МИФ 10. Полная пожизненная ремиссия – единственный критерий успеха лечения.

РЕАЛЬНОСТЬ.

Правильно ли игнорировать промежуточные достижения лечения, ориентируясь только на абсолютную «необратимую» абстиненцию?

Правильно ли лечить пациента с хроническим заболеванием только в период обострения?

Любое хроническое заболевание, в том числе и наркозависимость, включает периоды обострения и ремиссии. К сожалению, по ряду причин, акцент в лечении хронических состояний часто смещен в сторону обострения, а состояние ремиссии оставляют без внимания. Кроме того, оценка результатов лечения наркозависимости сводится чаще всего к сопоставлению статуса «до» и «после» лечения: «употребляет» – «не употребляет», в то время как промежуточные достижения игнорируются.

Модель лечения наркозависимости включает три этапа:

- детоксикация;
- терапия;
- поддержка ремиссии, профилактики рецидива.

Выводы: понимание лечения наркозависимости как непрерывного динамического процесса лечения хронического и рецидивирующего состояния позволяет увеличить его эффективность. Кроме того, такое лечение снижает стигму зависимости и делает лечение более привлекательной альтернативой для самих пациентов.

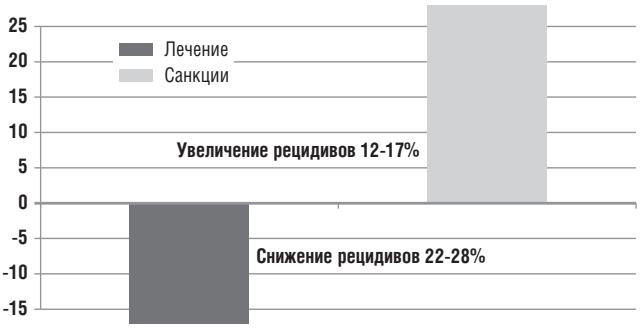

Рис. 3. Данные мета-анализа, которые показывают преимущество лечения зависимости над санкциями в снижении рецидивов

В заключение хочу отметить, что это лишь малая часть мифологий в области психиатрии зависимостей. Здесь собраны лишь наиболее частые, стереотипные и устойчивые мифы и заблуждения, с которыми автор сталкивался в ходе работы в более 40 странах мира, в различных культурах, организационных системах здравоохранения, идеологиях, и медицинских традициях. Единственный способ создания более эффективных терапевтических опций для пациентов – это замещение мифов научным знанием и терапевтическими стратегиями, основанными на доказательствах, а не идеологиями или личными мнениями.

ДЕСЯТЬ МІФІВ ПРО ПОХОДЖЕННЯ І ЛІКУВАННЯ ЗАЛЕЖНОСТІ ВІД ПСИХОАКТИВНИХ РЕЧОВИН

І. Куценок

В статті зосереджено увагу на основних міфах, які існують у суспільній свідомості відносно залежних станів, їх походження, значення та лікування, зважаючи на багаторічний досвід автора. Також сфокусовано увагу на необхідності перегляду хибних поглядів відносно осіб, залежних від психоактивних речовин.

Ключові слова: психоактивні речовини, психіатрія залежних станів, рецидив.

TEN MYTHS ABOUT ORIGIN AND TREATMENT SUBSTANCE DEPENDENCE

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This article focuses on the major myths that exist in social consciousness a relatively the dependent states, their origin and meaning of treatment, given the many years of experience of the author. There is a need to review misperceptions regarding people dependent on psychoactive substances.

Key words: psychoactive substances, psychiatry dependent states, relapse.

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WANDERING BEHAVIOR AND ALZHEIMER'S DISEASE

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Wandering, in patients with dementia, is a common behavior that can cause great risk for the person. Historically, wandering was defined as a "moving about aimlessly" [2]; although more recent definitions have considered wandering as "purposeful" and "need driven" [1; 3]. It is estimated to be the most common form of disruption leading to care-provider stress both within institutions and the community. Although it occurs in several types of dementia, wandering is especially common in persons with Alzheimer's disease (AD). Wandering can be caused by several reasons including neurological, psychosocial and environmental.

D. Thomas [3] identified two ***typologies of wandering «continuous»*** and ***«sporadic»*** which are distinguished based on the amount of time-in-motion. Thomas, in his study, found that the "continuous" wanderer moves about 77 % of his or her wakeful time compared to 22 % for the "sporadic" wanderer. Although both types are considered "wanderers", each has different needs. Interventions for "continuous wanderers" should emphasize modification of the environment while organized social activities and verbal communication techniques should be stressed for the "sporadic wanderer." Additional empirical research is needed that studies the different needs of wanderers based on the percentage of time spent in motion.

A critical ***problem associated with wandering*** is the risk of elopement. **Elopement** is a special concern for caregivers and search and rescue responders. Wandering can result in the person's being lost out of doors day or night, dressed inappropriately, and unable to take many ordinarily routine steps to ensure his or her personal safety. This is a situation of great urgency especially in the community and other unsecured settings.

In some countries the social costs of elopement are significant. A search and rescue mission lasting more than a few hours is likely to expend many hundreds to thousands to

tens of thousands of skilled workers' hours and, per mission, those involving subjects with dementia typically expend significantly more resources than others. Other negative effects of wandering are; falls, invasion of other patient's privacy, malnutrition, dehydration, and early mortality, compared to people with dementia who do not wander.

As it was previously noted, many factors can cause wandering behavior; proximal factors like the physical and social environment, along with background factors of neurological, cognitive, and psychosocial.

D. Thomas [4] studied the effect of psychosocial factors by comping wanderers and non-wanderers with dementia based on personality facets. Surrogates of the sample completed the NEO Five-Factor Inventory (NEO-FFI) (Costa & McCrae, 1992). All subjects were rated as middle to late dementia using the Global Deterioration Scale for Assessment of Primary Degenerative Dementia (GDS) [Reisberg et al., 1982].

Scores between the two groups were statistically compared using an independent t-test and chi-square test (0.5 level of significance) for each of the demographic and personality factors. In addition qualitative follow-up was conducted based on 25 % of random sample of the two groups, which further analyzed the statistically significant quantitative result.

The results of the research (Table) found that wanderers had a personality make-up that was continually active and socially seeking along with a greater positive regard toward oneself and others. These facets represented a more "extraverted" personality type than non-wanderers. Thomas suggested that wandering is an expression of one's personality ingrained over a lifetime of development. 3. Viewing wandering as "normal" would encourage staff and informal care providers to respond not in punitive and controlling ways, but with creativity and acceptance.

Table. Differences in Personality Facets between Wanderers and Non-Wanderers

Facet	Wanderer Mean Score	Non-Wanderer Mean Score	T-Score
Warmth	3.50	3.00	1.88*
Gregariousness	5.45	3.95	2.37*
Assertiveness	1.70	1.35	9.3
Activity	7.70	6.10	2.07*
Excitement Seek	2.10	1.80	8.4
Positive Emotion	11.10	8.45	2.70**
Trust	4.55	3.60	9.2
Straightforward	2.75	2.55	4.8
Altruism	17.55	15.30	2.07
Compliance	8.30	6.95	1.60
Tender-Minded	1.40	1.20	4.9

*Note: df = 38, *≤ 05, **≤ 0.1*

Helping people with Alzheimer's disease is complicated process and include many methods. One of them is music therapy. Music has power –especially for individuals with Alzheimer's disease and related dementias. And it can spark compelling outcomes even in the very late stages of the disease.

When used appropriately, music can shift mood, manage stress-induced agitation, stimulate positive interactions, facilitate cognitive function, and coordinate motor movements.

This happens because rhythmic and other well-rehearsed responses require little to no cognitive or mental processing and are stored in parts of the brain less effected by Alzheimer's disease. Responses influenced by the motor center of the brain that responds directly to auditory rhythmic cues. A person's ability to engage in music, particularly rhythm playing and singing, remains intact late into the disease process.

In another study, D. Thomas and M. Smith [5] found that music therapy is helpful in increasing caloric intake among people with Alzheimer's disease. Possible reasons for music's effectiveness on caloric consumption were identified as:

1. The medial prefrontal cortex where music memories are stored, stays relatively intact with AD. 2. Engagement in a musical experience (listening and singing) helped to keep the person at their seat allowing more time to refocus attention to the food. 3. Music increased positive emotions resulting in reduced anxiety and need to move about. 4. A white noise effect that covered stress-reducing sounds in the eating environment.

Wandering in the Community. In other efforts to help keep residents safe, mitigate liability, and protect reputations, Long Term Care and Assisted Living Facilities may use radio frequency (RFID) products to protect their residents. A resident wears a wrist, pendant, or ankle transmitter. This RFID tag can be read by receiving antenna units, which are placed usually at door or hallway locations that are deemed likely routes of egress and need monitoring. The system will then either sound an alarm or briefly lock a door when a door monitor reads a transmitter worn by a resident that is at risk for wandering. This helps prevent an elopement as staff can be notified by alarms at the door, pocket pagers, and email. A caregiver will be able to quickly find the person at risk and keep them safely inside. Smaller scale versions of this technology are also used in private residences.

Newer versions of this equipment have become more advanced. The newest types of systems may have the ability to: identify a RFID tag by a specific resident and forward that name to the staff; give staff a last known location of the resident; show a photo of the resident at the staff station with a mapped out door location; report the frequency, times and severity of the incidents; and finally, integrate with other access control systems, HVAC, fire alarm equipment and phone equipment. The reason this type of system seems to be preferable is that it helps monitor those at risk for wandering and elopements while not infringing on the freedom of other residents or visitors to a facility.

In conclusion, wandering is a significant problem in any country. Recognizing the wanderer's needs and incorporating non-pharmaceutical interventions that emphasize creativity and understanding can lead to satisfying outcomes for both the wanderer and care-provider.

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