THE EPM FAD STUDY pdf

1: Why Do We Long for Happiness? - Resources - Eternal Perspective Ministries

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While sold under a variety of names, they are all cannabinoids and act on the same receptors as marijuana. While they act on the same receptors and for the most part are sold legally, their effects are much more toxic than marijuana and as dangerous as many other illegal or scheduled drugs. While synthetic cannabinoids may look like marijuana, their pharmacologic properties are not similar, which leads to a very different clinical picture than what is typically associated with marijuana. In fact, their physical appearance is only similar to marijuana because manufacturers spray these chemicals on herbaceous materials to make them look alike, which unfortunately leads the user to believe that they may not be any more dangerous than typical marijuana. This has severe consequences because these drugs can cause sympathomimetic effects and severe agitation that is not normally seen with marijuana. They are associated with myocardial infarctions, intracranial hemorrhages, and seizures. Also even with the signing of The Synthetic Drug Abuse Prevention Act and other state-level legislation, most of these cannabinoids are still legal, and unfortunately, easily assessable at gas stations and head shops. In addition to being difficult to outlaw, synthetics are easily and cheaply produced in large capacity in countries such as China. From there, they are shipped to the US where they flood the market with cheap drugs that can easily be replaced with new versions once older forms become illegal. Unfortunately, this epidemic has only continued to get worse. In March of , cases were reported to poison centers. This number jumped to 1, case in April of that year [4]! New York had to issue a health alert after more than citizens were hospitalized over a 9 day period in April [5]. Over an 11 hour period one Tuesday in July , 33 people collapsed in Brooklyn after abusing synthetic cannabinoids [6]. This trend was also reported by the DEA, who recently reported 22 clusters including 2 deaths and another 25 episodes including 18 more deaths in 5 states between â€” [7]. What makes this so remarkable is that, in general, as emergency physicians become more familiar with certain drugs of abuse, they tend to call the poison center less to ask for management assistance. How many of us call a poison center, for instance, for each heroin overdose? So the fact that the number of K2 cases did not level off but has astronomically increased is even more concerning than it already seems. ToxIC is a voluntary registry composed of patients personally evaluated by a medical toxicologist for any reason. During that time period, medical toxicologists treated patients with synthetic cannabinoid intoxication. While that may not seem like a lot, consider 2 points: Among the exposures, This is disturbing not only due to how dangerous these drugs are, but also, we know that use of drugs at an early age predisposes people to further drug addiction and substance abuse later in life. In addition in , the annual percentage of reported cases increased in all US regions. In , less than 1. In , this jumped to approximately 3. While some of the increase could be from better recognition, it likely is better explained by increasing toxicity and morbidity. As alarming as these numbers are, they likely represent an underreporting for a variety of reasons. Currently, there is not a clinically useful test to confirm the diagnosis. Even if the correct diagnosis is made, the correct ICD code is inconsistently applied, which could make cases difficult to find when retrospectively reviewing data. While poison center data is likely coded better, this data is well known to be underreported as calling the poison center is voluntary in most states. Most emergency physicians associate these drugs with agitation and sympathomimetic toxicity. In many cases, these patients require some sedation but can be discharged from the emergency department. Of course some can get very sick, including a patient who developed a hemorrhagic stroke after smoking Spice [9]. However, recent data seems to indicate this pattern is changing for the worse. In addition to agitated delirium, many patients are now presenting with significant central nervous system CNS or respiratory depression, in some cases so severe that patients are intubated for airway protection. Lately, we have seen a large number of patients presenting to our institution with CNS depression and bradycardia. While many recovered with general supportive care, it took a while to recognize this new pattern leading to large and unnecessary evaluations to determine the cause of their

symptoms. Even after determining the cause, many patients still re-quired intensive monitoring and even ICU admissions in a few cases. Even more interesting is that recently published data demonstrates that a number of patients have rapidly fluctuating mental statuses ranging from severe agitation to unresponsiveness. This makes it very challenging to treat them because patients can present so differently. In addition it is difficult for the physician to anticipate the effect of treatment on these patients. Eleven patients recently presented over 1. Some patients fluctuated between obtundation and severe agitation, while some remained obtunded until they became sober and woke up. Only 2 of the 11 could be discharged the same day; many were admitted to the ICU and some occupied hospital beds for almost a week. Adamowicz reports 2 patients that were found unresponsive after smoking synthetic cannabinoids; 1 patient developed respiratory depression [11]. One patient had waxing and waning of his mental status before developing respiratory failure; the second patient presented obtunded and apneic. Agitated patients need emergent sedation and cooling if they are hyperthermic. Sedated or unconscious patients need close monitoring of their airway and may need to be intubated. Best treatment practices are based on opinion and personal experiences. Most toxicologists would treat agitation with aggressive titration of benzodiazepines. While that literature does not specifically include patients with synthetic cannabinoid intoxication, it is reasonable to conclude that ketamine should be effective in managing these patients. While neuroleptics are commonly administered in the emergency department, most toxicologists would likely recommend benzodiazepines. If neuroleptics are to be used, haloperidol has a negligible amount of anticholinergic activity. Neuroleptics with more anticholinergic activity can be dangerous as they can prevent hyperthermic patients from sweating and cooling themselves. However, haloperidol can lower the seizure threshold, something these patients are already at an elevated risk of having. In addition to new presentations of acute intoxication, withdrawal from these agents is also now being reported. While the validity of a withdrawal syndrome is not established, one cohort study reported on 47 patients presenting with synthetic cannabinoid withdrawal [14]. Of course, the majority of symptoms were subjective and not life threatening in nature. Zimmerman reported a 20 year old who developed diaphoresis, nausea, tremor, hypertension, tachycardia, and cravings four days after abstaining from Spice [15]. Depending on the amount and frequency of drug use, withdrawal symptoms can develop even sooner after patients stop smoking synthetic cannabinoids. Some have reported withdrawal symptoms as their main reason for continued use, which is not too different than some patients with opioid use disorders [14]. One patient reported smoking every 45 minutes throughout the night to avoid withdrawal [16]. Common adverse events reported included cravings, headache, anxiety, and insomnia; seizures, chest pain, palpitations were also reported [1]. Synthetic cannabinoids continue to be a source of major morbidity and mortality. This is particularly unfortunate as many underestimate the severity of their effects as they are legal and made to look like common marijuana. There may even be a withdrawal syndrome associated with them. Given the constant changes to their chemical structures, we can continue to expect that patients will present with new and constantly changing signs and symptoms, which makes diagnosis and treatment challenging. Adverse Effects of Synthetic Cannabinoids: Management of Acute Toxicity and Withdrawal. Curr Psychiatry Rep ;18 5: Accessed August 6, Increase in reported adverse health effects related to synthetic cannabinoid useâ€"United States, Januaryâ€"May West J Emerg Med ;17 3: Suspected overdose of synthetic pot, K2, sends 33 people to Brooklyn hospitals. Accessed on August 5, Schedules of controlled substances: Acute Poisonings from Synthetic Cannabinoids U. Toxicology Investigators Consortium Registry Sites, Clin Toxicol ;54 8: Adamowicz P, Gieron J. Forensic Sci Int ; Jinwala FN, Gupta M. Synthetic cannabis and respiratory depression. J Child Adolesc Psychopharmacol ;22 6: Marfarlane V, Christie G. Drug Alcohol Rev ; Withdrawal phenomena and dependence syndrome after the consumption of Spice Gold. Dtsch Arztebl Int ; Inpatient detoxification from a synthetic cannabinoid and control of postdetoxication cravings with naltrexone.

THE EPM FAD STUDY pdf

2: About Ira Mayer | Mayer On Marketing, Licensing, and Merchandising

The EPM Fad Study by Karen Raugust, June 1, , EPM Communications edition, Mass Market Paperback in English.

Opioid abuse is no longer merely a topic for medical discussion. The numbers speak for themselves, justifying the concern. Over 10 million Americans reported nonmedical use of prescription opioids in Most troubling was the rising number of deaths from opioids. There were 16, deaths from prescription opioids in , which increased to 18, in During this same time period, rates of heroin use and overdose also increased. Heroin users were found to be 3. Another study determined that prescription-opioid abusers were 40 times as likely to abuse heroin as compared to those without a history of prescription-opioid abuse. In response to this epidemic, both the state and federal governments are taking active steps to combat these alarming numbers. PDMPs are implemented in every state, aside from Missouri. While their impact is still unknown in many places, pill mill laws and the PDMP in Florida may be associated with decreased rates of opioid prescribing and use. States and state-wide hospital associations including Maryland, New York, and recently Missouri released opioid prescribing guidelines. Even though EDs are only a small part of the problem, many of the guidelines are directed at or incorporate ED prescribing. In addition to state or hospital-derived policies, emergency medicine associations also released guidelines of their own. A recent study explored the impact of opioid prescribing guidelines on two large urban EDs. They described the change in prescription practices in patients discharged with dental, neck and back, and chronic pain after the dissemination of a guideline. In the months and months after dissemination, the rate of opioid prescriptions decreased from The Food and Drug Administration FDA also just announced plans in February to reassess their approach to opioid medication approval in light of increasing governmental and political pressure. Due in part to the complexity of the issue, the government and other organizations can seem schizophrenic in their messaging to emergency providers. At times, governmental agencies openly advocate for new approaches to fight the epidemic, only then to place roadblocks in the way of other initiatives. While supporting and initiating policies and increasing funding for addiction programs, governmental agencies are also impeding some actions taken by emergency physicians. They informed the ED administration that such signs might be misconstrued as intimidating and coercive, and therefore, might be considered an EMTALA violation. Unfortunately, the same thing occurred in Ohio when their regional CMS offices were contacted about posting similar verbiage. Given the threat of an EMTALA violation, most hospitals are not going to risk large fines to post similar guidelines, even if the signs are not meant to intimidate or prevent patients from seeking legitimate care. Patient satisfaction may also be subverting attempts to initiate guidelines. Since the movement to make pain the 5th vital sign, there is an increased emphasis to provide appropriate analgesia in the ED. While this movement was likely an appropriate response to oligoanalgesia, it has morphed into the perception that patients must have their pain controlled with opioids or other controlled medications. Whether this perception is true or not, emergency providers are concerned that implementing guidelines or policies may upset patients and negatively impact patient satisfaction scores and lead to more complaints. Maintaining high patient satisfaction is important as it can impact reimbursement, and in some cases, the ability of an ED group to keep their contract. While some organizations are disseminating a mixed message, the release of opioid prescribing guidelines from the CDC is ultimately welcome. Although intended for primary care providers who account for nearly half of all dispensed opioid prescriptions and whose prescription rates are growing at an above average rate, large parts of these guidelines do pertain to emergency providers. Even recommendations not meant for the ED can be modified into useful information for the emergency provider. It is important to mention that none of the guidelines are meant to be used to advocate for undertreating pain, a common concern from at least a few of my colleagues. In addition, using guidelines may make having these discussions with patients easier, and possibly more accepting, when the decision is made not to treat them with narcotics. The guideline consists of 12 recommendations broken into three categories: Some key take home points for the emergency physician include: Nonpharmacologic therapy and nonopioid therapy are preferred for chronic, non-cancer pain. While providers should be allowed to prescribe opioids as they feel is appropriate, other therapies including

NSAIDS, tricyclic antidepressants, gabapentin, lidocaine patches, and physical therapy should be considered Providers should establish realistic treatment goals. Having these conversations early in their visit can make it easier to establish a treatment plan that will satisfy both the physician and patient. Discuss risks of opioid therapy. It is well known that patients can get addicted even with a short-term prescription. Many patients, although not all, will appreciate if you explain this to them as your rationale for not treating them with narcotics. Risks also extend beyond addiction, including complications such as in patients with sleep apnea or those already receiving sedatives such as benzodiazepines. If opioids are used, they should be prescribed at the lowest dose that adequately controls pain. Extended release or long acting preparations should probably not be prescribed from the ED. Only prescribe for the shortest duration that is appropriate. This duration will likely be influenced by follow up availability. If someone has a true indication for opioids and cannot get follow up for 2 weeks, your script might be for longer than for the patient that can be re-evaluated in 3 days. If you live in a state with a good PDMP, consider using it before writing a prescription. If you suspect opioid addiction, attempt to refer your patient for treatment. Clearly, resources are currently inadequate. Hopefully if the federal and state governments continue to increase funding as promised, more resources will become available. Centers for Disease Control and Prevention. N Engl J Med ; Non-medical use, abuse and dependence on prescription opioids among U. Drug Alcohol Depend ; Maryland emergency department opioid prescribing guidelines. Opioid use in Missouri: Strategy for reduced misuse and abuse. Ann Emerg Med ; The Washington College of Emergency Physicians. Impact of an opioid prescribing guideline in the acute care setting. J Emerg Med ;50 1: Trends in opioid analgesic-prescribing rates by specialty, U. Am J Prev Med ; The Food and Drug Administration. Accessed on February 2, The oxy free ED: Lack of association between Press Ganey emergency department patient satisfaction scores and emergency department administration of analgesic medications. Ann Emerg Med ;64 5:

3: K2: From Fad to Enemy #1 - Emergency Physicians Monthly

The EPM Fad Study brings you extensive data and analysis, never before organized in this form. You'll see at a glance: the total life cycle of fads.

This interview was conducted in How long have you been responsible for facilitating the Balanced Scorecard process within Scottish Enterprise? Your actual job title is network director, learning and performance. How much of your time is dedicated to the Balanced Scorecard? In theory, therefore, all of my time should be dedicated to scorecard issues as the scorecard is about turning strategy into action. Who do you report to? He sits on the corporate management team and therefore reports directly to the chief executive. Along with our chief executive officer CEO Robert Crawford who has left the company since , Charlie Woods has been incredibly supportive in the whole scorecard effort and acted as a bridge between the development team, which I led, and the chief executive and chairman. How did you come to be involved in the Balanced Scorecard design and implementation program? The Balanced Scorecard program came out of a Business Transformation project, which was a wide-ranging initiative to implement organizational change across the SE network. Through Business Transformation we reviewed everything we did. This included performance management, which for almost four years has been my area of responsibility. So the scorecard project was seen as naturally aligning to my work area, especially as I was, and still am, also responsible for resource allocation across the network. What did Scottish Enterprise see as the key personal and professional qualities for your role in scorecard facilitation? Facilitating a scorecard process is fundamentally about putting our strategy into action. Therefore what Scottish Enterprise was looking for was somebody who could bridge the strategy world and the operations world and feel at ease in each. I really believe this is the key skill in scorecard facilitation. It was also important that the person had strong analytical and synthesis skills and was able to communicate with people at all levels of the organization. Softer skills are also required in areas such as pragmatism and perseverance, as anyone involved in change management will testify. There are other skills, such as facilitation, people management, improvisation and possessing an inquiring and challenging mind that are true of any change management project, and not exclusive to the scorecard. How were you trained in facilitating a Balanced Scorecard program? I had previously had broad training in both facilitation and strategy implementation. But in terms of the scorecard specifically it was essentially learning on the job. However, this was greatly assisted by Jonathan Chocqueel-Mangan, who acted as the adviser to the scorecard program. He provided real support to me in taking the scorecard forward, acting almost as a personal mentor, tutor and coach, as well as inputting into the content of the scorecard. My boss Charlie Woods gave his authority and his support, which was obviously important, and he was very helpful in helping to secure wider senior management support. In addition to that we paid close attention to generating our own authority. We did a fair amount of piloting before we rolled the scorecard across the network; the success we achieved, and could demonstrate, was very useful in building support organization-wide. We have found that although you need authority from the top, the best way to get people excited about the scorecard is through successes in the field. So authority has both top-down and bottom-up dimensions. What are the major challenges you face when facilitating the process of building and implementing Balanced Scorecards and how are these overcome? I think that sometimes there can be a pressure to show quick benefits, and from a Business Transformation perspective this was not surprising as demonstrating quantifiable benefits was a key reason for the initiative. Showing how the scorecard will track progress towards goals two to three years out is very important, after all the scorecard is a strategy implementation framework, but being able to get across the importance of the longer-term perspective can be a challenge. Are there people dedicated full-time or part-time to the scorecard within Scottish Enterprise? If so, what are their roles? These staff provide a range of support services, from collating and analyzing data to facilitating the decision making process in the organization. This will include supporting workshops, developing strategy maps, objectives and measures, and â€" critically â€" the actual ongoing implementation and refinement of the scorecard approach. To be frank, it would simply be impossible to do this work without the support of the great staff around me. We have trained 50 people throughout the

network to facilitate the scorecard building process. These employees now have a very good understanding of what the scorecard is, what it sets out to achieve and how it should be designed. As well as helping to roll the scorecard out they have become a powerful community of practice sharing learnings and best practices across the network. Interestingly some of these employees were previously fully involved in back-office number crunching roles and now they are, in some case, facilitating the decision-making process at senior levels. This makes for a much more enjoyable job and provides them with valuable skills. How do you see your role developing over the next years? In saying that, there will probably always be a need for somebody behind the scenes pulling it all together. From your own career perspective, how do you think this role will benefit you personally in the longer-term? The scorecard process has been invaluable in gaining an understanding of the right questions to ask in planning how strategy can be implemented. From your experience what are the critical success factors in succeeding as a Balanced Scorecard manager? The path to success is very windy and you need courage of convictions. You also need to recognize that there will be times when there are delays and when all is not going as smoothly as you like, and here you do need a senior sponsor to assure people that all will work out well in the long run. For this reason, amongst others, you do need a supportive environment and importantly a high level sponsor. As long as the CEO is not anti the scorecard, I think broad high-level support is good enough to start with. James Creelman wrote a case study on how Scottish Enterprise implemented the Balanced Scorecard for his report: Further information on Scottish Enterprise can found at: It is a long-term project with goals such as: In the course of a wide-ranging interview, Julian Taylor discusses how long he has been managing the Balanced Scorecard in Scottish Enterprise, how the Balanced Scorecard is managed within Scottish Enterprise, the reasons why his job of Balanced Scorecard Manager is a full-time position, how he first got involved with the Balanced Scorecard, his involvement with the Balanced Scorecard initiative in Scottish Enterprise, the key personal and professional qualities necessary for a Balanced Scorecard manager, the training he received, the use of his functional background in managing the Balanced Scorecard program, the nature of senior management backing he received, the major challenges he faced when building and implementing the Balanced Scorecard, how to overcome the challenges and maintain the momentum of the scorecard initiative, and the system Scottish Enterprise has in place for managing the Balanced Scorecard. Further, Julian Taylor also tells us what he enjoys most about working with the Balanced Scorecard, how it benefits him personally and tries to see how his role would evolve years down the line. Finally, drawing from his experience, he identifies critical success factors in succeeding as a Balanced Scorecard manager.

4: The CDC Weighs In With Opioid Prescribing Guidelines - Emergency Physicians Monthly

waned, although the product was still available (EPM Fad Study ()). Is it true that there were no 'obvious external stimuli' that caused this product to become a fad?

Why Do We Long for Happiness? Chapter 1 of Happiness by Randy Alcorn By Randy Alcorn October 2, The Shawshank Redemption contains a poignant scene in which a prisoner, Andy, locks himself into a restricted area and plays a record featuring opera singers. Beautiful music pours through the public address system while prisoners and guards stare upward, transfixed. Another prisoner, Red, played by Morgan Freeman, narrates: I have no idea to this day what those two Italian ladies were singing about. I tell you, those voices soared higher and farther than anybody in a gray place dares to dream. It was like some beautiful bird flapped into our drab little cage and made those walls dissolve away, and for the briefest of moments, every last man in Shawshank felt free. The first panel shows happy schoolchildren entering a street-level subway stationâ€"laughing, playing, tossing their hats in the air. The next panel shows middle-aged adults emerging from the station looking like zombiesâ€"dull, joyless, unenthusiastic. A study indicates that children laugh an average of four hundred times daily, adults only fifteen. I have some fond memories of my childhood and the idealistic dreams of my early life. I grew up knowing almost nothing of Jesus, God, the gospel, the Bible, and the church. My father owned taverns and operated Alcorn Amusements, which supplied and serviced game machines for taverns. Before computers and video games, I grew up in a home filled with foosball and pool tables, pinball and bowling machines. I even had two jukeboxes in my bedroom. My house was a popular place for my friends to hang out! These amusement machines were designed to make people happy. This was a second marriage for both my parents. Every time Dad came home drunk and he and Mom yelled at each other, I lay in bed wondering whether this fight would end in divorce. I had brief tastes of happiness, but I spent far more time seeking happiness and longing for it than experiencing it. I bought comic books by the hundreds, subscribed to fantasy and science fiction magazines, and spent nights gazing through my telescope, pondering the universe. The night sky filled me with aweâ€"and a small taste of happiness. I yearned for something bigger than myself. Since I knew nothing of God, aliens were the primary candidates. One unforgettable night, I gazed at the great galaxy of Andromeda, 2. I longed to explore it someday, to lose myself in its immensity. But my wonder was trumped by an unbearable sense of loneliness and separation. I wept because I felt so incredibly small. Unknown to me, God was using the marvels of his universe to draw me to himself. That gnawing emptiness grew until eventually I set the telescope aside. If the universe had meaningâ€"if I had meaningâ€"I had no clue what it was. I later learned that at the height of his success, Lennon wrote a personal letter to an evangelist. The point is this, I want happiness. Explain to me what Christianity can do for me. Can He love me? I want out of hell. As for me, I looked for ways to fill that hungry void, but unhappiness and loneliness prevailed. I found distraction, but never fulfillment. When I first read the Bible, it was new, intriguing, and utterly disorienting. I opened it and discovered these words: Then I read the greatest understatement ever: Countless stars in a universe one hundred billion light-years across are a mere add-on: But when I reached the Gospels, something changed. I was fascinated by Jesus. Everything about him had the ring of truth, and soon I came to believe he was real. Then, by a miracle of grace, he transformed me. This life change was characterized by many factors, but the single most noticeable difference was my newfound happiness. Still, I regularly find happiness in the one who reached out to me with his grace decades agoâ€"and continues to do so every day. Though I live in a world that sells false happiness at newsstands, websites, and big-box stores, I thank God for authentic happiness in Jesus. Seeking happiness is as natural as breathing. This is without exception. All their plots, purposes, and endeavors aim at this end only. He is a creature that desires happiness, and cannot but desire it. The desire of happiness is woven into his nature, and cannot be eradicated. It is as natural for him to desire it as it is to breathe. No, he only wants you to believe on him, that you might be saved. This, this, is all the dear Savior desires, to make you happy, that you may leave your sins, to sit down eternally with him. Their message was simply that true happiness could be found only in Christ. Seeking happiness is a givenâ€"a universal constant. Any pastor who tries to motivate people to stop seeking

happiness, any parent who tries to make his or her child repent of being motivated by happiness, is fighting a losing battle. Neither will succeed, and both will do damage by distancing the gospel from the happiness everyone craves. But what if our desire for happiness comes from God? What if he wired his image bearers for happiness before sin entered the world? How might this perspective change our approach to life, parenting, church, ministry, business, sports, and entertainment? Where have they seen it, that they so love it? What else does this longing and helplessness proclaim, but that there was once in each person a true happiness, of which all that now remains is the empty print and trace? We try to fill this in vain with everything around us, seeking in things that are not there the help we cannot find in those that are there. Yet none can change things, because this infinite abyss can only be filled with something that is infinite and unchangingâ€”in other words, by God himself. God alone is our true good. Scripture portrays our connection to the sin of Adam in a way that transcends timeâ€” as if we were there in Eden with him see Romans 5: Similarly, I believe we inherited from our Eden-dwelling ancestors a sense of their pre-Fall happiness. This explains why our hearts refuse to settle for sin and suffering and we long for something better. But even those who have never been taught about the Fall and the Curse intuitively know that something is seriously wrong. He has lost the blessedness [happiness] for which he was made, and has found the misery for which he was not made. Our answer to that question will dramatically affect the way we see the world. Did Adam and Eve want to be happy before they sinned? Did they enjoy the food God provided because it tasted sweet? Did they sit in the sun because it felt warm and jump into the water because it felt refreshing? When we separate God from happiness and from our longing for happiness, we undermine the Christian worldview. Putting God on the side of holiness and Satan on the side of happiness is a dangerous maneuver. The devil has mastered this strategy. The truth is, God wants us to seek real happiness in him, while Satan wants us to seek imitation holiness stemming from our self-congratulatory pride. The Pharisees had a passionate desire to be holy on their own terms. He dispenses rat poison in colorful, happy-looking wrappers. The devil has no power to implant in us a desire for happiness. God is the one who planted our desire for happiness. Baptist pastor and professor John Broadus â€” put it this way: The minister may lawfully appeal to the desire for happiness and its negative counterpart, the dread of unhappiness. Those philosophers who insist that we ought always to do right simply and only because it is right are not philosophers at all, for they are either grossly ignorant of human nature or else indulging in mere fanciful speculations. Few find the lasting happiness they crave. Anselm wrote what seems tragically obvious: However, they never lost their desire to be happy. Why are many people so unhappy? We sense that unhappiness is abnormal, and we ache for someone, somehow, to bring us lasting happiness. That someone is Jesus, and that somehow is his redemptive work. Ages later, we retain a profound awareness that we were once happyâ€” and that we should be happy. Longing for the happiness humankind once knew, we can be drawn toward true happiness in Christ, which is offered us in the gospel. God used my persistent desire for happiness to prepare me for the gospel message. The gospel is good news only to those who know they need it.

THE EPM FAD STUDY pdf

5: Case study: fads | The Times

The result, "The EPM Fad Study," fetches a princely US$ and charts the life span of Pet Rocks, Rubik's Cubes, Nehru \[\] The Behavior of Fads | WIRED The Behavior of Fads.

Figure 1 shows unit of sales of clothes dryers, which shows a bell-shaped type curve emerging gradually over 12 years. This is the fad life-cycle described by Raugust It is this fad pattern that we attempt to explain in this paper. It is the rapid acquisition over a short period of time, with a quick drop off, that is the hallmark of a fad. Model We start by determining a more rigorous definition of what a fad is. The anthropologists Aguirre, Quarantelli, and Mendoza AQM, list specific defining characteristics of fads that we shall use to help generate the model. The first set of items is referred to as the descriptive characteristics, and is that a fad should be 1 Homogenous 2 Novel, and 3 Odd. The last set of items is how the fad develops, called the career of a fad. However, it too is merely descriptive, rather than explanatory. We shall restrict our analysis to fads that exist in products, rather than in other areas such as ideas, for sake of simplicity of nomenclature. The life cycle of a fad is most curious. At first, a product exists either in a small sector of the economy, or only in the 1 The final characteristic they list is one that we will not employ, that fads are Nonutilitarian. Therefore all fads can be considered to have utility. Then, suddenly, seemingly inexplicably, everyone knows about it, and must make the decision whether or not to purchase it. There is a period where a large number of people do become part of the fad and then just as quickly it either disappears from the shelves, or becomes a footnote in history rather than a currently popular good. Normal demand patterns do not explain this. We propose a model with several heterogeneous economic actors, or agents. These agents each have a different set of behaviors. Broadly these behaviors allow them to be classified into one of two groups, although within each group the agents remain heterogeneous. These are termed the Fad Setter and the Fad Follower, based on their roles during a fad. As we will see, however, their behavior often results in outcomes other than fads. Fad Setters Fad Setters FS are the people who have access to the newest, most interesting, products available. They could be thought of as the people who specialize in the discovery of new products. In addition, due to some characteristic such as age, status, wealth, or popularity they are known to be the people who others wish to emulate. They choose products independently of any other Fad Setters that may be present, but their decision to stop using a good is dependent on the actions of the Fad Followers. As mentioned above, it is not necessarily true that the Fad Setter will cause a fad to start in every situation, but they do choose a good in every time period. This emphasizes their possibility of becoming fads, but is not intended to limit their eventual acquisition pattern to only fads. This utility value is based on many things, including the combination of the usefulness and novelty of the item. At this point, they will choose the first good they see that is higher in utility value than the good they own. They will hold this good and receive positive per-period utility from it until they choose to stop utilizing the product. Since the utility of the good is based partly on its novelty, the more people involved in it reduce this novelty. The following equations characterize the choice set of the Fad Setter: A reason for this could be because they only find goods interesting if other people also have them. So, instead they search among their neighbors looking for a good that has a higher utility value than the one they currently possess. This utility is a private value and varies over time and is not connected to any sort of societal utility value of the good. Ideally, they would like to be able to observe the choice of a FS directly, but they can only see the choices of agents within a certain distance from themselves. If they find a good within this distance that has a utility value higher than the one they currently possess they will acquire it. Currently they are not limited by income for the actual purchase of the goods. Therefore this is not a restrictive assumption. This decay rate has interesting implications that will be discussed later in the paper. They can also become aware of the absence of the Fad Setter without needing direct contact. This is the cause of why the good decays. When the good decays, eventually its value will fall below the threshold value of the FF. This threshold value represents the point at which the good has either lost usefulness, or had become uninteresting. The exact amount of the threshold value will be different for different goods. The actions of the Fad Follower are summarized in these equations: Motion Fad Setters pick a fad that has utility value V. They will keep this product, receiving a

value of V in each time period. When the number of Fad Followers reaches SFS, the switch value defined above, they will leave this good, ending their role in the current fad. Fad Followers look at the goods their neighbors have, and if the utility value of one of the goods is higher than their present good, they will acquire that good. If the values are lower, they will remain with their present good. Each good the FF sees has a probability of being a Fad Setter good. This probability depends on how many other agents have already acquired, and still maintain, the FS good. Regardless of whether the good they see is the Fad Setter good they seek they always pick the highest valued good they see. Fad Followers continuously search for higher valued goods, and all Fad Followers choose simultaneously, based on the good their neighbor had in the last time period. If the Fad Setter leaves in a time period, then the good immediately begins to decay. This threshold is different for every Fad Follower.

6: EPM Review - Enterprise Performance Management Review - A Resource Portal

Here are results from an EPM Fad Study by Karen Raugust. The characteristic is underlined followed by a description of a fad or trend: Underlying reason for the rise.

7: Strategist Blog: Is It a Fad or a Trend?

The EPM Fad Study is based on original research into the history of more than fads, and includes case studies for 74 American fads in the 20th Century. Research and Markets: Are you ready to capitalize on the next Power Rangers, Rubik's Cube or Hula Hoop?

8: What does EPM stand for in Medical category?

The sales curve corresponds dramatically to that of a "true fad" as defined in The EPM Fad Study (www. MGA's Bratz face soft demand, retailers reducing shelf space The idea is to invest in fashion and, if you must, buy only one fad piece a year.

9: Spreading Yourself Too Thin: The Atkins Diet and Other Fads - Knowledge@Wharton

Figure 2 Source: EPM Fad Study () 5 The life-cycle of durable goods was described by Bass () to be a bell-shaped curve. Figure 1 shows unit of sales of.

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