Warum es so schwer fällt, aufzuhören

Suchtfachtage

Ribnitz-Damgarten, 19. September 2019

Michael Lucht

Psychiatrie und Psychotherapie HELIOS

Hanseklinikum Stralsund

ERNST MORITZ ARNDT
UNIVERSITÄT GREIFSWALD

Wissen
lockt.
Seit 1456


DIE GROSSEN ufa KLASSIKER
HANS ALBERS · ILSE WERNER · HANS SÖHNKER
Große Freiheit Nr. 7
FARBFILM
HELMUT KÄUTNER

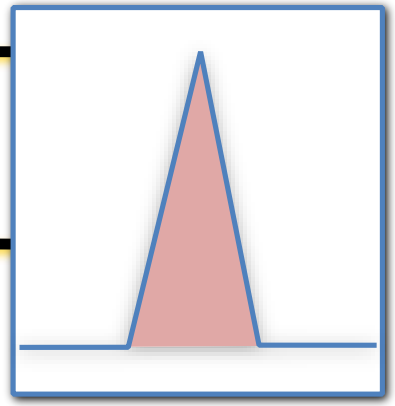




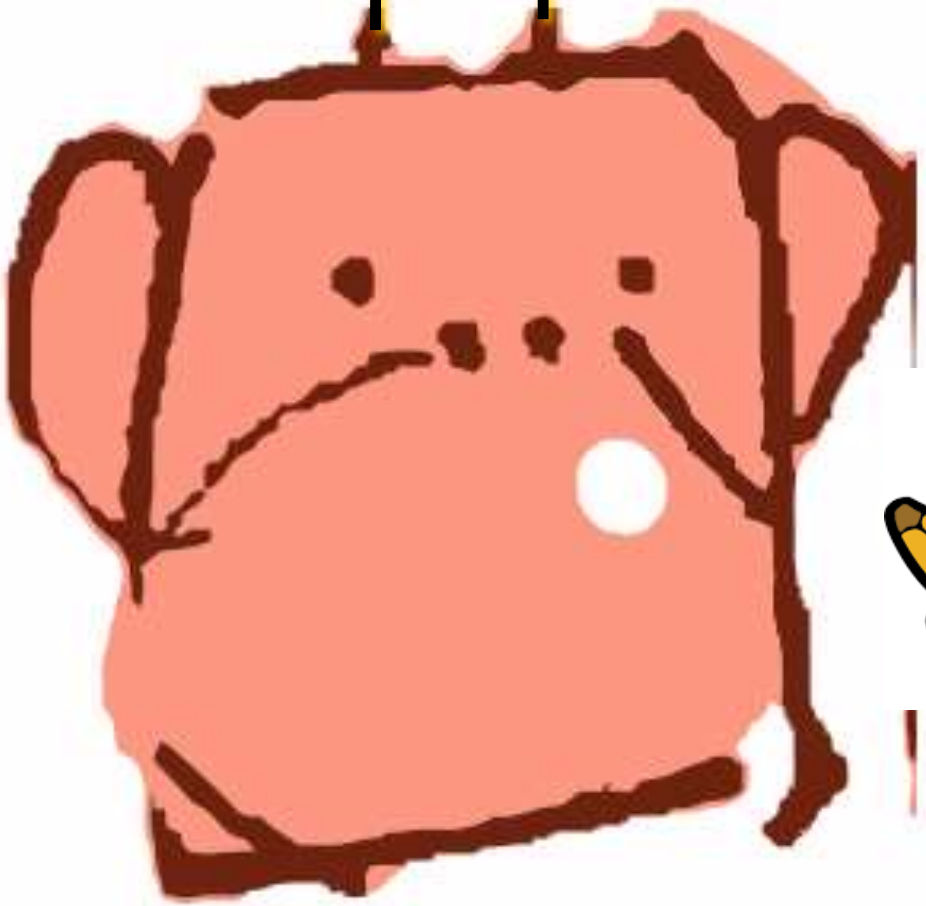


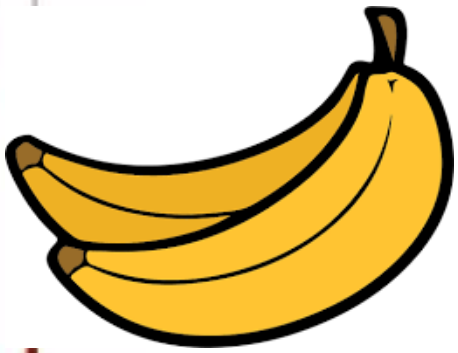


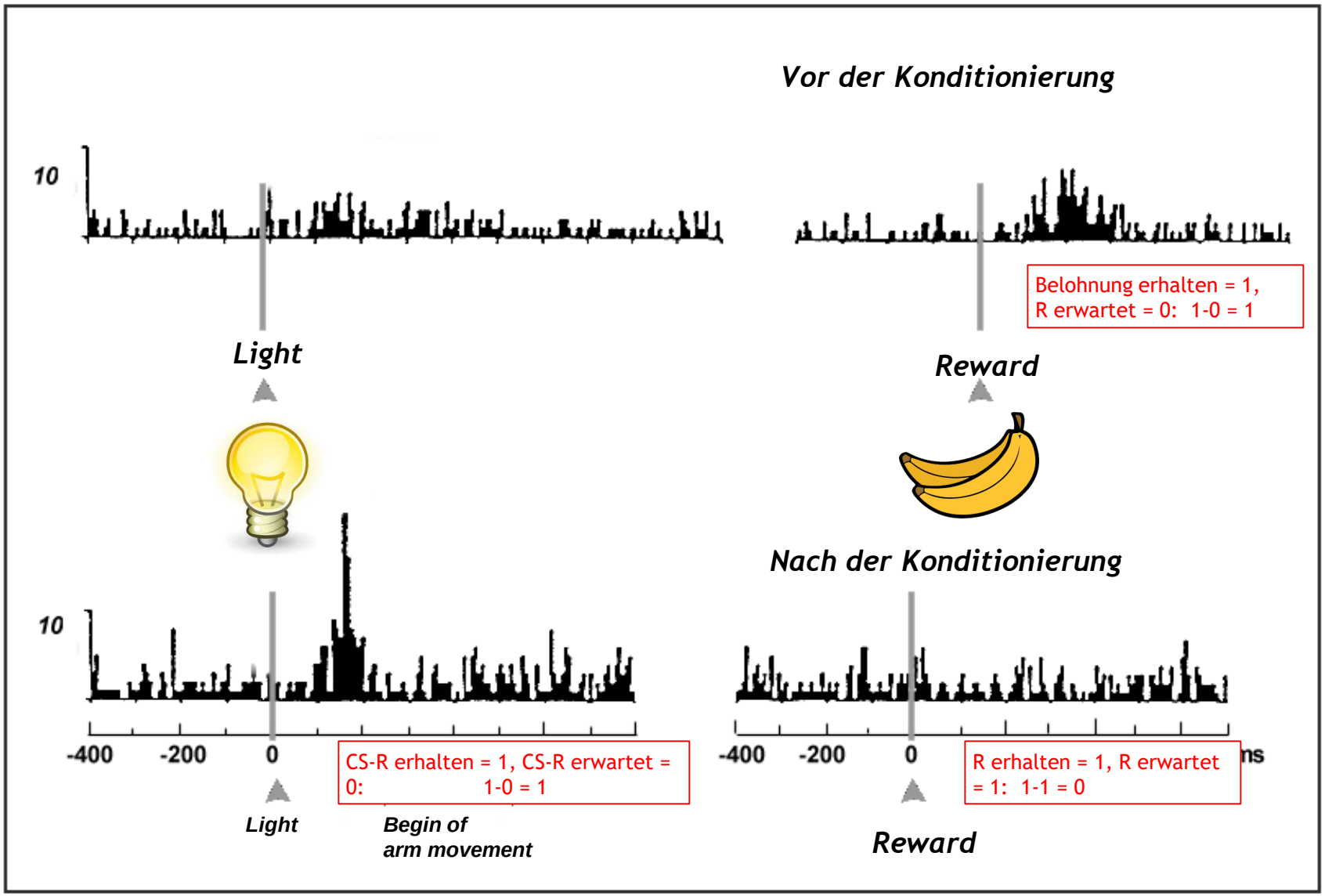
WARUM WIRKEN SICH ALKOHOLFOLGEN NICHT AUS?



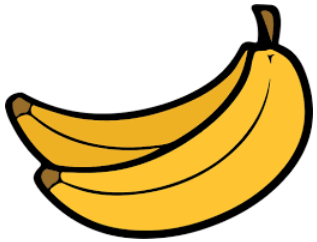
Dopamin-Aktivität

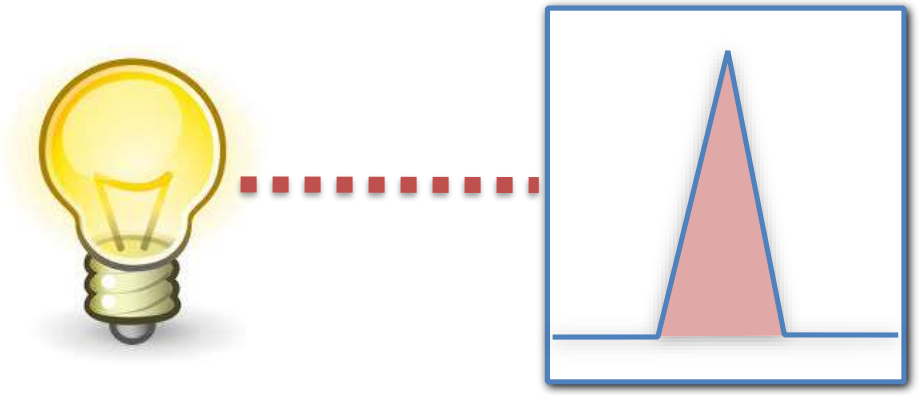




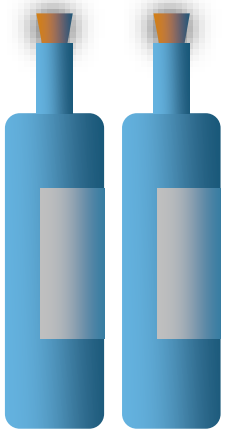


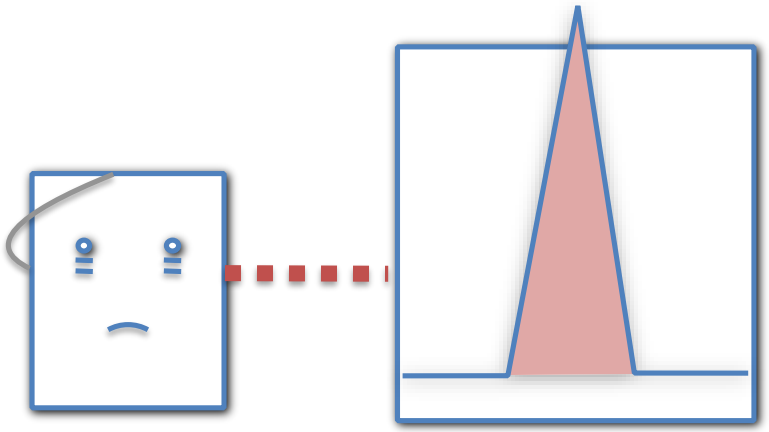
Schultz et al., 1993

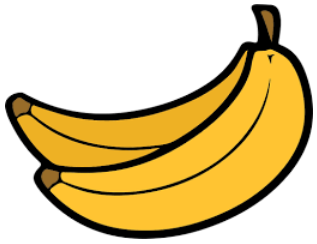


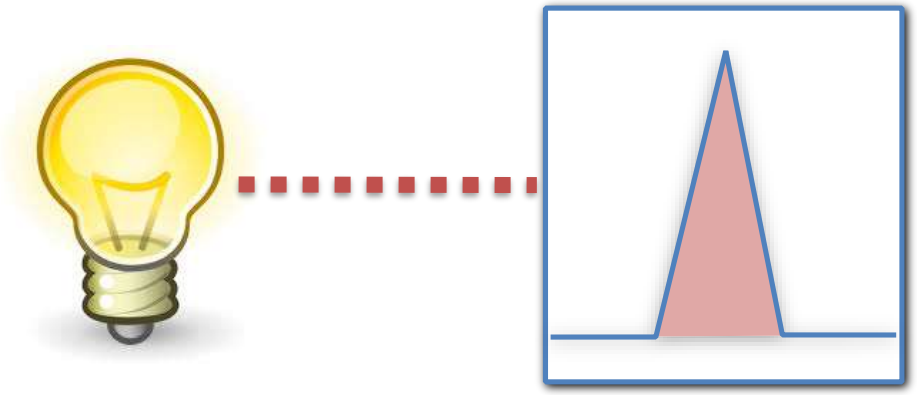


Dopamin-Aktivität



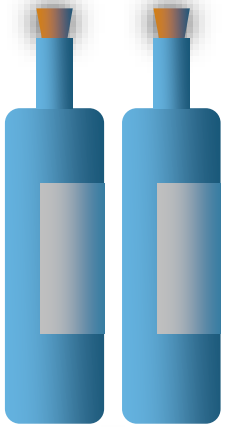


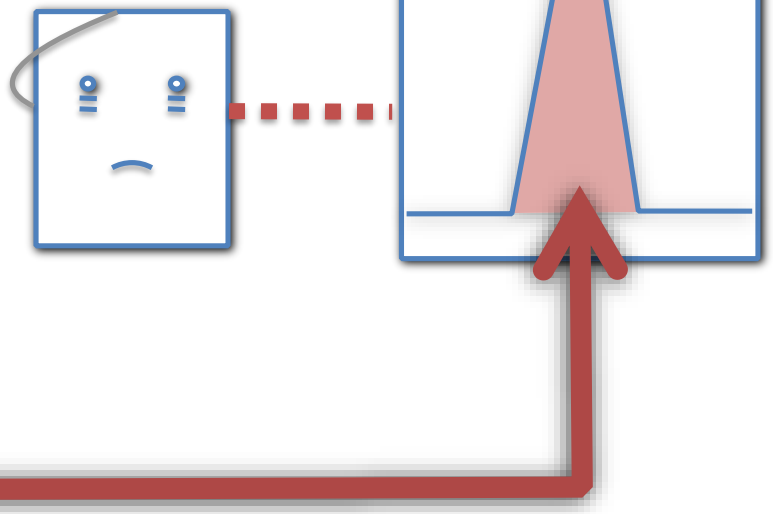




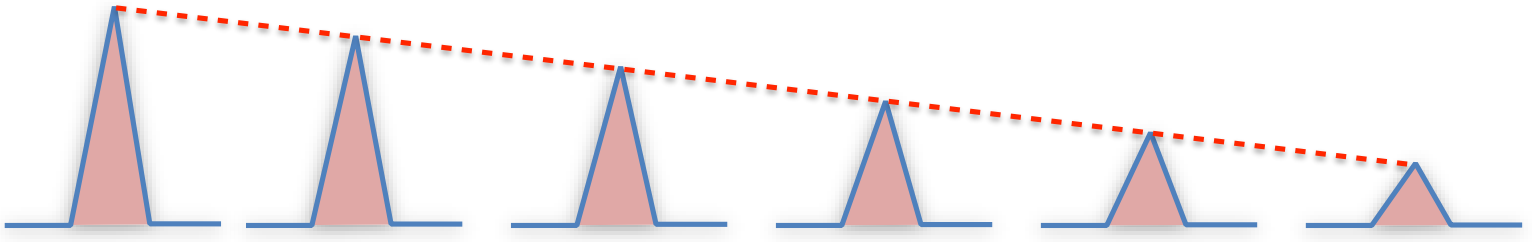
Dopamin-Aktivität

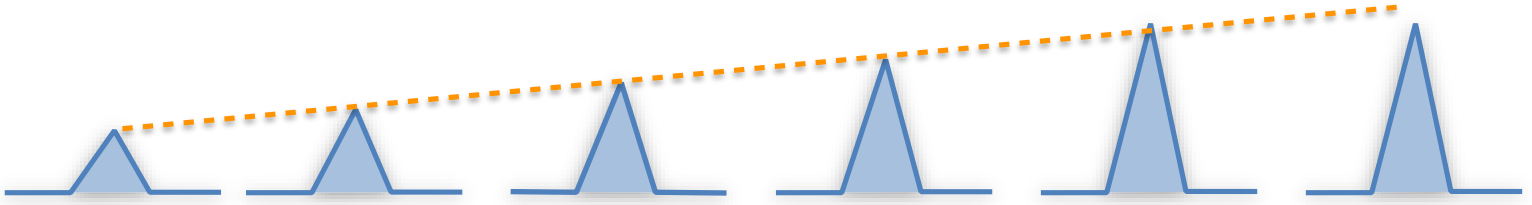
assoziatives Lernen

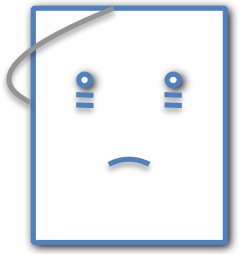




Natürliche Verstärker: Essen, Wasser, Sex, Familie

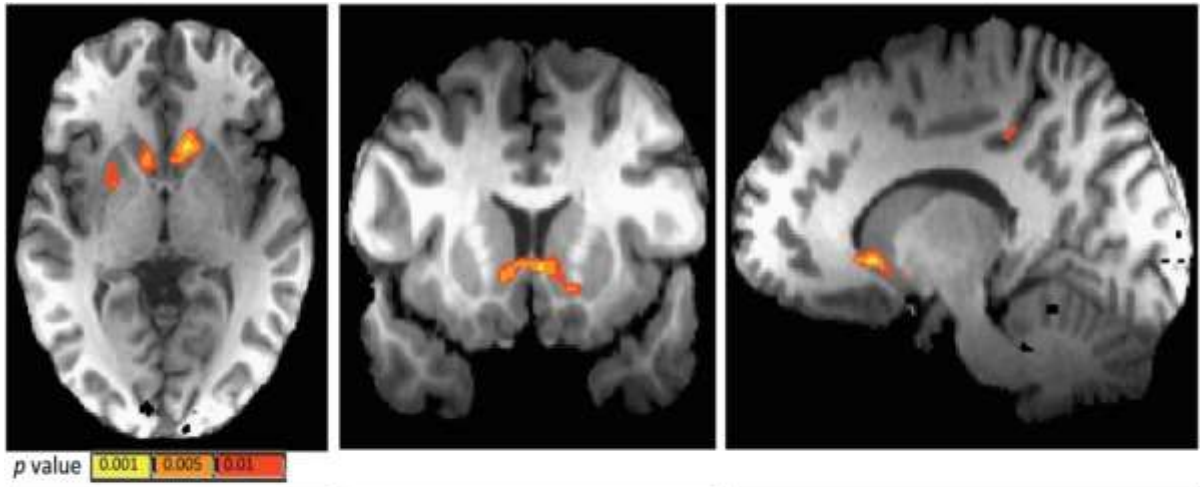






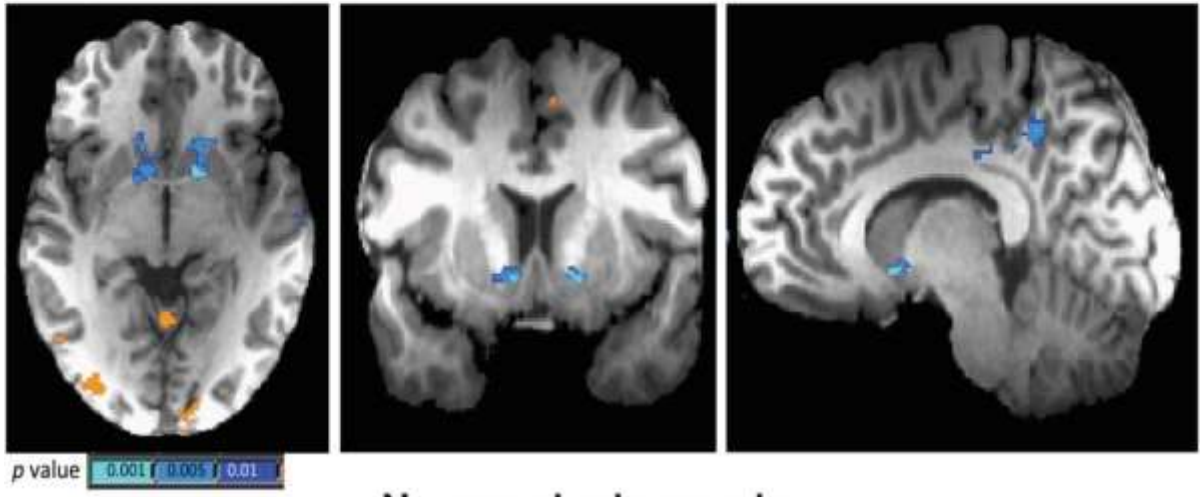
Aktivierung im ventral Striatum durch Alkohol ”brennt” bei Starkem Konsum aus

Alcohol activates ventral striatum in **light social drinkers** →



This activation is markedly lower in **heavy social drinkers** →

(and is absent in alcoholics)



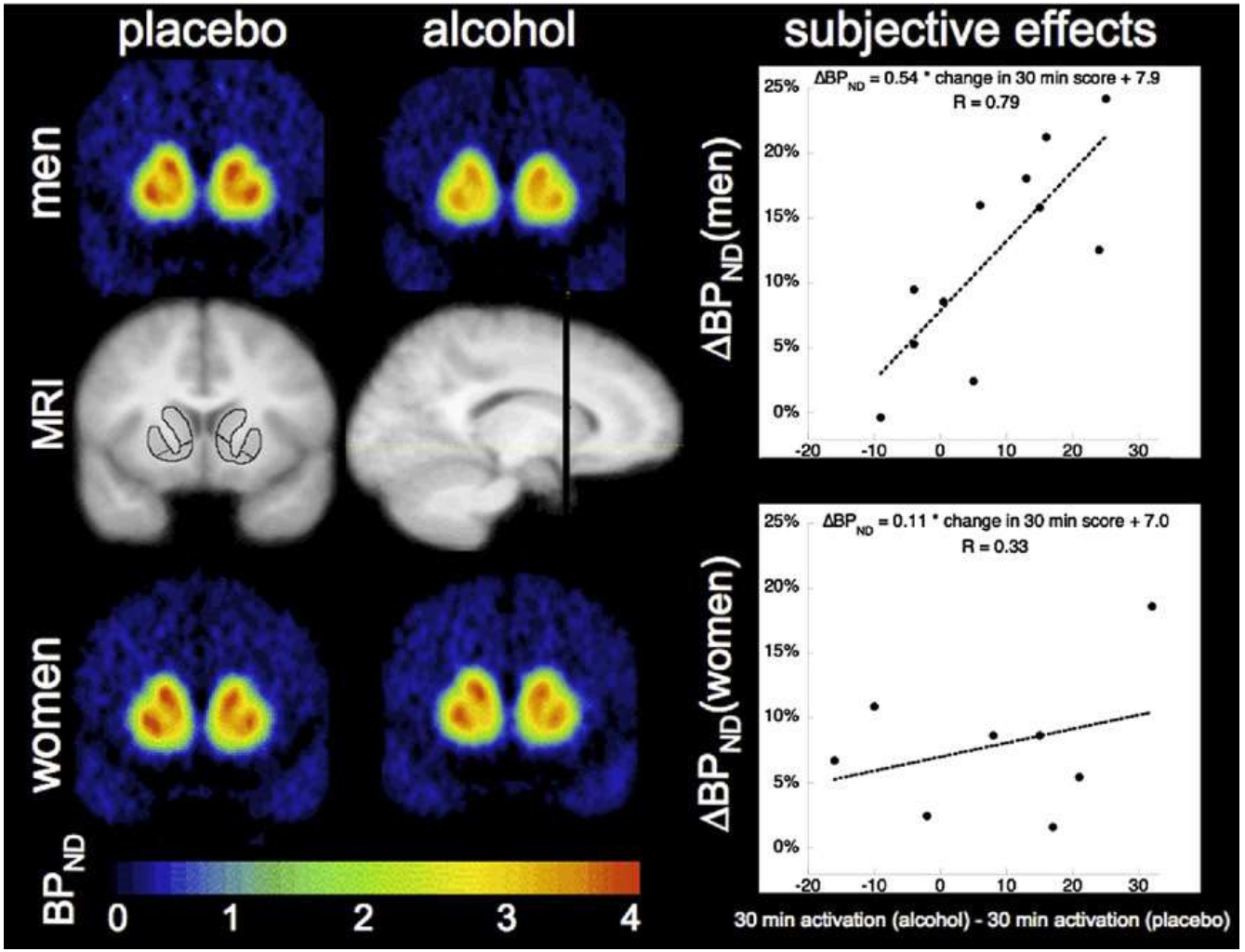
Neuropsychopharmacology

(Gilman et al, Neuropsychopharm 2010)

Dia von Markus Heilig

Psychomotorische Stimulation und Dopaminausschüttung durch Alkohol sind auf Männer beschränkt

Urban et al., Biol Psychiat 2010



M

F

Dia von Markus Heilig

Umprogrammieren

Mit dem Joystick gegen das Suchtgedächtnis

Neuropsychologische Rückfallprävention

Johannes Lindenmeyer

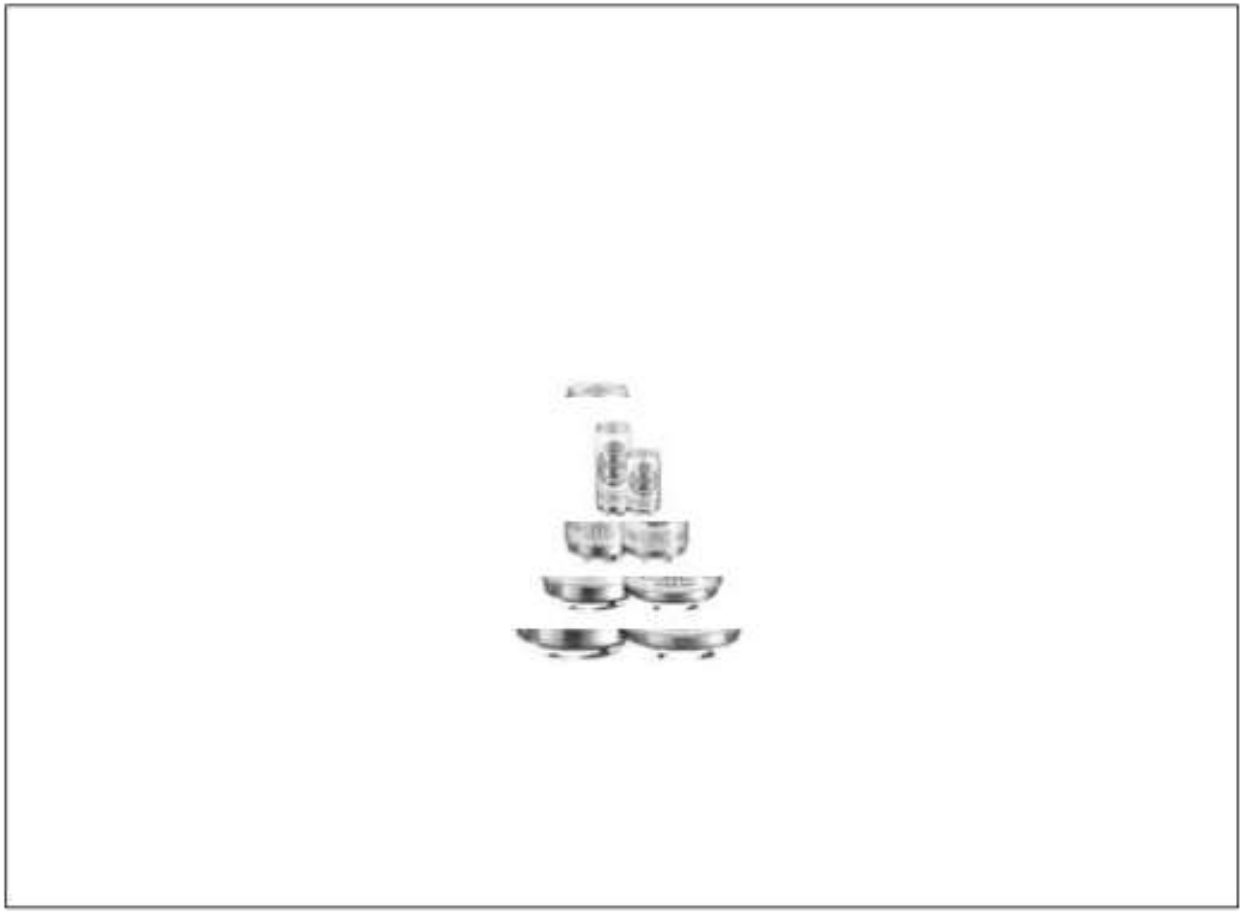
salus klinik Lindow

Bild: Lindenmeyer

Messung

Die Joystick-Aufgabe (AAT, Rinck & Becker, 2007)

Die Joystick-Aufgabe



Alkohol-Bilder: Wegschieben

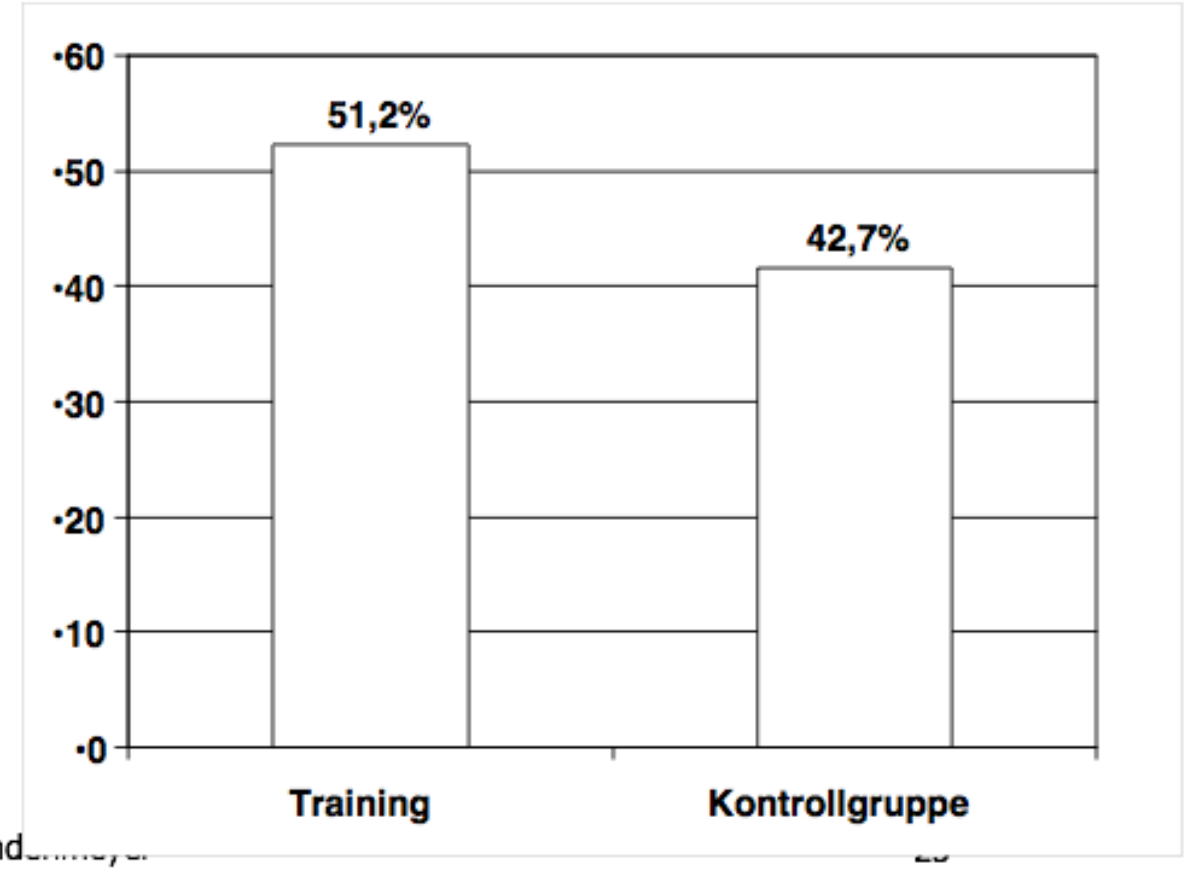
Die Joystick-Aufgabe

Alkoholfreie Getränke-Bilder: Heranziehen

Phase 2 Ergebnisse

1-Jahreskatamnese

DGSS 4 N=475



p=.039*

Neuropsychology Review
https://doi.org/10.1007/s11065-018-9386-4

REVIEW

Cognitive Bias Modification for Behavior Change in Alcohol and Smoking Addiction: Bayesian Meta-Analysis of Individual Participant Data

Marilisa Boffo[1] · Oulmann Zerhouni[2] · Quentin F. Gronau[1] · Ruben J. J. van Beek[3] · Kyriaki Nikolaou[4] · Maarten Marsman[1] · Reinout W. Wiers[1]

Received: 25 January 2018 / Accepted: 18 September 2018

Abstract
Cognitive Bias Modification (CBM) refers to a family of interventions targeting substance-related cognitive biases, which have been found to play a role in the maintenance of addictive behaviors. In this study, we conducted a Bayesian meta-analysis of individual patient data from studies investigating the effects of CBM as a behavior change intervention for the treatment of alcohol and tobacco use disorders, in individuals aware of the behavior change goal of the studies. Main outcomes included reduction in the targeted cognitive biases after the intervention and in substance use or relapse rate at the short-to-long term follow-up. Additional moderators, both at the study-level (type of addiction and CBM training) and at the participant-level (amount of completed training trials, severity of substance use), were progressively included in a series of hierarchical mixed-effects models. We included 14 studies involving 2435 participants. CBM appeared to have a small effect on cognitive bias (0.23, 95% credible interval = 0.06–0.41) and relapse rate (−0.27, 95% credible interval = −0.68 – 0.22), but not on reduction of substance use. Increased training practice showed a paradoxical moderation effect on relapse, with a relatively lower chance of relapse in the control condition with increased practice, compared to the training condition. All effects were associated with extremely wide 95% credible intervals, which indicate the absence of enough evidence in favor or against a reliable effect of CBM on cognitive bias and relapse rate in alcohol and tobacco use disorders. Besides the need for a larger body of evidence, research on the topic would benefit from a stronger adherence to the current methodological standards in randomized controlled trial design and the systematic investigation of shared protocols of CBM.

Keywords Alcohol · Tobacco · Smoking · Cognitive bias modification · Behavior change intervention · Meta-analysis · Bayesian meta-analysis

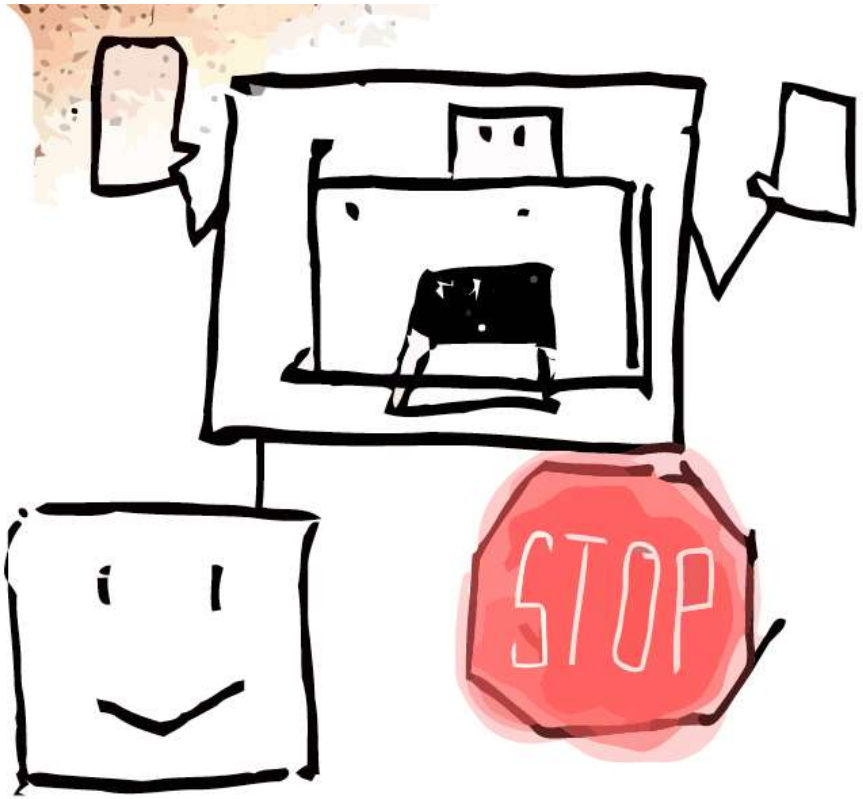
Ergebnisse: Meta-Analyse Cognitive Bias Modification Boffo et al. 2019

- 14 Studien
- 2345 Probanden
- Kein Effekt auf **Substanzkonsum**
- **Hohe Trainingsintensität** (geringere Rückfallwahrscheinlichkeit in der Kontrollbedingung)
- Kleine Effekte
  - Cognitive Bias (0.23, 95% CI = 0.06–0.41)
  - Relapse Rate (−0.27, 95% CI = −0.68 – 0.22)

We included 14 studies involving 2435 participants. CBM appeared to have a small effect on cognitive bias (0.23, 95% credible interval = 0.06–0.41) and relapse rate (−0.27, 95% credible interval = −0.68 – 0.22), but not on reduction of substance use. Increased training practice showed a paradoxical moderation effect on relapse, with a relatively lower chance of relapse in the control

Argumente

Ratschläge



Angst

Strafen

Nützt Therapie?

Alcohol Clin Exp Res. 2013 Jan;37(1):156-63. doi: 10.1111/j.1530-0277.2012.01863.x. Epub 2012 Oct 16.

Excess mortality of alcohol-dependent individuals after 14 years and mortality predictors based on treatment participation and severity of alcohol dependence.

John U[1], Rumpf HJ, Bischof G, Hapke U, Hanke M, Meyer C.

Author information

Abstract

BACKGROUND: Little is known about excess mortality and its predictors among alcohol-dependent individuals in the general population. We sought to estimate excess mortality and to determine whether alcohol dependence treatment utilization, alcohol dependence severity, alcohol-related problems, and self-rated health may predict mortality over 14 years.

METHODS: A random sample of the general population between the ages of 18 and 64 in 1 region in Germany was drawn. Among 4,070 respondents with valid data, 153 alcohol-dependent individuals were identified. For 149 of these 153, vital status information was provided 14 years later. Baseline data from the Composite International Diagnostic Interview (German version M-CIDI) included a diagnosis of alcohol dependence according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) of the American Psychiatric Association, alcohol dependence treatment utilization, alcohol dependence severity based on the number of DSM-IV alcohol dependence diagnostic criteria fulfilled and a symptom frequency questionnaire, alcohol-related problems, self-rated general health, cigarettes smoked per day, and the number of psychiatric disorders according to the DSM-IV at baseline.

RESULTS: Annualized death rates were 4.6-fold higher for women and 1.9-fold higher for men compared to the age- and sex-specific general population. Having participated in inpatient specialized alcohol dependence treatment was not related with longer survival than not having taken part in the treatment. Utilization of inpatient detoxification treatment predicted the hazard rate ratio of mortality (unadjusted: 4.2, 90% confidence interval 1.8 to 9.8). The severity of alcohol dependence was associated with the use of detoxification treatment. Alcohol-related problems and poor self-rated health predicted mortality.

CONCLUSIONS: According to the high excess mortality, a particular focus should be placed on women. Inpatient specialized alcohol dependence treatment did not seem to have a sufficient protective effect against dying prematurely. Having been in detoxification treatment only, the severity of alcohol dependence, alcohol-related problems, and self-rated health may be predictors of time-to-death among this general population sample.

Ergebnisse
149 Alkoholabhängige

	Lebend	Verstorben	Total
Entwöhnungsbehandlung			
nein	**85,7%**	**14,3%**	**100**
ja	**76,5%**	**23,5%**	**100**

John, Rumpf, Bischof, Hapke, Hanke & Meyer (2013) Alcoholism: Clinical and Experimental Research

Den Ergebnissen zufolge hat zudem eine Alkoholtherapie keine positive Auswirkung auf die Lebense

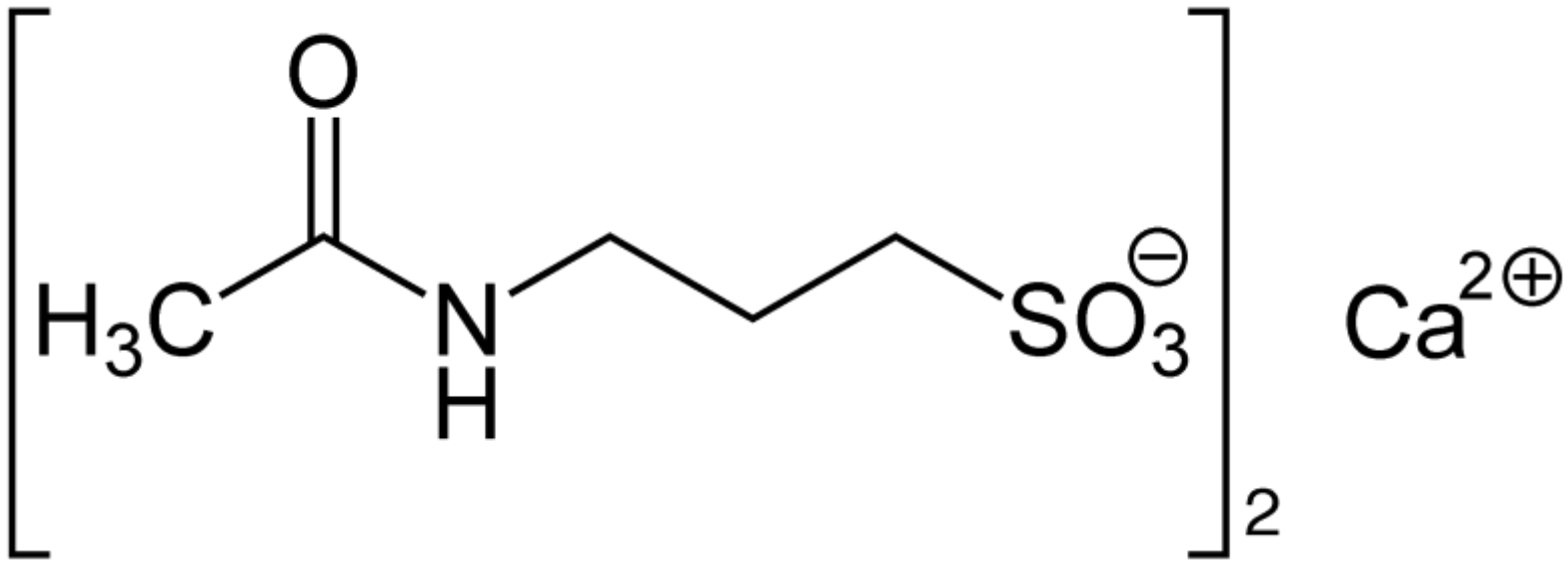
Table 2. Survival Analysis—Hazard Rate Ratios (90% Confidence Intervals) $N = 149$

		Multivariate			
Baseline	Univariate	Model 1		Model 2	
Inpatient alcohol dependence treatment					
Never	Ref	Ref	Ref	Ref	Ref
Specialized alcohol dependence treatment	1.71 (0.83–3.51)	0.69 (0.27–1.76)	0.83 (0.38–1.82)	0.60 (0.23–1.60)	0.81 (0.37–1.77)
Detoxification	4.18 (1.79–9.79)†	3.16 (1.10–9.11)	3.85 (1.44–10.31)*	3.06 (1.05–8.89)	4.07 (1.54–10.74)*
Number of alcohol dependence criteria DSM-IV	1.31 (1.05–1.64)*	1.08 (0.76–1.53)	–	1.14 (0.79–1.65)	–
Severity scale of alcohol dependence (SESA)	1.33 (1.05–1.69)*	–	0.92 (0.69–1.23)	–	0.91 (0.68–1.21)
Alcohol-related problems	1.05 (0.99956–1.11)	1.08 (1.01–1.15)*	1.09 (1.02–1.17)*	1.07 (1.01–1.14)	1.09 (1.02–1.16)*
Self-rated health	0.57 (0.41–0.79)†	0.59 (0.42–0.82)†	0.59 (0.42–0.82)†	0.52 (0.35–0.77)†	0.53 (0.36–0.78)†
Number of psychiatric disorders lifetime	1.03 (0.87–1.21)	–	–	0.89 (0.72–1.09)	0.90 (0.73–1.11)
Pack-years smoked	1.01 (1.005–1.02)†	1.01 (0.996–1.02)	1.01 (0.997–1.02)	1.01 (0.997–1.02)	1.01 (0.998–1.02)
Age	1.08 (1.04–1.11)‡	1.08 (1.04–1.12)†	1.08 (1.04–1.13)†	1.07 (1.03–1.12)*	1.08 (1.03–1.12)†
Female	1.36 (0.66–2.78)	1.22 (0.50–2.96)	1.36 (0.59–3.14)	1.45 (0.57–3.71)	1.71 (0.67–4.36)

*$p < 0.05$, †$p < 0.01$, ‡$p < 0.001$ (corresponding to 95% confidence interval).
DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. SESA: quintiles.

Entgiftung: Mortalität 4.18 mal so hoch verglichen mit Patienten ohne Entgiftung

Aufhören mit Acamprosat?



Acamprosat

Calcium

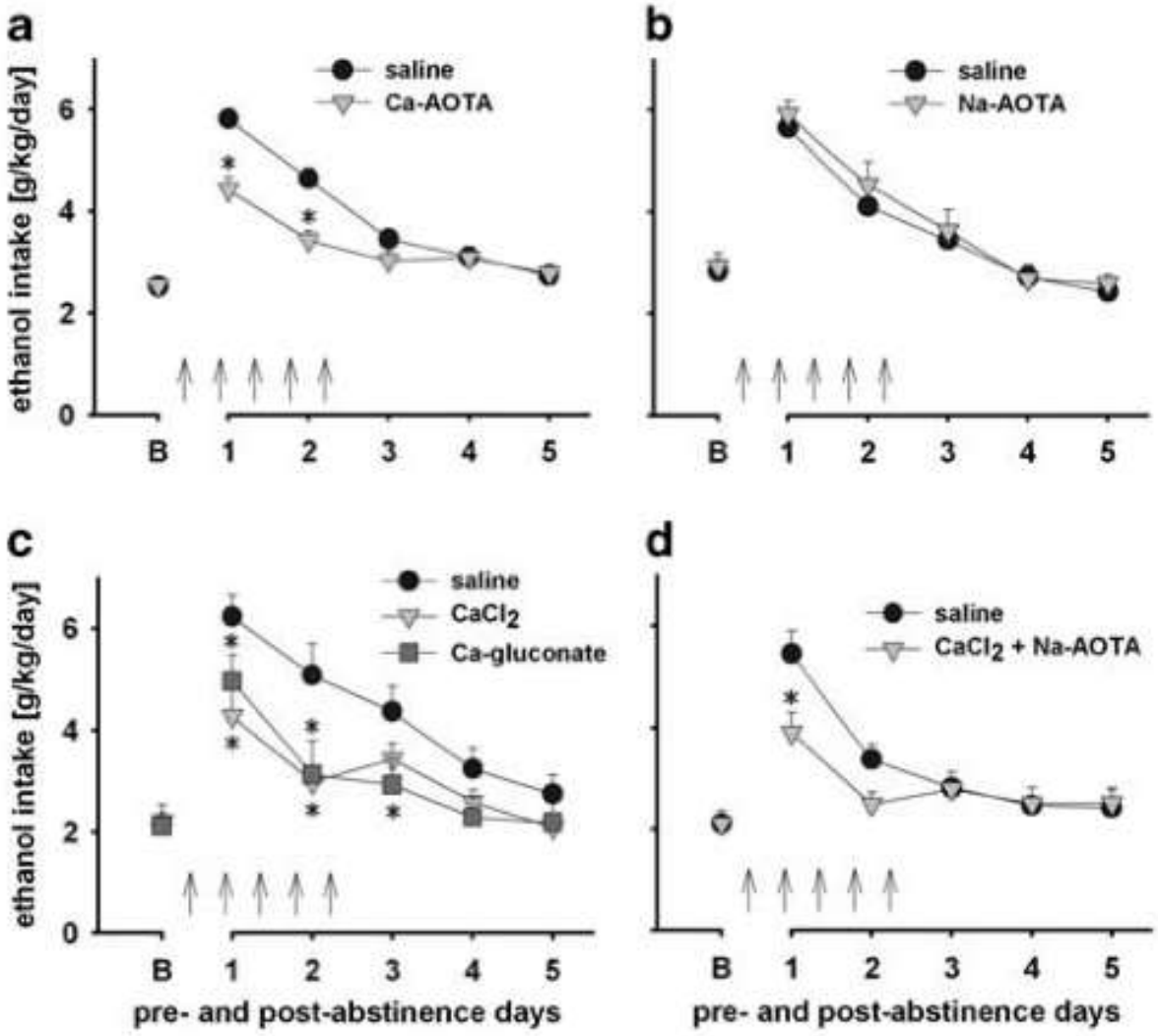
Neuropsychopharmacology (2014) 39, 783–791

www.neuropsychopharmacology.org

Acamprosate Produces Its Anti-Relapse Effects Via Calcium

Rainer Spanagel[*,1,5], Valentina Vengeliene[1,5], Bernd Jandeleit[2,5], Wolf-Nicolas Fischer[2], Kent Grindstaff[2], Xuexiang Zhang[2], Mark A Gallop[2], Elena V Krstew[3], Andrew J Lawrence[3] and Falk Kiefer[4]

[1]Institute of Psychopharmacology, Central Institute of Mental Health, University of Heidelberg, Medical Faculty Mannheim, Mannheim, Germany; [2]XenoPort, Inc., Santa Clara, CA, USA; [3]Florey Institute of Neuroscience & Mental Health, University of Melbourne, Melbourne, Australia; [4]Department of Addictive Behavior and Addiction Medicine, Central Institute for Mental Health, Mannheim, Germany



Neuropsychopharmacology (2014) 39, 783–791

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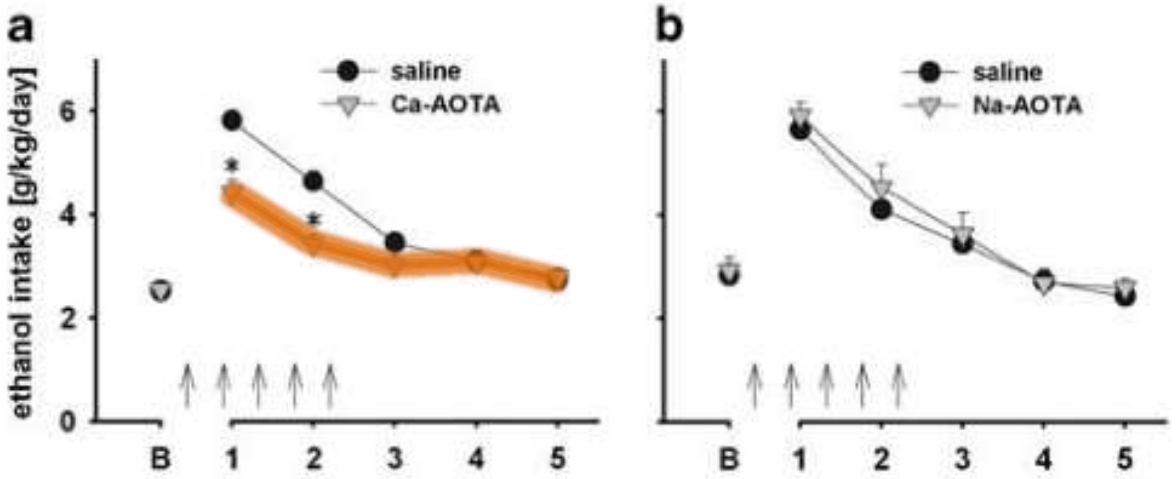

Neuropsychopharmacology (2014) 39, 783–791
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www.neuropsychopharmacology.org

Acamprosate Produces Its Anti-Relapse Effects Via Calcium

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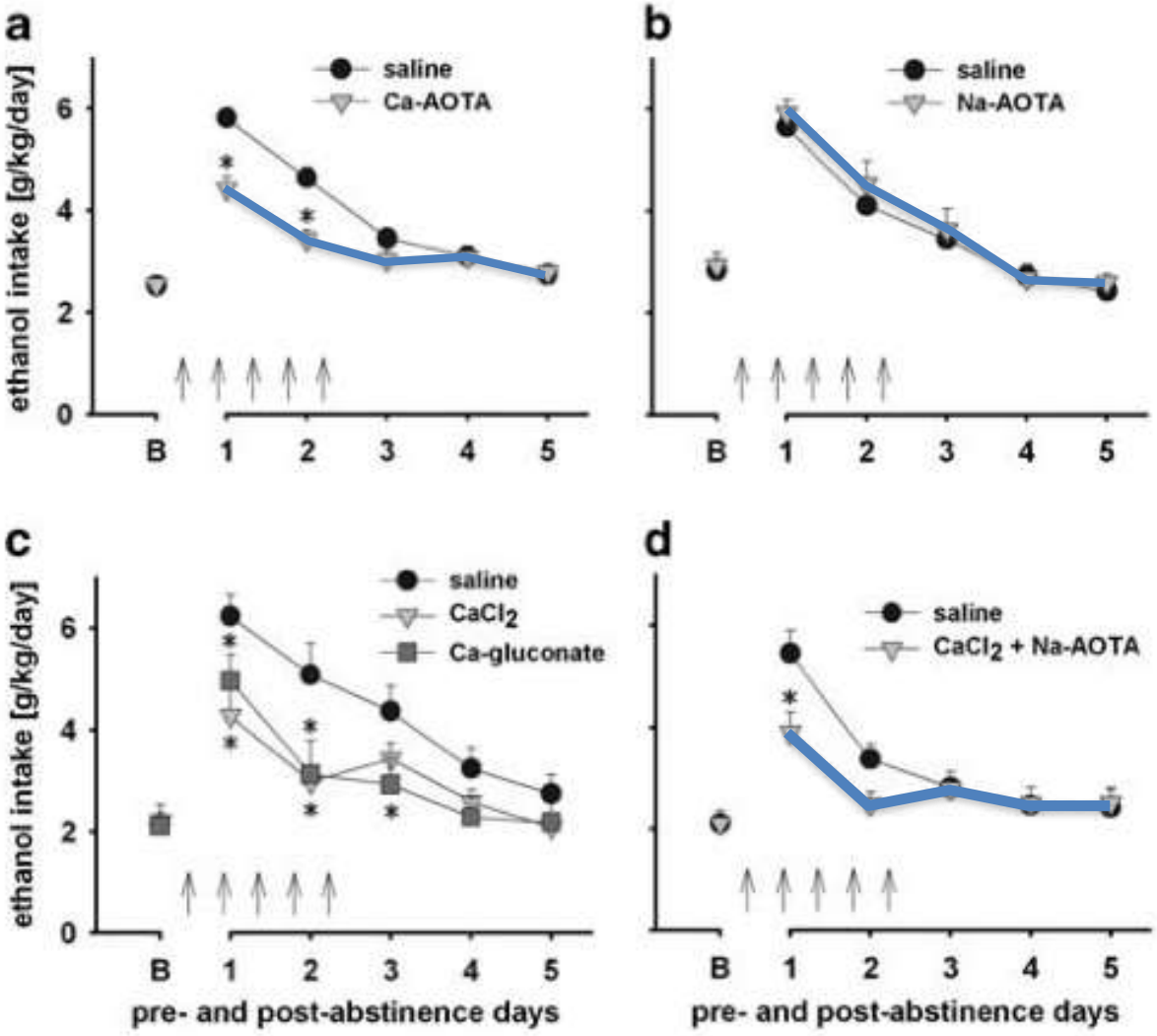

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Eur Neuropsychopharmacol. 2017 Jan;27(1):42-47. doi: 10.1016/j.euroneuro.2016.11.007. Epub 2016 Nov 25.

Association of plasma calcium concentrations with alcohol craving: New data on potential pathways.

Schuster R[1], Koopmann A[2], Grosshans M[2], Reinhard I[3], Spanagel R[4], Kiefer F[2].

Author information

Abstract

Recently, calcium was suggested to be the active moiety of acamprosate. We examined plasma calcium concentrations in association with severity of alcohol dependence and its interaction with regulating pathways and alcohol craving in alcohol-dependent patients. 47 inpatient alcohol-dependent patients undergoing detoxification treatment underwent laboratory testing, including calcium, sodium, liver enzymes as well as serum concentrations of calcitonin, parathyroid hormone and vitamin D. The psychometric dimension of craving was analyzed with the Obsessive Compulsive Drinking Scale (OCDS). The severity of withdrawal was measured with the Alcohol Dependence Scale (ADS) and with the Alcohol Dependence Scale for high-risk sample (ADS-HR). The main findings of our investigation are: a) a negative correlation of plasma calcium concentrations with alcohol craving in different dimensions of the OCDS; b) a negative correlation of plasma calcium concentrations with breath alcohol concentration; c) lowered calcitonin concentration in the high-risk sample of alcoholics; d) lowered plasma vitamin D concentrations in all alcoholic subjects. Our study adds further support for lowered plasma calcium concentrations in patients with high alcohol intake and especially in patients with increased craving as a risk factor for relapse. Lowered calcitonin concentrations in the high-risk sample and lowered vitamin D concentrations may mediate these effects. Calcium supplementation could be a useful intervention for decreasing craving and relapse in alcohol-dependent subjects.

KEYWORDS: Alcohol dependence; Calcitonin; Calcium; Craving; Parathyroid hormone; Vitamin D

PMID: 27890540 DOI: 10.1016/j.euroneuro.2016.11.007

Similar articles

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Review Craving and relapse measurement in [Alcohol Alcohol. 1999]

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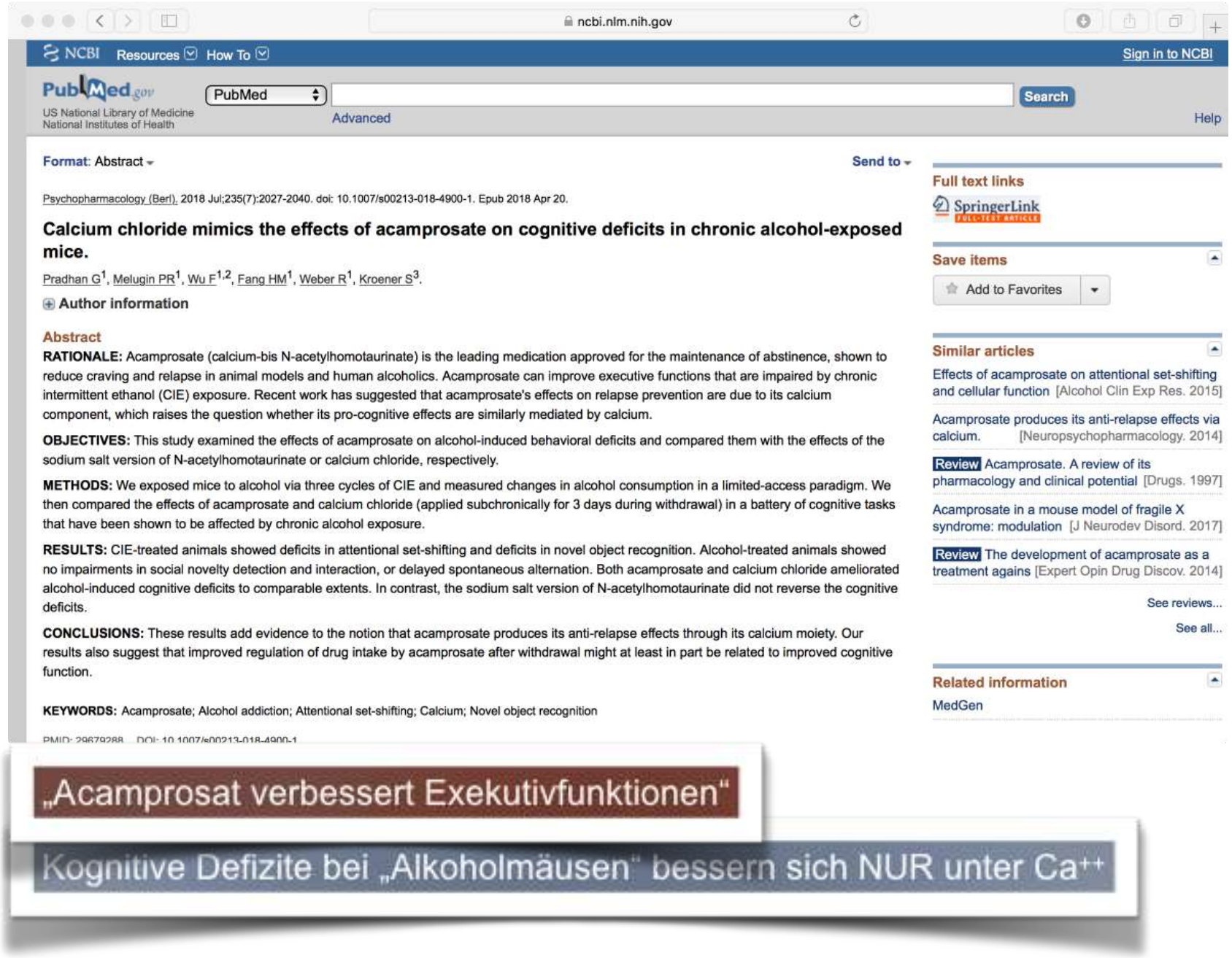
Ca^{++} NEG. Korreliert: Craving und Atemalkohol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Psychopharmacology (Berl). 2018 Jul;235(7):2027-2040. doi: 10.1007/s00213-018-4900-1. Epub 2018 Apr 20.
Calcium chloride mimics the effects of acamprosate on cognitive deficits in chronic alcohol-exposed mice.
Pradhan G[1], Melugin PR[1], Wu F[1,2], Fang HM[1], Weber R[1], Kroener S[3].
Author information
Abstract
RATIONALE: Acamprosate (calcium-bis N-acetylhomotaurinate) is the leading medication approved for the maintenance of abstinence, shown to reduce craving and relapse in animal models and human alcoholics. Acamprosate can improve executive functions that are impaired by chronic intermittent ethanol (CIE) exposure. Recent work has suggested that acamprosate's effects on relapse prevention are due to its calcium component, which raises the question whether its pro-cognitive effects are similarly mediated by calcium.
OBJECTIVES: This study examined the effects of acamprosate on alcohol-induced behavioral deficits and compared them with the effects of the sodium salt version of N-acetylhomotaurinate or calcium chloride, respectively.
METHODS: We exposed mice to alcohol via three cycles of CIE and measured changes in alcohol consumption in a limited-access paradigm. We then compared the effects of acamprosate and calcium chloride (applied subchronically for 3 days during withdrawal) in a battery of cognitive tasks that have been shown to be affected by chronic alcohol exposure.
RESULTS: CIE-treated animals showed deficits in attentional set-shifting and deficits in novel object recognition. Alcohol-treated animals showed no impairments in social novelty detection and interaction, or delayed spontaneous alternation. Both acamprosate and calcium chloride ameliorated alcohol-induced cognitive deficits to comparable extents. In contrast, the sodium salt version of N-acetylhomotaurinate did not reverse the cognitive deficits.
CONCLUSIONS: These results add evidence to the notion that acamprosate produces its anti-relapse effects through its calcium moiety. Our results also suggest that improved regulation of drug intake by acamprosate after withdrawal might at least in part be related to improved cognitive function.
KEYWORDS: Acamprosate; Alcohol addiction; Attentional set-shifting; Calcium; Novel object recognition
PMID: 29679288 DOI: 10.1007/s00213-018-4900-1
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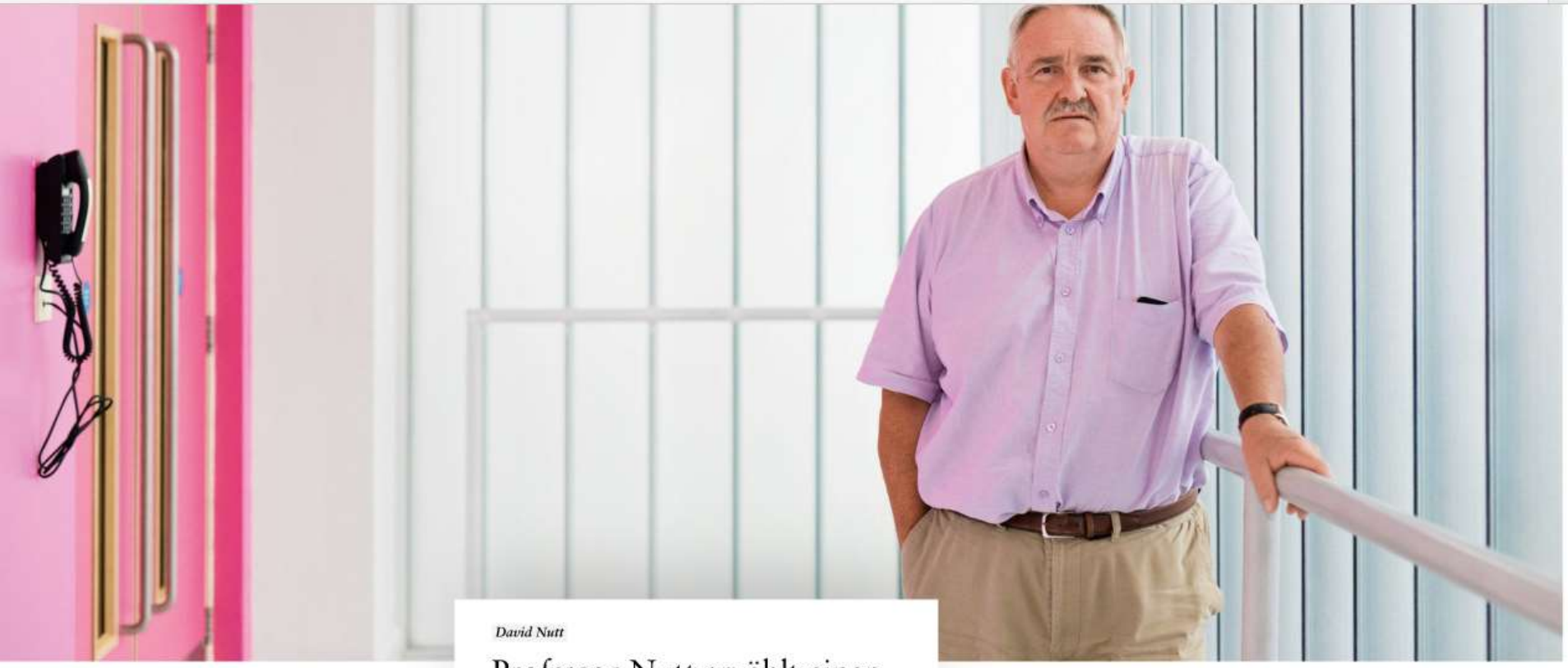
Alkoholersatz

Rausch ohne Reue

Tolle Idee! Was wurde daraus?

Trinken ohne Kater am nächsten Morgen: 2013 verkündete der britische Forscher David Nutt, er habe mehrere Substanzen gefunden, die betrunken machen, ohne die Gesundheit zu schädigen. Klingt gut – doch Fördergelder gibt es für die Forschungen nicht. Auch die Getränkeindustrie hat kein Interesse.

Von Anneke Meyer



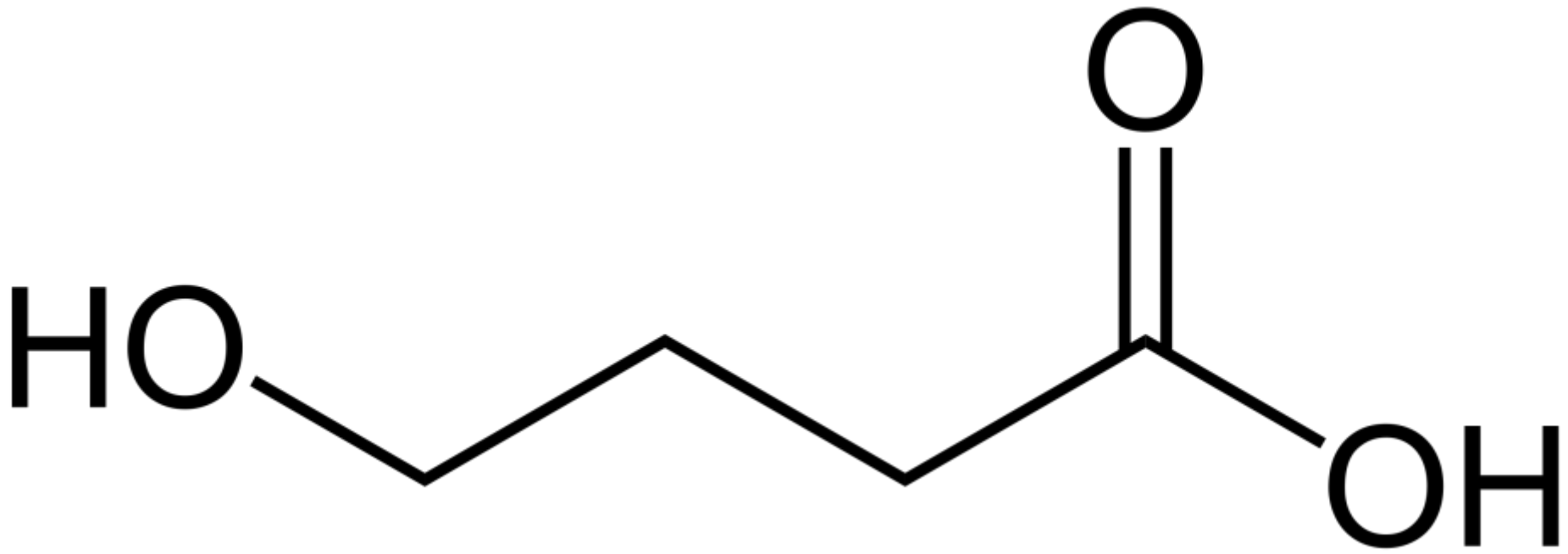
David Nutt

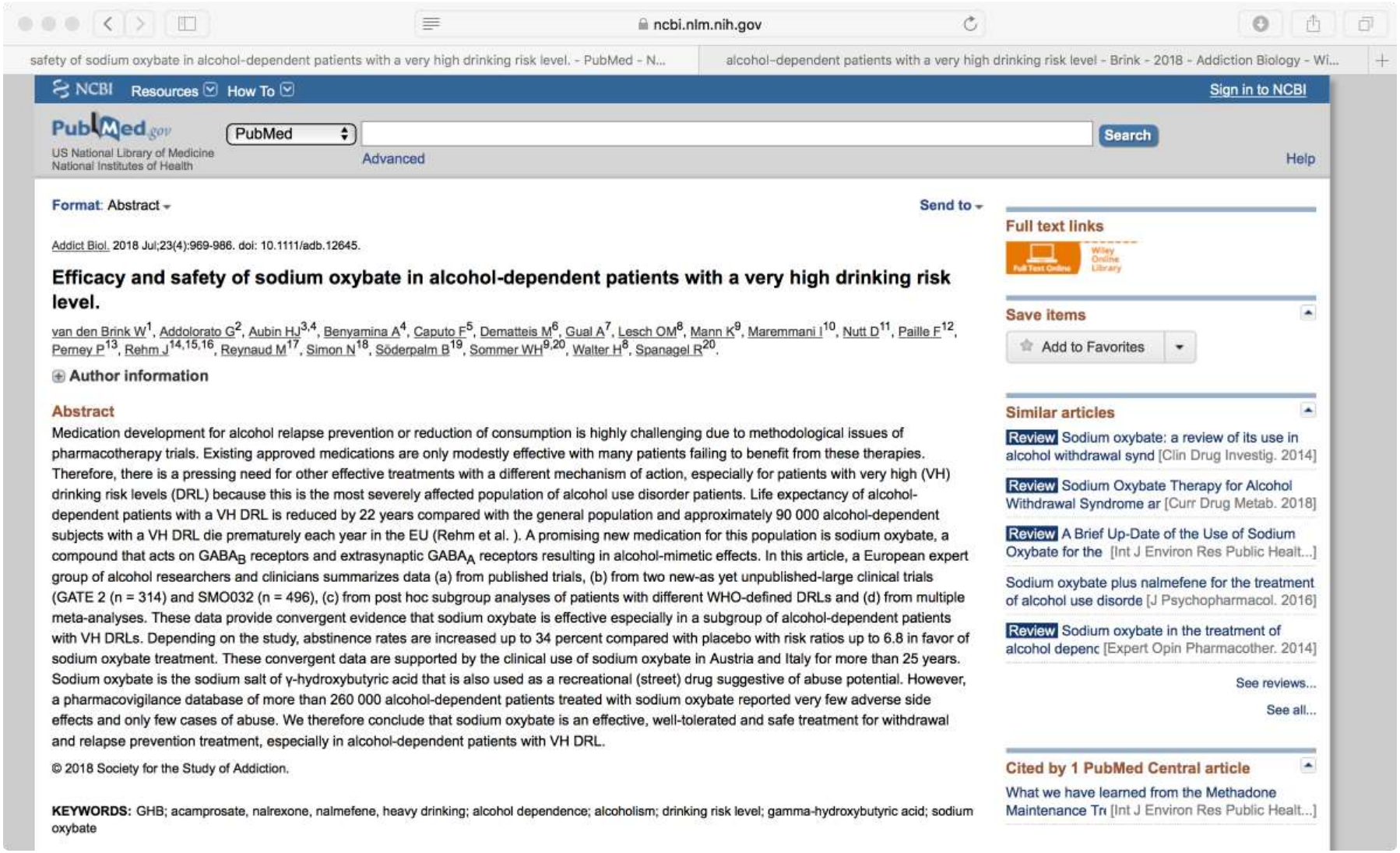
Professor Nutt erzählt einen vom Pferd

Wie ein Wissenschaftler lernte, dass sich rationales Denken nicht lohnt (und warum ihm das egal ist).

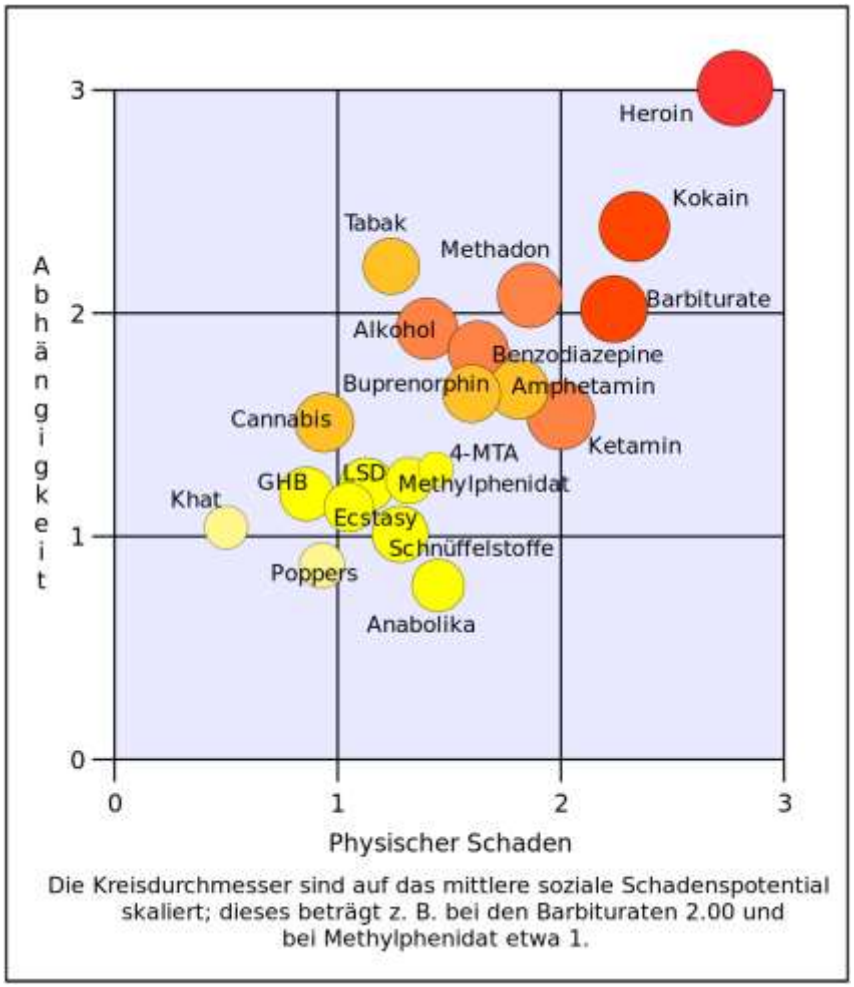
4-Hydroxybutansäure

4-Hydroxybutansäure oder **γ-Hydroxybuttersäure**, kurz **GHB** (Gamma-Hydroxybuttersäure)
Hydroxy-Carbonsäure deren Salze als **4-Hydroxybutyrate** oder in der Pharmazie als **Oxybate** bezeichnet werden
GHB ist eng verwandt mit dem menschlichen Neurotransmitter GABA (Gamma-Aminobuttersäure) und ist zugleich



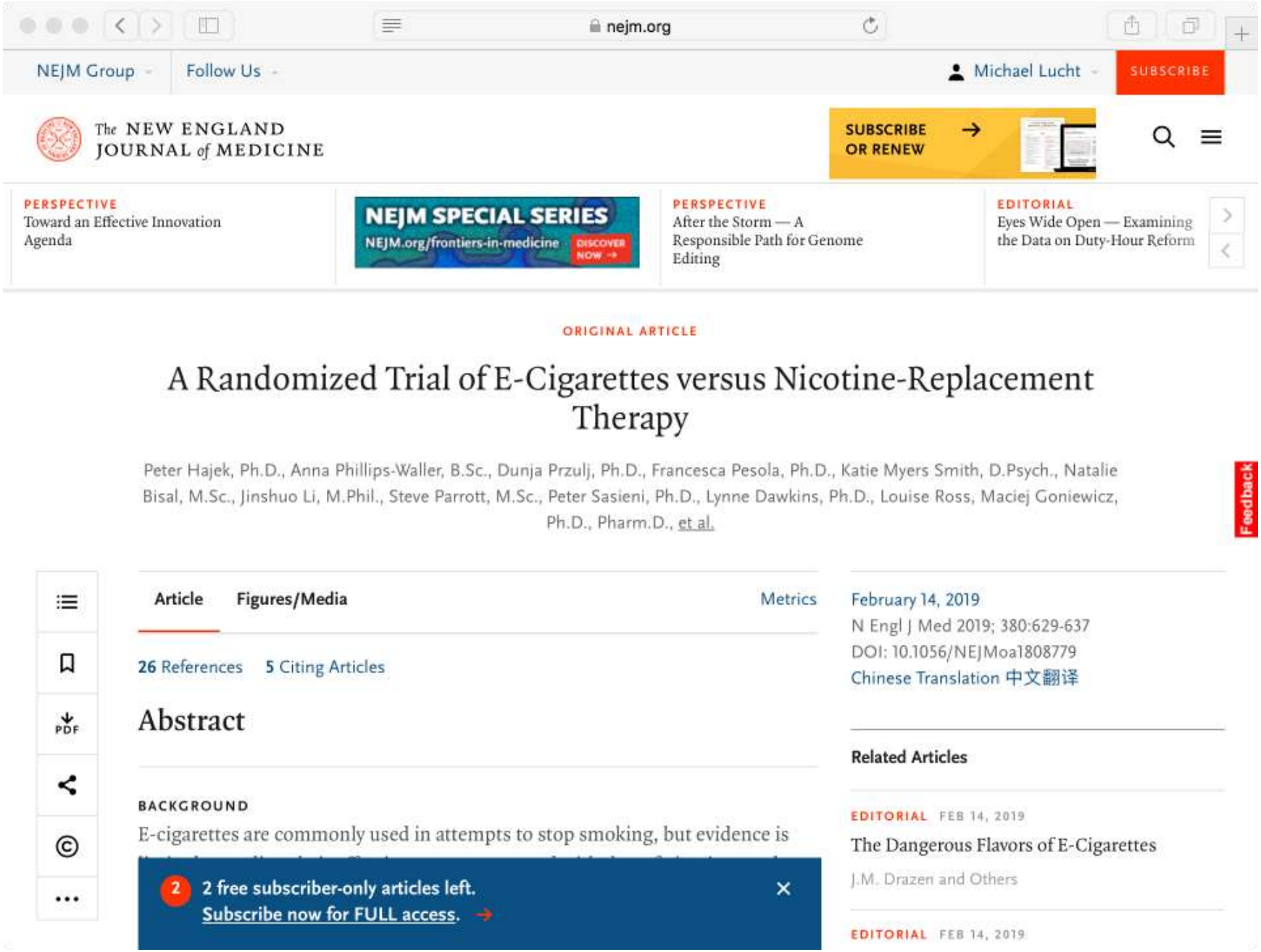


GHB:Placebo: pro Abstinenz pro GHB bis 6.8 (RR)



Liquid Ecstasy

K.O. Tropfen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A Randomized Trial of E-Cigarettes versus Nicotine-Replacement Therapy
Peter Hajek, Ph.D., Anna Phillips-Waller, B.Sc., Dunja Przulj, Ph.D., Francesca Pesola, Ph.D., Katie Myers Smith, D.Psych., Natalie Bisal, M.Sc., Jinshuo Li, M.Phil., Steve Parrott, M.Sc., Peter Sasieni, Ph.D., Lynne Dawkins, Ph.D., Louise Ross, Maciej Goniewicz, Ph.D., Pharm.D., et al.
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Abstract
BACKGROUND
E-cigarettes are commonly used in attempts to stop smoking, but evidence is
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February 14, 2019
N Engl J Med 2019; 380:629-637
DOI: 10.1056/NEJMoa1808779
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J.M. Drazen and Others
EDITORIAL FEB 14, 2019
Feedback

Table 2. Abstinence Rates at Different Time Points and Smoking Reduction at 52 Weeks.*

Outcome	E-Cigarettes (N=438)	Nicotine Replacement (N=446)	Primary Analysis: Relative Risk (95% CI)†	Sensitivity Analysis: Adjusted Relative Risk (95% CI)
Primary outcome: abstinence at 52 wk — no. (%)	79 (18.0)	44 (9.9)	1.83 (1.30–2.58)	1.75 (1.24–2.46)‡
Secondary outcomes				
Abstinence between wk 26 and wk 52 — no. (%)	93 (21.2)	53 (11.9)	1.79 (1.32–2.44)	1.82 (1.34–2.47)§
Abstinence at 4 wk after target quit date — no. (%)	192 (43.8)	134 (30.0)	1.45 (1.22–1.74)	1.43 (1.20–1.71)¶
Abstinence at 26 wk after target quit date — no. (%)	155 (35.4)	112 (25.1)	1.40 (1.14–1.72)	1.36 (1.15–1.67)‡
Carbon monoxide–validated reduction in smoking of ≥50% in participants without abstinence between wk 26 and wk 52 — no./total no. (%)	44/345 (12.8)	29/393 (7.4)	1.75 (1.12–2.72)	1.73 (1.11–2.69)‖

* Abstinence at 52 weeks was defined as a self-report of smoking no more than five cigarettes from 2 weeks after the target quit date, validated biochemically by an expired carbon monoxide level of less than 8 ppm at 52 weeks. Abstinence between week 26 and week 52 was defined as a self-report of smoking no more than five cigarettes between week 26 and week 52, plus an expired carbon monoxide level of less than 8 ppm at 52 weeks. Abstinence at 4 weeks was defined as a self-report of no smoking from 2 weeks after the target quit date, plus an expired carbon monoxide level of less than 8 ppm at 4 weeks. Abstinence at 26 weeks was defined as a self-report of smoking no more than five cigarettes from 2 weeks after the target quit date to 26 weeks; there was no validation by expired carbon monoxide level.

† The analysis was adjusted for trial center only.

‡ The analysis was adjusted for trial center, marital status, age at smoking initiation, and score on the Fagerström Test for Cigarette Dependence.

§ The analysis was adjusted for trial center, age, score on the Fagerström Test for Cigarette Dependence, and age at smoking initiation.

¶ The analysis was adjusted for trial center, education level, partner who smokes (yes or no), and score on the Fagerström Test for Cigarette Dependence.

‖ The analysis was adjusted for trial center, sex, age, and partner who smokes (yes or no).

P Hajek et al. N Engl J Med 2019;380:629-637.

The NEW ENGLAND JOURNAL of MEDICINE

Table 5. Respiratory Symptoms at Baseline and at 52 Weeks.*

Symptom	E-Cigarettes (N=315)		Nicotine Replacement (N=279)		Relative Risk (95% CI)†
	Baseline	52 Weeks	Baseline	52 Weeks	
	number (percent)				
Shortness of breath	120 (38.1)	66 (21.0)	92 (33.0)	64 (22.9)	0.9 (0.7–1.1)
Wheezing	102 (32.4)	74 (23.5)	86 (30.8)	59 (21.1)	1.1 (0.8–1.4)
Cough	173 (54.9)	97 (30.8)	144 (51.6)	111 (39.8)	0.8 (0.6–0.9)
Phlegm	137 (43.5)	79 (25.1)	121 (43.4)	103 (36.9)	0.7 (0.6–0.9)

* Symptoms were assessed by asking whether participants had the symptom (yes or no).
† Relative risk was calculated by means of logistic regression. Symptoms at 52 weeks were regressed onto trial group, with adjustment for baseline symptoms and trial center.

P Hajek et al. N Engl J Med 2019;380:629-637.

The NEW ENGLAND JOURNAL of MEDICINE

Fitness-Armbänder bringen nicht den gewünschten Effekt

Dienstag, 18. Oktober 2016, 11:17 Uhr

Sandra Büchi

1

Fitness-Armbänder sollen beim Abnehmen helfen und liegen im Trend. Zwei neue Studien zeigen aber nun: Sie nützen nicht jedem, und viele legen ihr Armband nach kurzer Zeit beiseite.

Effectiveness of activity trackers with and without incentives to increase physical activity (TRIPPA): a randomised controlled trial

Eric A Finkelstein, Benjamin A Haaland, Marcel Bilger, Aarti Sahasranaman, Robert A Sloan, Ei Ei Khaing Nang, Kelly R Evenson

Summary

Background Despite the increasing popularity of activity trackers, little evidence exists that they can improve health outcomes. We aimed to investigate whether use of activity trackers, alone or in combination with cash incentives or charitable donations, lead to increases in physical activity and improvements in health outcomes.

Methods In this randomised controlled trial, employees from 13 organisations in Singapore were randomly assigned (1:1:1:1) with a computer generated assignment schedule to control (no tracker or incentives), Fitbit Zip activity tracker, tracker plus charity incentives, or tracker plus cash incentives. Participants had to be English speaking, full-time employees, aged 21–65 years, able to walk at least ten steps continuously, and non-pregnant. Incentives were tied to weekly steps, and the primary outcome, moderate-to-vigorous physical activity (MVPA) bout min per week, was measured via a sealed accelerometer and assessed on an intention-to-treat basis at 6 months (end of intervention) and 12 months (after a 6 month post-intervention follow-up period). Other outcome measures included steps, participants meeting 70 000 steps per week target, and health-related outcomes including weight, blood pressure, and quality-of-life measures. This trial is registered at ClinicalTrials.gov, number NCT01855776.

Findings Between June 13, 2013, and Aug 15, 2014, 800 participants were recruited and randomly assigned to the control (n=201), Fitbit (n=203), charity (n=199), and cash (n=197) groups. At 6 months, compared with control, the cash group logged an additional 29 MVPA bout min per week (95% CI 10–47; p=0·0024) and the charity group an additional 21 MVPA bout min per week (2–39; p=0·0310); the difference between Fitbit only and control was not significant (16 MVPA bout min per week [–2 to 35; p=0·0854]). Increases in MVPA bout min per week in the cash and charity groups were not significantly greater than that of the Fitbit group. At 12 months, the Fitbit group logged an additional 37 MVPA bout min per week (19–56; p=0·0001) and the charity group an additional 32 MVPA bout min per week (12–51; p=0·0013) compared with control; the difference between cash and control was not significant (15 MVPA bout [illegible] –42 to –4; p=0·0184) was seen when comparing the cash group with the Fitbit group. There were no improvements in any health outcomes (weight, blood pressure, etc) at either assessment.

Interpretation The cash incentive was most effective at increasing MVPA bout min per week at 6 months, but this effect was not sustained 6 months after the incentives were discontinued. At 12 months, the activity tracker with or

Lancet Diabetes Endocrinol 2016

Published Online
October 4, 2016
http://dx.doi.org/10.1016/S2213-8587(16)30284-4

See Online/Comment
http://dx.doi.org/10.1016/S2213-8587(16)30264-9

Program in Health Services and Systems Research (Prof E A Finkelstein PhD, M Bilger PhD, A Sahasranaman PhD) and Centre for Quantitative Medicine (B A Haaland PhD), Duke-NUS Medical School, Singapore, Singapore; H Milton Stewart School of Industrial & Systems Engineering, Georgia Institute of Technology, Atlanta, GA, USA (B A Haaland); The Graduate School of Medical and Dental Sciences, Kagoshima University, Kagoshima, Japan (R A Sloan PhD); Lee Kong Chian School of Medicine, Nanyang Technological University, Singapore, Singapore (E K Nang PhD); Gillings School of Global Public Health, Department of Epidemiology, University of North Carolina, Chapel Hill, NC,

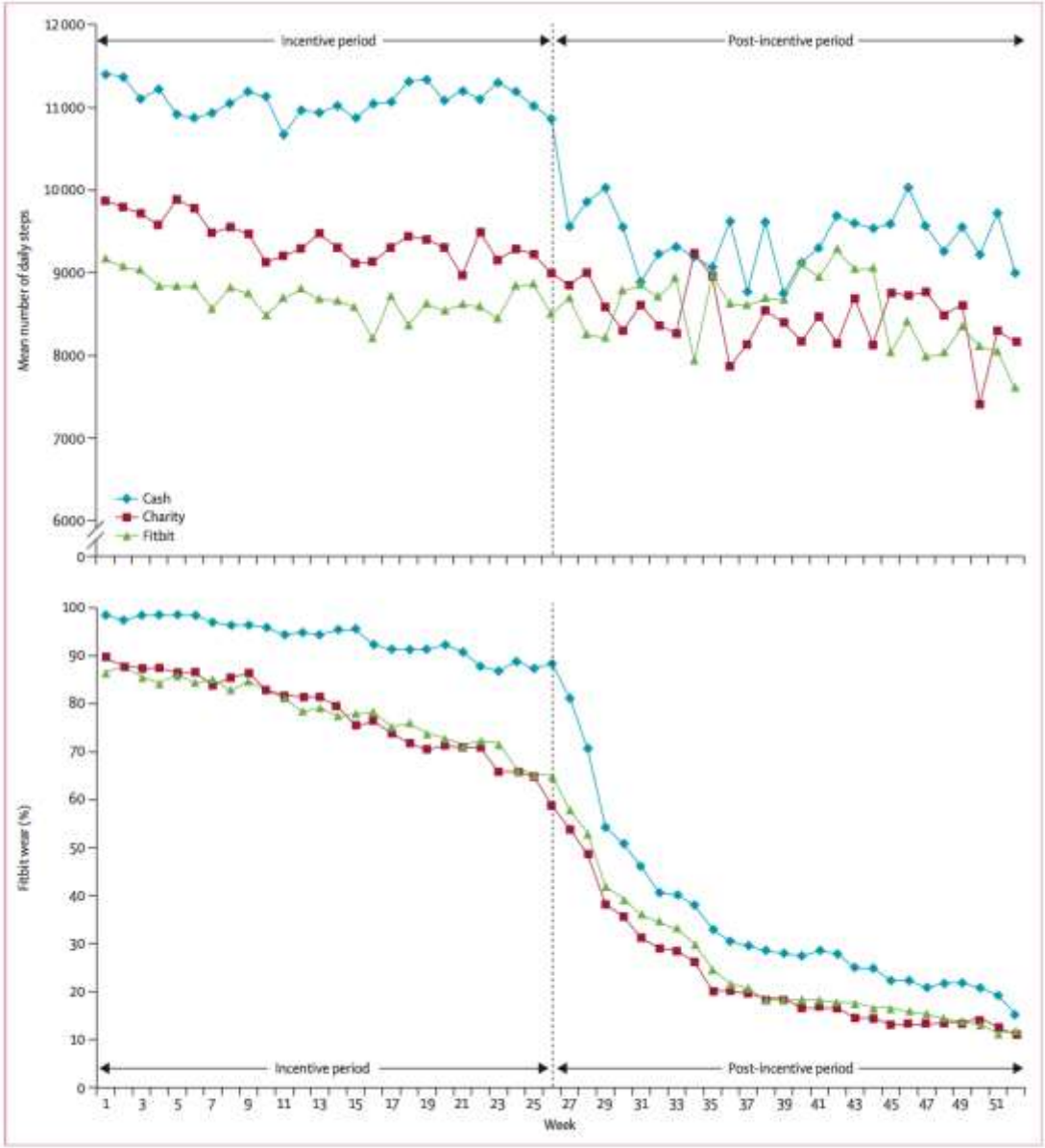


Figure 2: Mean number of daily steps and percentage of Fitbit Zip wear, by study group

Percentage of Fitbit wear indicates the percentage of participants who wore the Fitbit for at least 1 day in that week. Any day during which a participant logged 500 or more steps on the Fitbit was regarded as a valid day and constituted wearing the tracker for that day. The control group is not included in these graphs because control group participants did not receive the Fitbit activity tracker.

JAMA | Original Investigation

Effect of Wearable Technology Combined With a Lifestyle Intervention on Long-term Weight Loss
The IDEA Randomized Clinical Trial

John M. Jakicic, PhD; Kelliann K. Davis, PhD; Renee J. Rogers, PhD; Wendy C. King, PhD; Marsha D. Marcus, PhD; Diane Helsel, PhD, RD; Amy D. Rickman, PhD, RD, LDN; Abdus S. Wahed, PhD; Steven H. Belle, PhD

IMPORTANCE Effective long-term treatments are needed to address the obesity epidemic. Numerous wearable technologies specific to physical activity and diet are available, but it is unclear if these are effective at improving weight loss.

OBJECTIVE To test the hypothesis that, compared with a standard behavioral weight loss intervention (standard intervention), a technology-enhanced weight loss intervention (enhanced intervention) would result in greater weight loss.

DESIGN, SETTING, PARTICIPANTS Randomized clinical trial conducted at the University of Pittsburgh and enrolling 471 adult participants between October 2010 and October 2012, with data collection completed by December 2014.

INTERVENTIONS Participants were placed on a low-calorie diet, prescribed increases in physical activity, and had group counseling sessions. At 6 months, the interventions added telephone counseling sessions, text message prompts, and access to study materials on a website. At 6 months, participants randomized to the standard intervention group initiated self-monitoring of diet and physical activity using a website, and those randomized to the

Author Video Interview and JAMA Report Video

Supplemental content

Fitness-Tracker

significant difference between groups.

	Standard Intervention	Enhanced Intervention
Weight, mean (95% CI), kg		
Baseline	95.2 (93.0-97.3)	96.3 (94.2-98.5)
24 mo	92.8 (90.6-95.0)	89.3 (87.1-91.5)
Estimated weight loss, mean (95% CI), kg	5.9 (5.0-6.8)	3.5 (2.6-4.5)

CONCLUSIONS AND RELEVANCE Among young adults with a BMI between 25 and less than 40,

Au

Science News

from research organizations

Impulsive Behavior May Be Relict Of Hunter-gatherer Past

Date: December 9, 2004

Source: University Of Minnesota

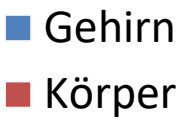
Summary: Drawing on experiments with blue jays, a team of University of Minnesota researchers has found what may be the evolutionary basis for impulsive behavior. Such behavior may have evolved because in the wild, snatching up small rewards like food morsels rather than waiting for something bigger and better to come along can lead to getting more rewards in the long run.

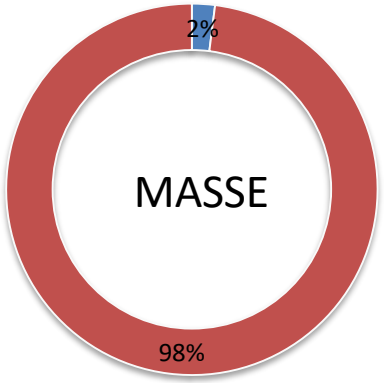
RELATED TOPICS FULL STORY

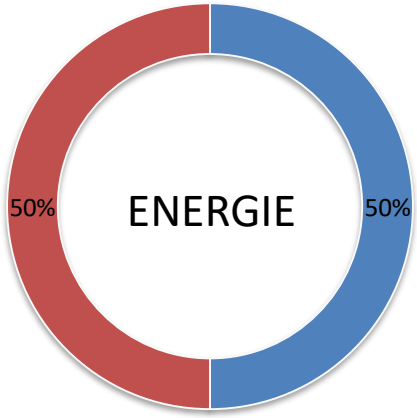
Das egoistische Gehirn

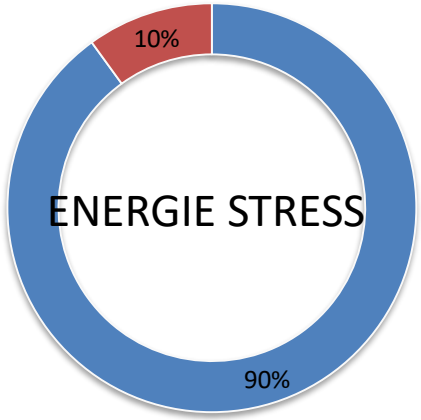
Gehirn und Energie

NUR durch Glucose: 80 - 140g/Tag









Bei Hunger: Organe ↓; Gehirn ↔

Kein Speicher

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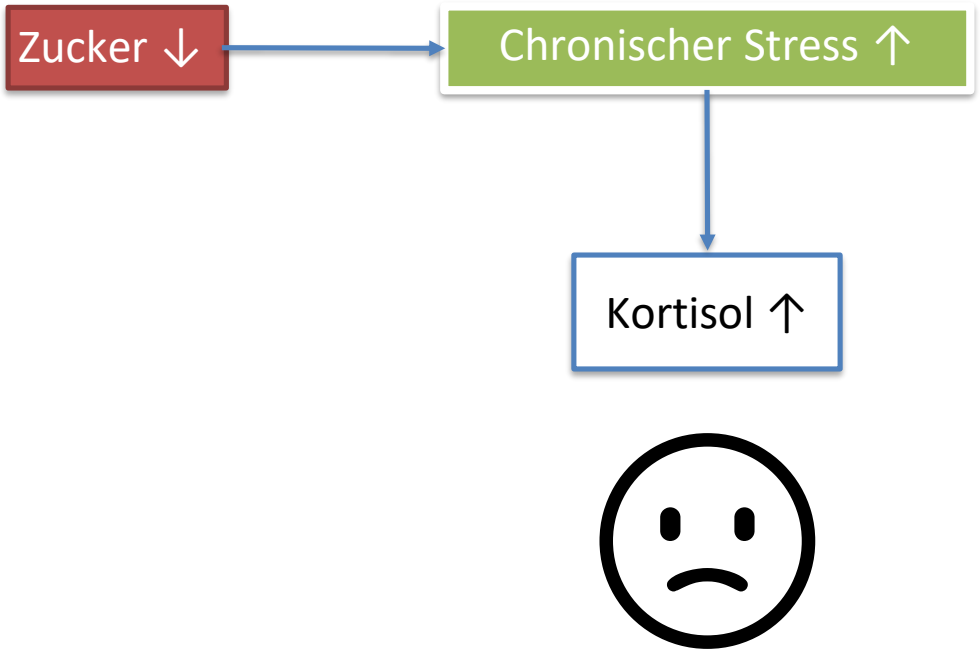

Einsamkeit

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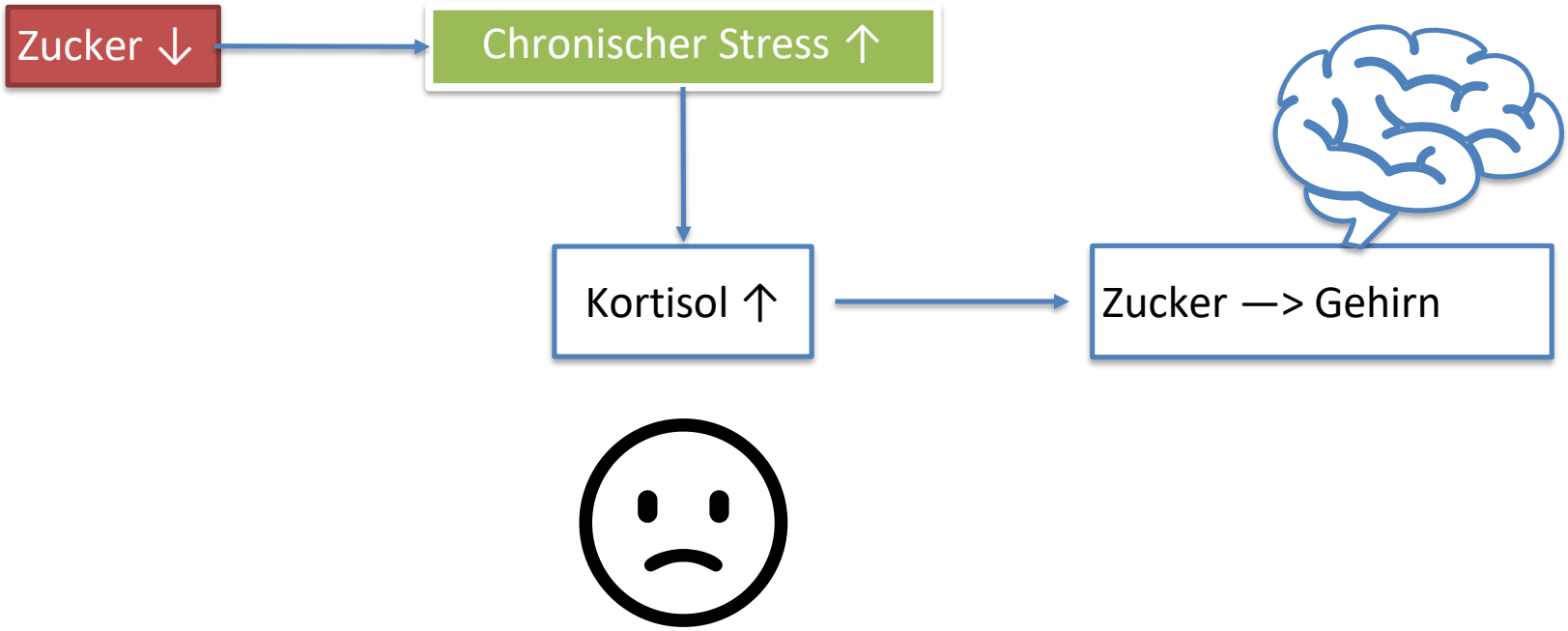

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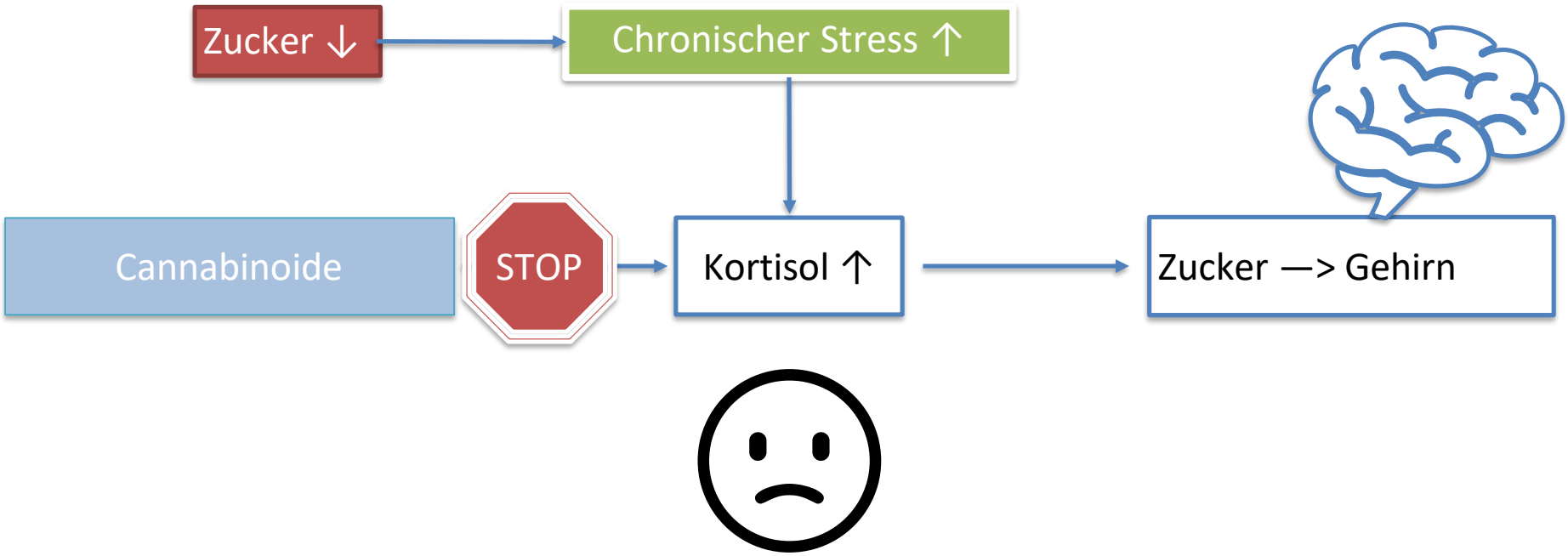

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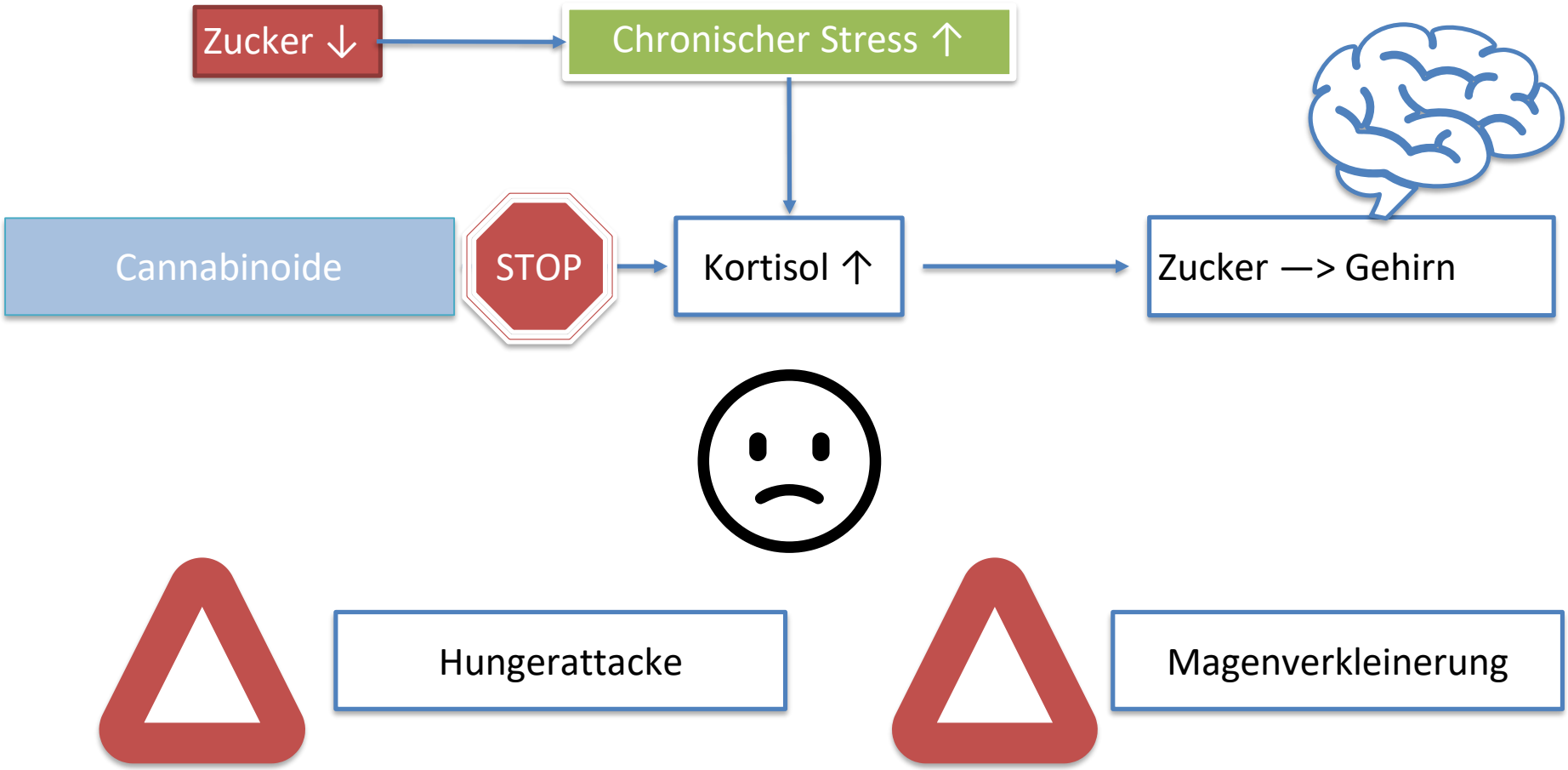
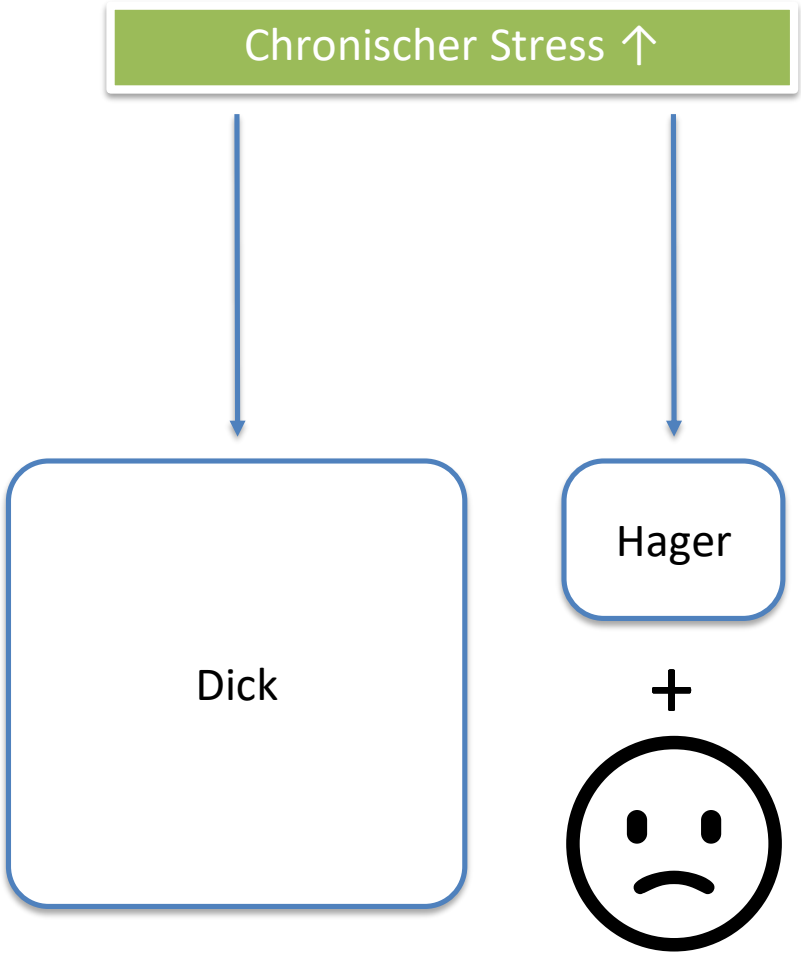
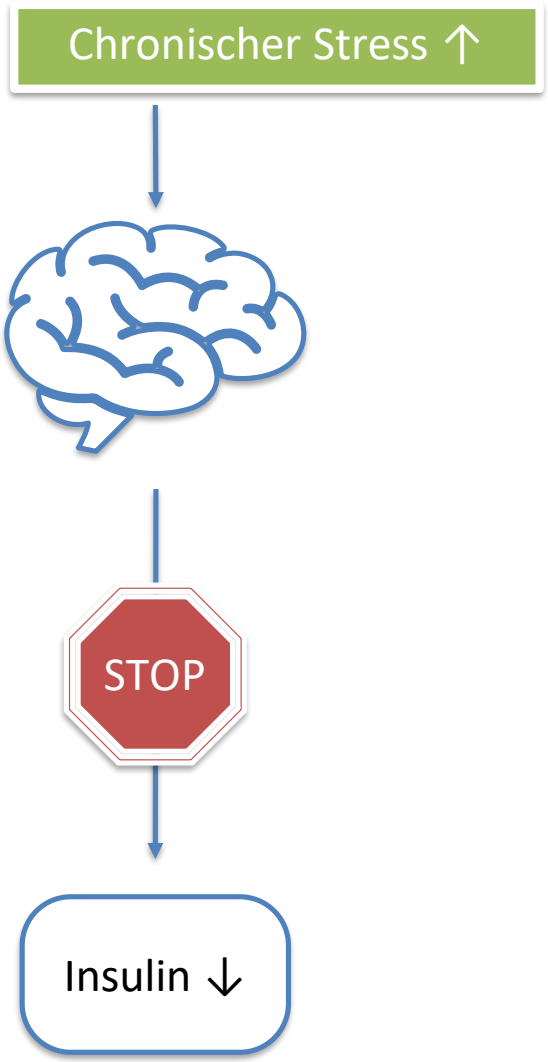
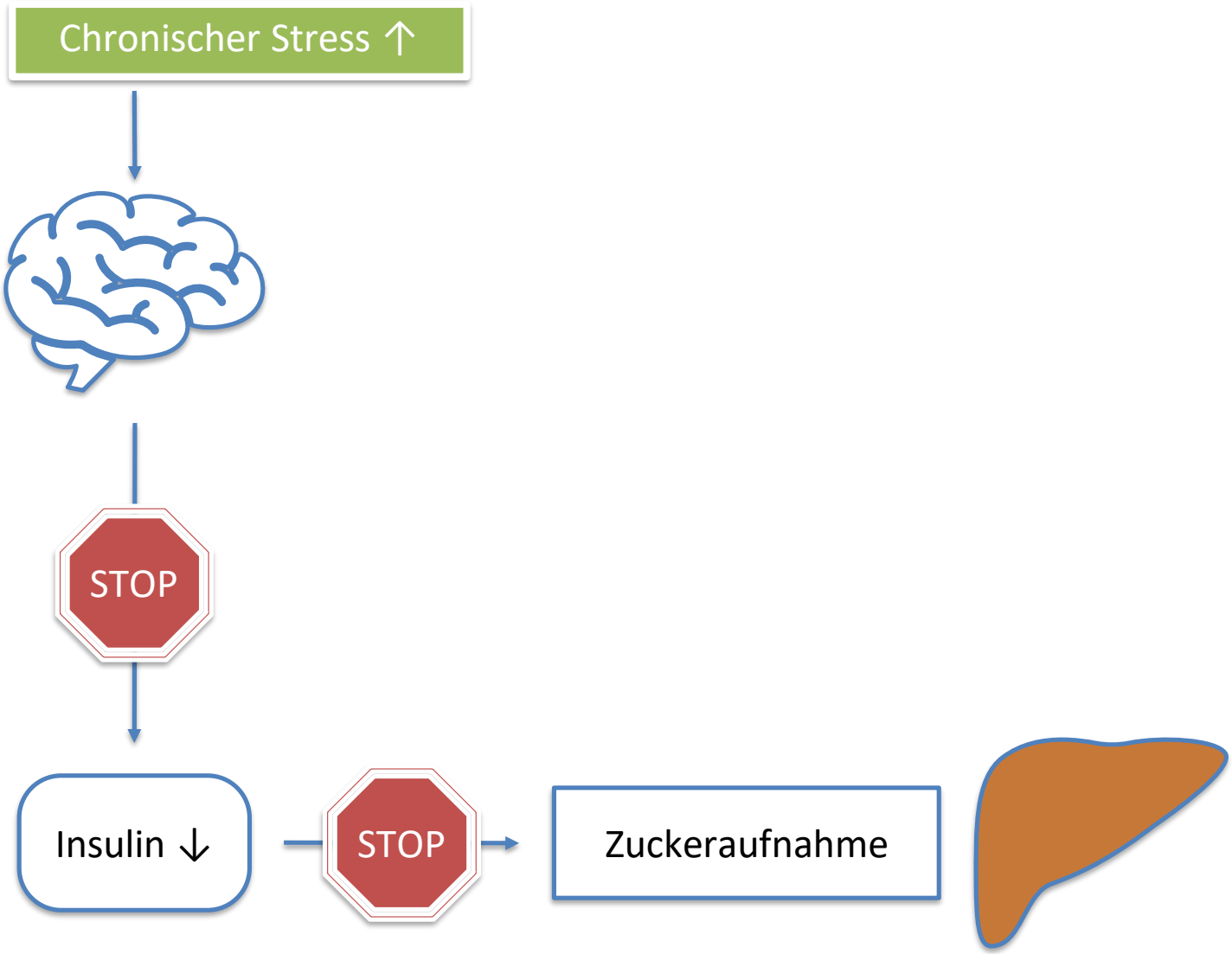


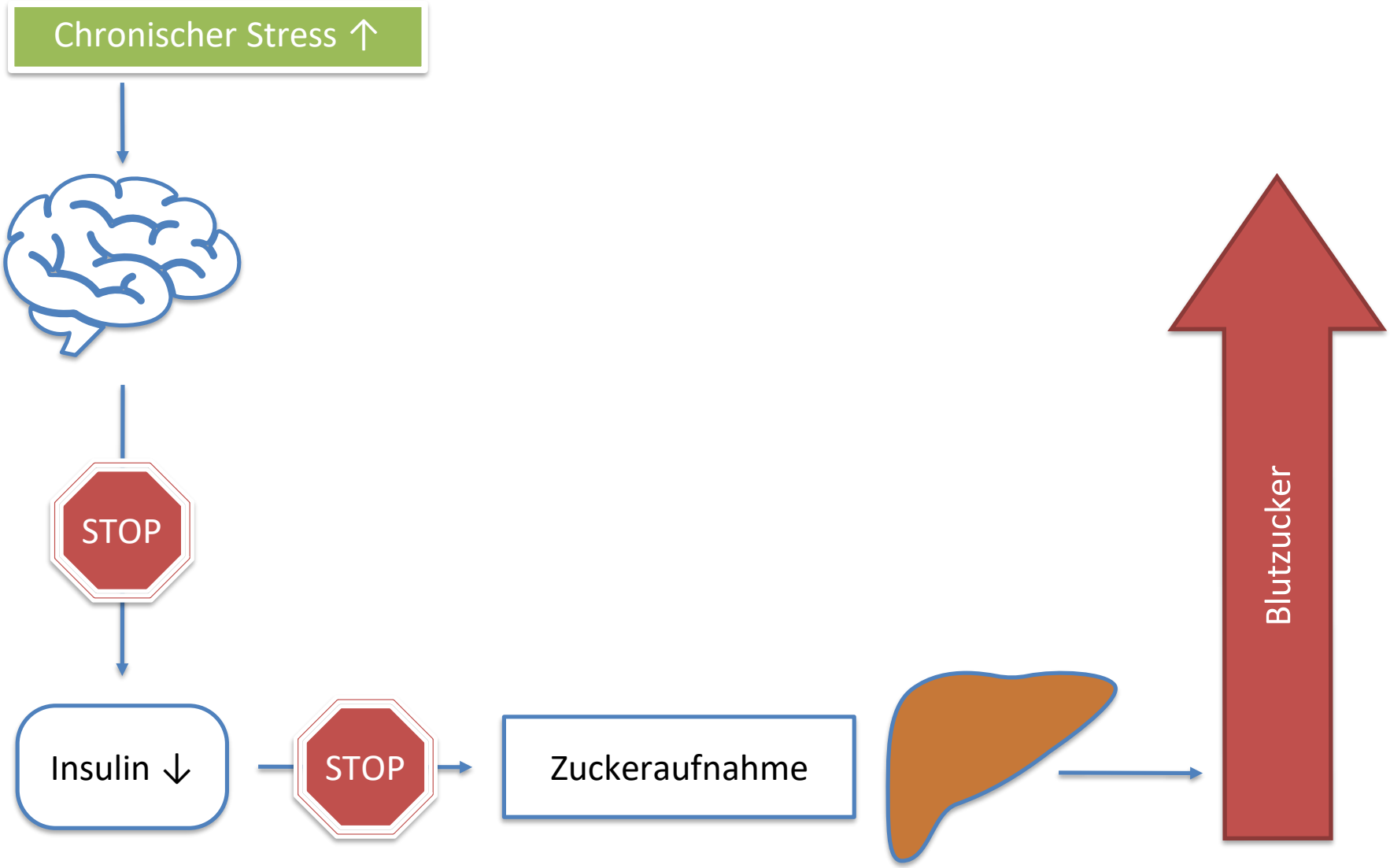

Chronischer Stress ↑
Dick
Hager
+



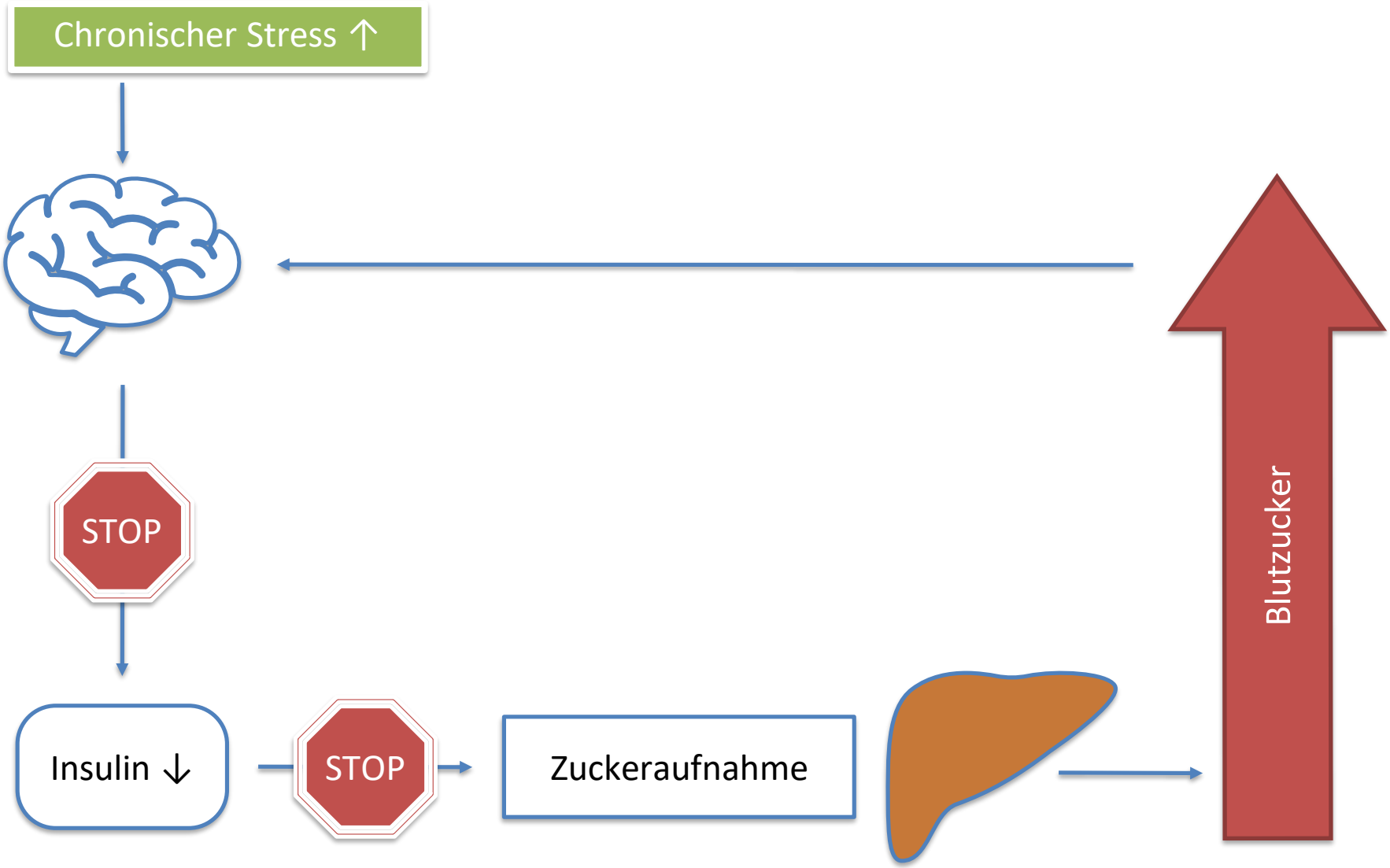
Das Gehirn kann das Insulin im Körper bremsen



Die Zuckeraufnahme in die Organe sinkt



Der Blutzucker steigt



Das Gehirn holt sich Glucose auf Kosten des Körpers

Chronischer Stress ↑

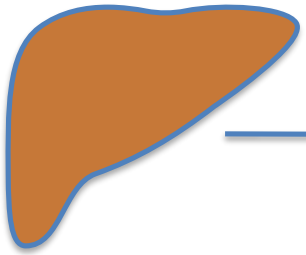
Typ A: zielstrebig; Zucker normal, Gewicht sinkt

STOP

Insulin ↓

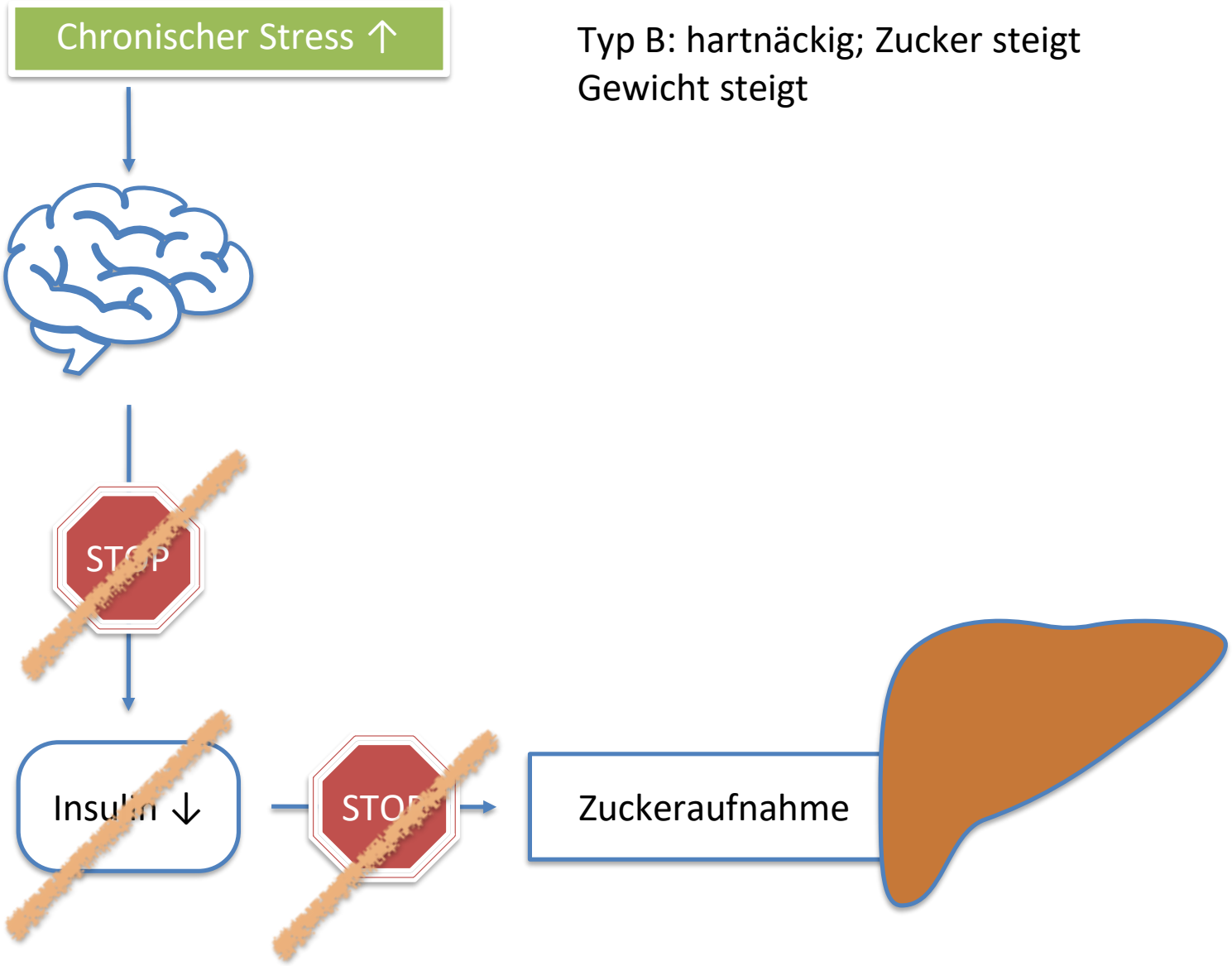
STOP

Zuckeraufnahme



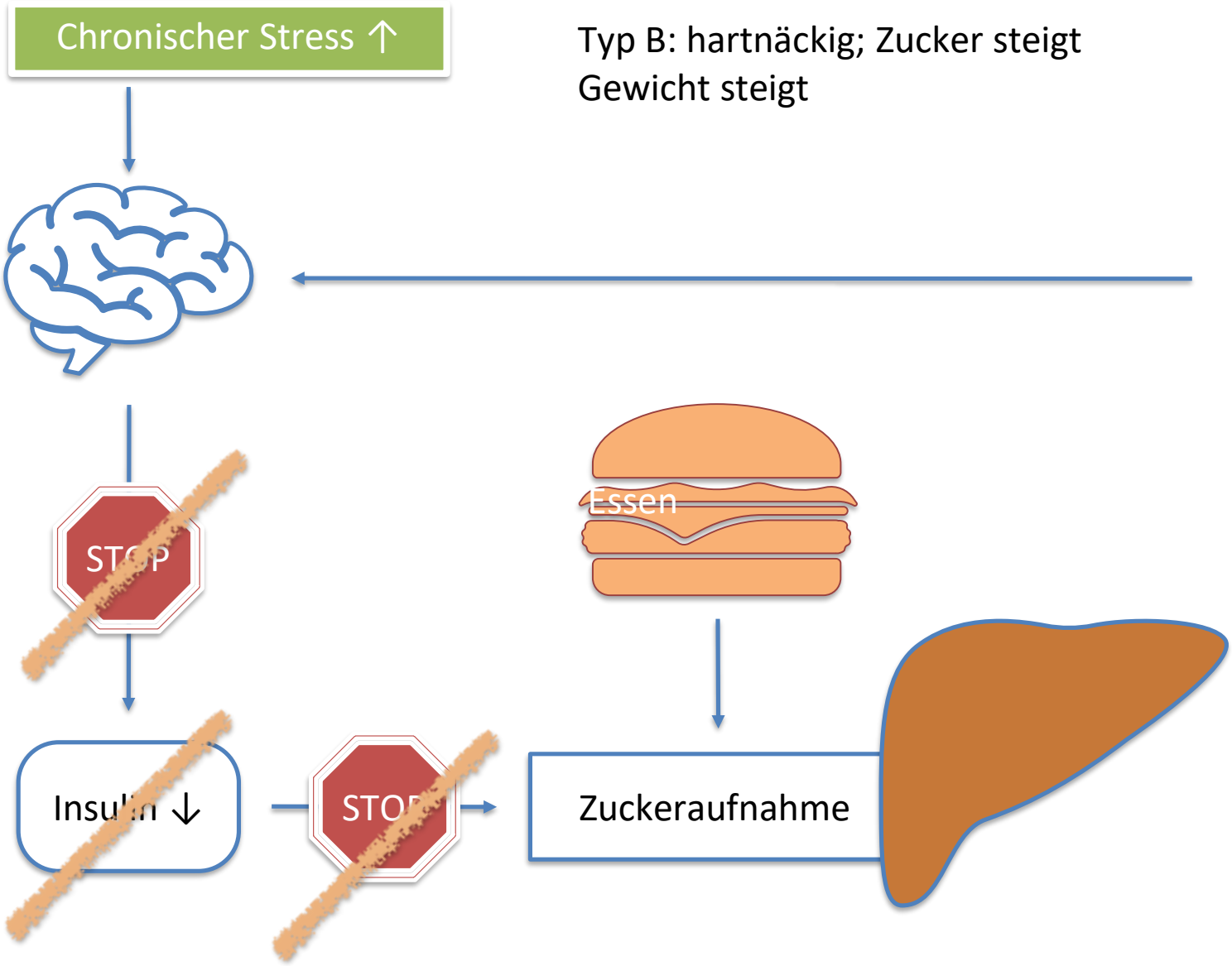
Blutzucker

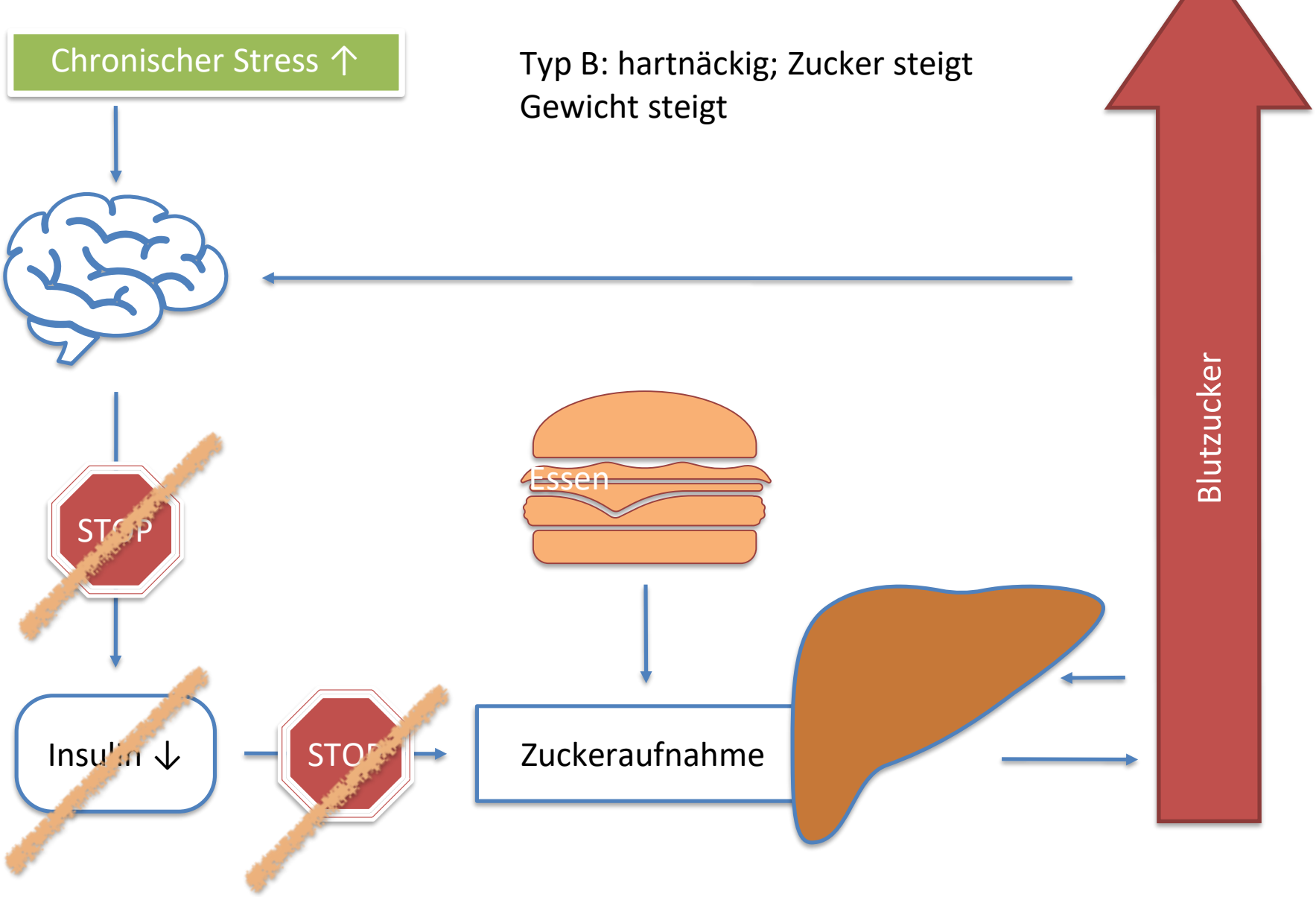
Das Gehirn holt sich Glucose auf Kosten des Körpers



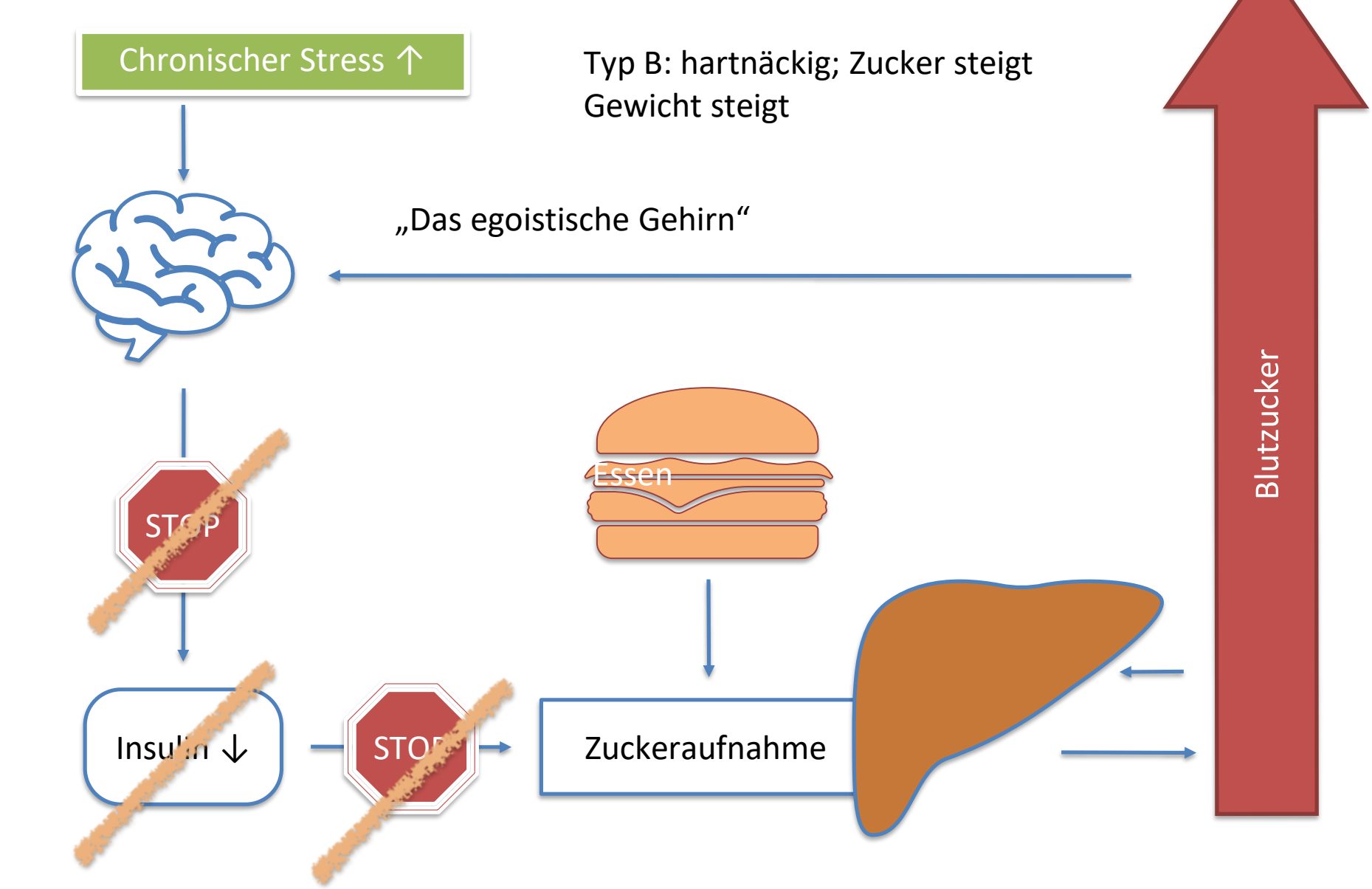
Typ B: hartnäckig; Zucker steigt
Gewicht steigt

Die Insulinbremse leiert aus, die Zuckeraufnahme in die Organe steigt


Chronischer Stress ↑
Typ B: hartnäckig; Zucker steigt
Gewicht steigt
Essen
Insulin ↓
Zuckeraufnahme
Der Zuckerbedarf steigt, mehr Essen muss her



Der Blutzucker steigt weiter, Zucker wandert in die Organe und wird zu Fett

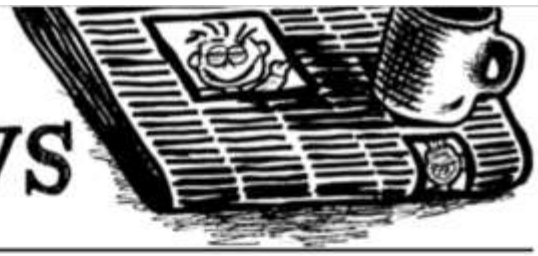


Der Blutzucker steigt weiter, Zucker wandert in die Organe und wird zu Fett

Vielen Dank

Psychotherapie

addiction & recovery news



← The adoption of 12-step practices and beliefs.

If it wasn't rational, cont'd →

BY JASON SCHWARTZ | OCTOBER 8, 2013 · 6:35 AM

Is low therapist empathy toxic?

Miller and Moyers make the case that low therapist empathy is toxic with a review of some research on the topic.

> In one study, a single in-session therapist behavior predicted 42% of the variance in clients' 12-month drinking outcomes: the more the therapist confronted, the more the client drank (Miller, Benefield, & Tonigan, 1993).

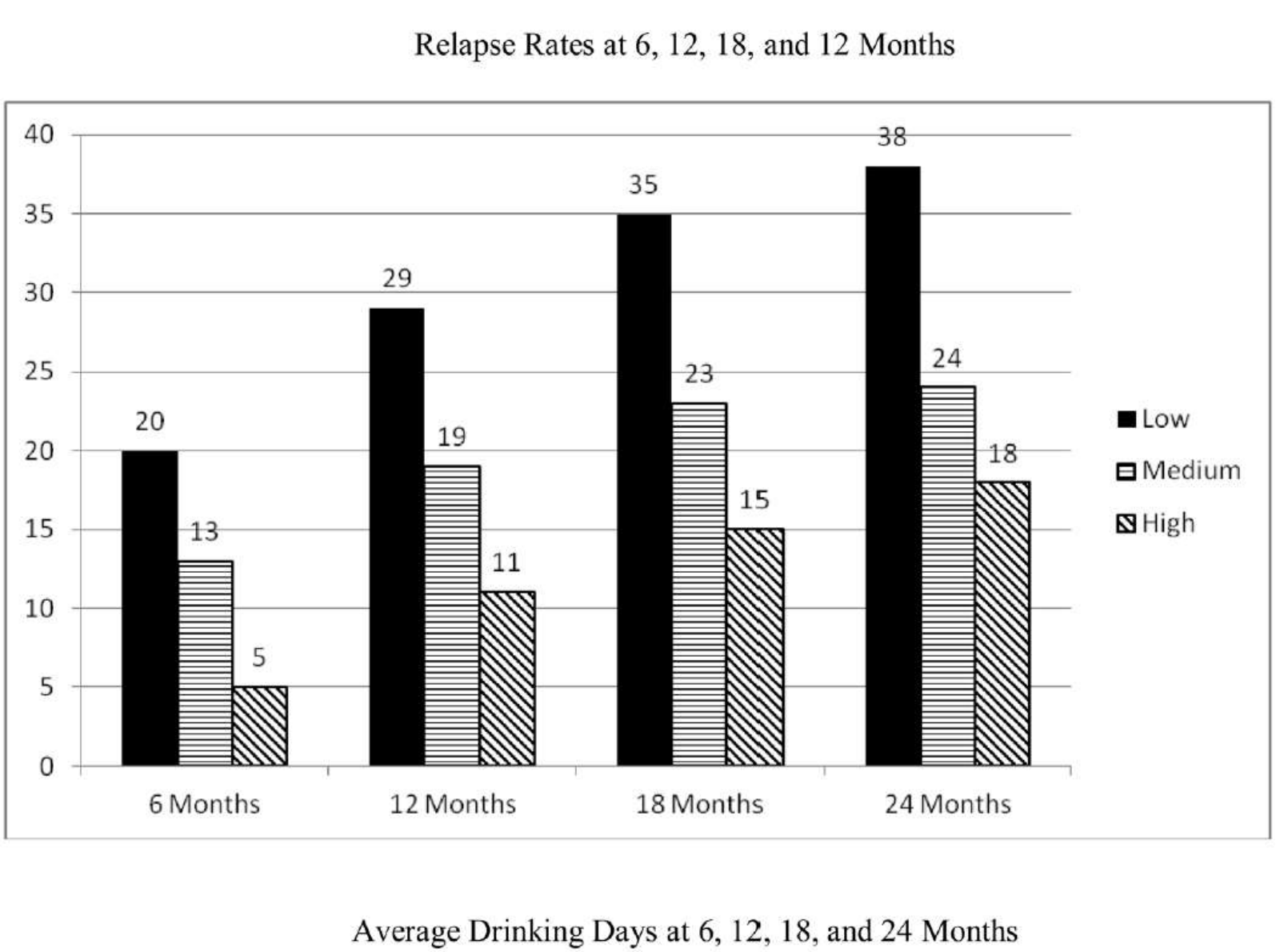


Figure 1.
Outcomes for Clients of Counselors with Low, Medium, and High Levels of Rogerian Interpersonal Functioning (from Valle, 1981)

Warum Alkoholselbstheiler keine Behandlung in Anspruch nehmen

Addiction. 2003 Dec;98(12):1737-46.

Types of natural recovery from alcohol dependence: a cluster analytic approach.

Bischof G[1], Rumpf HJ, Hapke U, Meyer C, John U.

Author information

Abstract

BACKGROUND: Social capital and a low severity of alcohol-related problems have been focused upon to explain the processes of natural recovery from alcohol dependence. However, studies using control groups have not found significant differences in these variables. Subtypes of natural remission which might account for this inconsistency have only been described on grounds of qualitative data.

AIMS: To identify subtypes of natural remitters using cluster analysis.

PARTICIPANTS: One hundred and seventy-eight media-recruited natural remitters were interviewed personally. Several triggering mechanisms and maintenance factors of remission were assessed using standardized questionnaires. Based on age of onset and severity of dependence, adverse consequences from drinking, social pressure and social support, cluster analyses were performed.

RESULTS: Cluster analyses yielded three groups of natural remitters: one cluster with a high severity of dependence, low alcohol-related problems and low social support ('low problems-low support'; n = 65), one group characterized by high severity of dependence, high alcohol-related problems and medium social support ('high problems-medium support'; n = 37), and a third group which consisted of subjects with high social support, late age of onset, low severity of dependence, and low alcohol-related problems ('low problems-high support'; n = 76). Cluster solutions were confirmed using discriminant analyses. Analyses of variance (ANOVAs) revealed further group differences on other triggering and maintaining factors of remission.

CONCLUSIONS: Failure to identify specific pointers to natural recovery in previous research might be due to heterogeneous subgroups of natural remitters. In order to build a conceptual framework for understanding the processes of natural recovery, interactions of different independent variables should be considered.

PMID: 14651506

[Indexed for MEDLINE]

John Therapie verändert nicht Lebenswert

SCIENCE 11/16/2015 03:57 pm ET | Updated Nov 16, 2016

Mindfulness-Based Relapse Prevention Holds Promise For Treating Addiction

The treatment protocol targets the very roots of addictive behavior.

By Carolyn Gregoire

Mindfulness-Based Relapse Prevention Holds Promise For Treating Addiction

psychologist at Pacific University in Oregon, about how mindfulness works to short-circuit addictive behaviors and why researchers are optimistic about MBRP's potential to change the landscape of addiction recovery. Here's what we learned.

Dr. Sarah Bowen told HuffPost that mindfulness-based relapse prevention is a "radical" treatment for drug and alcohol addiction.

Original Investigation

Relative Efficacy of Mindfulness-Based Relapse Prevention, Standard Relapse Prevention, and Treatment as Usual for Substance Use Disorders

A Randomized Clinical Trial

Sarah Bowen, PhD; Katie Witkiewitz, PhD; Seema L. Clifasefi, PhD; Joel Grow, PhD; Neharika Chawla, PhD; Sharon H. Hsu, MS; Haley A. Carroll, BS; Erin Harrop, BS; Susan E. Collins, PhD; M. Kathleen Lustyk, PhD; Mary E. Larimer, PhD

IMPORTANCE Relapse is highly prevalent following substance abuse treatments, highlighting the need for improved aftercare interventions. Mindfulness-based relapse prevention (MBRP), a group-based psychosocial aftercare, integrates evidence-based practices from mindfulness-based interventions and cognitive-behavioral relapse prevention (RP) approaches.

OBJECTIVE To evaluate the long-term efficacy of MBRP in reducing relapse compared with RP and treatment as usual (TAU [12-step programming and psychoeducation]) during a 12-month follow-up period.

DESIGN, SETTING, AND PARTICIPANTS Between October 2009 and July 2012, a total of 286 eligible individuals who successfully completed initial treatment for substance use disorders at a private, nonprofit treatment facility were randomized to MBRP, RP, or TAU aftercare and monitored for 12 months. Participants medically cleared for continuing care were aged 18 to 70 years; 71.5% were male and 42.1% were of ethnic/racial minority.

INTERVENTIONS Participants were randomly assigned to 8 weekly group sessions of MBRP, cognitive-behavioral RP, or TAU.

MAIN OUTCOMES AND MEASURES Primary outcomes included relapse to drug use and heavy drinking as well as frequency of substance use in the past 90 days. Variables were assessed at baseline and at 3-, 6-, and 12-month follow-up points. Measures used included self-report of relapse and urinalysis drug and alcohol screenings.

RESULTS Compared with TAU, participants assigned to MBRP and RP reported significantly lower risk of relapse to substance use and heavy drinking and, among those who used substances, significantly fewer days of substance use and heavy drinking at the 6-month follow-up. Cognitive-behavioral RP showed an advantage over MBRP in time to first drug use. At the 12-month follow-up, MBRP participants reported significantly fewer days of substance use and significantly decreased heavy drinking compared with RP and TAU.

CONCLUSIONS AND RELEVANCE For individuals in aftercare following initial treatment for substance use disorders, RP and MBRP, compared with TAU, produced significantly reduced relapse risk to drug use and heavy drinking. Relapse prevention delayed time to first drug use at 6-month follow-up, with MBRP and RP participants who used alcohol also reporting significantly fewer heavy drinking days compared with TAU participants. At 12-month follow-up, MBRP offered added benefit over RP and TAU in reducing drug use and heavy drinking. Targeted mindfulness practices may support long-term outcomes by strengthening the ability to monitor and skillfully cope with discomfort associated with craving or negative affect, thus supporting long-term outcomes.

TRIAL REGISTRATION clinicaltrials.gov Identifier: NCT01159535

JAMA Psychiatry. 2014;71(5):547-556. doi:10.1001/jamapsychiatry.2013.4546
Published online March 19, 2014.

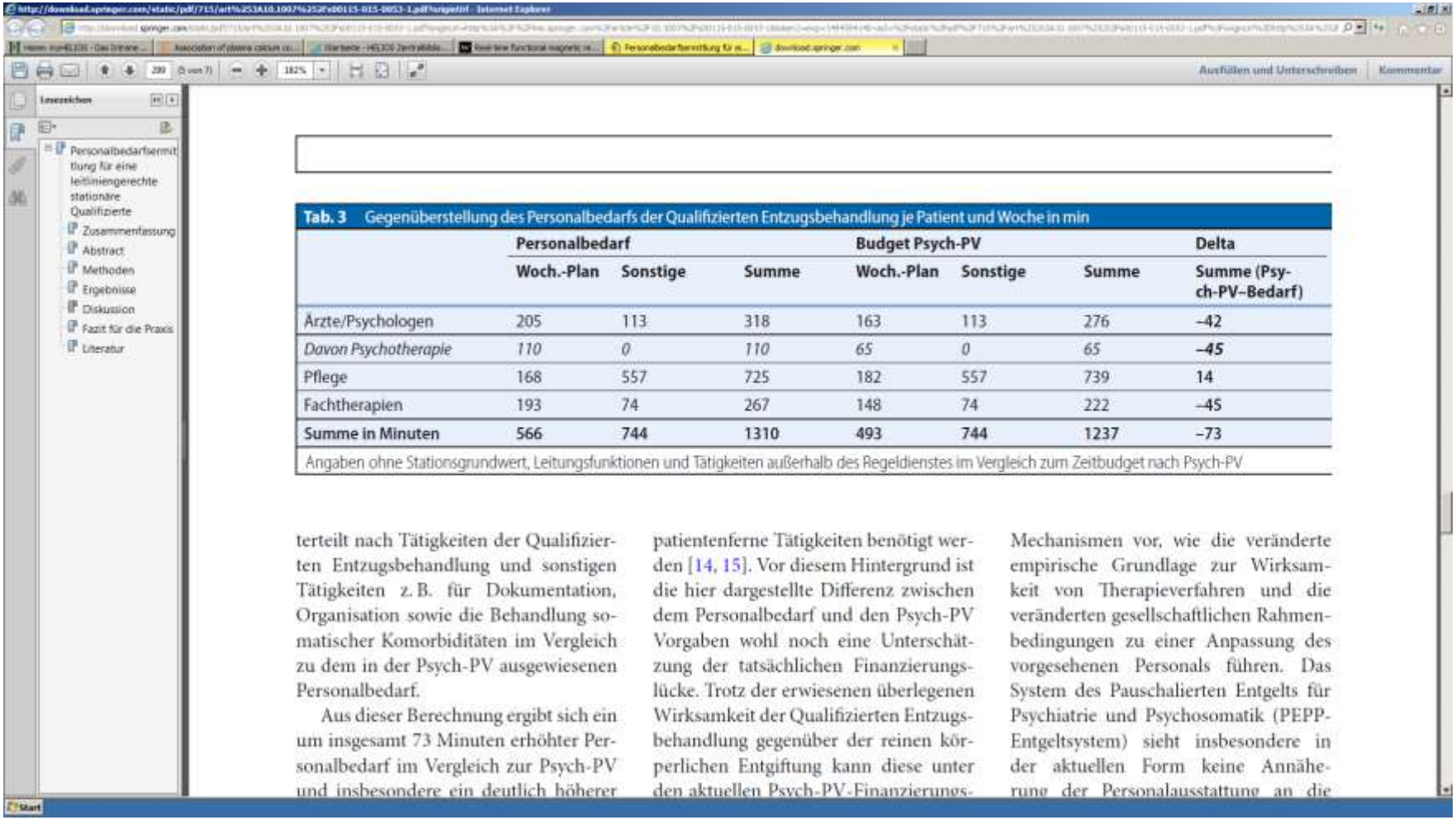
CME Quiz at jamanetworkcme.com and **CME Questions** page 592

Author Affiliations: Psychology Department, Addictive Behaviors Research Center, Seattle, Washington (Bowen, Clifasefi, Grow, Chawla, Hsu, Carroll, Harrop); Psychology Department, University of New Mexico, Albuquerque (Witkiewitz); Department of Psychiatry and Behavioral Sciences, University of Washington–Harborview Medical Center (Collins); Psychology Department, Seattle Pacific University, Seattle, Washington (Lustyk); Center for the Study of Health and Risk Behaviors, Psychiatry and Behavioral Sciences, University of Washington, Seattle (Larimer).

Corresponding Author: Sarah Bowen, PhD, Center for the Study of Health and Risk Behaviors, University of Washington, 1100 NE 45th St, Ste 300, Seattle, WA 98105 (swbowen@uw.edu).

Table 2. Outcome Variable Findings at Follow-up

Characteristic	TAU (n = 95)	RP (n = 88)	MBRP (n = 103)
Sample size % completed, No. (%)			
3 mo	82 (86.3)	80 (90.9)	95 (92.2)
6 mo	77 (81.1)	75 (85.2)	89 (86.4)
12 mo	76 (80.0)	72 (81.8)	83 (80.6)
Drug use days, TLFB, mean (SD)			
3 mo	5.23 (15.43)	2.09 (10.65)	3.92 (16.24)
6 mo	5.81 (19.11)	1.71 (10.77)	2.73 (12.00)
12 mo	4.63 (16.03)	6.09 (19.05)	3.06 (15.08)
Any drug use, TLFB, No. (%)			
3 mo	20 (21.0)	11 (12.5)	14 (13.6)
6 mo	20 (21.0)	7 (8.0)	10 (9.7)
12 mo	13 (13.7)	15 (17.0)	9 (8.7)
Heavy drinking days, TLFB, mean (SD)			
3 mo	2.64 (10.64)	2.13 (7.75)	1.99 (8.06)
6 mo	2.61 (9.93)	1.13 (5.96)	1.63 (8.53)
12 mo	4.65 (14.93)	3.89 (12.17)	1.44 (7.66)
Any heavy drinking, TLFB, No. (%)			
3 mo	19 (20.0)	18 (20.5)	12 (11.7)
6 mo	15 (15.8)	8 (9.1)	8 (7.8)
12 mo	19 (20.0)	17 (19.3)	8 (7.8)



Tab. 3 Gegenüberstellung des Personalbedarfs der Qualifizierten Entzugsbehandlung je Patient und Woche in min

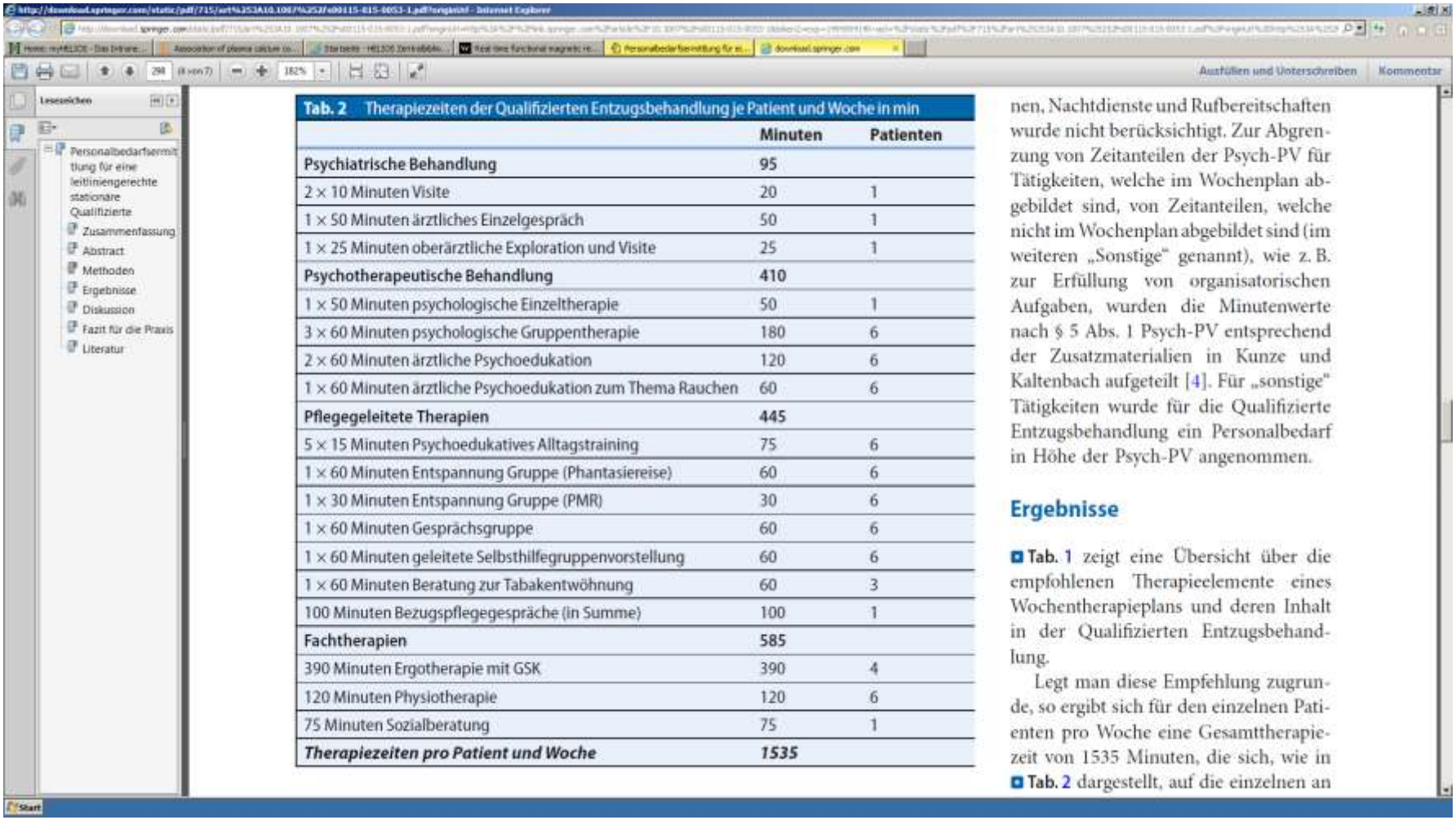
	Personalbedarf			Budget Psych-PV			Delta
	Woch.-Plan	Sonstige	Summe	Woch.-Plan	Sonstige	Summe	Summe (Psych-PV–Bedarf)
Ärzte/Psychologen	205	113	318	163	113	276	–42
Davon Psychotherapie	*110*	*0*	*110*	*65*	*0*	*65*	***–45***
Pflege	168	557	725	182	557	739	14
Fachtherapien	193	74	267	148	74	222	–45
Summe in Minuten	**566**	**744**	**1310**	**493**	**744**	**1237**	–73

Angaben ohne Stationsgrundwert, Leitungsfunktionen und Tätigkeiten außerhalb des Regeldienstes im Vergleich zum Zeitbudget nach Psych-PV

terteilt nach Tätigkeiten der Qualifizierten Entzugsbehandlung und sonstigen Tätigkeiten z. B. für Dokumentation, Organisation sowie die Behandlung somatischer Komorbiditäten im Vergleich zu dem in der Psych-PV ausgewiesenen Personalbedarf.

Aus dieser Berechnung ergibt sich ein um insgesamt 73 Minuten erhöhter Personalbedarf im Vergleich zur Psych-PV und insbesondere ein deutlich höherer patientenferne Tätigkeiten benötigt werden [14, 15]. Vor diesem Hintergrund ist die hier dargestellte Differenz zwischen dem Personalbedarf und den Psych-PV Vorgaben wohl noch eine Unterschätzung der tatsächlichen Finanzierungslücke. Trotz der erwiesenen überlegenen Wirksamkeit der Qualifizierten Entzugsbehandlung gegenüber der reinen körperlichen Entgiftung kann diese unter den aktuellen Psych-PV-Finanzierungs-

Mechanismen vor, wie die veränderte empirische Grundlage zur Wirksamkeit von Therapieverfahren und die veränderten gesellschaftlichen Rahmenbedingungen zu einer Anpassung des vorgesehenen Personals führen. Das System des Pauschalierten Entgelts für Psychiatrie und Psychosomatik (PEPP-Entgeltsystem) sieht insbesondere in der aktuellen Form keine Annäherung der Personalausstattung an die



Personalbedarfsermittlung für eine leitliniengerechte stationäre Qualifizierte
Zusammenfassung
Abstract
Methoden
Ergebnisse
Diskussion
Fazit für die Praxis
Literatur

Tab. 2 Therapiezeiten der Qualifizierten Entzugsbehandlung je Patient und Woche in min

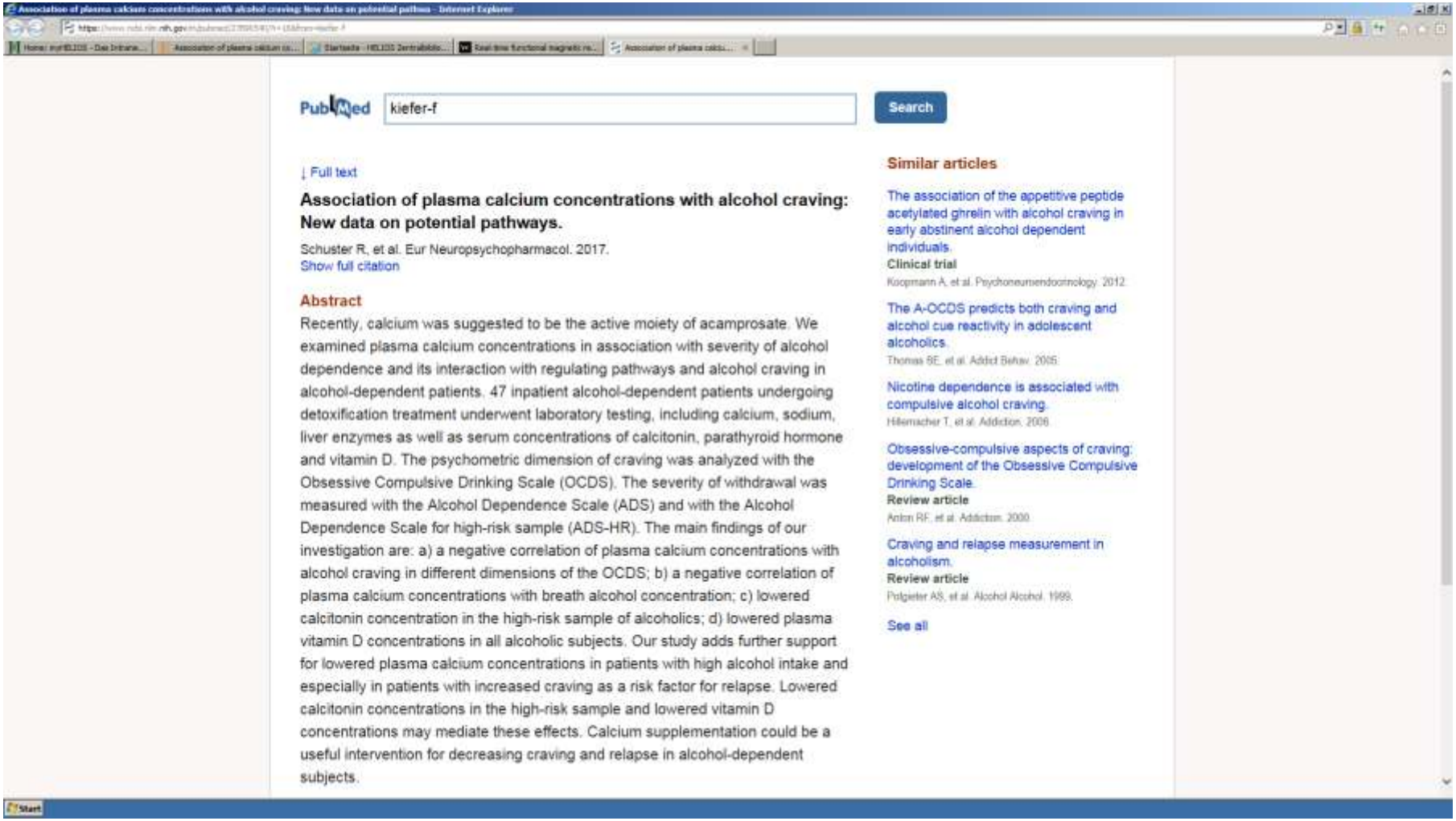
	Minuten	Patienten
Psychiatrische Behandlung	**95**	
2 × 10 Minuten Visite	20	1
1 × 50 Minuten ärztliches Einzelgespräch	50	1
1 × 25 Minuten oberärztliche Exploration und Visite	25	1
Psychotherapeutische Behandlung	**410**	
1 × 50 Minuten psychologische Einzeltherapie	50	1
3 × 60 Minuten psychologische Gruppentherapie	180	6
2 × 60 Minuten ärztliche Psychoedukation	120	6
1 × 60 Minuten ärztliche Psychoedukation zum Thema Rauchen	60	6
Pflegegeleitete Therapien	**445**	
5 × 15 Minuten Psychoedukatives Alltagstraining	75	6
1 × 60 Minuten Entspannung Gruppe (Phantasiereise)	60	6
1 × 30 Minuten Entspannung Gruppe (PMR)	30	6
1 × 60 Minuten Gesprächsgruppe	60	6
1 × 60 Minuten geleitete Selbsthilfegruppenvorstellung	60	6
1 × 60 Minuten Beratung zur Tabakentwöhnung	60	3
100 Minuten Bezugspflegegespräche (in Summe)	100	1
Fachtherapien	**585**	
390 Minuten Ergotherapie mit GSK	390	4
120 Minuten Physiotherapie	120	6
75 Minuten Sozialberatung	75	1
Therapiezeiten pro Patient und Woche	***1535***	

nen, Nachtdienste und Rufbereitschaften wurde nicht berücksichtigt. Zur Abgrenzung von Zeitanteilen der Psych-PV für Tätigkeiten, welche im Wochenplan abgebildet sind, von Zeitanteilen, welche nicht im Wochenplan abgebildet sind (im weiteren „Sonstige" genannt), wie z. B. zur Erfüllung von organisatorischen Aufgaben, wurden die Minutenwerte nach § 5 Abs. 1 Psych-PV entsprechend der Zusatzmaterialien in Kunze und Kaltenbach aufgeteilt [4]. Für „sonstige" Tätigkeiten wurde für die Qualifizierte Entzugsbehandlung ein Personalbedarf in Höhe der Psych-PV angenommen.

Ergebnisse

Tab. 1 zeigt eine Übersicht über die empfohlenen Therapieelemente eines Wochentherapieplans und deren Inhalt in der Qualifizierten Entzugsbehandlung.

Legt man diese Empfehlung zugrunde, so ergibt sich für den einzelnen Patienten pro Woche eine Gesamttherapiezeit von 1535 Minuten, die sich, wie in **Tab. 2** dargestellt, auf die einzelnen an


Association of plasma calcium concentrations with alcohol craving: New data on potential pathways - Internet Explorer
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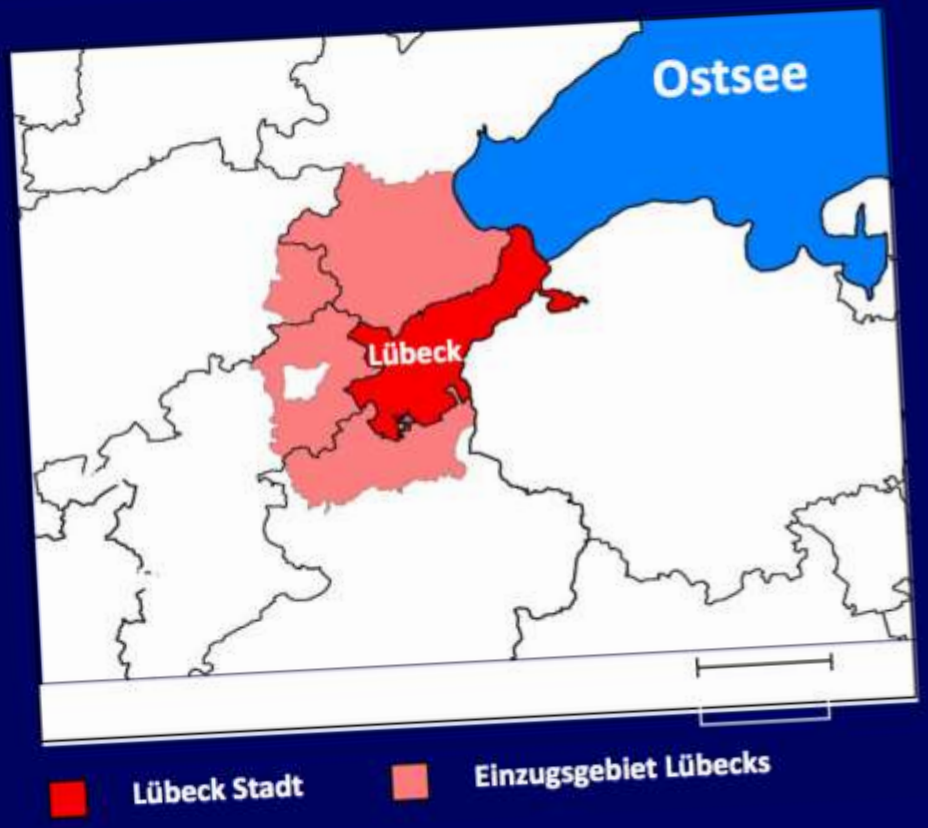
Association of plasma calcium concentrations with alcohol craving: New data on potential pathways.
Schuster R, et al. Eur Neuropsychopharmacol. 2017.
Show full citation
Abstract
Recently, calcium was suggested to be the active moiety of acamprosate. We examined plasma calcium concentrations in association with severity of alcohol dependence and its interaction with regulating pathways and alcohol craving in alcohol-dependent patients. 47 inpatient alcohol-dependent patients undergoing detoxification treatment underwent laboratory testing, including calcium, sodium, liver enzymes as well as serum concentrations of calcitonin, parathyroid hormone and vitamin D. The psychometric dimension of craving was analyzed with the Obsessive Compulsive Drinking Scale (OCDS). The severity of withdrawal was measured with the Alcohol Dependence Scale (ADS) and with the Alcohol Dependence Scale for high-risk sample (ADS-HR). The main findings of our investigation are: a) a negative correlation of plasma calcium concentrations with alcohol craving in different dimensions of the OCDS; b) a negative correlation of plasma calcium concentrations with breath alcohol concentration; c) lowered calcitonin concentration in the high-risk sample of alcoholics; d) lowered plasma vitamin D concentrations in all alcoholic subjects. Our study adds further support for lowered plasma calcium concentrations in patients with high alcohol intake and especially in patients with increased craving as a risk factor for relapse. Lowered calcitonin concentrations in the high-risk sample and lowered vitamin D concentrations may mediate these effects. Calcium supplementation could be a useful intervention for decreasing craving and relapse in alcohol-dependent subjects.
Similar articles
The association of the appetitive peptide acetylated ghrelin with alcohol craving in early abstinent alcohol dependent individuals.
Clinical trial
Koopmann A, et al. Psychoneuroendocrinology. 2012.
The A-OCDS predicts both craving and alcohol cue reactivity in adolescent alcoholics.
Thomas SE, et al. Addict Behav. 2005.
Nicotine dependence is associated with compulsive alcohol craving.
Hillemacher T, et al. Addiction. 2006.
Obsessive-compulsive aspects of craving: development of the Obsessive Compulsive Drinking Scale.
Review article
Anton RF, et al. Addiction. 2000.
Craving and relapse measurement in alcoholism.
Review article
Polgeter AS, et al. Alcohol Alcohol. 1999.
See all
Start

Selbstheilung

TACOS-Studie

- Stadt Lübeck und 46 umliegende Gemeinden
- 325.107 Einwohner
- Zufallsstichprobe Einwohnermeldeämter
- 18-64 Jahre
- 4075 Teilnehmer
- Teilnahmerate 70%



Meyer et al., 2000, 2001

Dia von Hans-Jürgen Rumpf

Methoden

Fälle

n=153 Personen mit Alkoholabhängigkeit DSM-IV

Lebenszeitpävalenz von 3,8 % (3,2-4,3%)
n= 98 remittiert
n= 55 aktual

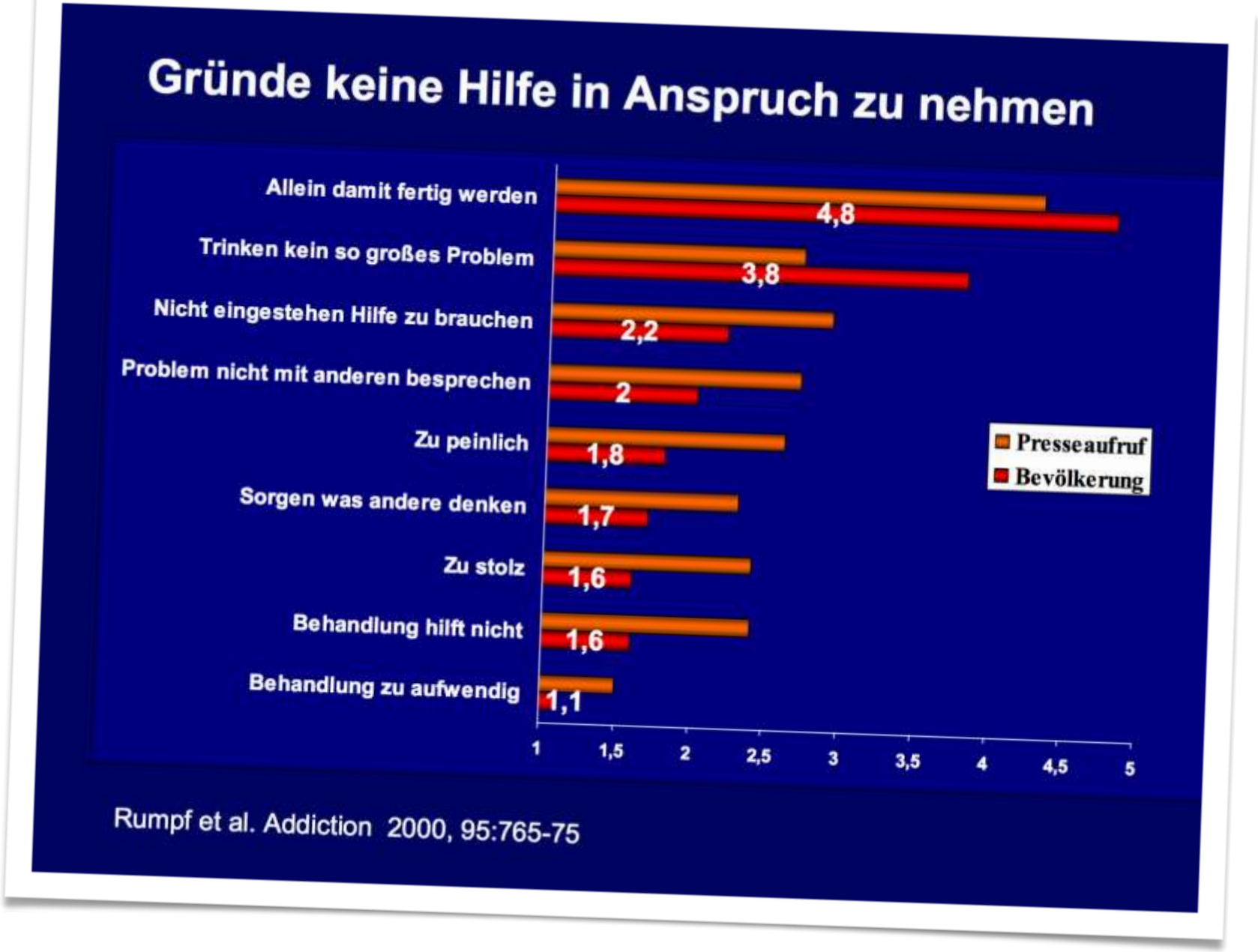
Vitalstatus

Einwohnermeldeamtsanfrage 14 Jahre nach Baseline

Erhebung => Lebend oder Todesdatum

Informationen ermittelt für N=149 Personen

Dia von Hans-Jürgen Rumpf



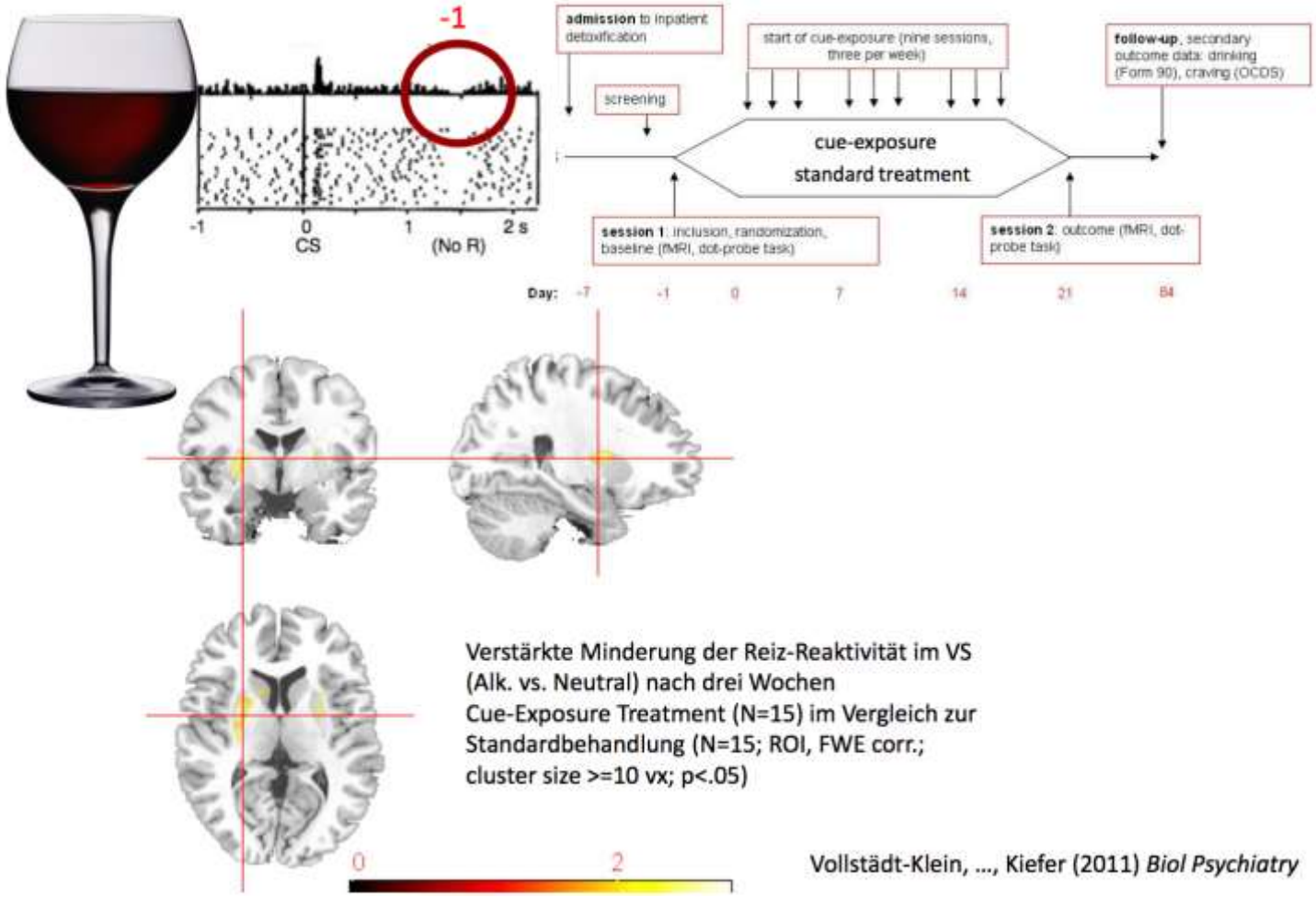
Dia von Hans-Jürgen Rumpf

Extinktion: Umlernen lernen

Alte Verhaltensweisen und falsch Einstudiertes zu korrigieren: Das geht mit Hilfe des Extinktionslernens. Dieses aktive Umlernen ist eine der wichtigsten Formen des Lernens. Forscher widmen sich nun intensiver als je zuvor diesem Thema.

Es ist nur einmal passiert. Sie hörte Schritte hinter sich, schnelle und zielstrebige Schritte. Es war eine laue Sommernacht und eine Straßenlaterne flackerte. Dann spürte sie die Hand des Mannes auf ihrer Schulter und erschrak. Bis heute hat jene Frau Angst. Wenn sie hastige Männerschritte hinter sich vernimmt, dann lässt sie den Passanten vorsorglich vorbeiziehen. Ihr Gehirn hat auf den einmaligen Übergriff hin gelernt, sie bei den leisesten Anzeichen einer ähnlichen Situation in einen Alarmzustand zu versetzen. Diese Reaktion verselbstständigte sich, obwohl seit dem Überfall kein weiteres Unheil geschehen ist.

Alkohol-Reizexposition bei Alkoholabhängigen nach Expositionstraining

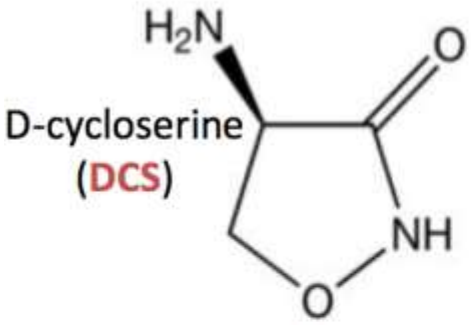


Verstärkte Minderung der Reiz-Reaktivität im VS (Alk. vs. Neutral) nach drei Wochen Cue-Exposure Treatment (N=15) im Vergleich zur Standardbehandlung (N=15; ROI, FWE corr.; cluster size >=10 vx; p<.05)

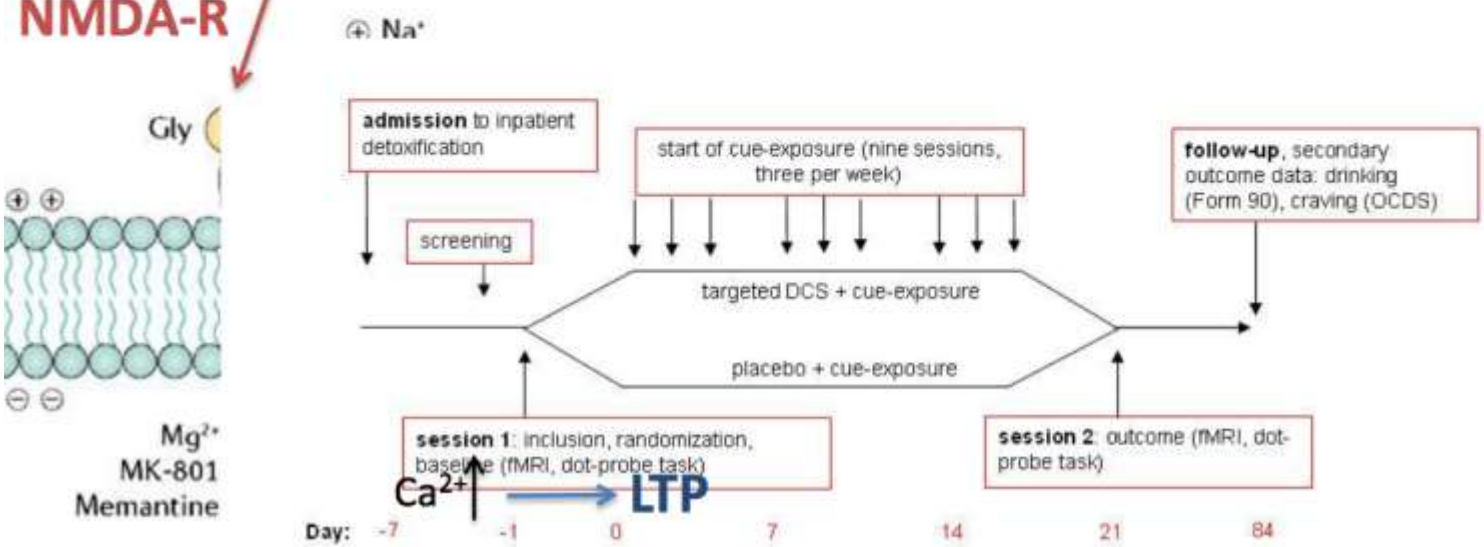
Vollstädt-Klein, ..., Kiefer (2011) *Biol Psychiatry*

Dia von Falk Kiefer

Alkohol-Reizexposition mit Konsolidierungsverstärkung



Dia von Falk Kiefer

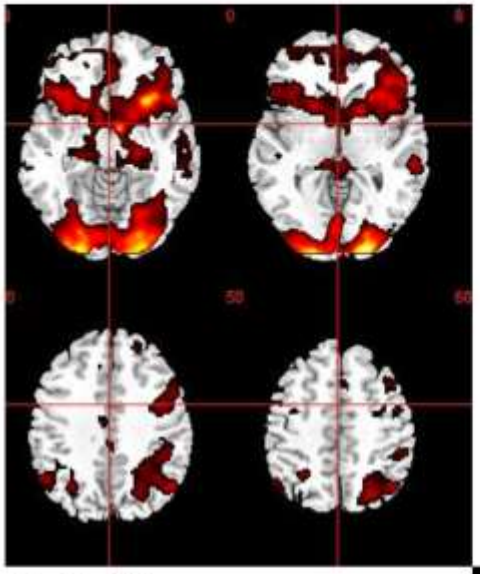


Kiefer & Dinter (2013)
Curr Top Behav Neurosci

Kiefer et al.
(submitted)

Dia von Falk Kiefer

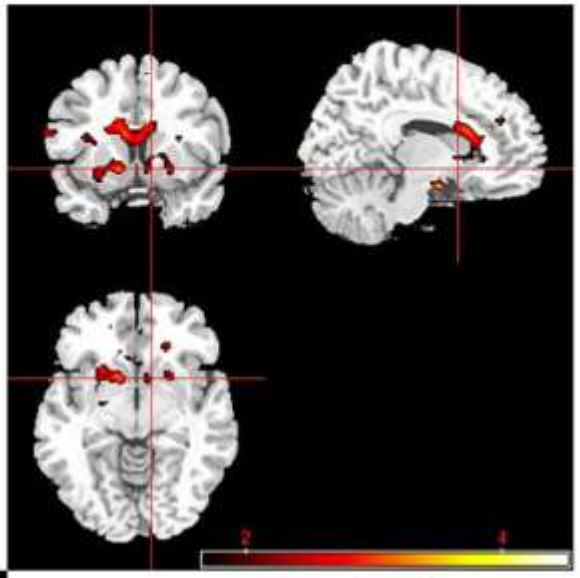
Alkohol-Reizexposition mit Konsolidierungsverstärkung



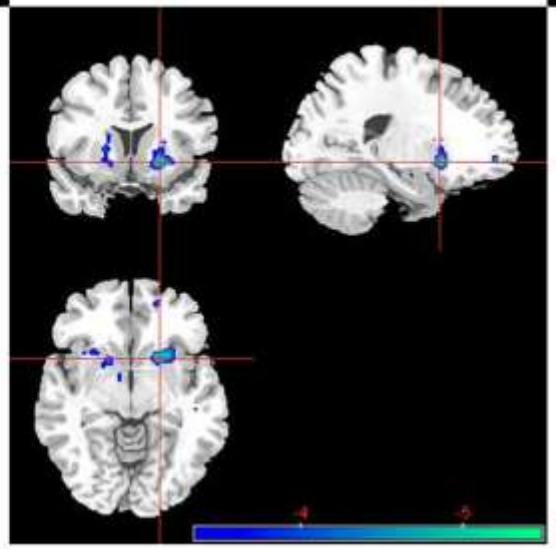
*t*1, N=32

DCS: 18.9 %
PLA: 31.2 %

Rückfall



*t*2, DCS < Placebo



*t*1>*t*2
Minderung der CR im VS;
p<0.001 uncorrected;
cluster size >= 20 vx

2x N=16
p<0.05, ROI, FWE corr.
cluster size >= 20 vx

Kiefer et al.
(submitted)

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Biernotruf

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Biernotruf

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Hornsche Str. 61b

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Montag - Freitag	00:00 - 01:30, 20:00 - 24:00
Samstag, Sonntag	00:00 - 03:00, 20:00 - 24:00

Bewertungen

★★★★★

Ø 4,92 Sterne

Greifswald

Drucken Text + −

Sozialmediziner fordert: Alkohol soll teurer werden

Der Greifswalder Mediziner Ulrich John will mit höheren Preisen Jugendliche vom Komasaufen abhalten.

VORIGER ARTIKEL
Vier Machos auf Eis

NÄCHSTER ARTIKEL
Uniklinikum droht Streik

Artikel veröffentlicht: Freitag, 24.01.2014 19:00 Uhr

Artikel aktualisiert: Samstag, 25.01.2014 06:54 Uhr

Alkohol soll teurer werden, fordert ein Suchtexperte. Denn immer mehr Jugendliche in MV landen mit einem akuten Rausch im Krankenhaus.

Quelle: Arno Burgi

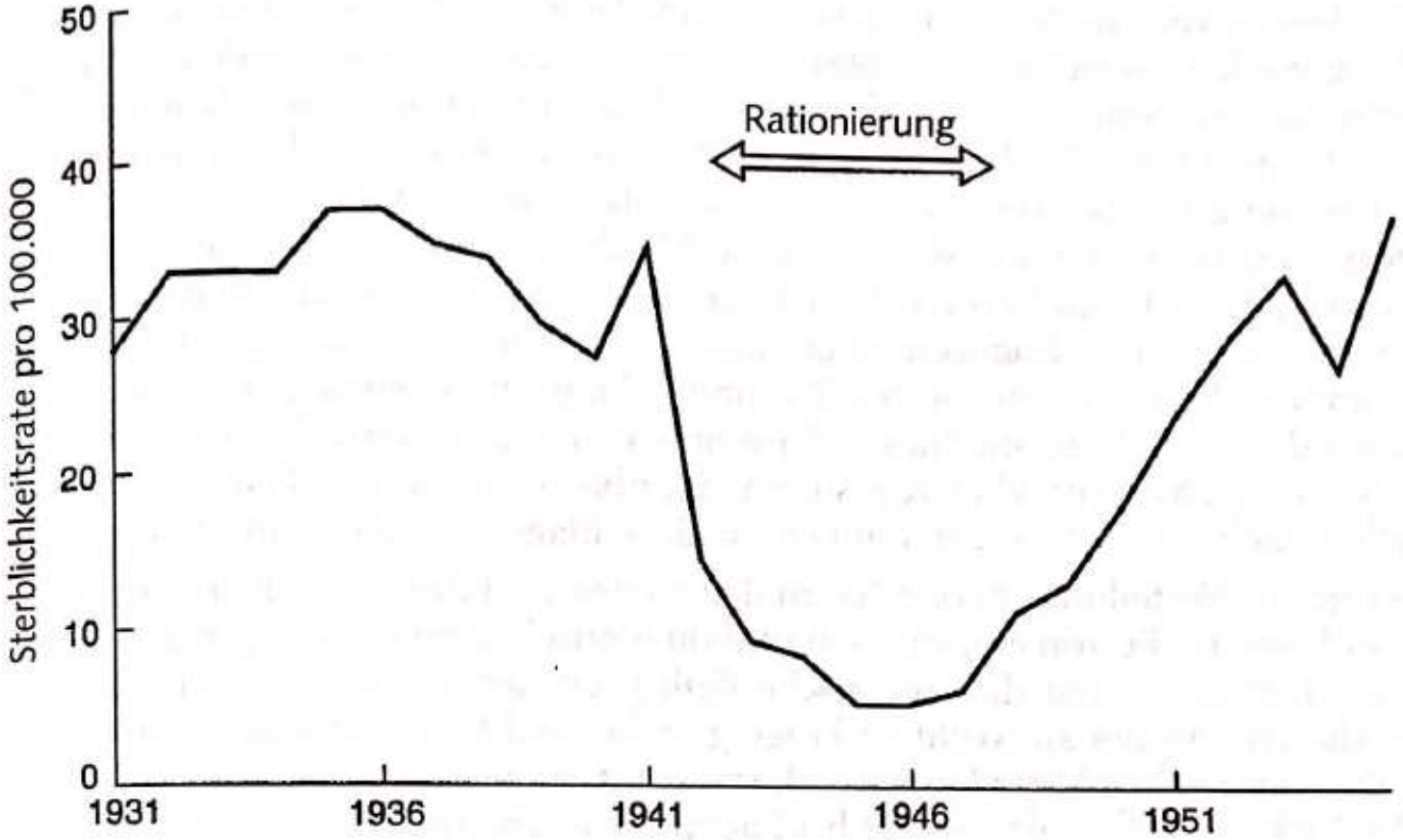


Abbildung 4.1: Leberzirrhosesterblichkeit in Paris zwischen 1930 und 1956 (Daten von Ledermann 1964)

Edwards: Alkoholkonsum und Gemeinwohl

Selbst


SO VIEL IST ES NICHT
NA, ICH LEBE JA NOCH
BUMM
DIE GELBSUCHT IST ABER SCHON WIEDER BESSER
Stop!
ABER DIE LEBER IST SCHON GANZ KAPUTT
IHRE LEBENS-ERWARTUNG SINKT

Gemma De las Cuevas

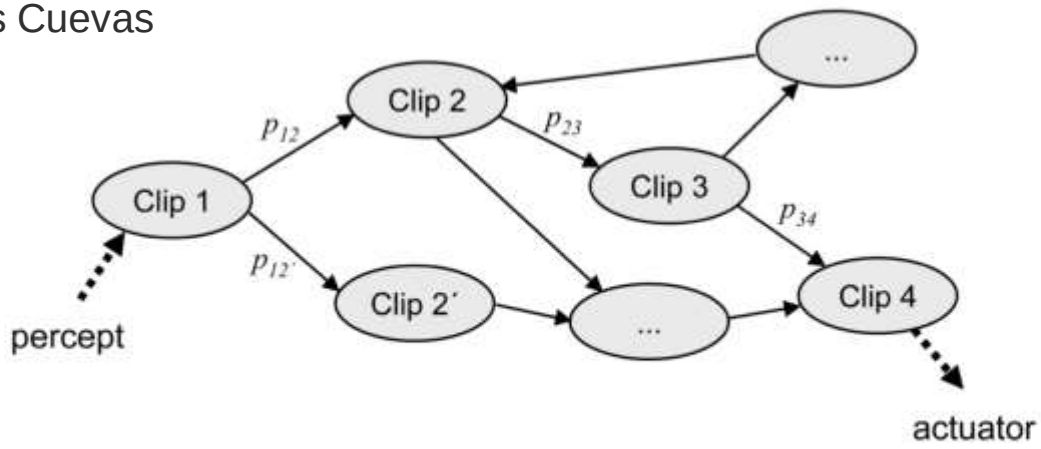
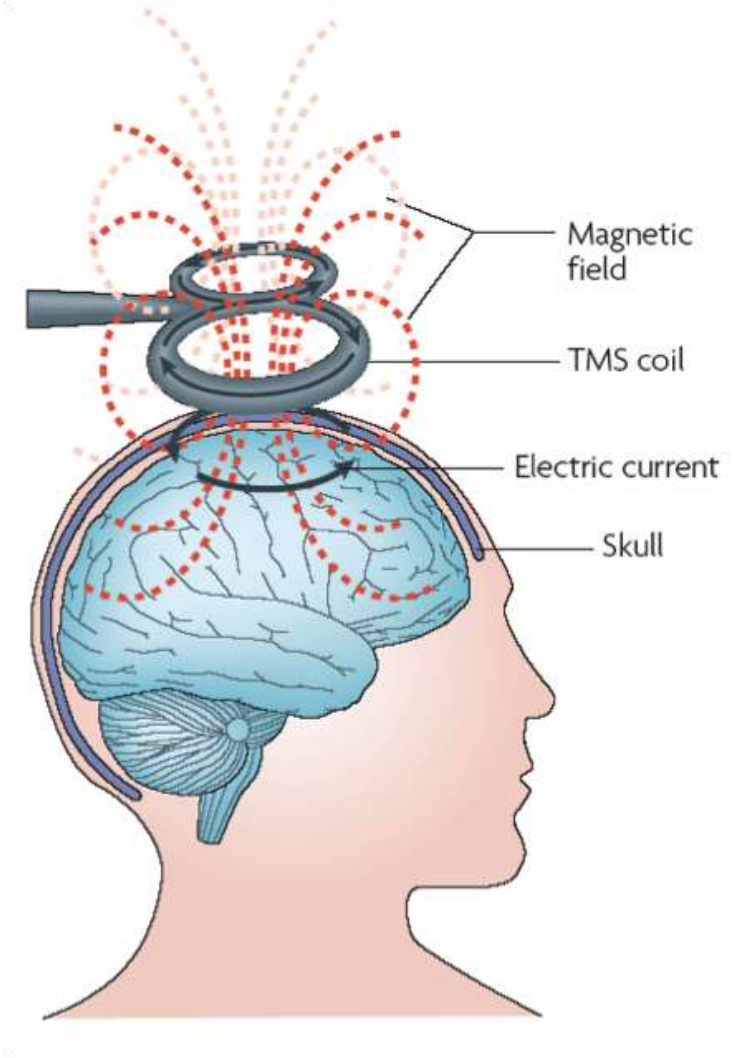


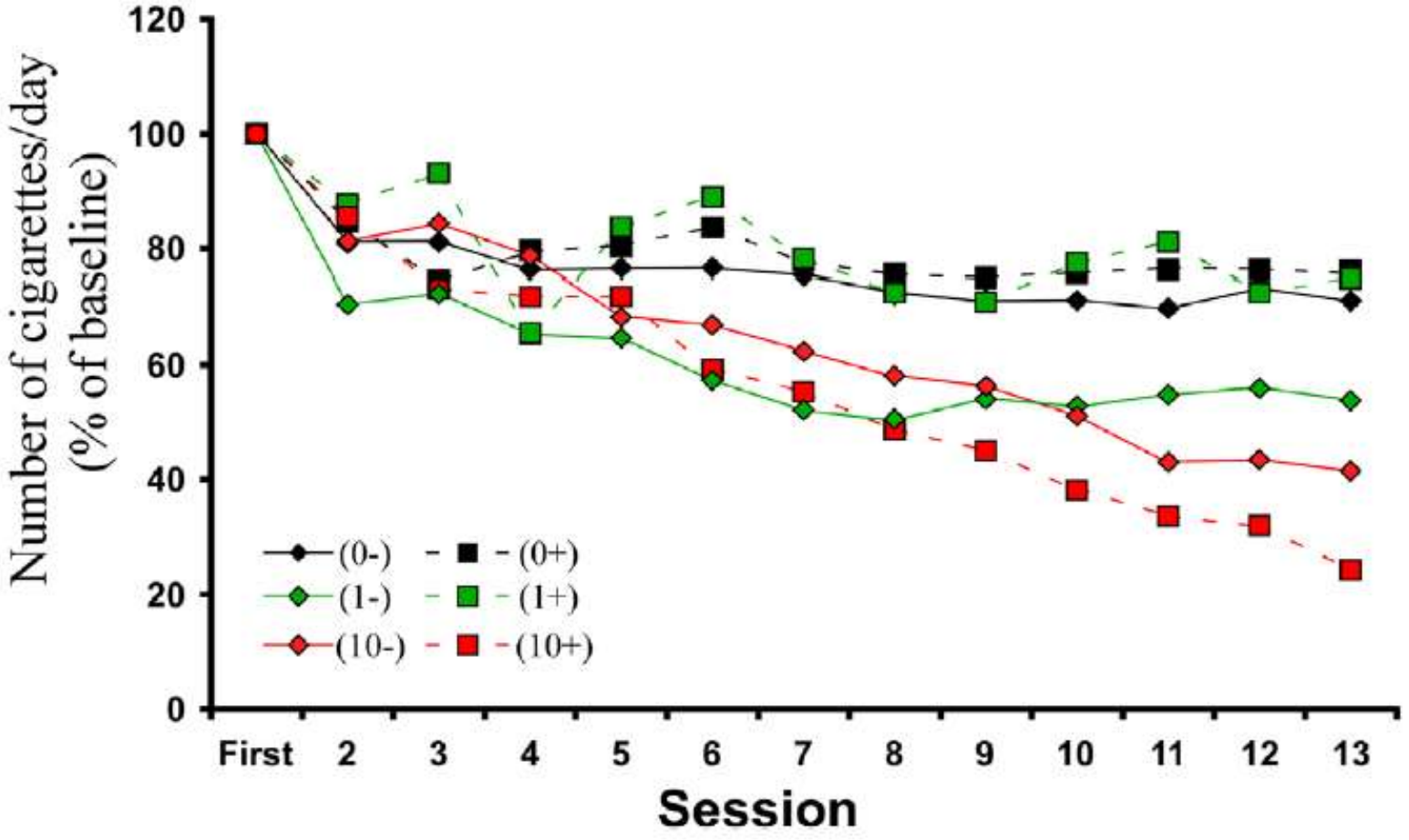
Figure 1 | Model of episodic memory as a network of clips. Triggered by perceptual input, the process of projected simulation starts a random walk through episodic memory, invoking patchwork-like sequences of virtual experience. Once a certain feature is detected, the random walk stops and is translated into motor action (See also Ref.[11]).

Transcranial Magnetic Stimulation (TMS)

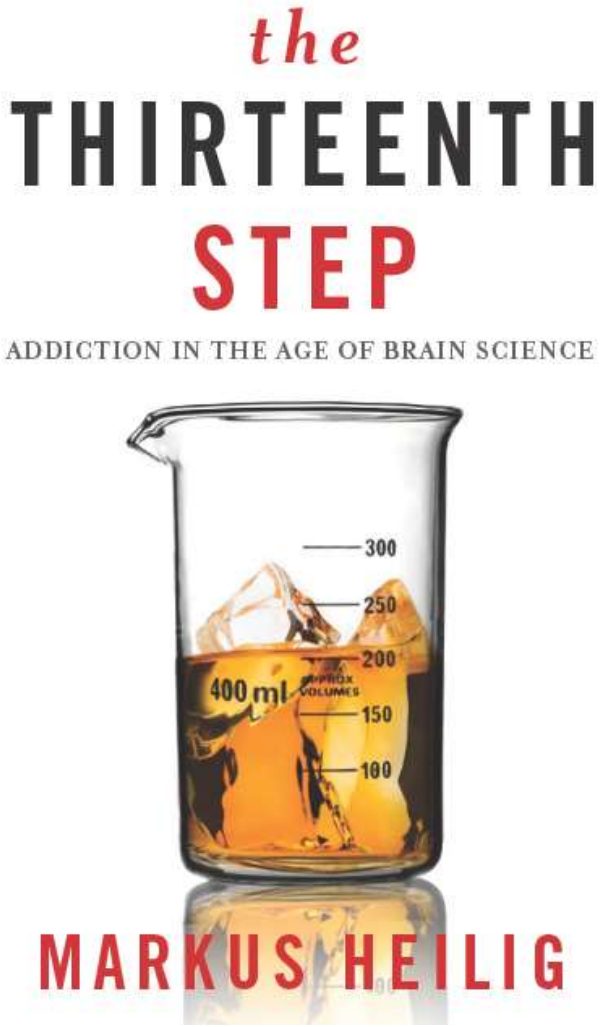


Raucherentwöhnung nach tiefer, repetitive Transkranieller Magnetstimulation

(Dinur-Klein et al, Biol Psychiat 2014)



Read all about it



10 preiswerte Maßnahmen

- Vor Tabakrauch schützen
- Vor Tabakrauch warnen
- Werbung für Tabakprodukte verbieten
- Steuern auf Tabakprodukte erhöhen

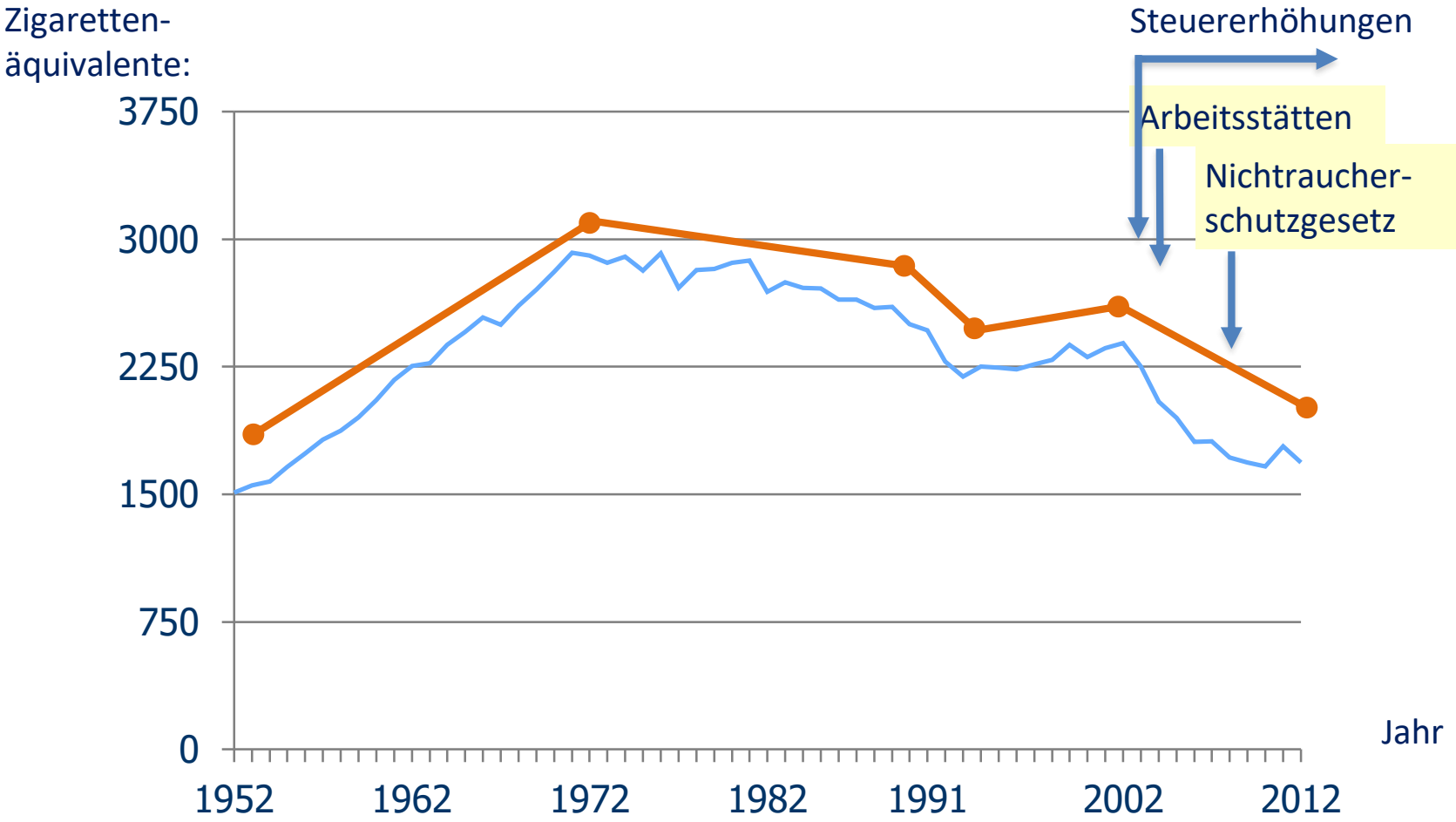
- Erhältlichkeit von Alkohol erschweren
- Werbung für Alkohol verbieten
- Steuern auf Alkoholprodukte erhöhen

- Salzaufnahme reduzieren
- Transfette ersetzen
- Medienkampagnen zu Ernährung und Bewegung

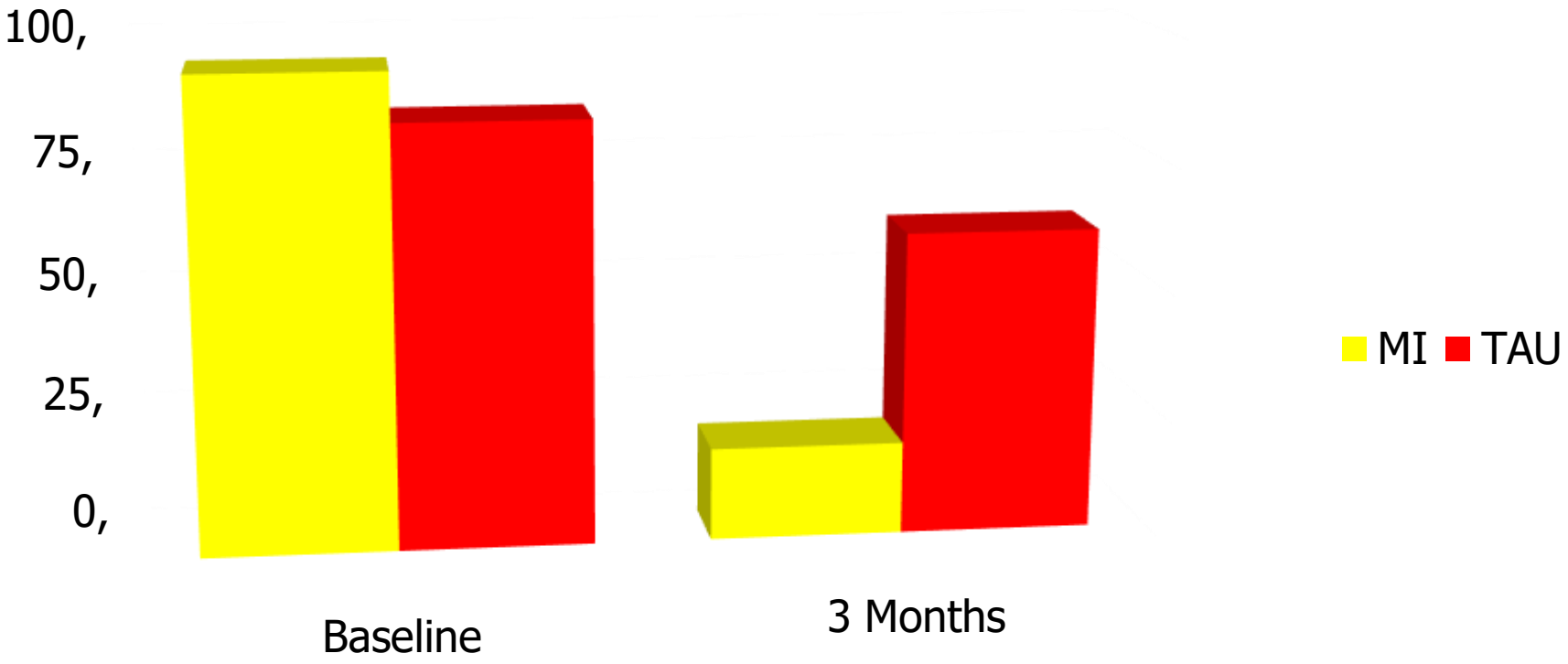
WHO, 2011

Verkaufte Zigarettenäqivalente

pro Einwohner ab 15 Jahre



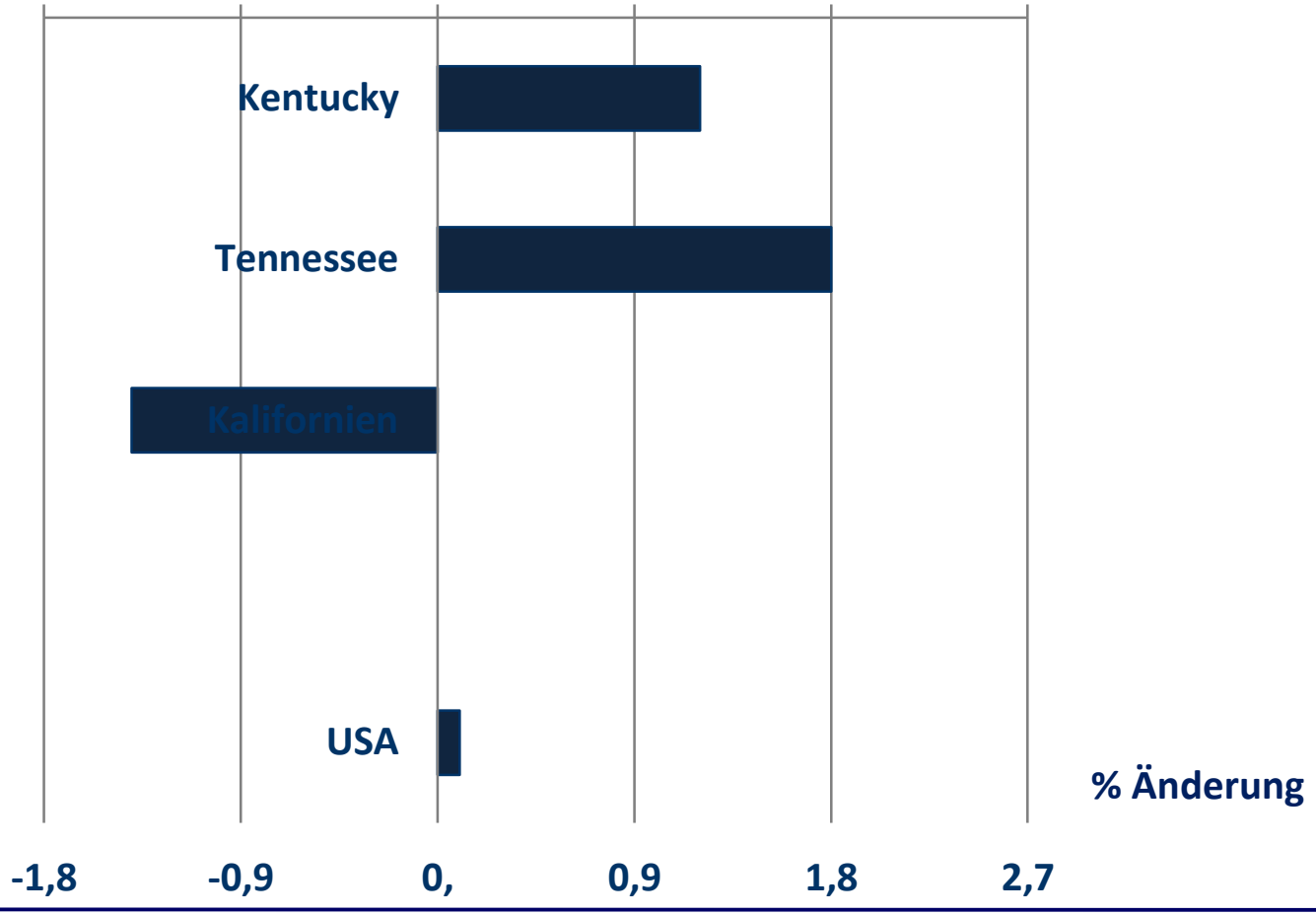
Standard Drinks / Week



Brown & Miller, 1993

p<.001

USA
Lungenkrebs-Todesfälle
Trends 1995 – 2005
Frauen, jährliche Änderung

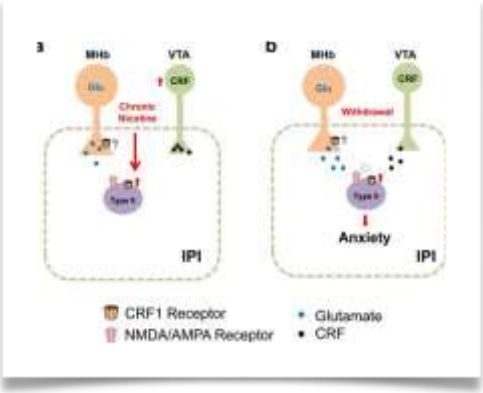


Jemal, 2008

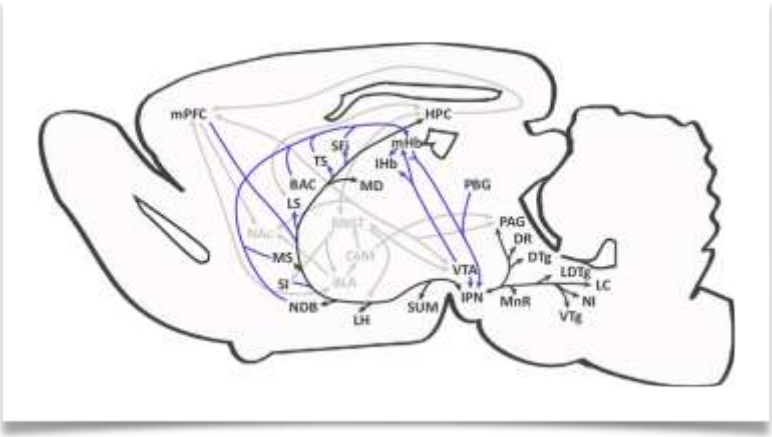
Ulrich John, Greifswald

Das **Angst-Entzugssystem**:
ein neues System neben dem Verstärkungssystem

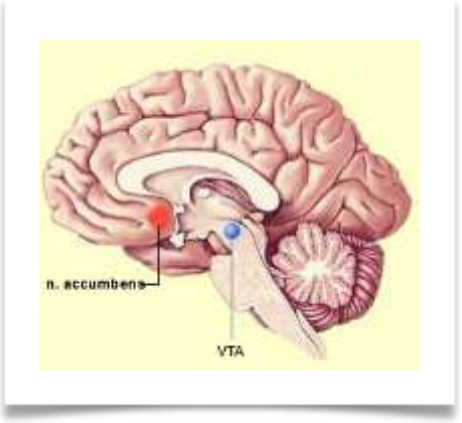
Angst und Entzug

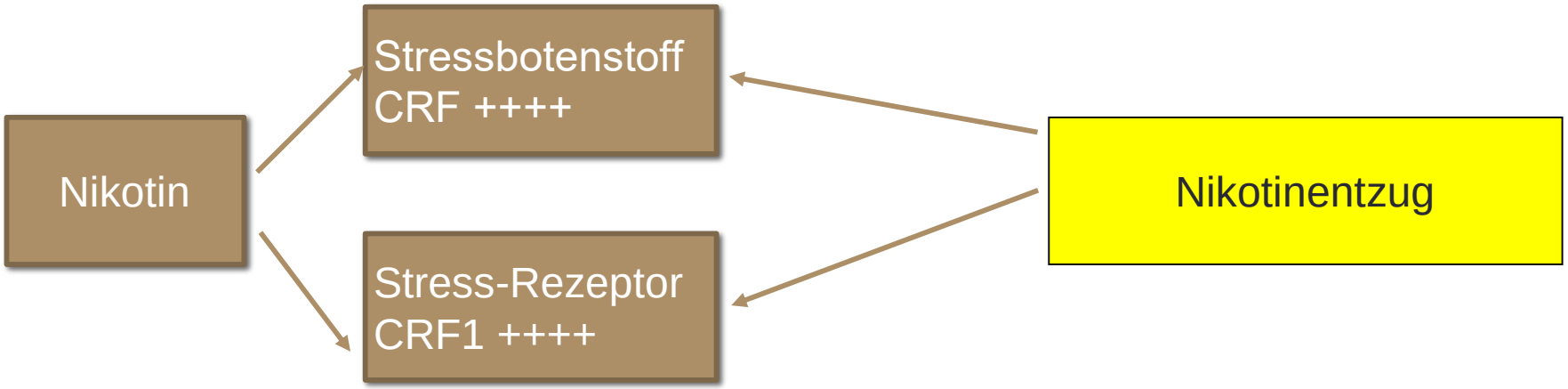


Zhao-Shea et al. 2015



Molas et al. 2016





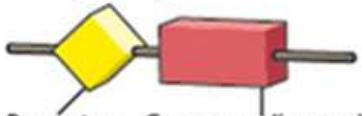
Mediale Habenula —> Ncl.interpedunclulares

SIX STEPS TO OPTOGENETICS

With optogenetic techniques, researchers can modulate the activity of targeted neurons using light.

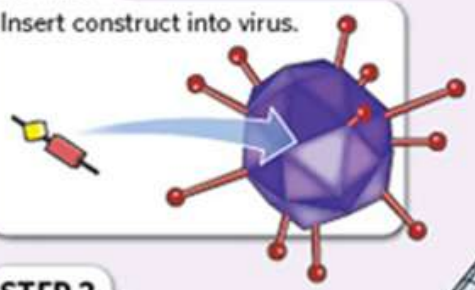
STEP 1

Piece together genetic construct.



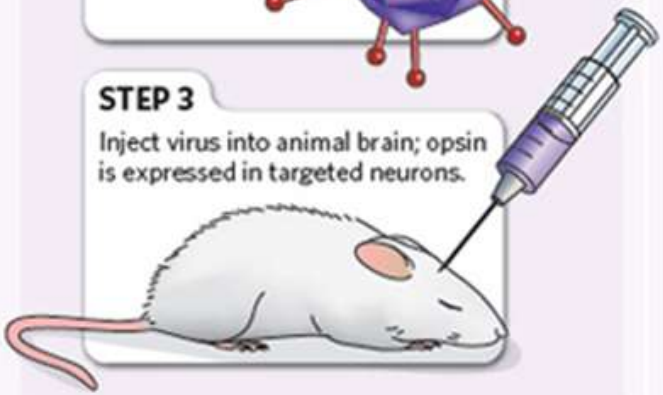
STEP 2

Insert construct into virus.



STEP 3

Inject virus into animal brain; opsin is expressed in targeted neurons.

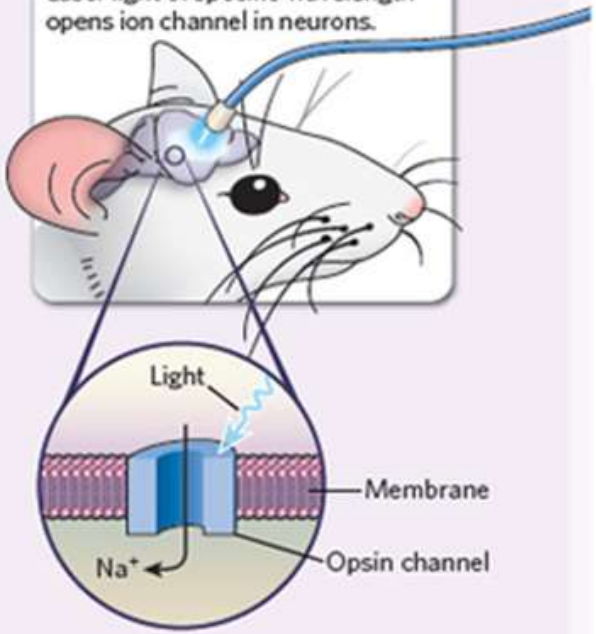


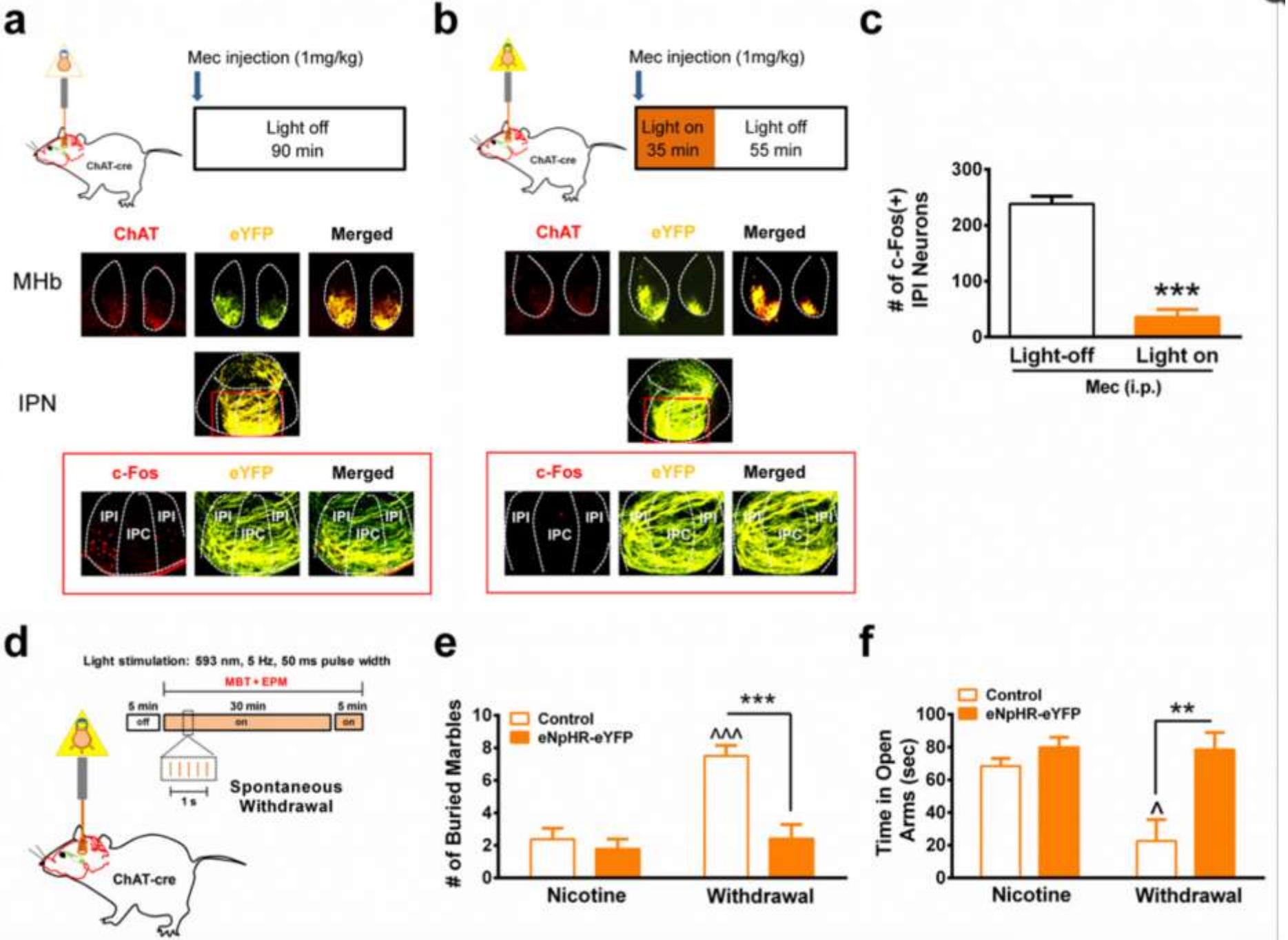
STEP 4

Insert 'optrode', fibre-optic cable plus electrode.

STEP 5

Laser light of specific wavelength opens ion channel in neurons.




a
Mec injection (1mg/kg)
Light off
90 min
ChAT-cre
ChAT
eYFP
Merged
MHb
IPN
c-Fos
IPI
IPC
b
Mec injection (1mg/kg)
Light on
35 min
Light off
55 min
c
# of c-Fos(+) IPI Neurons
300
200
100
0
***
Light-off
Light on
Mec (i.p.)
d
Light stimulation: 593 nm, 5 Hz, 50 ms pulse width
MBT + EPM
5 min
30 min
5 min
off
on
1 s
Spontaneous Withdrawal
e
# of Buried Marbles
Control
eNpHR-eYFP
***
^^^
Nicotine
Withdrawal
f
Time in Open Arms (sec)
**
^

Wissenschaftsmüll

Wenn Forschung nicht hält, was sie verspricht

Biomediziner sollen in ihren Laboren unter anderem nach Substanzen gegen Krebs oder Schlaganfall suchen. Sie experimentieren mit Zellkulturen und Versuchstieren, testen gewollte Wirkungen und ergründen ungewollte. Neuere Studien zeigen jedoch, dass sich bis zu 80 Prozent dieser präklinischen Studien nicht reproduzieren lassen.

Von Martin Hubert

Eur J Psychotraumatol. 2019 Feb 19;10(1):1577092. doi: 10.1080/20008198.2019.1577092. eCollection 2019.

A multisite randomized controlled trial of Seeking Safety vs. Relapse Prevention Training for women with co-occurring posttraumatic stress disorder and substance use disorders.

Schäfer I[1], Lotzin A[1], Hiller P[1], Sehner S[2], Driessen M[3], Hillemacher T[4,5], Schäfer M[6], Scherbaum N[7], Schneider B[8], Grundmann J[1].

Author information

Abstract in **English**, Chinese, Spanish

Background: Co-occurring posttraumatic stress disorder (PTSD) and substance use disorders (SUD) are associated with a more severe course and worse outcome than either disorder alone. In Europe, few treatments have been evaluated for PTSD and SUD. Seeking Safety, a manualized, integrated, cognitive-behavioural treatment, has been shown to be effective in studies in the USA. **Objective**: To test the efficacy of Seeking Safety plus treatment as usual (TAU) in female outpatients with PTSD and SUD compared to Relapse Prevention Training (RPT) plus TAU and TAU alone. **Method**: In five German study centres a total of $N = 343$ women were randomized into one of the three study conditions. PTSD severity (primary outcome), substance use, depression and emotion dysregulation (secondary outcomes) were assessed at baseline, post-treatment, as well as at three months and six months post-treatment. **Results**: Treatment participants attended $M = 6.6$ sessions (Seeking Safety) and $M = 6.1$ sessions (RPT). In an intent-to-treat analysis, Seeking Safety plus TAU, RPT plus TAU and TAU alone showed comparable decreases in PTSD severity over the course of the study. Seeking Safety plus TAU showed superior efficacy to TAU alone on depression and emotion regulation and RPT plus TAU was more effective than TAU alone on number of substance-free days and alcohol severity. Minimum-dose analyses suggest additional effects of both programmes among participants who attended at least eight group sessions. **Conclusions**: With respect to PTSD symptoms, a brief dose of Seeking Safety and RPT in addition to TAU was not superior to TAU alone in women with PTSD and SUD. However, Seeking Safety and RPT showed greater reductions than TAU alone in other domains of psychopathology and substance use outcomes respectively. Future studies should investigate further variables, such as what aspects of each treatment appeal to particular patients and how best to disseminate them.

KEYWORDS: Posttraumatic stress disorder; Seeking Safety; addiction; alcohol abuse; drug abuse; dual diagnosis; randomized controlled trial; relapse prevention; substance use disorder; trauma; • We compared a treatment programme for co-occurring PTSD and substance use disorders (Seeking Safety) to another cognitive behavioural treatment (Relapse Prevention Training) and to treatment as usual (TAU).•Decreases in PTSD severity were comparable in all three conditions.• The Seeking Safety group improved more on depression and emotion regulation than TAU alone.• The Relapse Prevention group improved more on alcohol and drug use than TAU alone.

PMID: 30815234 PMCID: PMC6383607 DOI: 10.1080/20008198.2019.1577092

Free PMC Article

European Journal of Psychotraumatology
Taylor & Francis
Taylor & Francis Group

PMC full text: Eur J Psychotraumatol. 2019; 10(1): 1577092.
Published online 2019 Feb 19. doi: 10.1080/20008198.2019.1577092

Prev Figure 2. Next

Figure 2.

PTSD

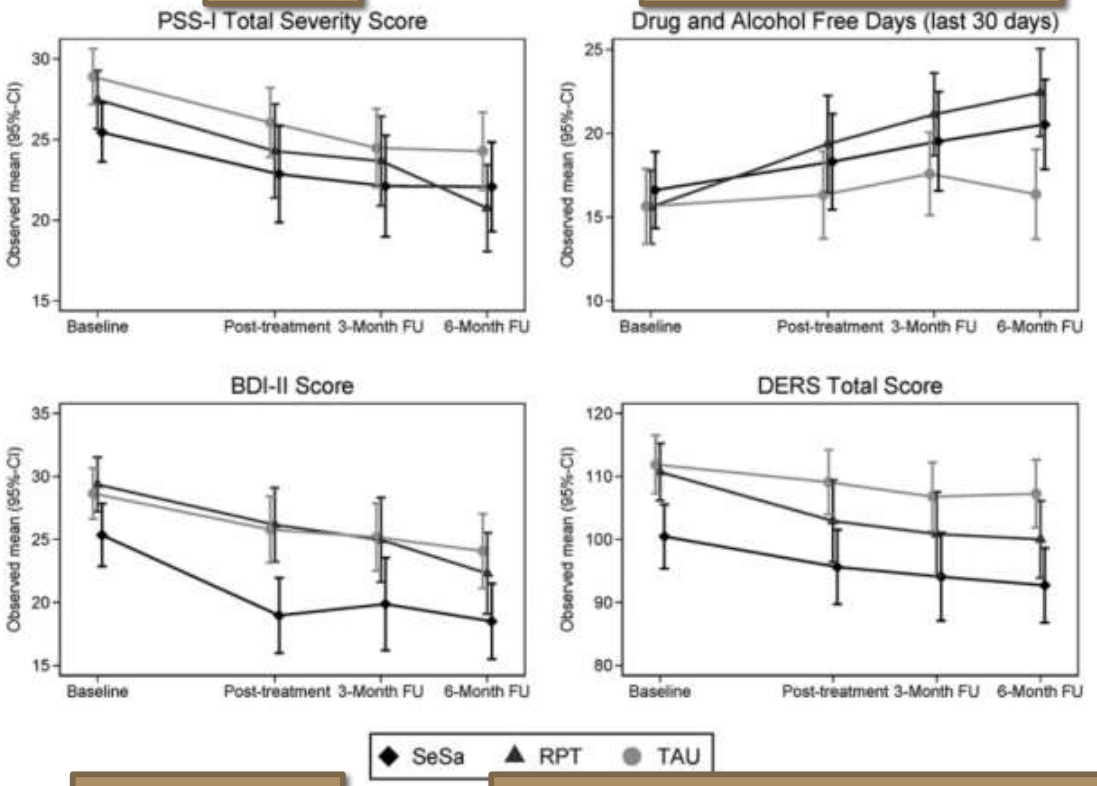
Tage ohne Alkohol

Kein Unt.

RPT>TAU

SeSa>TAU

SeSa>TAU



Depression

Schwierigkeiten Emo-Regulation

in a separate window

Observed courses of PSS-I PTSD severity scores (upper left), numbers of drug- and alcohol-free days (upper right), BDI-II depression scores (lower left) and DERS emotion dysregulation scores (lower right). PSS-I = PTSD Symptom Scale Interview (Foa et al., 1993), BDI-II = Beck Depression Inventory II (Beck et al., 1996), DERS = Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), SeSa = Seeking Safety, RPT = Relapse Prevention Training, TAU = treatment as usual.

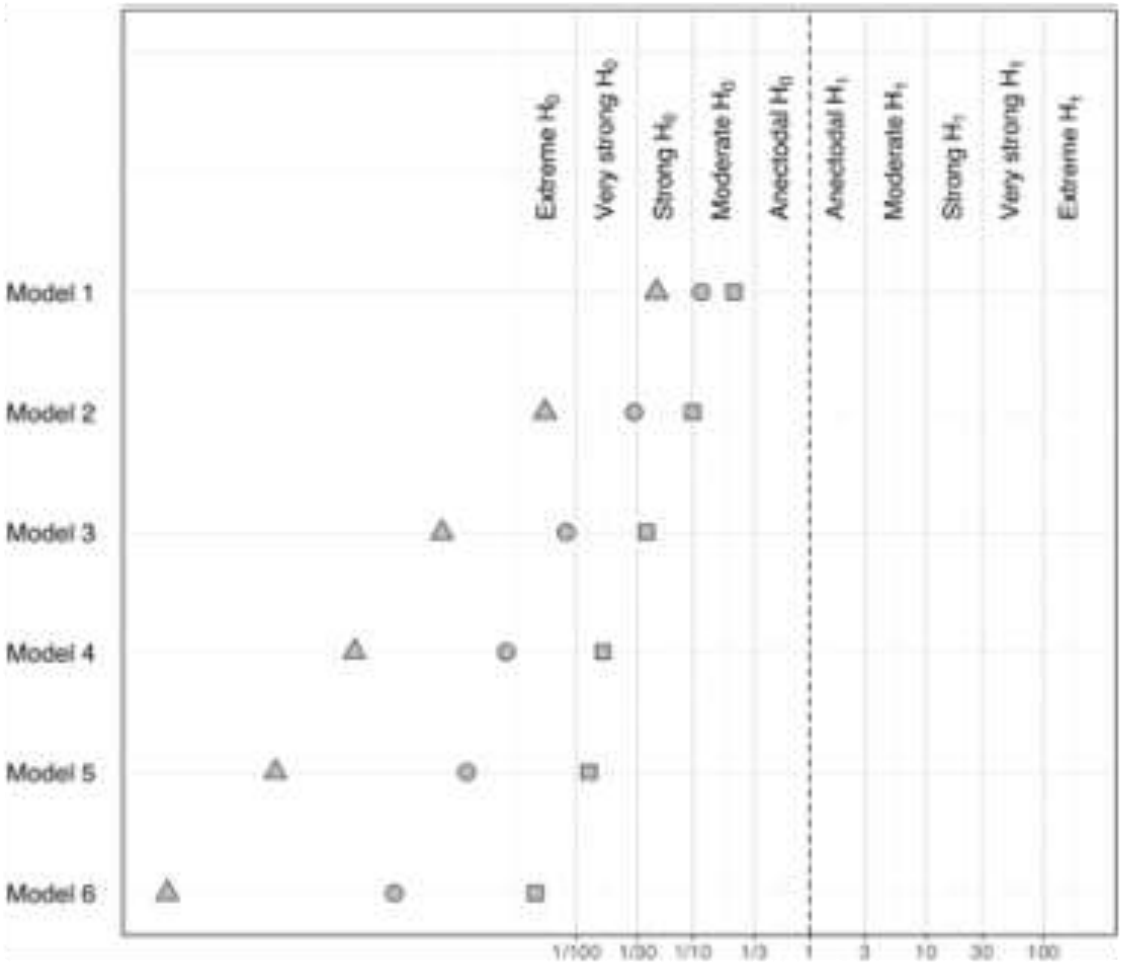
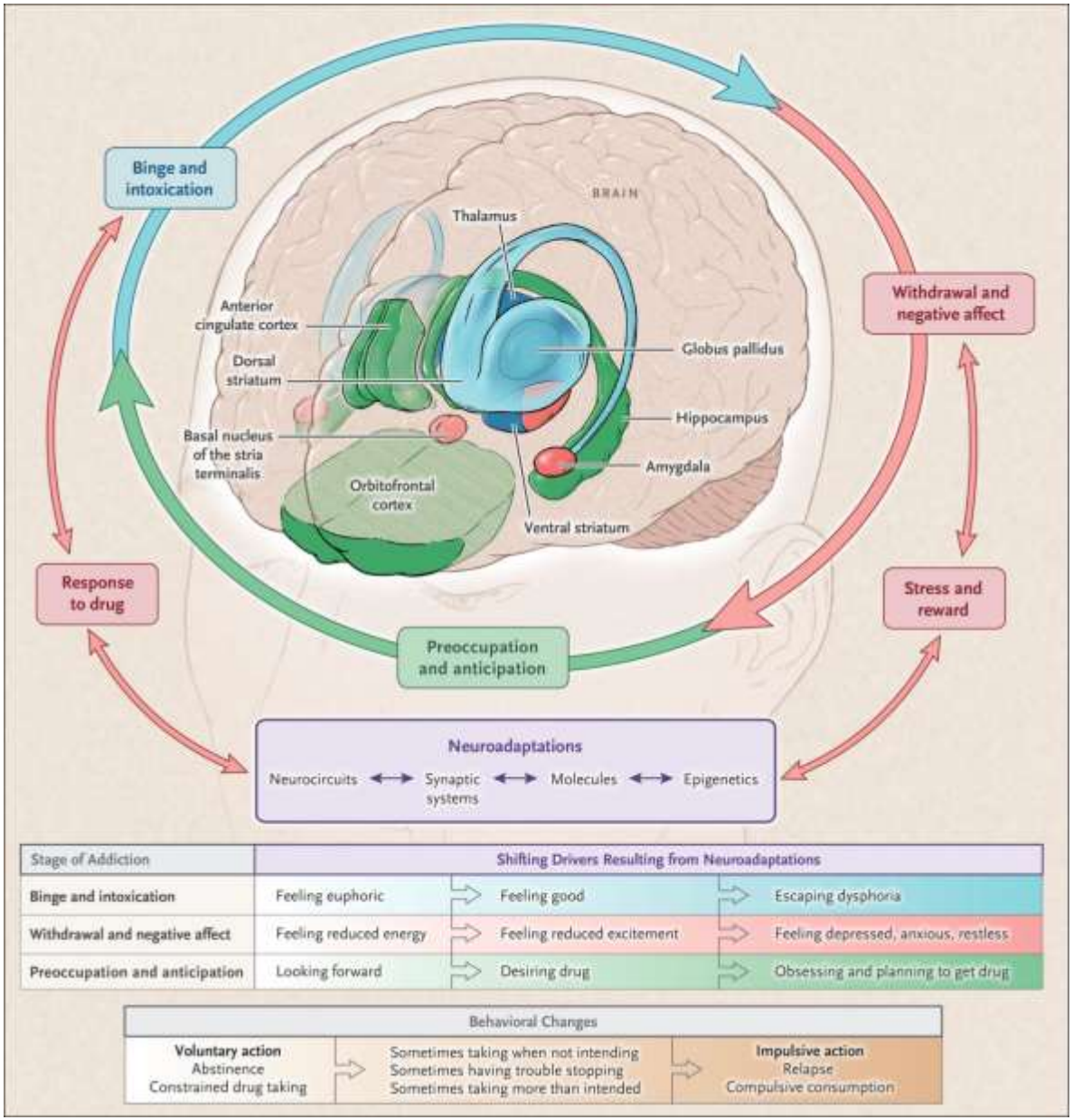


Fig. 6 Sensitivity analysis of reduction in substance use outcome showing Bayes factors for models $M_1 - M_6$ against model M_0, computed with the three different prior distributions on the main parameters of interest: primary prior distribution (scale of 1; circle), wider prior (scale 2.5; triangle) and narrower prior (scale 0.5; square). The direction of the hypothesis refers to the two-sided BF10. The top margin indicates the evidence categories proposed by Jeffreys (1961)



Stage of Addiction	Shifting Drivers Resulting from Neuroadaptations		
Binge and intoxication	Feeling euphoric	Feeling good	Escaping dysphoria
Withdrawal and negative affect	Feeling reduced energy	Feeling reduced excitement	Feeling depressed, anxious, restless
Preoccupation and anticipation	Looking forward	Desiring drug	Obsessing and planning to get drug

Behavioral Changes		
Voluntary action Abstinence Constrained drug taking	Sometimes taking when not intending Sometimes having trouble stopping Sometimes taking more than intended	**Impulsive action** Relapse Compulsive consumption

Figure 1. Stages of the Addiction Cycle.
During intoxication, drug-induced activation of the brain's reward regions (in blue) is enhanced by conditioned cues in areas of increased sensitization (in green). During withdrawal, the activation of brain regions involved in emotions (in pink) results in negative mood and enhanced sensitivity to stress. During preoccupation, the decreased function of the prefrontal cortex leads to an inability to balance the strong desire for the drug with the will to abstain, which triggers relapse and reinitiates the cycle of addiction.

The compromised neurocircuitry reflects the disruption of the dopamine and glutamate systems and the stress-control systems of the brain, which are affected by corticotropin-releasing factor and dynorphin. The behaviors during the three stages of addiction change as a person transitions from drug experimentation to addiction as a function of the progressive neuroadaptations that occur in the brain.

Research Allegiance
Allegiance: Treuepflicht, Gehorsam, Loyalität

Research Allegiance ist vorladen, wenn der Autor
1. die jeweilige Psychotherapie einer anderen gegenüber bevorzugt
2. bei der Entwicklung der Therapie beteiligt war
3. bei der Entwicklung und Erforschung des ätiologischen Modells beteiligt war

Imel, Wampold et al.

Researcher allegiance is defined to be present if the author -
1. Recommends the respective psychological therapy over another therapy
2. Involved in the development of the respective psychological therapy
3. Involved in research/development of the aetiological model of the psychological therapy.

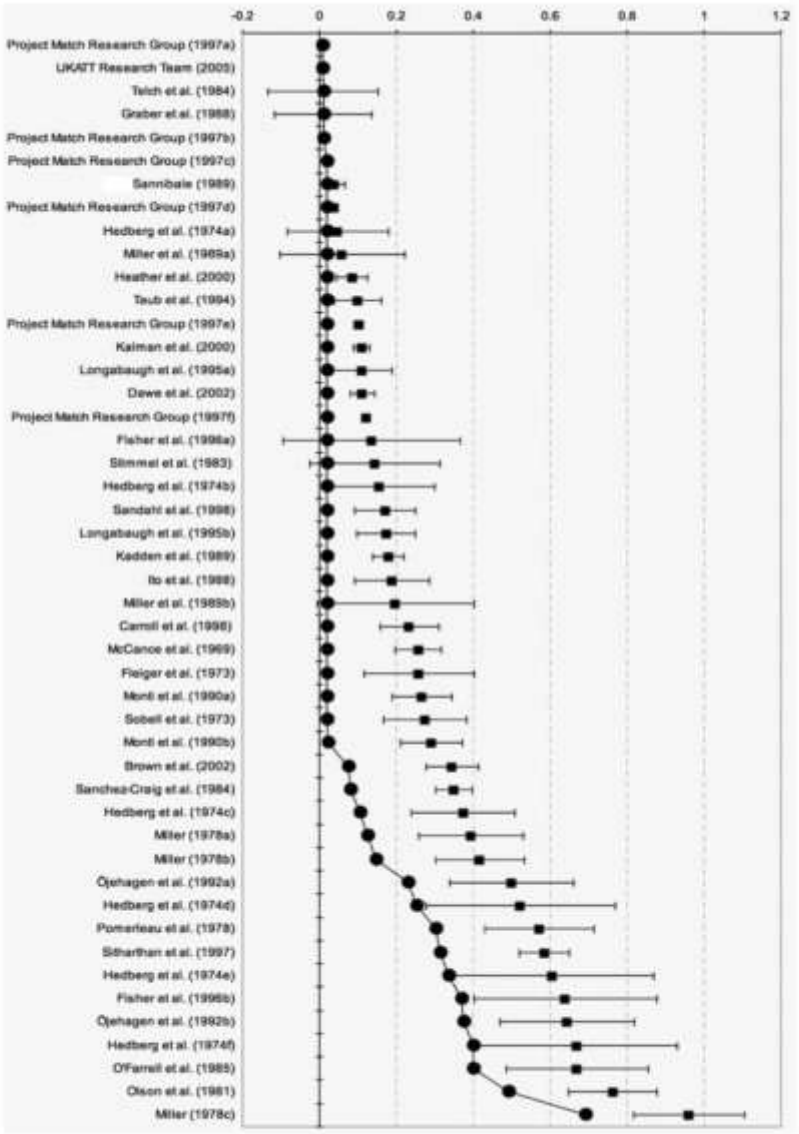
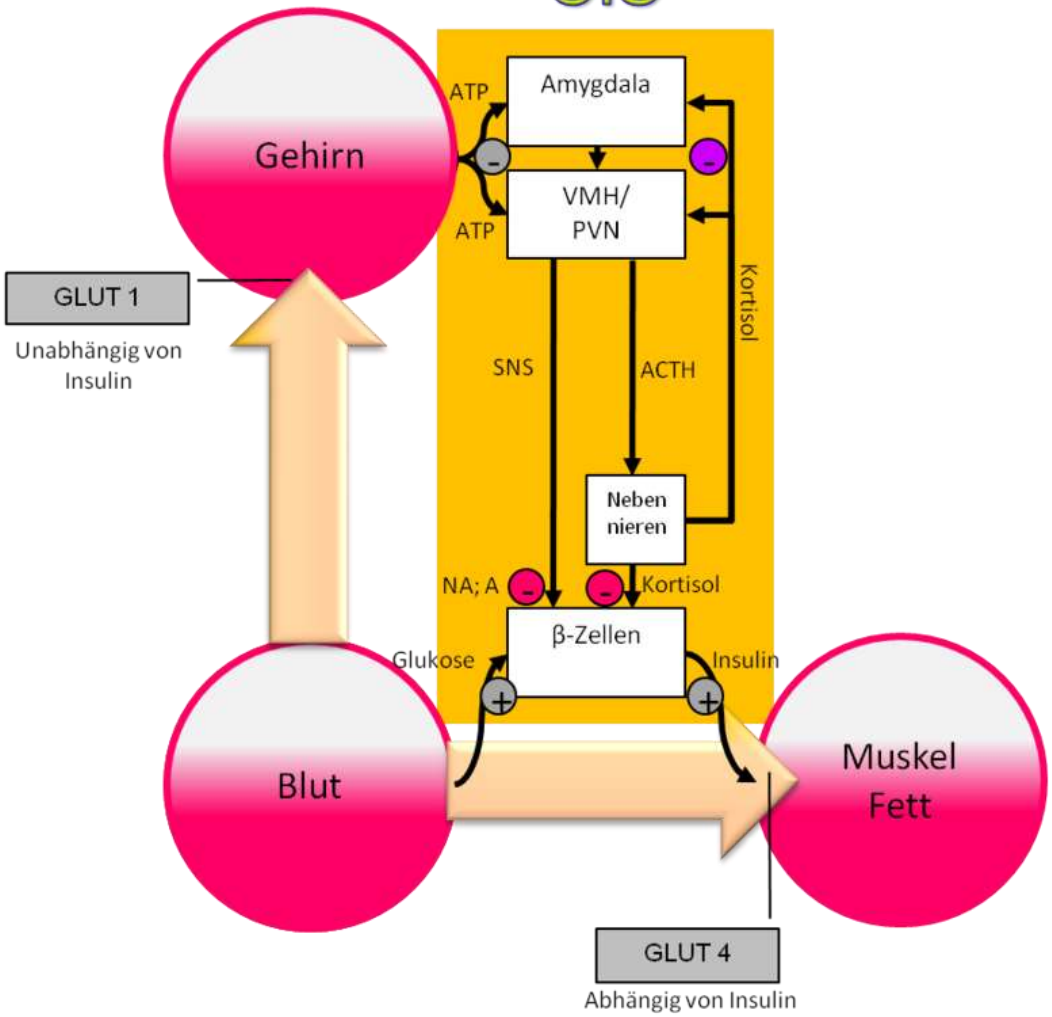
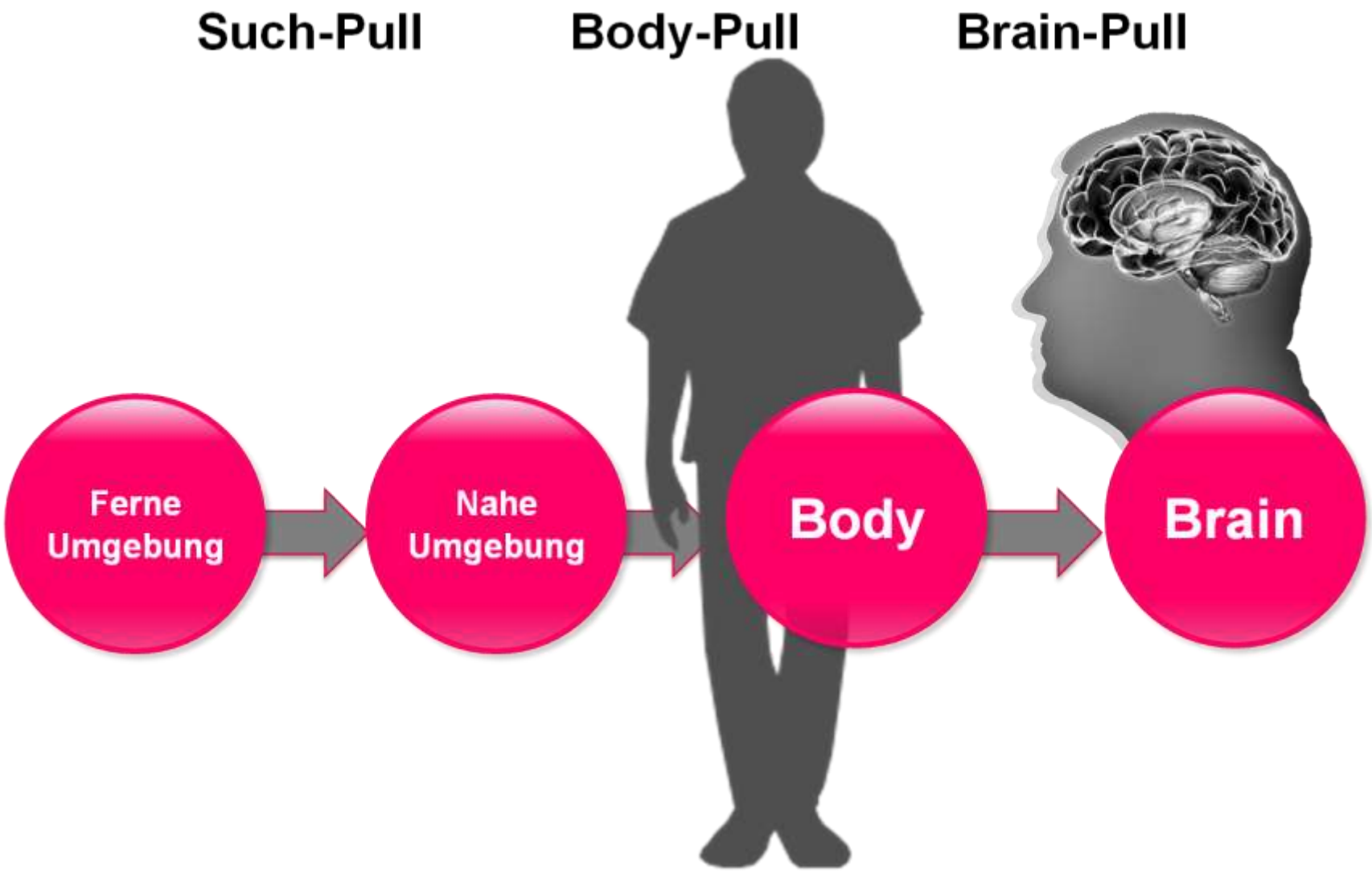


Figure 1. This figure provides the absolute value of the effect size (Cohen's *d*) for each treatment comparison. Square points indicate the actual effect size entered in the meta-analysis, and ovals indicate the absolute value of each effect size corrected for allegiance. Error bars provide a 95% confidence interval. We corrected for allegiance by calculating the predicted allegiance score for each comparison and multiplying by the allegiance coefficient (λ_j = .09; see Table 1). Finally, we subtracted this product from the observed effect size.

Brain-Pull CIS




Such-Pull
Body-Pull
Brain-Pull
Ferne Umgebung
Nahe Umgebung
Body
Brain

Intervallfasten