

Codman Awards

Reducing Adolescent Clients' Anger in a Residential Substance Abuse Treatment Facility

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Sundown Ranch is a residential behavioral health care treatment facility for adolescents that is located in rural eastern Texas. The facility operated on the basis of a Twelve Step program for chemical dependency at its inception in 1987 and for many years to follow. Key to the Twelve Step model is the client's acceptance of a higher power to trust and believe in and the client's acknowledgment that his or her "own best thinking" had led to his or her addiction and the denial or minimization of the negative consequences.¹ Clients are encouraged to work through the twelve steps with more-experienced recovering persons or with their counselors.

In 1999 the Joint Commission on Accreditation of Healthcare Organizations required treatment facilities to use performance measures for ongoing tracking of information about the progress and results of treatment.² The program's leadership selected performance measures from a psychosocial screening inventory,^{3,4} and in July 1999 staff began to collect data on the clients. Data based on the psychosocial screening measures were used for treatment planning and contributed to a larger database for analysis of the clinical effects of treatment.

This article describes the facility's clinical performance improvement (PI) project and its effects on clients' ability to manage anger.

Identifying the Problem

In March 2001 a project team consisting of the facility's consulting psychologist, clinical director, director of administrative services, a counselor, and an assistant

Article-at-a-Glance

Background: Sundown Ranch, a residential behavioral health care treatment facility for adolescents, tracked the progress and results of treatment by selecting performance measures from a psychosocial screening inventory. The temper scale was one of the two highest scales at admission and the highest scale at discharge. A clinical performance improvement (PI) project was conducted to assess improvements in clients' ability to manage anger after the incorporation of Rational Emotive Behavior Therapy (REBT) into treatment.

Methods: Eighteen months of baseline data (July 1, 1999–February 1, 2001) were collected, and 20 months of data (May 1, 2001–December 31, 2002) were collected after the introduction of the PI activity. In all, data were collected for 541 consecutive admissions.

Results: A comparison of five successive quarterly reviews indicated average scores of 1.4 standard deviations (SDs) above the mean on the temper scale before the PI activity and .45 SD above the mean after. The performance threshold of reduction of the average temper scale score to ≤ 1 SD was met for 17 of 20 months.

Discussion: The fact that the PI activity reduced the temper scale elevations by almost one full SD is highly suggestive of the efficacy of REBT with the treatment population. After the project was completed, REBT was promoted as an additional therapeutic modality within the treatment program.

counselor (technician) was formed to conduct a clinical PI project. The team used the FOCUS-PDCA method for identifying and clarifying a clinical process to be improved, selecting an improvement activity, and monitoring the effects of implemented changes on the clinical process.

The team decided to evaluate the clinical process of the resolution of client anger problems in the course of treatment. The team made this selection on the basis of the clinical elevations observed on the aggregate psychosocial screening inventory profiles at admission and discharge for an 18-month (baseline) period (July 1, 1999–February 1, 2001). Temper was one of the two highest scale scores (the other was impulsivity) at admission and was the highest scale score on the last few days before discharge. Thus, anger issues appeared to be highly typical of the clinical population of adolescent substance abusers and was the clinical problem area least affected by the treatment received.

The team reached a consensus that clients tended to be highly emotional and behaviorally reactive, which led to staff's intervention with physical restraint using crisis prevention intervention techniques or placement in the intensive treatment unit. Client displays of anger were agreed to be a detriment to the treatment process in general and a major contributor to staff burnout.

The team hypothesized that the direct care staff, although trained to work with issues of chemical dependency, lacked the specialized training and skills to effectively deal with this type of client emotional disturbance. The team also hypothesized that the clients lacked sufficient coping skills to effectively handle their frustrations in interacting with the structure of the treatment milieu. The team decided on Rational Emotive Behavior Therapy (REBT) as the best intervention to help improve clients' ability to manage anger and ability to fully participate in treatment.

Incorporating REBT into the Project

REBT is the first model of cognitive-behavioral therapy to be developed and its most fundamental tenet—that distorted thinking habits drive emotional and behavioral dysfunction—has been adopted by virtually all the succeeding forms of cognitive-behavioral approaches.⁵ It has been applied with good success to a wide range of clinical problems—including anxiety

disorders, depression, anger, and addictive and self-destructive behaviors—and to a wide range of clinical populations.⁶

The team met monthly throughout the duration of the project (March 2001–December 2002). Once the project was up and running, the team reviewed the performance measurement data at each meeting. These reviews also resulted in further recommendations, such as additional staff training and the training of new employees.

The team leaders (consulting psychologist and the director of administrative services) educated themselves on PI methodology and disseminated information to the team and to staff teams working on other projects. Training included a telephone consultation with the founder of REBT, Dr. Albert Ellis; clinical training with the Albert Ellis Institute; and a series of staff training events (for example, on Physiology and Pharmacology of Anger, Cognitive Therapy Approaches to Anger, Adolescent Mental Health). In May 2001, formal training in REBT across all levels of direct care staff began. Specialized REBT groups and anger management groups were first integrated into the client schedule in September 2001.

Methods

Performance Measures

The psychosocial screening inventory used is a 107-item, 15-scale questionnaire written at a sixth-grade level.^{2,3} The decision was made to test all clients to avoid any possible measurement biases that would restrict the interpretation of the data and to provide data for individual treatment planning (scoring and reporting was conducted by the performance measurement system that published the measure). The performance threshold for the project was the reduction of the average temper scale scores at the time of discharge to ≤ 1 standard deviation (SD) above the mean.

Data Collection

Eighteen months of baseline data (July 1, 1999–February 1, 2001) were collected before the PI activity was introduced. (The psychosocial screening inventory was administered within 72 hours of admission.) Data collection for the project continued for 20 months (May 1, 1999–December 31, 2002), for a total of 541 consecutive admissions. Monthly aggregate profiles

Temper/Violence Scale, July 1999–December 2002

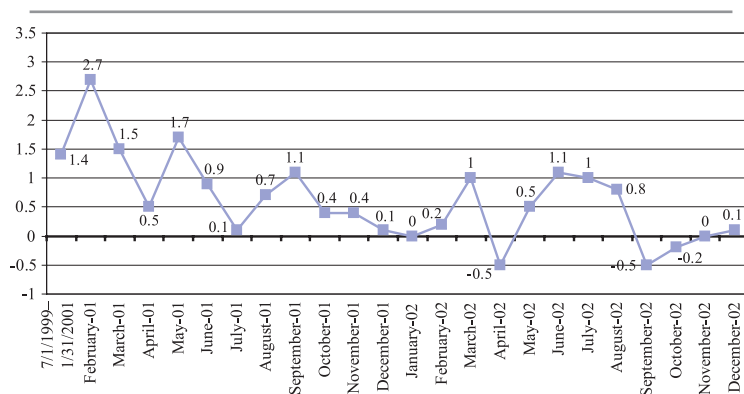


Figure 1. The descending curve of average temper scale scores maps the general lessening of anger problems in the treatment population over time following the multipronged introduction of Rational Emotive Behavior Therapy.

provided an ongoing picture of the temper scale scores for the clinical population from admission to discharge.

Results

The project and its preliminary results were presented at a clinical staff in-service and at a meeting of facility leadership and department heads in early 2002. Anger resolution was measured by reviewing changes in the temper scale scores monthly and quarterly. A comparison of five successive quarterly reviews indicated average scores of 1.4 SDs above the mean on the temper scale* before the PI activity and .45 SD after the introduction of the performance activity. Review of the run chart (Figure 1, above) shows that the performance threshold of reduction of the average temper scale score to ≤ 1 SD was met for 17 of 20

* The performance measurement system refactored the Treatment Outcome Package in 2001 and renamed the temper scale as the violence scale.

months. Although the results do not qualify as a trend as defined by performance measurement nomenclature, significant movement in the desired direction is evident.

Discussion

The fact that the PI activity reduced the temper scale elevations by almost one full SD is highly suggestive of the efficacy of REBT with the treatment population. After the project was completed, REBT was promoted as an additional therapeutic modality within the treatment program. In addition to its use in client special therapy groups and individual therapy, it was also used by assistant counselors (aides or technicians) to help de-escalate emotionally aroused clients, as an additional client relapse

prevention tool, and to train parents to communicate more effectively with their adolescents. In addition, a regular cycle of training (three per year) and a formalized curriculum for REBT training was established for all direct care staff, including counselors, assistant counselors, nurses, and teachers. An introduction to REBT was also given to all new employees beginning in October 2002. Discussions were also begun on the ways in which REBT and the Twelve Step treatment approaches could be used in a complementary fashion to improve client care. **J**

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References

1. Alcoholics Anonymous World Services: *Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous Publishing, 1998.
2. Joint Commission on Accreditation of Healthcare Organizations: *ORYX: The Next Evolution in Accreditation*. Oakbrook Terrace, IL: Joint Commission, 1997.
3. Behavioral Health Laboratories: *The Treatment Outcome Package (TOP)*. Ashland, Massachusetts. <http://www.bhealthlabs.com/products/> (last accessed Apr. 7, 2005).
4. Kraus D.R., et al.: Validation of a behavioral health treatment outcome and assessment tool designed for naturalistic settings: The Treatment Outcome Package. *J Clin Psychol* 61:285–314, Mar. 2005.
5. Dobson K.S. (ed.): Historical philosophical bases of the cognitive-behavioral therapies. *Handbook of Cognitive-Behavioral Therapies*. New York: Guilford Press, 1987, pp. 3-39.
6. Haaga D.A., Davison G.C.: Outcome studies of Rational-Emotive Therapy. In Bernard M.E., DiGiuseppe R. (eds.): *Inside Rational-Emotive Therapy*. New York: Academic Press, 1989, pp. 155–197.