A Conversation About… Anger and Mental Health: Treating Anger

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Mark Creamer (00:18):

Hello and welcome to this episode of MHPN Presents, A Conversation About Anger and Mental Health. This is the final episode in our three-part series. In our first episode, we looked at the nature of anger and its impacts on person and on the people around them. And in our last episode we discussed why it is that some people suffer from problematic anger and others don't. And if you haven't listened to those two episodes yet, I strongly encourage you to do so because they were both brilliant. Mine name is Mark, Mark Creamer. I'm a clinical psychologist and a professorial fellow in the department of Psychiatry at the University of Melbourne. And as I've mentioned in both the previous episodes, I'm really pleased to be hosting this series because as a clinician I do find that I encounter anger from time to time with my clients and I don't feel very comfortable in working with it. So it's great to be able to pick the brains of our expert guests. We have a special guest in each episode to help us explore the topic, but I also have an outstanding co-host for the whole series in the form of Dr. **Tony McHugh**. Welcome Tony.

Tony McHugh (01:26):

Thank you. Mark.

Mark Creamer (01:27):

Tony's bio is on the MHPM webpage for this episode, and I certainly encourage you to check it out. But briefly, Tony's a clinical psychologist in private practice and he's got enormous clinical and research experience in the area of anger and mental health. We talked in the last episode, Tony, about why it is

that some people get very angry and others don't, and we discussed some of the possible mechanisms. What do you think were the key sort of take home messages from that episode?

Tony McHugh (01:54):

There were various important messages. I think Mark, the first one was even though it's hard to explain theoretical descriptive models of any phenomenon to clients, there are actually important explanatory theories about anger and irritability. And if we can do plain language translation of those clients are actually reassured by them because as we've said across both episodes, people can become angry in a patinated kind of way and they don't understand why they are. They think poorly of the fact that they are and explanations that can help them understand. I think take away that mystery of why am I like this, so important to explain things to clients. We talked about short-term gains in being irritable versus long-term losses. We talked about situations that will exacerbate irritability. We talked about important motivational aspects of treatment, helping people to understand patterns and habits. And we also talked about this very important point and that is often in as Glen identified supervisors actually want to know about anger. The client with irritability is often for them perplexing and difficult to work with. And this is a very important topic area.

Mark Creamer (03:12):

Absolutely. It was a very interesting episode. I must say in this episode. I should reiterate the fact that we're going to talk about how we will help people with anger problems and how we can manage and treat those problems in our clients. And I'm very excited now to be able to welcome our special guest for this episode, Michelle Birkic, who has joined us here in the studio today. Welcome Michelle.

Michelle Birkic (03:35):

Thank you Mark. It's good to be here.

Mark Creamer (03:36):

Michelle's bio is on the MHPN website as well, so please take a look at her. Very impressive clinical track record. But briefly, Michelle is an accredited mental health social worker. She provides specialist trauma treatment in both private practice and for Phoenix Australia. And she's got loads of experience working with first responders. And as we saw in the last episode, that is an occupational category that often has a lot of problems with anger. So you've had loads of experience, Michelle, in treating high risk groups in a full range of mental health conditions, but you do have a strong interest in anger. And I usually ask our guests how and why it was that they developed an interest in anger. So I'll ask you the same thing, why did you develop an interest in anger?

Michelle Birkic (04:18):

That's an interesting question Mark because it's not something I really thought of consciously. But having thought about it now as a social worker, I think social workers are quite comfortable with anger. It's used as a catalyst for change. It can be functional when contained and used with purpose. So I suppose for me, it's never been something that I fear or I'm uncomfortable with. I see it as a useful emotion. However, without it we wouldn't be able to as a social worker, drive change in society and to challenge things like oppression, inequality, and injustice. I think it can be a very useful tool when used correctly and contained and channeled.

Mark Creamer (05:02):

And that's probably the key thing, isn't it? That idea of managing the anger, containing the anger, controlling the anger. It's a crucial aspect, I suppose, when we're thinking about problematic anger. So yeah, very interesting. So let's go on and talk about treatment. And I'd like to kick off talking a little bit about treatment planning. We talked about assessment in our last episode, but I'd like to ask you both to build on that and think about what factors are important for you when you are planning an anger intervention. Perhaps I'll start with you, Tony, and what do you think is important in terms of planning an intervention.

Tony McHugh (05:34):

Beyond the safety issue that we identified in the last episode Mark, I think the critical thing is to develop with the client and for the client, why change, have you been winning? Because often people have these cognitions about, anger gets me what I want. And as Glen described in the previous episode, that's short term, we lose typically in the long term. So developing a key motivational aspect of the work and promoting optimism that this can be changed. And we talked about the science of habit formation, habit change, they're really important things to get up early, I think.

Mark Creamer (06:09):

Absolutely. I quite agree. I quite agree that sort of engagement and motivation as you say, because I can imagine my experience, people come in with the idea that actually anger has been very good for me. It's been successful, I get what I want when I'm angry. The only reason I'm here is because my wife has told me I have to come or whatever. Treatment planning. Michelle, what kind of things jump into your head?

Michelle Birkic (06:28):

I think about establishing ownership and appealing to the personality of the person and what motivates them to actually address their anger and what they want to achieve from the treatment. So similar to what Tony was talking about, looking at beliefs versus facts. So really having them challenge themselves using behavioural experiments to challenge their beliefs about anger being a functional and productive emotion.

Mark Creamer (06:56):

Absolutely. I'm sure we'll talk about that more as we get into treatment. Looking at the kinds of beliefs they have, the kind of perhaps distorted beliefs they have about it. What else is important? Would you be interested, for example, in substance abuse, do you want to check that out? Is that going to interfere with treatment outcome?

Tony McHugh (07:11):

Yeah, critically important. We were talking about the previous episode that alcohol and other substances are disinhibiting and people have a tendency to act out on their angry beliefs or cognitions when they're less in control of themselves because of some substance. Critically important.

Michelle Birkic (07:30):

I would agree.

Mark Creamer (07:31):

Are we going to insist that they give up alcohol or what are the kind of limits you are going to put on your patients here?

Tony McHugh (07:38):

Well, one thing at a time Mark, they might be smoking cigarettes as well. So I think to develop some kind of hierarchy of what is able to be worked upon is really important. But we know that when people are drinking, for example, their capacity to understand, comprehend and stick to plans is impaired so they become impulsive. So key focus I think.

Michelle Birkic (08:02):

I agree and I think it's important for them to, and this is something that Tony and I have talked about before, is for them to develop their own treatment plan so that it's their goals that they're meeting not mine. It's very important that it's a collaborative arrangement and if that's not something they want to work on, then there's limitations to what can be worked on and they need to understand that so that they can then make a decision.

Mark Creamer (08:25):

Absolutely. And again, across mental health, I guess being clear on what our treatment goals are collaboratively is a crucial part of that first stage, isn't it? When we're thinking about treatment just before we leave substance use, I guess my rule of thumb, and I'm thinking particularly when I'm working with prolonged exposure in treating PTSD, they have to be able to get into the session sober, not having anyone coming in who's drunk. And secondly, they have to be able to manage the arousal that's caused by the session without resorting to alcohol. How successful we are at that, I'm not sure, but that would be the idea that you're not allowed to leave here and have a drink to make you feel better as a result, cognitive capacity. Does that worry you? Do you think people need to have a certain cognitive capacity to benefit from treatment?

Michelle Birkic (09:06):

Yes, yes, I do. I think it's important. I think insight can be taught to some extent. I think cognitive capacity is something that definitely is critical for understanding concepts and for being able to apply concepts. So not just the understanding but also the application and then the evaluation of that.

Mark Creamer (09:28):

It's been a big topic of controversy, I'd say in the air of cognitive therapy. Have you got any comments on it, Tony? Do you think cognitive capacity is important?

Tony McHugh (09:36):

I think it's really important, but we shouldn't labour under the misapprehension that we can't adjust our methods to people's cognitive capacities. Ray Novaco has produced a volume of material around working with offenders and sometimes offenders with intellectual disabilities. So we're obliged to cut our cloth accordingly, but the capacity to develop insight is very, very important.

Michelle Birkic (09:58):

I think the capacity for the therapist to be agile is equally important and I agree with Tony with that to adjust, it's not a manualized treatment. If you use manualized treatments, you'll suffer.

Mark Creamer (10:09):

Or I guess what I would say, because I'm a big supporter of manualized treatments, is that as long as you treat them as what they are, it's not a question of taking it off the shelf and following every sentence. It's about adjusting that intervention to the particular needs of the clients.

Michelle Birkic (10:23):

As long as that's what happens, then I think that's good.

Mark Creamer (10:27):

Partners. Do you like to involve partners, Tony, in treatment for anger?

Tony McHugh (10:31):

I think it's critically important to involve partners where that is what everyone agrees should be done and there are some caveats around this. To work with people who are irritable and not take account of the safety of others who are important to them or in their orbit is probably folly. Really we need to be thinking about that. I think the real reason for involving partners in treatment for any presenting condition is information. Why is he working on this with you? I think if everyone is able to be on the team and support the treatment, I think that's fundamentally important.

Michelle Birkic (11:06):

And I would agree with that as well. It's complex and there's safety issues sometimes involved and that has to be taken into account. But it's often also the relationship, the partner relationship is a motivating factor and that can be used very successfully as long as there's adequate safety for everybody involved.

Mark Creamer (11:26):

Sure. Alright, so let's move on and talk about what we're actually going to do. And while we might have some pros and cons perhaps to manualize treatment, but there are nevertheless components of treatment that we are going to want to get through, I imagine. So can we just spend a few minutes talking about what those components of treatment might be, Tony?

Tony McHugh (11:43):

So I think there are four areas that we need to focus on. Cognition, we've talked a little bit about that. People sometimes have very unusual ideas when they're angry about what works. So we are obliged to work cognitively, but also with affect in terms of distress, tolerance and regulation. And then the body, we talked quite a bit in the second episode of this series about agitation, bodily agitation being a very great predictor of treatment response and then behaviours. Some behaviours are completely out of bounds and they need to be challenged. So there's those four domains we need to work in each of them and I'm pleased to say that are evidence-based treatments for each of those four domains.

Mark Creamer (12:26):

Michelle, what about components of treatment for you?

Michelle Birkic (12:28):

I think certainly in the first instance, for me, education is critically important and in terms of clients understanding that myths can be dispelled and that they do have control over their anger and they can learn to do that and that research tells us that this is possible. So I think them learning this and understanding this is very important. So that for me, on top of all the things that Tony spoke about is something that I always start with.

Mark Creamer (12:52):

Yeah, I think that's very important. In fact, last episode we were talking in the context of assessment. We were talking about how we can use assessment to do psychoeducation and to help them understand about their anger and so on. I'm going to put you a bit more under the spotlight though. So can we talk more specifically about the actual things that you might do? We talked for example last time, Tony, about identifying triggers that's going to be important as treatment progresses.

Tony McHugh (13:17):

Critically important. And that enables us to help people reframe their responses to triggers and the science of habit formation we talked about last time talks about cues and triggers, the behaviours and then the contingencies that either dampen the behaviours or exacerbate or accelerate the behaviours. So to talk about all those things is really, really important.

Mark Creamer (13:38):

Okay. Arousal management, arousal reduction. Do we give people strategies to manage their arousal?

Michelle Birkic (13:43):

Yes, distress tolerance strategies, acceptance, distraction techniques, breathing techniques, mindfulness, if that's what helps them and supports them. Self-instruction. So self-talk is very important. I mean I use a lot of behavioural experiments with people. They do their own and then they come back and talk about what they've done and what worked and what didn't. So it's not a blame, there's no shame involved. It's a simple experiment.

Mark Creamer (14:09):

So I want to lead onto that, but just to clarify then. So we are talking about helping the person to manage their arousal better, particularly in difficult situations because if we can manage the arousal, they're less likely to spike off into uncontrolled anger. Let's talk about what you're calling their behavioural experiments, which I agree was a good term. That whole concept of either imaginal or in vivo what I would call exposure I suppose, but getting people out there, is that an important part of treatment do you think? You've already mentioned, lemme just bring Tony in -

Tony McHugh (14:39):

Critically important. I still think behavioural experiments, Michelle has nominated them are the most powerful tool at our disposal. And this is where organised process of scenario testing, preparation for the experiment is critically important. You would do that in a session, you would work through the what ifs of what might happen. And then once the client understands what the project is, they are more confident to go and try these things and then learn from the process and what happened.

Mark Creamer (15:13):

Do you want to add anything to that, Michelle, about behavioural experiments, what they are, how you set them up or anything?

Michelle Birkic (15:18):

It's definitely done in vivo. So it's not done in a counselling room. It's done outside the counselling room and then it's reviewed together within session and then reset if it needs to be. Certainly it's done within the community. Often it's done at airports. I mean, I'm a prolonged exposure therapist too, so I'm a big fan of doing it. It's done in cars, it's done everywhere on trains, public transport, nowhere is sacred.

Mark Creamer (15:44):

And thinking again, back to my background as prolonged exposure, do we try to develop a kind of hierarchy? Do we start off with those situations that might be easier for the person?

Tony McHugh (15:54):

That's a really good question and I'd like to answer it in this way. Yes, we do, but I think there's one thing we need. It's a really important learning point because part of the PE protocol is to imagine situations. I think we have to go very carefully about that in relation to anger because I think imagining angry situations rather than being in scenario testing can actually increase people's anger unless they're well enough prepared for it.

Mark Creamer (16:22):

And I know in some of your earlier writings, Tony, you've made this point strongly, haven't you, about the role of imagining really is in prompting anger. Yeah. Talk to me about rumination because that is something that I think in many disorders, particularly depression and anger is very difficult. How do we work with rumination?

Michelle Birkic (16:38):

I think it's not dissimilar to what we've already discussed to be honest. I think rumination is a behaviour that requires challenging in itself. The productivity of rumination needs to be questioned and self challenged. What is the outcome, did you achieve your outcome by spending hours and hours going over what has happened to you, what you don't want to have happened to you? I think it's unproductive. I often talk about what people want in their treatment and they want growth and they want to be well and they want to recover well. Those things, rumination does not lend itself to that.

Tony McHugh (17:15):

I would also add further to what Michelle has said. You can use really important concepts like opportunity cost while you are ruminating, while you're spending all that time and energy on that, what is it that you could be doing instead? Because rumination is utterly futile. It doesn't change anything. And we're born with so much energy. If we are putting it into ruminating, we're wasting our time in a sense, but we don't make that argument in an invalidating way. We just look at the possibilities, the opportunity.

Mark Creamer (17:48):

Sure. And the question, is it productive? Is it helping you?

Michelle Birkic (17:52):

I suppose it's challenging the positive beliefs about rumination. Is it actually achieving anything?

Mark Creamer (17:58):

Yeah. Okay. Now I realise that we've gone through those stages obscenely quickly, and I'm sure our listeners would like a bit more detail, but we do sort of need to move on. I did want to talk about formats. So presumably we are talking about individual treatment largely, but is it something that can be offered in groups?

Michelle Birkic (18:16):

I think it can be. I think it needs to be handled very carefully and I think that's probably one of the places where I do like manualized treatment is in groups because groups can often end up in venting for the sake of venting, which is essentially rumination over and over again and unhelpful. So I think when you have a lot of very angry people together, unless there's some sort of resolution in place or some sort of skill development, then it can not go well.

Mark Creamer (18:46):

They can gear each other up as it were. So we need a good leader. What do you think about groups, Tony?

Tony McHugh (18:50):

Look, groups have been part and parcel of working on all kinds of effective disorders for a long time. I think as long as the purpose of the group and its methods are understood, there's a roadmap. I think there can be clear benefit from a small group, not a large group that's constructed properly. That's a topic for another time where people can learn from each other and quietly be encouraged to challenge each other around the depth of the problem, the patterns, and taking up active treatments. So groups have an important role to play.

Mark Creamer (19:21):

I agree. I think when groups work well, they can be very therapeutic. When they work badly, they can be extremely counter therapeutic, destructive. What about in this modern day and age? Can we treat anger? Do you think through the web, web-based treatments or other self-help kind of models?

Michelle Birkic (19:37):

I think if somebody is willing and they have capacity, then sure, but it very much depends on those two things. It's not, I think people who struggle more with that, and I would say that would have to be most of my clientele, then that would not be a suitable pathway for them.

Mark Creamer (19:52):

You would go along with that Tony?

Tony McHugh (19:53):

Adjunctively yes, but I think the best combinations always to be with your treater, for example, Michelle, where you talk about what was on the web, what its motivations were, what the roadmap

was, and you workshop their response to those treatments. And then I think do that magic of helping people to understand and develop their own goals. Yes, but I think the individual session is primary. It's an adjunct perhaps.

Mark Creamer (20:23):

Yeah, quite very good for education psychoeducation at times. Absolutely. But as you say, you really need that therapist input at some point. Yeah. What about medication? Does that have a part to play? I kind of get the feeling that increasingly some of the atypical antipsychotics things like clozapine and olanzapine are being used for people with very significant anger problems. Is it being used? Is it helpful?

Tony McHugh (20:46):

Oh, absolutely. I dunno that they're prescribed precisely for the problem of anger because as we said in the first episode, there are no particular anger disorders. So I think they're being prescribed for anger as a symptom of other things. But if they help people become less physically aroused and they have their place, I would then say psychology is still the treatment and how those medications may be weaned while people are doubling down on their skills is going to be really important.

Mark Creamer (21:15):

I think that's a crucial distinction, isn't it, between what might be symptom management or symptom even for suppression or whatever. And what's treatment. They're two quite different things and we might come back to that in a minute. We talked last time about anger problems being particularly prevalent in some high-risk occupations. I'm wondering whether peers and perhaps peer support services have any kind of role. What do you think, Michelle? You've got a lot of experience in this area.

Michelle Birkic (21:41):

I used to run a peer support program and I sit on the board of police Veterans Victoria, which is a peer support program in itself. I think it has incredible opportunities to support others. I think it runs the same risk as the conversation we were having about the groups though, if there's for example, collusion between people rather than the desire to get well. So I think if someone who is the peer is not resolved in themselves, then that could spill out onto the relationship they have with the people they're supporting. But I think when they're trained and they have good boundaries and they know what their role is and there's a pathway, then I think it can be very effective as an adjunct.

Mark Creamer (22:24):

As an adjunct, as an adjunct. Okay. Good point. Good point. Yeah, no, I think it's a very important point that you make there though. I think we could do a whole podcast series on peer support. It's a fascinating area and complex area, but I take your point. So first of all, it's an adjunct. Secondly, well-trained, well supported, well supervised peers if we're going to do it. Yeah, quite. And you both use the word adjunct a fair bit, and I would like to go down there a little bit. So perhaps we're not necessarily talking about treatment for anger here, but we are talking about perhaps some symptom management or some things that are going to assist with arousal. Is there a place for things like aerobic exercise or meditation or whatever?

Tony McHugh (23:02):

Obvious question Mark, and I'm glad to answer that there is, but there's this fascinating thing that I think we would all be wise to remember. So there's a paper by a fellow called Bushman 2002 and it's about catharsis and in it he makes the point that we don't want people exercising before or after an adversive event in the extreme. So to go to the gym is the classic and punch one's anger away on th the bag. It doesn't actually work. The cognition is not altered by it. But the fascinating thing that he made clear is to do that before you go into a potentially conflictual event. It doesn't work either. So being fit, being well, mind and body are connected, being fit is going to help you deal with your stressors. But you have to be wise about this.

Mark Creamer (23:57):

I'm surprised that actually doing it before is not helpful because you think that would reduce your rise. What do you think about aerobic exercise, Michelle?

Michelle Birkic (24:04):

I think it's very useful as an adjunct. I think it's part of a wellness regime that people should engage in on a daily basis. We know that it improves mood and probably supports stabilisation. But it's something you do afterwards or beforehand? No, I don't agree with Tony and I've also read Bushman and it's not helpful.

Mark Creamer (24:23):

Yeah, I have a nice little graph that I show people that says, these are the strategies that we're going to use to help you reduce your overall level of arousal as kind of lifestyle change. And we have these different strategies that we're going to use in acute situations where you can feel the anger. Excellent. Okay. And then you were saying before, Michelle, maybe things like meditation and so on, again, probably a similar kind of thing. Would we be right that it's good for reducing our overall level of uptightness, which makes it less likely that we're going to spike off?

Michelle Birkic (24:53):

Well, it can also be used as avoidance if it's not done in the correct way. So if people are not accepting what they need to do differently and reverting to two other things instead, then they're actually not dealing with the anger. So I think it actually can result in avoidance.

Mark Creamer (25:11):

Do we have, I wonder any reliable predictors of treatment outcome? Can you tell whether someone's going to get better or not? Someone's going to respond, Tony?.

Tony McHugh (25:20):

So there's a fascinating predictor and it's an irony. I dunno how you escape the problem, but there's been a systematic review. It's quite old now, 2009 by G Glancy, and it noted that the modal number of sessions for treating someone with an acknowledged anger problem is eight. That's an incredibly low number. And part of the problem is that anger interferes with treatment, so people drop out early. I think one of the most important predictors of treatment outcome is their capacity just to adhere to the treatment process. It's fascinating.

Mark Creamer (25:57):

That's a very interesting point and presumably that has a lot to do with the quality of the relationship and the engagement and all that kind of stuff. What about predictors of treatment outcome for you? Michelle, do you have any ideas about what predicts outcome?

Michelle Birkic (26:11):

I'm not someone who would definitely say someone's going to get well or not in a certain amount of sessions. I think things can get in the way, and I think it's important, as I said before, that this therapist is agile and is curious and prepared to alter their approach if needed and their setbacks. Things are not always linear. People don't always go in a linear trajectory and I think they're human beings and things get in the way at times, and I think we have to go with that sometimes.

Mark Creamer (26:37):

Absolutely. In fact, we talked last time about the role of psychosocial stresses and might be things like poverty and so on in driving anger or contributing to anger. And of course we notice that in therapy, don't we? People come in, they've had a crisis during the week. Well, you can't necessarily stick to what your agenda was for that week, Tony. How good are we? How effective are the approaches that we've got?

Tony McHugh (26:58):

So that same systematic review noted that our treatments are best when they're multi-component. We do a bit of cognitive work, we do behavioural work skill building that Michelle's mentioned, for example, we do some bodily based work and they're all important. Relaxation is very important from the point of view of deescalating arousal. But all of the other things I've mentioned are important too. The literature says that basically we have about 80% of the effectiveness for anger that we have when we use those techniques and interventions for anxiety and depression, for example. So there's a 20% gap. It's fascinating. We are missing something or we need to develop our tools a bit more specifically for irritability, but 80 percent's a pretty good pass Mark. We just need to think about what are we missing.

Mark Creamer (27:50):

Sure. Just to clarify that you're saying that it's 80% as good as we can do with depression or anxiety?

Tony McHugh (27:55):

Correct.

Mark Creamer (27:55):

It doesn't mean that 80% of people walk through the door, get better.

Tony McHugh (27:58):

No, no.

Mark Creamer (27:59):

No. Okay. But even so, yes, that's pretty good. I quite agree. I quite agree. There are lots of anecdotal ideas around, and actually both of you have made a comment about myths and so on. Do either of you have any sort of, perhaps I want to come back to this idea of catharsis and this idea that somehow if we let it all out, that's the way we should do with anger. And in fact, the opposite side of that really, that if

we don't let it out, then there's going to be some kind of problem and so on. Is that Michelle? What do you think about that?

Michelle Birkic (28:25):

Well, I'm very much in agreement with the previous comments about catharsis series the balance between expression of anger, then management of that before it becomes rumination or aggression.

Mark Creamer (28:37):

But it's not as simple as just letting it all out that somehow that's going to be the cure. We just let it all out. Everything's going to be all right.

Michelle Birkic (28:44):

No, I've seen many instances where that's not all right.

Mark Creamer (28:47):

Quite, quite, quite. Absolutely.

Tony McHugh (28:49):

And to pick up on Michelle's point, the Bushman paper of 2002 says, catharsis, cathartically expressing anger in a relationship is probably the worst thing you can do.

Mark Creamer (29:03):

I can well understand that. And yet I do think it is a myth. It's a fairly common myth that well, you've got to let it out. Okay, good. I'm glad you think that's a myth. I certainly think it's a myth. My final question in our last minute or less in fact is I'm wondering about the future. And I'm wondering whether either of you have any ideas about what the future of treatment holds, what we might do differently, what we might do better to get that 20% extra if you like, Tony.

Tony McHugh (29:28):

So I think to go back to what Amy Adler said in the first episode is this has been a chronically under-researched area. I think Glen said that in the second episode. So always room for more research. I think for me though, I think the research that looks at better intervention application is going to be really important because angry people, if I can use that term, are difficult to be with. And sometimes we can get lost in their anger. The capacity to quietly, thoughtfully, respectfully come back to the issue and apply the intervention effectively is going to be really important. And I think there's one thing that's really missing in this area. It's guidelines. I think there's an absence of guidelines on what to do with angry clients.

Mark Creamer (30:15):

So more research, better training for therapists. But this idea of guidelines, and I always like to end up with what kind of resources we can suggest, and it's a pity that we don't have any evidence-based guidelines you're saying that we can actually direct people to. Do you have any thoughts, Michelle, about the future of treatment and how we might better get better outcomes?

Michelle Birkic (30:35):

I think focusing on process over content is very important. So rather than getting mired in the weeds with what people are angry about, it's about supporting them to do things differently. So I think people can sometimes get bogged down. Therapists can get bogged down, understandably in the content.

Mark Creamer (30:55):

Yeah, sure, sure. And we talked last time very briefly about prevention and your comments about peers and so on. There's an area where we might be able to identify this anger early on and give people the skills that they need to stop it spiralling out into properly anger. Wonderful. Look, time is always against us and unfortunately it has run out. This is an area, of course, the treatment of anger we could have spent days on quite honestly. But we have run out of time. But it was a very good discussion. It was really useful. And again, I learned a great deal from today's discussion as I have from all three episodes in this series. And as I'm sure have our listeners, I hope our listeners enjoyed the conversation today as much as we have. So thank you very much for your extremely valuable input throughout the three episodes, Tony, and it's been a great pleasure co-hosting with you and also particular thanks today to you, Michelle, for your contribution to our discussion. If you want to learn more about Michelle, Tony, or me, or if you want to access any of the resources that we've mentioned in any of the episodes in this series, go to the landing page. You'll also find a feedback survey. So please if you could take the time to fill that in, let us know what you thought. And you can also tell MHPN how best they can meet your needs. But for now, it's thanks again very much indeed to you for joining us today, Michelle, and sharing your enormous clinical experience.

Michelle Birkic (32:14):

Thank you Mark. It's been great to be here today and to discuss this important topic.

Mark Creamer (32:18):

Great. Thank you very much. And of course, thank you to you very much, Tony, for joining me for these three episodes and for admirably co-hosting it with me.

Tony McHugh (32:26):

My pleasure Mark.

Mark Creamer (32:26):

Grand. And a very, very special thanks to all of you out there for joining us today and for listening to the podcast. Bye for now.

Host (32:36):

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