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The effects of relaxation creative visualization on a recovering cocaine addicted person

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ABSTRACT

SOCIAL WORK


THE EFFECTS OF RELAXATION CREATIVE VISUALIZATION ON A RECOVERING COCAINE ADDICTED PERSON

Advisor: Anne Fields-Ford, Ph.D

Thesis dated May, 1994

The overall objective of this single systems research project was to reduce anger associated with a recovering cocaine addicted person. The study introduced Relaxation Creative Visualization Technique as a method for decreasing the intensity of anger displayed by the participant. The State-Trait Anger Expression Inventory (STAXI) was used to measure anger as a situational emotional response (state) and as predispositional quality (trait).
THE EFFECTS OF RELAXATION CREATIVE VISUALIZATION
ON A RECOVERING COCAINE ADDICTED PERSON

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
PEARLINE WALKER

SCHOOL OF SOCIAL WORK

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I would like to first and foremost thank my advisor, Dr. Anne Fields-Ford who has been an inspiration to me from the beginning of my education, a motivator who kept me focused and helped me to understand the importance of research, and a friend who helped me keep hope alive in the completion of this research.

I would like to extend thanks to the participant of this study who allowed me to step into his world and share a part of him in this research. I would also like to thank my student colleagues for words, wisdom, friendship, and concerns. I would like to thank my family (Lisa, Mike, Nitqua, Wayne and Julie) for love, inspiration, understanding and moral support given me throughout this college year of 1994. Finally, this research project is dedicated to my late mother, Mrs. Frankie Robson, and my grandchildren, Triana, Michael, Madiah, Maleck, and Kariffe.
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CHAPTER ONE

INTRODUCTION

Drug abuse has been cited as a leading cause for breakdown of the family and community in American society. Glamour, a sense of euphoria, a sense of well-being, job performance, and stress relievers are cited as leading to drug abuse. Many victims are drawn into the drug culture to escape the pain of reality. Generally, people who are "high" on cocaine believe that despite being intoxicated, they are capable of "normal" functioning, both interpersonally and intellectually. While cocaine has been regarded as a problem for people in lower socio-economic classes, there is a growing recognition that cocaine abuse has reached the larger community, affecting people from all walks of life. Abusers include not only young middle managers but doctors, lawyers, judges, teachers, ministers, law enforcement officers and athletes as well.

Drug and/or cocaine dependence is now defined by the American Psychiatric Association in terms of behavioral criteria, rather than purely physiological definitions. The classical definition of an addicted drug person, is one whose withdrawal is associated with intense physical

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1Roger D. Weiss, M.D., and Steven M. Mirin, M.D., Cocaine (New York: R.R. Donelley & Sons Co, 1911), 171.
symptoms, and does not apply to cocaine, which is currently the most abused substance. For instance, more than six times as many cocaine addicts as compared to heroin addicts require treatment. Cocaine addiction suggests that the concept of addiction needs revision. The psychological symptoms that accompany cocaine withdrawal, i.e., such as emotional distress and craving for drug-induced euphoria may present very serious problems for eliminating the addiction. Treatment for the effects of cocaine, viewed as producing 'psychological' rather than 'physiological' effects, may have ignored important neurophysiological mechanisms. It would logically appear, that the problem of cocaine abuse is just the epitome of the pursuit of hedonism, pleasure seeking, and self-indulgence that society has been pursuing for the past several years. The abuse of cocaine does not occur in a vacuum. It is important that for every cocaine abuse, there are family members and members in society, who usually suffer greatly through anger, guilt, fear, shame, and denial. Anger is probably the most common feeling experienced by relatives of cocaine abusers. They feel manipulated, unloved and abused; they resent playing second fiddle to the drug. Aside from the difficulty that some family members have expressing anger, there is a profound

sense of guilt, which stems from the belief that they are somehow responsible for person’s continuing drug use.\textsuperscript{3} Frequently parents, spouses and children believe that if they had only acted properly, the addiction would never have occurred. Fear is also observed in family members as cocaine dependence worsens. Family members become increasingly afraid: afraid for themselves, and afraid for the family as a whole.\textsuperscript{4} Shame is also a by-product, as family members frequently become more and more despondent and hopeless. Their feelings about themselves may be characterized by self-blame, inadequacy, and at times self-loathing. They may believe that the cocaine abuser has disgraced the entire family, symbolizing their failure as parents, spouses, or children. Families try to avoid the pain of cocaine dependence by using denial. When faced with the painful feelings of anger, guilt, fear, and shame, family members frequently seek a way out. The fastest escape from these feelings is reported as the same mechanism used by the abuser: denial. Denial in the family can take many forms.\textsuperscript{5}


\textsuperscript{4}Ibid., 174-176.

\textsuperscript{5}Ibid, 179-180.
Relatives may join in with the abuser's denial by blaming his or her problems on other people. Relatives often look for an alternative explanation for erratic behavior, difficulties at work, mood swings, paranoia, unexplained weight loss, disappearing money, and odd sleeping habits, rather than facing the fact that they have an addicted relative.6

Significance of the Problem

Cocaine use and abuse has been reported as a major health and social problem throughout the United States. Many behavioral scientists believe that cocaine, coupled with alcohol has been known to compound problems facing Americans. The extent of the health risk is massive. While few physiological characteristics are demonstrated resulting from cocaine abuse, emotional and psychological damages are highly visible.7 Anger has been recognized as a leading concomitant associated with drug abuse. Cocaine has been known to cause healthy individuals to experience psychiatric symptoms when sufficient amounts are injected.8 These symptoms occur in four overlapping stages: cocaine


7Ibid., 179.

euphoria, cocaine dysphoria, cocaine hallucinosis, and psychotic symptoms. The first stage, cocaine euphoria, is characterized by sexual arousal, and feelings of remarkable energy. The second stage, cocaine dysphoria demonstrates symptoms similar to those of major depression, symptoms increase in intensity, the individual begins to experience anxiety, sadness, apathy, anorexia, insomnia and aggressiveness. At this point an intense, irresistible "craving" to use more substance occurs. Cocaine hallucinosis is demonstrated when symptoms of psychosis began to occur. Reality testing is absent once a patient reaches the stage cocaine psychosis. The person may very well act on these paranoid delusions to the extent of doing harm to themselves or others in a desperate attempt to escape non-existent persecutions. Tactile hallucinations also present danger to cocaine user. Many have been known to injure themselves in an attempt to rid their bodies of "bugs" and "worms" crawling under their skin.9 Finally, the psychotic symptoms of cocaine abuse depend on the individual's underlying predisposition to psychiatric illness as well as the frequency of the person's use of cocaine. Use of cocaine has been known to precipitate other illnesses in unsuspecting but vulnerable persons. Some of these illnesses which are prolonged and persist after the

cocaine has been discontinued are bipolar disorders and schizophrenia.\textsuperscript{10}

Cocaine abusers have a serious impact on the lives of family members creating disruption in families from suicide, divorce, to homicide, rape, child abuse, and a range of other criminal type behaviors. Beginning in the mid-1980's, the United States, under the influence of President and Mrs. Reagan began to emphasize demand reduction of drug abuse through education. A wide range of school, community, workplace, religious, and family-based efforts aimed at reducing drug use has resulted in a dramatic reduction of drug use. In addition, the partnership for a Drug-Free American, an organization that uses many of the best advertising and marketing minds, has created a remarkable series of advertisements aimed at "unselling" drugs. These advertisements, in a direct and powerful manner, demystify and de glamourize drug use.\textsuperscript{11}


\textsuperscript{11}Ibid.
CHAPTER TWO

LITERATURE REVIEW

The literature review in this research reflects historical accounts of cocaine use and abuse, emphasizing periodic epidemics, highlights of the impact of cocaine substance on medical and psychiatric thinking, treatment facilities, programs and intervention methods.

Cocaine use and abuse in historical perspective; emphasis on epidemics of the 1950's, 1960's and the 1980's. These epidemics were spurred by psychological and medical experiments. Treatment facilities are designed to treat persons with addictions. Treatment interventions used in the treatment of those with the addiction, include both individual and group psychotherapy and one frequently aimed at short-term or a time-limited structures. Group psychotherapy is typically extended for those persons with psychotic disorders and concurrent cocaine dependency. Finally, inpatient and outpatient care is available. Those using inpatient care are generally persons unable to function independently. Outpatient care is more frequently used and is the preferred structure of care.

Historical Perspective

Cocaine is an alkaloid in the leaves of the coca brush, Erthroxylon coca. Since the time of the Inca Empire, which
flourished for hundreds of years in the Andean Mountain region of Peru until the arrival of the white man in the 1800's, Inca priests and those persons considered nobles chewed coca leaves in order to enhance their understanding of religious experiences. Using coca leaves was originally a mark of the aristocracy. The Indians discovered that besides helping to resolve religious truths, the magical leaves would prolong physical endurance, rotate fatigue and hunger, and in general give a pleasurable feeling of euphoria.¹

Today it is estimated that fully 90% of the adult male Indian population of Peru regularly chew coca leaves. The use of cocaine was thought useful in medical and psychiatric circles as a highly effective local anesthetic for certain operations. Experiments were conducted to discover what other disorders cocaine could cure, and a small circle of professional people began taking the drug. Freud insisted it helped in his work. He endorsed and praised cocaine in a series of papers, including a published document "on coca." He found beneficial properties of cocaine as a cure for morphine addiction, depression, fatigue, impotency, overeating and alcoholism. However, when reports of cases

of cocaine addiction and death, by overdose, began surfaced, Freud immediately ceased using the drug.²

By the early 1900's cocaine had found its way, through patent medicines, into the lives of many people. A great deal of cocaine was produced for use in portions and beverages. In fact, the corporation Coca Cola used cocaine in their products until 1906 when the company, at the insistence of the U.S. government, removed the ingredient from its recipe. The legislation diminished greatly the use of legalized cocaine.³

In the 1960's cocaine use and abuse began to rise again. Its appeal was due in part to the public's acceptance of amphetamines, the effects of which are remarkably similar to cocaine. The passing of the Harrison Act in 1914 reflected a change of usage and produced other types of users. Around the middle 1920's the availability of cocaine was scarce and expensive which limited its use to members of the elite.

Several cocaine epidemics were reported during the 1950's, 1960's, and 1980's. It was noted that African Americans in the Southern part of the United States were heavy users of cocaine in the 1950's. During the 60's and mid-20's cocaine use was especially pervasive among


³Ibid., 60-69.
America's middle class and/or affluent individuals. Cocaine use has spread to virtually all socioeconomic groups because of lower prices and increased supplies. It appears that a broader cross-section of America's population has become involved in this phenomenon. Recent trends in cocaine abuse as seen from the "800-COCAIN" hotline sited a geographic and demographic shift. In a 1985 survey findings indicated that cocaine has spread and is effecting virtually all areas of the United States. The profile of cocaine users no longer singles out the white middle/upper class professional male between the ages of 25-35. The epidemic of the 80's and 90's states that there is no longer a "typical" user of cocaine.

Outpatient and Inpatient Treatment

Treatment facilities have been designed to help those persons struggling with cocaine use and its residuals. Treatment intervention occurs both in out and in patient. Designed to work speedily with those persons addicted to cocaine as well as those with dual-diagnosis. In assessing an individual's capacity to successfully enter an outpatient

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treatment facility the patient's level of denial and commitment to treat. Outpatient treatment has been the most effective for patients who recognize the destructive impact of cocaine on their lives. Such persons enter treatment with a sincere desire to do what is required to discontinue the use of substance. In those instances for outpatient treatment where the individual is unable to sustain, inpatient care becomes a necessity. For those individuals with severe cocaine problems, the hospital stay may offer the safest place for treatment. Hospitalization is usually recommended when a cocaine abuser actively threatens to commit harm to self or others, takes poor care of himself, dangerous to others due to recklessness and poor judgment, absence of social supports, severe medical or psychiatric complications as a result of cocaine abuse or other substances, unwilling or unable to participate in an active outpatient treatment program and has failed in outpatient treatment. 6

Individual and Group Psychotherapy

Treatment invention includes both individual and group psychotherapy. The individual and psychotherapist discuss a range of personal issues, including the individual's drug use, difficulties with interpersonal relationships, and

issues or may examine in depth, the contribution of childhood experiences to current psychological difficulties. In group psychotherapy, six to 12 group members may meet with one or two professional leaders, to discuss both individual problems and relationship issues. Groups for drug-dependent individuals typically offer peer support to sustain abstinence, provide advice on issues that group members perceive places a member at risk for relapse. One advantage cited for the group approach is that drug-dependent individuals are astute at recognizing subtle signs of denial in each other. One potential limitation of group therapy is that passive individuals may not deal adequately with their own personal issues in a group.7

It was noted earlier, that anger is thought to accompany behaviors of the recovering addicted person. Therefore, anger is recognized in drug abusers as a crucial, complex psychophysical phenomenon with wide-ranging implications for anxiety, aggression, and acute depression. The definition of anger as defined by Speilberger:

"Anger is generally considered to be a more elementary concept than either hostility or aggression. The concept of anger usually refers to an emotional state that comprises feelings that vary in intensity from mild annoyance or aggravation to fury and rage, and that are accompanied by arousal of the automic nervous system. Anger and hostility both refer to feelings and

attitudes, the concept of aggression is generally used to describe destructive and punitive behavior.  

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In summary, the literature on cocaine use and abuse repeatedly provides historical accounts of its use, social legislation restricting its availability, and the impact of its use on physical, psychological and emotional well being.

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CHAPTER THREE

METHODOLOGY

The methodology section in this research is organized in the following manner: (1) Study Design, (2) Treatment Hypothesis, (3) Case Information, (4) Intervention Strategy and Implementation and (5) Setting.

Study Design

The design employed is a single system design. An "A-B" design was used to measure level of anger, which included psychological, physical, and emotional states and traits. Bloom and Fischer refer to the "A-B" design as the simplest logical structure permitting a planned comparison between two elements.¹

Design "A", The State-Trait Anger Expression Inventory (STAXI), was used for the measurement or observation of the participant's anger.² Design "B", Relaxation-Creative Visualization Technique, was the intervention used to determine its effect on the participant's anger.³


²Charles D. Spieberger, Ph.D., State trait Anger Expression Inventory (Odessa, FL: Psychological Assessment Resources, Inc., 1988), 2.

³Ibid.
Although the STAXI scales have been available for a relatively brief period of time, they have been used extensively in research in behavioral medicine and health psychology. Information about the test-retest reliability of the scales has been reported by Jacobs, Latham, and Brown (in press) and Stoner (in press). Stoner and her colleagues (Stoner & Spencer, 1986, 1987) have investigated age and gender differences. Miank (1981) investigated the relationship between T-Anger and job satisfaction.

Relationships between anger and health have been examined in a number of studies (Brooks, Walfish, Stenmark, & Canger, 1981; Davanaugh, Kanonchoff, & Bartles, 1987; Johnson & Broman, 1987; Johnson-Saylor, 1984; Schlosser, 1986; Vitaliano, 1984; Vitaliano, Maiuro, Ochs, & Russo, in press; Vitaliano et al., 1986). The STAXI scales have also been used extensively in research on the relationship between anger and Type-A behavior (Booth-Kewley & Friedman, 1987; Croyle & Jemmott, in press; Goffaux, Watson, Heim, & Shields, 1987; Herschberger, 1985; Janisse, Edguer & Dyck, 1986; Krasner, 1986; Spielberger, Krasner & Solomon, in press) and an investigation of the contribution of the components of anger to elevated blood pressure and hypertension (Crane, 1982; Deshields, 1986; Gorkin, Appel, Holroyd, Saab, & Stauder, 1986; Kearns, 1985; Schneider, Egan, & Johnson, 1986; Spielberger et al., in press; van der Ploeg, van Buuren, & van Brummelen, 1988).
Kinder and his colleagues (Curtiss, Kinder, Kalichman, & Spana, in press; Kinder, Curtiss, & Kalichman, 1986) have used the STAXI scales in a series of studies of psychological factors that contribute to chronic pain. The scales have also been used in recent studies of anger management and treatment by Deffenbacher and his colleagues (Deffenbacher, Demm & Brandon, 1986; Deffenbacher, Elsworth, & Stark, 1986; Demm & Deffenbacher, 1986; Hazaleus & Deffenbacher, 1986) and in research on the effects of situational factors on the experience and expression of anger (Aragona, 1983; Bromet & Lennart, 1987; Buck, 1987; Pape, 1986; Pederson & Hollandsworth, in press). Stoner and Spencer (in press) have studied the effects of marijuana use on the experience and expression of anger.

McMillan (1984) has used the STAXI scales to assess the anger experienced by patients undergoing treatment for Hodgkins disease and lung cancer. The STAXI scales have also been used to examine relationships between anger expression, hardiness and well-being, and coping with stress (Johnson-Saylor, 1984; Schlosser & Sheeley, 1985a, 1985b).

Treatment Hypothesis

The hypothesis and intervention used in this research was framed in social learning theory and emphasized that anger is learned and can be thus modified or controlled. Social learning theory has emphasized the influence of "central mediating processes" as perhaps a most influential,
regulating system. These are thought to be the most complex of cognitive processes through which people organize, codify and symbolically store their daily experiences. In time, these cognitive factors become stabilized into attitudes, beliefs and values and consequently play an essential part in governing behavior. The developing approaches in cognitive behavior therapy are designed to train clients in identifying and altering the cognitive patterns that may be operating to arouse unwanted and uncomfortable emotions. Thus, the working hypothesis in this study was that training in Relaxation Creative Visualization Technique, to teach the subject ways of dealing with anger, would reduce anger, thereby, enhancing a general sense of well-being.

Case Information

For purpose of anonymity throughout this research the participant is referred to as Jim. Jim is a married, white male. He married his college sweetheart, and three children ages 17, 6, 4 years of age have been born to this union. Jim agreed to participate in the study because he wanted help with his anger. Jim considered his anger displaced to family and others, for no explained reason. He works as an assistant CEO in a large business corporation. He spent six (6) weeks in a private facility out of state, to undergo treatment for the abuse of cocaine and alcohol. Jim’s drug abuse began about 20 years ago, during his college years, when he was introduced to cocaine after the birth of his
first child. He claimed the birth of the child, stress from the job, financial problems, his wife having to quit work, are all contributing factors to his substance abuse. Jim recounted that his cocaine use worsened when his wife returned to work. He added alcohol as an additional substance. In the past six years, Jim has moved three times holding executive positions for major corporations. Each time more money often meant more cocaine and alcohol. His wife left him twice, each time returning because of the children. He never sought treatment because he believed he had everything under control. Finally, the present employer threatened his position if he failed to seek treatment. This company is considered by Jim as having rescued him by saving his life and that of his family.

Jim believed that he has always been angry at or about something, but he never learned to appropriately express his angry feelings. When Jim was a child his anger was expressed through temper tantrums. This was carried over into his adolescent years, and there was no discipline from his parents. Jim’s anger was again expressed outward by hitting and throwing things. These feelings of anger were accompanied by physical feelings, changes of blood rushing to the face (blushing), and quickening of his heart beat. Jim would also have a concomitant desire to yell out, to use strong words, to wave one’s hands or arms and to let others know his feelings. Most of Jim’s adult anger was turned
both inward and outward only to be masked with the use of drugs and alcohol.

After Jim's treatment program he returned to Georgia, with his family, remained clean and sober for one and a half years, through the assistance of Cocaine Anonymous (CA) and Alcohol Anonymous (AA).

Jim and I met twice a week for three weeks in April 1994. Each session lasted about one and one half hours. During the first session he was introduced to the treatment intervention and procedures; the State-Trait Anger Expression Inventory package (STAXI); and the Relaxation Creative Visualization Technique.

**Intervention Strategy and Plans**

**Day 1, 2, 3**

The State-Trait Anger Expression Inventory was administered to the participant across three consecutive days, to acquire baseline information, regarding Jim's anger. Three days of observation for baseline was completed to establish a clear pattern of his anger, state and trait.

The State-Trait Anger Expression Inventory (STAXI) instrument assesses anger as an emotional state and trait that varies in intensity. State anger defines an emotional condition consisting of subjective feelings of tension, annoyance, irritation, or rage. Trait anger is defined in terms of the frequency a respondent feels-anger over-time. A person high in trait anger would tend to perceive more
situations as provoking and respond with higher state-anger scores. The instruments were developed with psychometric procedures, including the development of long and short forms which were highly correlated, ranging from .95 for state anger to .99 for trait anger.4

The inventory is divided into three parts: The first subscale has 10 items and measures general states of anger. The second subscale measures current reaction states of anger and has 10 items. The third and final subscale measures traits of anger and has 24 items. Altogether the inventory is comprised of 44 items.

Reliability of State-Trait Anger Expression Inventory has been reported by Spielberger and London. The internal consistency of the first 15 items trait anger measure was .87 for a sample of 146 college students. The trait anger measure had an internal consistency of .87 for male navy recruits and .84 for female navy recruits. The original state anger measure was found to be internally consistent with correlations of .93 for male and female navy recruits. The angry reaction subscale had internal consistency coefficients ranging from .84 to .89 for male and female college students and navy recruits. The angry reaction subscale had internal consistency coefficients

ranging from .70 to .75 for the same samples. All internal consistency results are based on Cronbach's alpha.

Validity of the State-Trait Anger Inventory was reported as having concurrent validity support is evidenced by correlations with three measures of hostility, and measurers of neuroticism, psychotism, and anxiety. Scores were not associated with state-trait curiosity.  

Day 4  

Day 4 centered on relaxing techniques; Jim entered the room and sat in a large comfortable brown chair. He had a very tensed, stern, nervous, with an anxious look on his face. Efforts were made to provide an atmosphere of warmth and relaxation by using quotes from (The Relaxation Response, by Herbert Benson, M.D.). Such efforts are supported by relaxation techniques, citing four basic components necessary to bring forth a response to induce relaxation. A quiet environment contributes to the effectiveness of the repeated word or phrase by making it easier to eliminate distracting thoughts. A mental device to shift the mind from logical, externally oriented thoughts, there should be a constant stimulus: a sound, word, or phrase repeated silently or aloud; or fixed gazing  

5Crane, Advances in Personality Assessment, 6-7.  

at an object. A passive attitude when distracting thoughts occur, they are to be disregarded and attention redirected to the repetition or gazing; one should not worry about how well one is performing the technique, because this may well prevent the relaxation from occurring. Finally, get into a comfortable position, posture is important so that there is no undue muscular tension. Close your eyes, deeply relax all your muscles, breathe through your nose and don't worry about whether you are successful in achieving a deep level of relaxation. The object of relaxation is to concentrate the mind and detach yourself from the inner dialogue that is with you continually.  

Day 5, 6

This session focused on both Relaxation and Creative Visualization Technique, the combination expected to reduce Jim’s anger levels. Creative visualization was the technique of using imagination to create something desired in your life. It is a natural power of imagination, the basic creative energy of the universe, which one uses constantly. Creative visualization is magic in the truest and highest meaning of the word. It involves understanding and aligning one’s self with the natural principles that govern the workings of the universe, and learning ways to

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8Ibid., 49-50.
use these principles in the most conscious and creative way. The process of change does not occur on superficial levels, through mere "positive thinking." It involves exploring, discovering, and changing one's deepest, most basic attitudes toward life. Learning to use creative visualization can become a process of deep and meaningful growth. Visualization is itself a link in this chain by helping you to discover how one can create happiness. By using the technique one is able to get to know the place where love, wisdom, and creativity reside within one's self. Before each session, discussion with Jim centered around his anger; exploration about his use of the technique between sessions, and exploration regarding the impact of the technique on his anger. In the final session Jim turned and said:

"I am not sure if I am angry with myself, my parents, my family or maybe it's society for turning me on to drugs to use as a comfort in life, anyway whatever it is, I hope this technique will help me with my anger."

Day 7, 8, 9

The State Trait Anger Expression Inventory was administered to measure Jim's levels of anger after intervention Relaxation Creative Visualization Technique.

The Setting

The study took place in a clinical room of the Corporation where Jim was employed. The room in which the procedures occurred was warm and comfortable. Book shelving
lined the walls, and with curtains and plants an atmosphere was created that was relaxing.
CHAPTER FOUR
PRESENTATION OF FINDINGS

The composite graph 1 presented on the following page represents the findings of this research. The State Trait Anger Expression Inventory (STAXI) was the instrument used for measuring anger as a situational emotional response (state) as a predispositional quality (trait).

Figure 1 represents baseline that was gathered over a period of nine days, broken down into three consecutive days of data gathering. Days 1, 2, and 3 show highly intense forms of anger. Day 1 shows a high level of anger state that is masked within the participant (Spielberger anger-in). Days 2 and 3 show a decrease in the intensity of anger. Days 7, 8, and 9 exhibit continual decrease in the anger pattern (Spielberger) referred to as reconstructive anger or anger control. Days 7, 8, and 9, demonstrates the anger pattern is increased but moves in the direction of decreasing, Trait (Spielberger anger-out), when patterns are observed over 9 days. Figure I also shows the onset of the intervention phase, a dramatic decrease in expressed anger. Bloom and Fischer note that from this point one can assert a reasonable judgment regarding the possibility that expressed behavior would continue to increase given no intervention procedures.
Figure I clearly exhibits an interesting pattern that occurred during the intervention phase, depicting limited consistency in expressed anger. Consistency in the decreased intensity of anger occurred on days 4, 5, and 6. Figure I represents the maintenance period, suggesting that the intervention may have had some lasting effect on the participant's behavior. On the final day of the maintenance period (day 6) the pattern of intense anger seem to continue to diminish to a much lower level of intensity.

Figure II depicts a picture of cross-sectional baseline data gathered to show overall levels of State-Trait anger. The baseline observed on days 1 and 2 gives a view of high intense anger throughout the overall observation. Day 3 shows a greater decline in the participant's anger. Days 4, 5, and 6 show intervention stabilization. The maintenance in Figure II is the follow-up period at completion of the intervention. Therefore, maintenance in this phase remains zero. (Day 7).
ANGER INTENSITY
OBSERVED DURING BASELINE

DAYS 1 - 9 (FIGURE I)
ANGER INTENSITY
DURING OVERALL BASELINE

SECTIONS
MEASUREMENTS

DAYS 1 - 7 (FIGURE II)
Limitation of the Study

The A-B design provides evidence that the intervention prompted observed changes in the participant's social learning with respect to expressions of anger. The findings point out that the participant's response to the intervention phase was positive. Bloom and Fischer cite that in some ways the limitation of the A-B design does not provide strong changes, nor does it permit control of many alternative explanations for why the results occurred as they did. In addition, the "A-B" design can not indicate which aspect of the intervention program was most influential in changing the participant's behavior.

The acknowledgment of anger by the participant may have been minimized, causing the measurement to be inaccurate. Measurement on the item sub-scale area of state-trait anger are generally subjective and perceptions are likely to differ. The intervention tool (Relaxation Creative Visualization) did not provide a time frame to suggest outer limits for its use in research. Conducting a study on State Trait anger, the time frame was limited while the baseline phase of 3 days was consistent with maintenance phase of 3-days, the study was limited in both directions. It is suspected that anger State and Trait take on a much more profound characteristic that warrants more extended time for observation than this study permitted.
CHAPTER FIVE

CONCLUSION

The findings of this study suggest that Relaxation Creative Visualization Technique had a positive effect on the participant's expression of anger. The goal of the study was to decrease the intensity of physical, mental, and emotional anger exhibited by a recovering cocaine addicted person. This participant used transfer of knowing technique based on relaxation, by using classical music to create an atmosphere of relaxation, visualization and creativity.

The short-term effect of Relaxation Creative Visualization Technique has proven to be effective, the participant was very receptive to the intervention and expressed interest in continuing beyond the research time. Long-term effect cannot be determined in this study, however, due to the positive impact of short-term effects it is reasonable to assume the long-term effect would be complimentary. Findings would be valuable to clinicians who are considering public or private practice or who may be part of an institution which will allow one to be creative with patients or clients.

Implications for Social Work Practice

Relaxation Creative Visualization Technique is not typically used as a method of treatment for substance
abusers. Social work agencies that work closely with drug facilities and drug treatment programs have the potential to make a serious impact in the problem of drug addicted persons. Recommended treatment approaches include corporate a variety of rehabilitative services i.e. such as, housing, education, vocational training, medical services and child care. Social workers are called upon to establish and sustain treatment programs in both public and private areas. This study has shown that self-control and anger management has potential through the use of Relaxation Creative Visualization Technique.

**Recommendations for Future Research**

Future research should caution against a limited time-frame for the baseline phase, and intervention phase, to more accurately assess State and Trait anger in an individual.
APPENDIX

MEASURING SCALE

USED TO CONDUCT THE EVALUATION
A number of statements that people use to describe themselves are given below. Read each statement and then fill in the blank with the number which indicates how you feel right now. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to best describe your present feelings.

Fill in 1 for Not at all
Fill in 2 for Somewhat
Fill in 3 for Moderately so
Fill in 4 for Very much so

How I Feel Right Now

1. I am furious.  
2. I feel irritated.  
3. I feel angry.  
4. I feel like yelling at somebody.  
5. I feel like breaking things.  
6. I am mad.  
7. I feel like banging on the table.  
8. I feel like hitting someone.  
9. I am burned up.  
10. I feel like swearing.
PART 2

DIRECTIONS

A number of statements that people use to describe themselves are given below. Read each statement and then fill in the blank with the number which indicates how you generally feel. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to best describe how you generally feel.

Fill in 1 for Almost never
Fill in 2 for Sometimes
Fill in 3 for Often
Fill in 4 for Almost always

How I Generally Feel

11. I am quick tempered. ______________________
12. I have a fiery temper. ______________________
13. I am a hotheaded person. ______________________
14. I get angry when I'm slowed down by others mistakes. ______________________
15. I feel annoyed when I am not given recognition for doing work. ______________________
16. I fly off the handle. ______________________
17. When I get made, I say nasty things. ______________________
18. It makes me furious when I am criticized in front of others. ______________________
19. When I get frustrated I feel like hitting someone. ______________________
20. I feel infuriated when I do a good job and get a poor evaluation. ______________________
PART 3

DIRECTIONS

Everyone feels angry or furious from time to time, but people differ in the ways that they react when they are angry. A number of statements are listed below which people use to describe their reactions when they feel angry or furious. Read each statement and then fill in the circle with the number which indicates how often you generally react or behave in the manner described when you are feeling angry or furious. Remember there are no right or wrong answers. Do not spend too much time on any statement.

<table>
<thead>
<tr>
<th>Fill in 1 for Almost never</th>
<th>Fill in 2 for Sometimes</th>
<th>Fill in 3 for Often</th>
<th>Fill in 4 for Almost always</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>When Angry or Furious</th>
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<tbody>
<tr>
<td>21. I control my temper.</td>
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<tr>
<td>22. I express my anger.</td>
</tr>
<tr>
<td>23. I keep things in.</td>
</tr>
<tr>
<td>24. I am patient with others.</td>
</tr>
<tr>
<td>25. I pout and sulk.</td>
</tr>
<tr>
<td>26. I withdraw from people.</td>
</tr>
<tr>
<td>27. I make sarcastic remarks to others.</td>
</tr>
<tr>
<td>28. I keep my cool.</td>
</tr>
<tr>
<td>29. I do things like slam doors.</td>
</tr>
<tr>
<td>30. I ball inside, but I don’t show it.</td>
</tr>
<tr>
<td>31. I control my behavior.</td>
</tr>
<tr>
<td>32. I argue with others.</td>
</tr>
<tr>
<td>33. I tend to harbor grudges that I don’t tell anyone about.</td>
</tr>
<tr>
<td>34. I strike out at whatever infuriates me.</td>
</tr>
<tr>
<td>35. I can stop myself from loosing my temper.</td>
</tr>
<tr>
<td>36. I am secretly quite critical of others.</td>
</tr>
<tr>
<td>37. I am angrier than I am willing to admit.</td>
</tr>
<tr>
<td>38. I calm down faster than most other people.</td>
</tr>
<tr>
<td>39. I say nasty things.</td>
</tr>
<tr>
<td>40. I try to be tolerant and understanding.</td>
</tr>
<tr>
<td>41. I’m irritated a great deal more than people are aware of.</td>
</tr>
<tr>
<td>42. I lose my temper.</td>
</tr>
<tr>
<td>43. If someone annoys me, I’m apt to tell him or her how I feel.</td>
</tr>
<tr>
<td>44. I control my angry feelings.</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY


Byrne, A. "Brief Interview on Cocaine." Atlanta, Georgia, 1988.


