



RELAPSE PREVENTION: STRATEGIES AND TECHNIQUES

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ABSTRACT

This article presents some views of strategies and techniques of relapse prevention in the context of drug treatment and rehabilitation in Malaysia. It outlines some strategies for relapse prevention, with the primary focus on anxiety reduction among drug dependents through several approaches such as spiritual, muscle relaxation and emotional imagery techniques. However, in Malaysia, focus should be given to finding employment for recovering drug dependents because they had a positive employment record before they were brought in for treatment and rehabilitation. The article also touches on the service delivery system of the drug rehabilitation program which among others suggests capacity building of personnel involved in the program.

ABSTRAK

Artikel ini membentangkan strategi dan teknik pencegahan penagihan semula dengan merujuk kepada program rawatan dan pemulihan dadah di Malaysia. Ia menggariskan beberapa strategi pencegahan penagihan semula dengan memberi tumpuan kepada pengurangan kebimbangan melalui beberapa pendekatan seperti kerohanian, teknik-teknik penyantaian otot dan pembayangan perasaan. Walaupun demikian, di Malaysia, tumpuan harus diberikan kepada mencari pekerjaan untuk mereka yang menghadapi masalah kebergantungan kepada dadah kerana mereka mempunyai rekod pekerjaan yang agak baik sebelum dimasukkan ke program pemulihan dadah. Artikel ini turut menyentuh isu mengenai sistem penyampaian perkhidmatan yang antara lainnya mencadangkan peningkatan keupayaan kakitangan yang berkhidmat dengan program rawatan dan pemulihan dadah.

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INTRODUCTION

Drug abuse is a major health concern and has reached epidemic proportions. The seriousness of drug abuse as a threat to the security of a country was best illustrated when Malaysia, on February 19, 1983, declared its drug problem a national emergency and launched a massive effort in law enforcement, preventive education and rehabilitation to eliminate this drug or “dadah” menace.

When drug abuse is discussed, one often fails to mention the vast contributions of medical research which has resulted in the discovery of a wide variety of drugs and antibiotics, which besides eliminating many of our most feared diseases, have been responsible for the world’s present level of technology and scientific sophistication. Few of us would dare question the importance and benefits of Pasteur’s discovery of vaccines in 1828, the development of sulfur drugs, or the development and use of tranquillizers to treat the mentally ill. The fact that the world is small pox-free is still difficult for many people to comprehend and because of the discovery of the Salk vaccine; parents no longer need to fear the dreaded child “crippler” of polio.

Although these medical miracles have been of immense benefit to humankind, they have also contributed to the mentality that drugs are a panacea, and can cure all of our ills. The enormous amphetamine epidemic that Japan faced after World War II was caused by both poor regulation and the belief that amphetamines could provide a person with the extra energy and “zip” necessary to help in the rebuilding of his or her war torn country.

In fact, most of today’s dangerous drugs were at one time viewed as panaceas. Morphine was supposed to be a non-addictive anesthetic or analgesic. A similar view was held when heroin was first synthesized. In fact, it took the medical profession 13 years before they acknowledged that a person could become physically dependent on heroin. Although the discovery of LSD was by accident, it was initially viewed as a possible treatment for schizophrenia and lauded for its mind expanding qualities. Therefore, it is the belief that drugs can be used as a means of problem solving and/or as a life organizing factor that contributes to abuse. Furthermore, I sincerely believe that a person must make a commitment that he or she wants to be drug-free. If not, I don’t feel that any intervention strategy will be effective.



I recall an old study that indicated that a person who simply decided to stop using drugs was as successful at maintaining sobriety as someone that avails him or herself to any of the numerous treatment interventions. Thus, I support the stages of change put forth by James Prochaska and Carlo DiClemente. It is interesting to note that Prochaska's interest in self change for the addict was aroused out of his anger and disappointment at not being able to help a person who was an alcoholic and was frequently depressed. That person was his father, who denied that he had a problem with alcohol, refused professional help and died when Prochaska was a junior in college.

Anyway, the theory of self-change involves six stages including Pre-contemplation, Contemplation, Preparation, Action, Maintenance and Termination. In Pre-contemplation, although others may believe the person has a problem with drugs, he or she denies it and the issues that others see as problems are viewed by the person as trusted ways of coping and as being under control. In Contemplation, the person admits that he or she has a drug problem and tries to understand how things got to be the way they are. He or she acknowledges that change is necessary but that the intended effort will be in the future. The person will delay any attempts to stop until there are perfect conditions. Unfortunately, there are never perfect conditions in life. In Preparation, the person is certain that the right decision is to stop taking drugs and makes arrangements to do so. The plan should be specific and realistic. In Action, the person takes the necessary steps that were developed during the Preparation stage. In Maintenance, he or she acknowledges a vulnerability to resort to old ways but makes a sustained effort to avoid relapses. In Termination, old behavior or cravings no longer tempt the person, and he or she has no fear of relapse. In this theory, it is important to note that the therapist acknowledges that a slip does not constitute a relapse. Among self-changers, 20% or less are completely successful in the first attempt and it is normal to recycle several times.

RELAPSE - REVOLVING DOOR SYNDROME

A major problem with treating drug abusers is the high recidivism rate. In America, research studies have indicated that the relapse rate (based on the use of one year as the time period) can range from 50% to 75%. I often use the term, "revolving door syndrome" when discussing the treatment of the drug abuser. That is, the addict comes for treatment, leaves and then returns.



In Malaysia, 1986 as a reference date to record drug addicts in the country, and based on that, the relapse rate is approximately 75%. There are two ways to look at recidivism and drug usage. The first view is that of the self-help movement or the 12 steps, such as Narcotics Anonymous. Their belief is that addiction is a disease and has no cure. Furthermore, relapse is a normal part of the disease process and can be expected since it may take many relapses before a person is able to maintain sobriety. Although this view has many supporters, and if applied to Malaysia, would indicate that your high relapse rate should be expected because addiction is a disease. Furthermore, the government should be tolerant because it may take a released inmate several attempts before he or she can maintain sobriety.

A Learning Process

Another view, which I adhere to, is that addiction is a learning process. That is, people learn either consciously or unconsciously, to become addicts and then they assume a deviant identity. They become addicts because of their positive expectations of the effects of drugs. Therefore, if a drug resulted in no positive effects, a person would not be motivated to take it. Thus, I believe a possible treatment approach for the opiate dependent is the use of opiate antagonists. These are drugs that block the receptor sites in the brain and prevent an opiate from occupying the site and having its effect. Nevertheless, this approach is not used in Malaysia.

High-risk Situation

With respect to relapse, I believe that it occurs when a person is in a high risk situation. This may pertain to a place, people or things (straw, needle or pipe). If the individual has good coping skills, he or she should be able to resist the temptation of drug usage. By resisting, he or she feels better, is reinforced and his or her self-efficacy is enhanced. With respect to rehabilitation and prevention, it is important to help clients identify their high risk situations and then to teach them how they can be avoided. However, this is often easier said than done in that an inmate who is released from a center may find him or herself among previous acquaintances who use drugs or in situations where drugs are used. If the person has poor coping mechanisms, then he or



she will use it voluntarily. When this is done, there is often self-blame and guilt, which unfortunately will lead to relapse.

Service Delivery System

In trying to explain the high relapse rate in Malaysia, one first must look at the rehabilitation model. This model is excellent in that research indicates that the longer a drug addict is confined to a treatment facility, the greater will be his or her chances of recovery. Thus, the 16-month program in a rehabilitation center should enhance sobriety. Because this is not happening, one must now look at the service delivery system. In order to truly help the drug abuser, who is in a rehabilitation center, the counselors must be well trained and competent in dealing with the substance abusers. The training received at the Islamic Science University of Malaysia (USIM) and Universiti Malaysia Sabah (UMS) is an example of this level of competency.

Furthermore, the religious teachers should be competent in the area of drug abuse. He should know the causes of addiction and have an understanding of the effects of drugs.

Finally, there is a need for trained, well-qualified occupational therapists. An occupational therapist is a professional who helps a client have an independent and productive life. They can help improve the person's coping skills, time management skills and help them develop activities that they can enjoy. They can plan work activities and assess whether the client is able to work, as well as develop recreational activities. It is important to note that sometimes drug abuse results from boredom in that the person does not know what to do with his or her free time.

STRATEGIES

In addition to improving the qualifications of the personnel in the rehabilitation centers, in the remainder of this presentation I will also propose two strategies that I feel would be effective in helping the inmate develop good coping skills so that he or she can resist temptation once he or she is released.

First of all, when one reviews the research about factors which help maintain sobriety, one finds evidence of a variety of personality



correlates and environmental factors that are supposedly related to sobriety or relapse. The personality correlates range from anti-social behavior to depression, while the environmental factors consist of things such as unemployment and family dysfunction. However, there are only two things that always appear consistent and this is anxiety reduction and employment.

There is a belief among many that drug addicts take drugs as a means of self-medication. Among opiate addicts, there is a belief that drug usage is ultimately for anxiety reduction. Thus, one can find many research and position papers that discuss the importance of anxiety reduction in treating the opiate dependent.

Within the last two years, I have conducted two empirical studies, on drug addiction and recidivism. The first consisted of reviewing the psychological evaluations of 266 drug addicts, of which 75% or 200 were opiate dependent. Of this group, 140 or 70% had anxiety disorders. The majority consisted of white, single males and the mean age was 28.6 years. The results of the study indicated that there was a significant relationship among the opiate dependent and a diagnosis of an anxiety disorder. The anxiety disorders of the sample ranged from panic disorders to generalized anxiety disorder.

In a follow-up that involved a letter and a phone call, 77 or 55% of those clients with an anxiety disorder responded. Among the 77 clients, 54 or 70% stated that they sought out treatment for their anxiety. The treatment consisted of methadone maintenance that included weekly drug counseling sessions, the use of benzodiazepines with a psychiatrist and individual counseling. All these clients stated that their anxiety was either eliminated or significantly reduced. Furthermore, all of them had a negative urinalysis for opiate use. Therefore, this small study was supportive of the research that indicates that anxiety reduction may be one way to help a client maintain sobriety.

However, anxiety reduction only pertains to opioid abuse, and does relate to cannabis, ecstasy or shabu – the other drugs that are causing difficulties in Malaysia. I believe that anxiety reduction is beneficial in itself and the beneficial results would carry over. This reminds me of what I do when I teach a class in substance abuse.



I always ask the students whether they smoke cigarettes. Of those that raise their hands, I then ask them to give the reasons for smoking. In all cases, the first reason given by the students is to reduce tension, stress or anxiety. I find this amusing, since you all know that nicotine is a stimulant, and it will not cause someone to relax. Yet, all the students still have the false belief that cigarette smoking results in relaxation.

Spiritual Approach

There are many ways to help a person reduce his or her anxiety. Among them are meditation and yoga as well as centering prayer. With respect to the latter, centering prayer is a spiritual technique in which a person focuses on a religious name, such as a prophet or God, closes his or her eyes, and repeats the name many times silently. As he or she does that, the tension leaves one's body. Of course, a person would have to believe in God to use the centering prayer.

Progressive Muscle Relaxation

The last two methods are referred to as muscle relaxation and emotive imagery. In muscle relaxation, a person tightens each of his muscle groups for 10 seconds three times. It takes about 30 minutes to go through the process but when completed the person is completely relaxed. For example, make a fist. Make it tighter, tighter and then release it. As you release, for a few microseconds, you felt the tension leave your hands and wrists. Thus, that body part was relaxed. The technique begins at your toes, and ends at your forehead in that you tighten the muscle group and then release it. With practice, a person can complete the exercises in less time.

Emotional Imagery

Emotional imagery involves the use of your active imagination in that you are actually imagining being in a specific situation. Basically, a client is asked to describe two situations, other than drug usage, which are relaxing to him or her. Once the situations are described, the client is asked to imagine as vividly as he or she can, that he or she is in the situation. When the person does that, he or she is relaxed and will not be anxious. In summary, these approaches are really counter conditioning or that you cannot stand and sit down at the



same time, or in these examples, it is impossible to be anxious if you are relaxed. Thus, I am suggesting that when you counsel an inmate in a rehabilitation center or prison, that you help him or her learn how to reduce his or her anxiety through any of these methods. Although I personally prefer muscle relaxation or emotive imagery, any one of these techniques will be effective. Therefore, once released the inmate is now able to reduce his or her anxiety without taking an opiate.

Employment

The last approach is employment, and again, I would like to briefly describe an empirical research study that I have conducted. In this study, a group of 110 opiate dependent patients of an outpatient detoxification center was the initial sample, and with their informed consent, demographic information, which included their employment status, was collected. The mean age of the group was 30.2 years, and most were white, single males. Briefly, outpatient detoxification is a medical approach in which a physician, with a specialty in addiction medicine, helps a client medically withdraw from a substance. Basically, the patient will see the physician seven times during a two-week period, and he or she is given a prescription for two days that includes anti-anxiety drugs, drugs to relieve nausea, muscle aches, diarrhea, chills, and all the signs of physical withdrawal. Each time the person sees the physician, he or she is given a urinalysis to ensure that he or she is still drug-free. After two weeks, the person is now free of the addictive drug, and a follow-up appointment is made for six months. Sometimes the patient may be prescribed an opium antagonist, or if he or she is an alcoholic, antabuse or campral. Campral is a new drug that when combined with counseling helps an alcoholic maintain sobriety. Once the demographic information was collected, each client was given the MMPI-2, which is a personality test that assesses psychopathology.

Briefly, the MMPI was developed in 1941 by a physician J. Charnley McKinley, and a psychologist, Starke Hathaway. The purpose of the test was to identify psychiatric disorders. Although the test was unable to do so, it did provide a thorough description of a person's abnormal behavior. The test has three validity scales and ten clinical scales. Since there are numerous studies about the MMPI,



many supplementary scales have been developed during the last 50 odd years. However, in my study, I only used the original clinical scales.

I will provide a brief overview of the MMPI for the benefit of those who has not been exposed to the instrument. First of all, the validity scales include a L or fake good scale, a F or fake bad scale and a K, or defensive scale. A high score on any of these scales may invalidate the test, since a high score on L or Lie would artificially deflate the clinical scores, a high F (eccentric responses that only 10% of the normal ones endorsed) would artificially elevate the clinical scales, and a high score on the K scale would artificially deflate the clinical scores. The clinical scales include: Scale 1 is anxiety related to bodily concerns or hypochondrias, Scale 2 is depression, Scale 3 measures anxiety or a person's inability to deal with any type of stress, referred to as hysteria; Scale 4 is immoral or sociopathic behavior, referred to as psychopathic deviate; Scale 5 is for masculine-feminine. When first developed, there was a belief that homosexuality was abnormal, and thus, if you are a male and got a high score it would indicate that your interests, likes and dislikes were more like women. Thus, the scale measures stereotype attitudes of women and men. When I was a child, only women were nurses and only men were police officers. But now as you know, there is no longer that much of gender biasness in the world of work and I usually ignore this scale. Scale 6 is paranoia; Scale 7 is really a measure of obsessive-compulsiveness; Scale 8 is schizoprehenia; Scale 9 is hypomania or hyper activity and agitation while Scale 10 is social-introversion. A high score on this scale indicates that the person is introverted. The test uses t-scores, mean 50 and s.d. of 10. Based on the 1989 revision (MMP-2) a high score is 65 or above and a low score is 35 and below. After six months, the clients were re-contacted for a follow-up visit. Of this initial group, only 65 could be contacted, and of this 65, most had relapsed (self-report and positive urinalysis).

A discriminate function analysis was used to determine what factors could discriminate clients who maintained sobriety versus those who relapsed. First of all, there were no significant differences between the sober group and those who relapsed on any of the MMPI-2 scales. Surprisingly, most of the clinical scales, especially the three



anxiety scales were very high and the validity scale of F was high for both groups of subjects. Therefore, the clinical scales may have been artificially elevated, but again t-tests indicated no significant differences between the groups. In fact, the only significant factor was employment in that those who maintained sobriety versus those who relapsed were more likely to be employed. The relationship between employment and sobriety again supported the literature on methods that prevent relapse.

With respect to Malaysia, I feel that if inmates were provided with suitable employment upon their release, this employment would enhance their self-esteem, increase their self-efficacy, and decrease the risk of relapse. Even though work does not have to involve paid employment and can pertain to any physical or mental activity, it is usually described in the framework of an activity resulting in some type of financial reimbursement. Most people, when asked, "Why do you work?" will probably indicate that they work in order to provide for themselves and their families with the basic needs of food and shelter. However, there are also other reasons that people work, and it may involve such things as a higher standard of living, contributing to humankind, a feeling of accomplishment, or that work is fulfilling and provides a sense of intrinsic satisfaction. Ideally, this last reason, a sense of intrinsic satisfaction, is of major importance when discussing the meaning of work, and is the best criteria in determining whether a person has obtained an optimal level of vocational adjustment. This is well illustrated by Japan, in that fostering employee satisfaction among its workers, the country has become a major industrial power, and has the second highest gross national product in the world (GNP). As previously stated, there is a relationship between drug abuse and un/under employment.

I apologize for the oldness of the data, but in a study in 1984, when there were only six rehabilitation centers in the country, approximately 83% of the inmates were employed before their detention. However, in examining the positions held by these drug abusers, the jobs were mainly unskilled and transitory in nature. In fact, in a survey of 300 inmates at the Pusat Serenti Rehabilitation Center, 19.7% were previously unemployed (compared to the national rate of 9%) and most of their jobs were unskilled, with



labourer, being the most frequently identified occupation. Now, it would be interesting to examine the employment rates in 2006, but I believe they may be similar. That is, the inmates worked only to obtain the basic needs of food and shelter, and that their work was not intrinsically satisfying.

Many drug abusers are unable to find or keep employment because of the lack of basic behaviors necessary for employment. Therefore, before one can implement vocational training and placement programs, attention must be focused on correcting these deficit behaviors. The term "work adjustment training" refers to the procedure and is frequently the first step in the process of community reintegration. As stated, the occupational therapist can help the inmate with preparation for the eventual entry into the world of employment. This may be incorporated into any work related activity, and enables a client to understand the importance of work factors such as production rates, quality of work, role of supervisors, how to get along with fellow employees, proper dressing and other work related behaviors. The drug abuser, because of an unsteady employment history and related personality problems may lack those appropriate work behaviors that many of us take for granted.

In helping the client correct these hindrances to employment, counseling, group discussions and simulated work are helpful. Moreover, transitional or supported work can be beneficial. This involves a job structuring technique in which a worker or group of workers (work crew) are provided with subsidized employment. The work brigade at the palm oil estates would be an example of this in Malaysia. As can be seen, it is important that vocational counseling or work adjustment training is implemented in the rehabilitation centers. Furthermore, it would be helpful if all the major corporations or companies in the country would agree to hire a selective number of inmates, based on the recommendations of the rehabilitation staff. By providing jobs, that involved a career ladder, inmates would have an incentive to remain drug free. Furthermore, a job which is satisfying will enhance one's self-esteem, strengthen self-efficacy, which in turn strengthens one's coping skills.



CONCLUSION

In closing, I would like to caution the audience that these are only my views and opinions, that I am a foreigner, and not a Malaysian. Yet all positions that were taken are backed by research. Therefore, if the personnel in the rehabilitation centers are well trained, anxiety reduction is utilized during counseling, and the inmates receive vocational counseling, work adjustment training and suitable employment, the relapse rate in Malaysia should significantly decrease.