A Conversation About… Anger and Mental Health: Why Do People Get Angry?

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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 (00:19):

Hello, and welcome to this episode of MHPN Presents, A Conversation About Anger and Mental Health. This is the second of a three-part series, and in our last episode, we looked at the nature of anger. We looked at its impact on the person and on other people. And if you haven't listened to that episode yet, I strongly encourage you to do so. My name's 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 said in the last episode, I'm really pleased to be hosting this series because as a clinician, I often find that anger in my clients is quite difficult to manage. And so I'm thrilled to be able to pick the brains of our esteemed guests. We have a special guest in each episode to help us explore the complexities of anger, but I am privileged also to have a brilliant co-host for the whole series in the form of Dr. **Tony McHugh**. Welcome again, Tony.

Tony McHugh (01:15):

Thank you Mark.

Mark Creamer (01:16):

Tony's bio is on the MHPN webpage and I encourage you to check it out, but very briefly, Tony's a clinical psychologist, loads of experience, clinical and research experience in the area of anger and mental health. We talked in the last episode, Tony, about what anger is and how it affects the person

and the people around them. What do you think were the key take home messages for our listeners? From that one?

Tony McHugh (01:42):

I thought the key messages were as follows, Mark, that anger is a natural human emotion and that very nice people can sometimes struggle with anger. And that's well documented in the research. They do not continue to be anything other than nice people but struggle to regulate their anger. Second, take home I thought was anger needs to be managed or regulated because of its potential for harm. The harm comes from the fact that those who are struggling with it have reduced judgement. They make poor decisions. They see people who are friends sometimes as enemies. And it's really important to note that anger has positive attributes, just not negative ones. And finding the balance is the point we finished towards the end of the first episode by talking about the consequences, the costs of anger. It promotes illness and does have a relationship with early mortality. It affects personal relationships, particularly familial relationships, more so than relationships with strangers. It compromises intellect and functionality and it has a very poor relationship with sociality. So the more angry people are, the more they can be rejected socially and even censured. And a really important motivational point for people who are struggling with anger is it's the inverse of happiness.

Mark Creamer (03:06):

Fascinating. I mean, for those who haven't listened to it, you can see we covered a huge amount of ground in that episode. But that last point you make, Tony, I do think is important. I don't know, maybe we do have a tendency to blame angry people to get angry with them. Just pull yourself together, stop being so stupid. But the reality is that it's not fun. And that idea of an absence of joy or whatever is profound.

Tony McHugh (03:26):

It's really interesting, Mark. We wouldn't become disappointed or annoyed with people with a whole range of mental health conditions, but we find people with anger irritating and difficult to work with at times. It's an irony.

Mark Creamer (03:38):

It is, isn't it? It is. But I take your point that anger at one level is a kind of normal human emotion, but that too severe, too frequent, lasts too long, then we start to call it problematic anger. And so the fact is that not everybody struggles with problematic anger. And I'm really interested to look today at why it is that some people get overly angry while others don't. And we'll also look at how we might try and assess anger in our clinical practice. And then in our next episode, the third and final episode, we'll talk about how we might manage and treat anger problems in our clients. But at this point, I am thrilled to be able to welcome our very special guest for this episode, Professor **Glen Bates** who's joined us here in the studio today. Welcome Glenn.

Glen Bates (04:26):

Thank you.

(04:28):

Glen's bio is also on the MHPN website, so please take a look at his extremely impressive track record. But very briefly, Glen is a professor of clinical psychology at Swinburne University of Technology. He's

got over 35 years' experience as a clinician. And in fact, I'm not sure if I should reveal this, Glen, but Glen and I did our clinical training together back in the dark ages decades ago, ages. So he's got a lot of clinical experience and experience also as a supervisor and a researcher. And his research focuses on anxiety disorders, on PTSD and on narrative models of personality. And of course very importantly for us also on anger management. I'd love to ask about some of those other research ideas, Glen, but we are here to talk about anger and I asked Tony in our last episode about how and why he got interested in anger. So can I ask you the same thing? What led you to develop an interest in anger?

(05:21):

Yeah, I think it was very similar to what you said at the start. These are the clients that engage you really intensely and they're difficult to form connections with often. And there's a lot of externalising in anger and it can come back to you as the therapist. So I found it as a therapist, it put me on my metal if you like. I had to learn a lot from that since I've been doing a lot more supervision. It's the first thing that the clinicians will bring to supervision if a client is angry in the session or if anger is a focus. There's a whole lot of stuff about the client but also about the therapist that we need to talk about. So from a clinical point of view, it's a really attractive issue for therapists. The researcher part of me also says that we have far too little research on this. It's a clinical phenomenon, it's really important, but there's a big open field for us to try to understand it better. So it appeals to all aspects of me, I guess.

Mark Creamer (06:17):

And I think last time we were talking about the fact that there isn't a particularly good diagnosis in the DSM for it. We do have intermittent explosive disorder, but the fact that once it's got a proper diagnosis that kind of legitimises, if you like the research, we saw it with PTSD as soon as PTSD was recognised, suddenly there's an explosion in research. And maybe the same thing would happen with anger.

Glen Bates (06:38):

Which will be an interesting issue in that anger is so interrelated with so many different conditions.

Mark Creamer (06:44):

Indeed.

Glen Bates (06:45):

And so it's hard just to try to isolate it.

Mark Creamer (06:47):

Indeed. And again, we did talk about that last time. Yeah. Particularly of course post-traumatic stress disorder or PTSD, but a range of others. Okay. What I'd like to do, if we could, is move on and talk about what we know about why some people get angry or particularly angry and others don't. And I guess looking at things like risk and protective factors or indicators and so on. And I wonder if we could start with individual characteristics of people who tend to have anger problems. And I'm wondering to kick off with whether there are any typical sociodemographic features of people with problematic anger. And I'm thinking of things like age. Do older people get more angry or gender or socioeconomic status or whatever?

Tony McHugh (07:32):

Look, I think the first point I would make Mark, and maybe the only point about predictors in one sense is gender. The literature has shown in recent times that there's no difference in the gender capacity to experience or express anger. It's just that different genders do it different ways. So the idea that it is a problem of one gender is not entirely accurate. I think the literature would back me up to move on to say that anger is directly related to the level of stress someone is experiencing and where one is experiencing, for example, socioeconomic distress, then you are more likely to be angry. It's known also that it's more of a problem in adolescence and that as people age, they tend to get less angry. Fascinating thing though is that their anger episodes remain about roughly the same duration. So less anger, but the anger, we're going to talk about rumination at some stage, still goes on as it were. But the older we get, perhaps the wiser we get, the less angry we get.

Mark Creamer (08:41):

I dunno, I think the older I get the grumpier I get to be quite honest, but maybe that's not problematic Anger.

Glen Bates (08:46):

Tony's point about the psychosocial sort of stresses and SES sort of things is an interesting one because I think it is the case that if you are continually struggling and frustrated to provide for your family or for yourself, that puts an added pressure on you. And anger to me becomes more likely. So yes, we can say that people with lower incomes with people from different backgrounds are at risk, but it comes down to how they handle that frustration. And of course the other one we've had recently is Covid, where we noticed there was increased aggression, but actually anger issues were much more prominent as Covid went on when we had the lockdowns and when you were restricted much more in how you lived your life. So I think this notion of there are background factors, economic and so on, are important. It's how you manage it, it's that emotion regulation sort of stuff that I think is important.

Mark Creamer (09:42):

Sure, sure. But those kind of increasing frustrations, and I wonder about the element of control, things over which we don't have any, can't seem to do anything about is very frustrating...

Glen Bates (09:53):

And feeling locked in.

Mark Creamer (09:54):

Yeah, yeah, exactly. Just to come back to your point about gender, Tony, I am interested in that. I would've thought that anger would be more prevalent in males, but as you say, maybe it is just about how it's expressed.

Tony McHugh (10:05):

Yeah. Anger has four components, the psychological ones of cognition and affect what happens in one's body and that's very important to the expression of anger, but behaviour. So there's a line of research to say that women have been socialised to not express anger where men have a freedom to express anger. So it's the differences in the behaviours.

Mark Creamer (10:27):

And we also alluded briefly last time to the notion of culture and what's culturally acceptable or not. And again, I guess there's a gender difference there. Let's move on and I dunno if we've got any research on this at all, but I'm thinking about personal history and I'm thinking is there any kind of genetic contribution to anger? Do we know?

Glen Bates (10:44):

My point on that would be just about every mental health condition, there's a large genetic component, it's transferred. We know that in anxiety, we know it in other conditions. So I think the vulnerability is there genetically. But as a psychologist, I guess I don't want to be labelling them as you are the victim of your genetics. I think what we see is how you adapt to that.

Mark Creamer (11:06):

I think it's a really important point, isn't it? You don't inherit depression or anxiety or anger. You might inherit a vulnerability to it, but we can work with that. Anything else on genetics before?

Tony McHugh (11:17):

Oh, I would endorse Glen's point. I know we're going to talk about theories. We can't leave out the modelling effect of parents with irritability issues.

Mark Creamer (11:27):

Well, I was going to talk about actually early childhood experiences and presumably there are certain, I dunno, family dynamics that might increase the chances of someone developing problem anger.

Tony McHugh (11:37):

I certainly think clinically we see cross generational anger. The grandparents were angry, the parents were angry, the children were angry.

Glen Bates (11:45):

And there is some epidemiological stuff about aversive childhood experiences, highly predictive of adult anger and particular parenting and modelling. And in my case, I would be thinking it'd be modelling how they manage the anger.

Mark Creamer (11:59):

Absolutely. It is that kind of emotion regulation that seems to be a theme we were talking about last week and this week. Yeah. Okay, moving on. We often associate rightly or wrongly, and we talked about this a lot last week, we associate being a combat veteran with increased risk of anger more broadly. Do you think there are particular occupations that perhaps carry a higher risk of anger?

Tony McHugh (12:20):

If I can have first bite at that Mark, I think yes, we talked about veterans, but I think anger issues because of their proximity to the experience of trauma are far more common in people in risky occupations. First responders would be your classic example, police, fire, ambulance, personnel, SES personnel. There's an intimate relationship between experiencing trauma and anger and I think that's the root by which people become angry. I throw in one other thing, Mark, and then we might throw to Glen, what is really important in all of those particular vocations, the military included, is exposure to

trauma does not predict directly only the anger experience. It's how you are treated by your organisation as well. And there's a lot of secondary anger towards command, for example, in those occupations.

Mark Creamer (13:13):

Absolutely. Well I'd like to add something there. Do you want to make a comment first, Glen?

Glen Bates (13:16):

I would go along very much with what Tony's saying and if you are in occupations like those where you are in high stress situations and potentially trauma situations, you've got intense arousal reactions and so on. And we know from those organisations it's how well you are managed by your seniors. That determines the anger connection. I've seen a lot more anger in senior managers in very political environments as well where there's a lot of conflict and fighting between people. So not necessarily the physical trauma. It comes down to interpersonal conflict is what I think is if you are in an environment where there's a lot of interpersonal conflict, you've got a toxic sort of environment. Anger I think is a bit of an adaption to that.

Mark Creamer (14:04):

That's an interesting point I was going to make the point that I acknowledge entirely people who are working in occupations where they might be exposed to trauma that that's going to increase the risk of developing a whole range of emotional disorders, including perhaps anger. But I also wondered about whether sometimes we see a kind of post hoc justification that it's management's fault, they're not prepared to say it was the death of that child that really upset me. They'll say it's because of those managers can't manage me properly. And I'm sure there's a little bit of that. I dunno how much it is. I take your point that certainly the interpersonal conflict is important.

Tony McHugh (14:37):

Mark, I think that's undoubtedly true, but I think in occupations, and I don't want to just talk about first responders, emergency departments in hospitals, mental health workers are also known to be exposed to this kind of stress. And I think how it's handled by the employing organisation is really, really important, to not invalidate people's experiences is really important.

Mark Creamer (15:02):

I'm interested in going on to triggers. If we've got someone who's vulnerable to problematic anger, what kinds of things are likely to trigger an episode? And you were talking about being put in these kinds of situations of frustration and perhaps lack of control.

Glen Bates (15:15):

With that, I guess I'd go for more direct situational triggers, like short-term ones, but also think about long-term ones. So in terms of the short-term ones, the ones that I see most in the research is disrespectful treatment. It's building a bit on what Tony's saying and that can be to others that you are responsible for as well as to you. And then a sense of injustice of treatment that people are not giving you due credit for what you've done or that it's an unfair sort of penalty that you are receiving. And the third one is frustration. Discomfort, difficulty in doing it. So if you should put it into a road rage sort of thing to move away from organisations, if you are stuck in traffic for long periods of time, anger levels

could be triggered and if other drivers are doing things that you think are unjust or unfair, they can be triggered.

(16:10):

So once we've got to the problem. is that those triggers really take off. So they're the situational ones and they're the ones that the clients are best able to tell us about. The other ones that interest me are the background sort of factors. And these are the past history of your interaction with other people and long-term sort of conflicts with people, but also the environment you are in. If you are in a noisy, smelly, hot and uncomfortable environment, your potential for anger can be triggered much more readily than that. A lot of people don't recognise that or if you're stuck in traffic for a long time, that sort of stuff. So they're what I would call the more distant factors that people may not acknowledge as readily and perhaps when you get treatment, that's an important part of what we need for them to recognise what's going on.

Mark Creamer (16:56):

Well treatment certainly, and we're going to have a quick chat at the end of today about prevention and it's got implications to that as well. Did you want to add anything about triggers Tony?

Tony McHugh (17:04):

I want to endorse something Glen was saying. There is a return to research that shows that anger escalates in environments that are hotter and it's been forgotten about, simply raising the temperature, whether it be physical or emotional is associated with anger.

Mark Creamer (17:19):

That's interesting. Even physical.

Tony McHugh (17:21):

Absolutely fascinating.

Glen Bates (17:23):

I'll add one thing there Tony, because I do a lot of work in Singapore, which is always hot or extremely hot. And what we looked at was it's not just hot, it's the discomfort if it's an uncomfortable hot and if you look at humidity and those things, when it becomes more humid, that's when you're going to get the double banger. So it's not just summer is going to be an anger time.

Tony McHugh (17:48):

But it's a really salient point. We can't ignore the environment. How would we react in an environment, helps us deal with clients to understand their irritability and not be judgmental.

Mark Creamer (18:00):

Yes, exactly. And in fact, I'm reminded of big pieces of research back around the Vietnam veteran era where they talked about, lost the word, but it's something like toxic environment or unpleasant environment, was exactly that. It was the heat and the flies and the insects and all that. I haven't really got time to go into it in great detail, but I do just want to put on the table the fact that there are certain processes, systems, bureaucracies, and I'm thinking particularly around the compensation systems that

we often see people getting very angry and I've got a lot of time for a lot of our compensation systems. I think people work really hard to try and do the right thing. But that's an example perhaps of the frustrations people might feel and might trigger anger.

Tony McHugh (18:40):

Absolutely. People will perceive there's been institutional injustice and it's related to anger.

Mark Creamer (18:47):

Okay. I'm always a bit concerned that as a clinician we might tune out if people talk too much about theory, but I do think it's really important that we have a model not only that we can understand what's happening with our clients, but also that we can explain to clients. And I'm wondering whether you've got any ideas about how you explain to clients what's happening to them, perhaps the mechanisms underpinning the development of their anger and so on.

Tony McHugh (19:12):

Yes, models, explanatory, descriptive models are hard to sell to clients, but it's critically important that we do because in the first episode we made the point a number of times that people don't want to be angry. In most cases they just dunno how to stop being angry. A model that explains things is really helpful. So I'm not the only one that's struggling with this.

Glen Bates (19:36):

Very much so, and actually reminds me working with anxious people, they often come in thinking they're the only one with this sort of problem. And I think we see that with anger people as well. And the idea that there are things going on in me that are producing this and I can control 'em a little bit in the sense of understanding them rather than accepting that perhaps. And the elements that you talked about earlier, Tony, about the cognitive sort of processes that are involved, the arousal factors and the behavioural outcomes. Sure. We don't want to put up a theoretical model and point to the blackboard. What we're trying to do is get experiential sort of elements. So in my feeling in explaining it to the client, I would use things like self-report scales, and I know we're going to say a little bit about that, not from the point of view of me making a diagnosis, but from the point of view of have a look at these items and how does that relate to you.

(20:33):

So if we're getting to the arousal bit, are you someone who has really intense but short-term arousal and what does that lead? Does that lead to impulsive acts or things like that? So giving them these sort of scales and then saying, we're just trying to understand your pattern so you can manage it better. And getting the message across that this is about management. There's nothing wrong with anger as an emotion. It's a human emotion as you said in the lead in and it can affect people's behaviour, but in certain situations when we don't manage it effectively, it has really negative repercussions for us later on. And we need to understand your model so we can see patterns,

Tony McHugh (21:11):

I can't emphasise that word enough, patterns to help people identify their patterns and the standards they're ascribing to and the meaning of their behaviour. They're really important things.

Mark Creamer (21:23):

And again, that's something I think that crosses diagnostic boundaries, isn't it? That idea of giving people a model that helps them understand what's going on is crucial. And I remember way back and there was cognitive behavioural psychologist called Donald Emba and I was always struck with what he said, which was that the actual veracity or the truth of the model is actually less important than its credibility to the client. If the client understands it and gets some kind of way of understanding what's going on, then that's the most important. Okay, so we've got some models that we're going to give and we're going to help them understand it. I would like to talk a bit about assessment and would I be right in saying that perhaps one of the first things we often need to do when we've got an angry patient in front of us is to think about safety and I'm thinking about safety of the people in their environment, perhaps partners and family and also perhaps safety themselves. Is that something we would kick off with in terms of assessment?

Tony McHugh (22:12):

Certainly be early. Early assessment is also about developing motivation. I think as we're building a model of how it's possible to regulate anger that can be in there, we have to develop a relationship with people early on and show them that we are trying to understand their struggles with anger. So it's a judgement call. Those things need to be covered off, but the sequence where we put them, it's really important I think.

Glen Bates (22:39):

I think also when you're talking about the nature of the therapy we are going to be doing, it's good to talk about that safety. So we are here dealing with this anger. It's been a problem for you in a number of relationships and work or whatever. At some time you may well become angry with me and my role here is to really help you understand what's going on with that so you can step back from that anger and manage it more effectively. But if you detect that, we'll discuss it so you could become angry with me at that time. I will make you aware of what we're trying to do in the therapy and so on. You might then, depending on what the client's issues is, if you've got someone who's been extremely violent on a regular basis, well then you'll probably emphasise safety stuff a bit more. But in a lot of clients that'll be just, we'll use that as grist for the mill.

Mark Creamer (23:25):

And of course this isn't necessarily anger. We talked last time about the relationship between anger and aggression and violence. There is a relationship, but it's by no means everybody's violent has got an anger problem. Nevertheless, of course, I just want to make crystal clear that if we think that someone is in danger, if we think that this person is going to go home and hurt somebody, clearly we have a responsibility there.

Glen Bates (23:45):

Absolutely. And to the family members.

Tony McHugh (23:46):

Yep. It's not just us who say that Mark, our code says that. Our code says we must put a high premium on safety.

Mark Creamer (23:53):

Absolutely. So we've done that and then we are going on to do an assessment. If you just talk broadly about doing an assessment in the consulting room, what kinds of things do we need to know? And you sort of alluded to it, Glen, already by saying we can use assessment in some ways as a way of working with the client to help them understand what's going

Glen Bates (24:10):

On. And that's where a self-report scale can be very useful in that early stage. There's hundreds of self-report scales out there that you might choose when they're going to paper last year broke them down into sort of three areas that you really want to find out, which I think overlaps again with what you were saying earlier and the first event that is arousal and intensity of the anger. We need to measure that and that's going to be a good progress for the client to see that that intensity is dropping. But the other areas is this rumination factor and there's one very good measure of anger rumination out there, which gets at things like revenge and the whole complexity of that rumination because angry people are ruminators. I remember one of our nurses once told about an angry client, he smouldered all morning and he was just going over and over this stuff. So ruminations important. And the last one being how they handle frustration and discomfort.

Mark Creamer (25:10):

Tony? Any key assessment points?

Tony McHugh (25:12):

Points very well made Glen. I always throw in a motivating element, the cost benefit analysis. They're there for a reason, as we might've said in this episode or the previous episode sometimes because people are telling them to be there. But all the time, I think trying to get across to people that it's possible to make progress. What are the costs, what are the benefits of how you are versus where you might go?

Mark Creamer (25:37):

And presumably we're going to talk a bit about triggers. What are the kinds of situations in which you find yourself getting angry? Is that an important part, do you think?

Glen Bates (25:45):

Oh, absolutely. And what's interesting is that people tend to have recurring sorts of situations that come up that they can predict and then we can build that into the treatment is understanding those. I had a road rage guy who just near St. Vincent's Hospital, every time he goes past there, the arousal comes up closed in traffic and things. So we could use that as something to really understand what was going on underneath.

Mark Creamer (26:11):

Very important in treatment planning

Tony McHugh (26:13):

And to emphasise, again, I think Glen's touching on it, pattern analysis is really, really important. Takes it out of the unknown. There must be something seriously wrong with me if I'm doing that, we break it down into the patterns and then they can be addressed.

Mark Creamer (26:27):

Yeah, yeah. Lovely. I do think it's important to emphasise that there are a number of reasons why we might do an assessment and one of them is planning treatment and so on. And indeed psychoeducation as you're alluding to. The other is of course to monitor treatment progress. And you alluded to that, Glen, that we might be using slightly different measures if we're going to monitor treatment progress and as good behavioural scientists. That's something we want to do as we go through treatment, I guess.

Tony McHugh (26:52):

And then if we collect that data Mark, we must talk to that data because clients want to know I'm filling these things out, what do they show?

Mark Creamer (27:00):

Absolutely. Absolutely. It's an important therapeutic device really, isn't it? Yeah. Wonderful. Now you, Glen mentioned a paper there, which sounds as though that might be very interesting for our listeners. We'll talk to you after about whether we might be able to put a link to that, if not the paper itself, then at least the journal and whether there are any simple questionnaires. I'm wondering about something like the DAR-5 dimensions of anger reaction.

Tony McHugh (27:23):

It's five questions Mark and it's got a clear cutoff for problematic anger. 12 out of a score of 20. It's easy to use, the questions make sense to clients. It's a quick and dirty check. We're not doing research. There are much more complicated anger inventories that people could use if they really wanted to go further. But the DAR-5 is a good start, I think.

Mark Creamer (27:45):

Okay. And we'll try and put a link to that as well, I think. Yeah. Okay. Time is running out, but I just want to spend the last couple of minutes if we could, just having a quick look at prevention. I have to say that my personal view is that we don't do a great job in terms of the empirical data we have on prevention in mental health generally, but we're trying and we're making progress. I just wonder whether you think there's anything that we can do to reduce the risk of anger, and I'm thinking particularly in high risk workplaces, for example, anything that you would suggest, Glen?

Glen Bates (28:15):

Absolutely. I think we've talked a lot about emotion regulation and we'll come back to that. But what we see in people who have anger problems is that they don't develop good communication skills. They don't develop social problem solving skills and they struggle a bit with empathy for other people. They tend to stay within. And I think that's partially because once you've got an established anger reaction, anger's quite good. If you want to get something in the short term, if you want to get served at a restaurant, become angry,

Mark Creamer (28:47):

Let's not encourage our listeners to that, then yeah,

Glen Bates (28:49):

The service will probably be pretty bad after that. But you will get attention. And I think because anger works in some ways, they then lose the capacity to actually communicate, discuss, because that usually closes other people down. So there are clear social skill or social emotional development factors because remember, anger stuff tends to happen, begin very early. This is kids in primary school and kinder if they've got anger externalising sort of problems that predicts later problems. So we need to act early and improve that capacity to perspective taking, communication and social problem solving. And they're not difficult things to do.

Mark Creamer (29:35):

But of course that's a very intriguing idea that we could pick up these tendencies when the person's very young and try and modify it then that would be great.

Tony McHugh (29:43):

I'd throw in one thing, I'm very pleased to know that there's a reemerging interest in the science of habit formation and habit change. And what people who are struggling with anger think that this is a life, it's deterministic, it's a lifelong habit. I'm going to be angry for the rest of my born. It's not true. The adage that you can't teach old dogs new tricks is simply not true. So to give people an understanding of this is how habits form, there's a trigger, there's a behaviour, there's a contingency that promotes that to go around. Again, I think it's really important to get across to people. Habits can be changed.

Mark Creamer (30:20):

So we do perhaps have potential in our perhaps high risk occupations like the military or the first responders or whatever to be doing some training around these issues, perhaps in the early days of training and reinforcing it as the person goes through their career be incredibly valuable really, wouldn't it?

Tony McHugh (30:38):

And then for leadership to model that in these organisations.

Mark Creamer (30:43):

That is the big challenge, isn't it? Yes. But you're absolutely right. Of course. Of course, Tony. You're absolutely right. Okay, look, unfortunately we've run out of time, but I think it was a fantastic discussion. It was very informative and I learned a huge amount. So I'm now keen to hear our next episode and to find out what we're going to do about it and how we might treat it. I hope that our listeners enjoyed today's episode as much as we have and that it's been of interest to you. Thanks very much again for your time today, Tony, and we'll talk to you again next week. And also thanks to you, Glen, for joining our discussion today. As I said, in our next episode, we'll look at how we as clinicians can do a better job in managing and treating anger in our clients. If you want to learn more about Glen, Tony or me, or if you want to access any resources mentioned in any of the episodes, go to the landing page. You'll find also there a link to the feedback survey. Do fill it in and let us know what you thought, and of course you can let MHPN know what else you'd like to get from them. But for now, look, thanks very much again to you, Glen. I really appreciate you spending your time and sharing your wisdom with us.

Glen Bates (31:49):

Thanks for the opportunity. Really valuable project, and I got a lot from it too.

Mark Creamer (31:54):

Good, good, good. That's the idea as well. And Tony, of course, thank you very much again from your perspective.

Tony McHugh (31:59):

Pleasure, Mark.

Mark Creamer (32:00):

And of course we will be talking to you again in our next episode. And at that point, it's goodbye from me. Don't forget to tune into our third and final episode in this three-part anger series when we'll talk about treatment. In the meantime, thanks very much indeed to you all for listening to our podcast today. Bye for now. Bye.

Host (32:20):

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