocabulary or language, improving his or her understanding of each patient. In the case of the sleep specialist, a scale can help him to distinguish fatigue from sleepiness in a patient, or elucidate the differences between sleepiness and alertness (which is not merely the inverse of the former). Sleep scales are developed by researchers and clinicians who have spent years in their field, carefully honing their preferred methods for assessing certain brain states or characteristic features of a condition. Thus, scales provide clinicians with a repertoire of questions, allowing them to draw upon the extensive experience of their colleagues when attempting to tease apart nuanced problems. Third, some scales are helpful for tracking a patient ’ s progress. A particular patient may not remember how alert he felt on a series of different stimulant medications. Scale assessments administered periodically over the course of treatment provide an objective record of the intervention, allowing the clinician to examine and possibly reassess her approach to the patient. Finally, for individuals conducting a double-blind crossover trial

or a straightforward clinical practice audit, those who are interested in research will find that their own clinics become a source of great discovery. Scales provide standardized measures that allow colleagues across cities and countries to coordinate their practices. They enable the replication of previous studies and facilitate the organization and dissemination of new research in a way that is accessible and rapid. As the emphasis placed on evidence-based care grows, a clinician ' s ability to assess his or her own practice and its relation to the wider medical community becomes invaluable. Scales make this kind of standardization possible, just as they enable the research efforts that help to formulate those standards. The majority of Rating Scales in Sleep and Sleep Disorders:100 Scales for Clinical Practice is devoted to briefly discussing individual scales. When possible, an example of the scale is provided so that readers may gain a sense of the instrument ' s content. Groundbreaking and the first of its kind to conceptualize and organize the essential scales used in sleep medicine, Rating Scales in Sleep and Sleep Disorders:100 Scales for Clinical Practice is an invaluable resource for all clinicians and researchers interested in sleep disorders.

Four interlinked long narrative poems by one of Australias foremost poets, John Tranter

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