



A Conversation About... Working with Anger Part 1

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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.

Tony McHugh (00:19):

Welcome to this episode of MHPN presents a conversation about wherein we will discuss maintaining effectiveness and achieving outcomes for and with clients challenged by dysregulated anger. I'm Tony McHugh, a clinical psychologist and your host for today. Last year I co-hosted a three-part series with Professor Mark Creamer exploring the relationship between mental health and anger. Today I'm continuing that conversation in a new two-part series with Professor Glen Bates, also a clinical psychologist. Glen, you joined us in episode two of last year's series where we discussed why people get angry. I'm delighted to welcome you back as we take the conversation on anger even further.

Glen Bates (01:03):

Thanks, Tony. It's really good to be here and perhaps talk a bit more in depth in terms of some of the issues that we raised last time.

Tony McHugh (01:08):

That would be great. In studying and working with a range of health populations across my career, I've been given many reasons to reflect upon the effect of anger on people in trying to understand anger and its impacts upon individuals, groups in society. It has been obvious to me that the clinical importance of anger is unrecognised or has been forgotten and that it is prone to being misunderstood and underestimated. That has stimulated my interest in how theorists, researchers, and clinicians might better work to assist clients to deal effectively with their anger and its impact upon others. For a long time, I've been aware that you Glen share a similar clinical and research interest in anger, and there is



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much to converse about. I'd like to think that the information discussed under each of the topics we'll cover here today and in the next fortnight's podcast, we'll have clinical utility and may assist our colleagues in the field in session as they work with clients with dysregulated anger. I'd be interested to know what you think.

Glen Bates (02:08):

Oh look, I really agree, Tony. We started talking about anger together many years ago, and at that stage there was very little available. There was some classic approaches to it, but it really didn't get the attention it deserved. I think that's changed a bit. I think there's more coming out. So we're now at a stage where we can reflect on a bit more of an evidence space than we had then. But it still goes back to understanding, well, how do we use that in working with this very complex group of clients?

Tony McHugh (02:37):

Thanks, Glen. So I have a number of questions to ask you. The first one I'd like you to reflect upon if possible, is the importance of addressing anger for clients.

Glen Bates (02:47):

It's almost taken as given, we know clinically and with the people that we supervise and work with, that when anger is present, it's really important to work with. A few reasons that perhaps we should really emphasise is we don't often check out anger as a factor in terms of treatment outcome. And one of the things I've been really impressed with is when we do measure anger, it's one of the main predictors of people not doing well in treatment. So it's a major emotion to understand and it has an impact on treatment response. The other things I guess I would add from a therapist's point of view, this is a group with one of the more fragile therapeutic relationships and one that can be breached quite quickly. And I think that's a nature of what anger is itself. People tend to externalise, put it onto other people, find it very hard to accept the problems that they're dealing with.

(03:44):

From a therapist point of view, this is a complex group of people which makes 'em important. And my final one is we should also think of the actual impact on the clients over their life and society. So the client's point of view, these are people who really suffer lots of physical ailments due to their anger, the effect on their body. They have really poor employment capacity, they don't hold jobs well. Their relationships can be limited and they can be very isolated people. So I think the consequences of not dealing with it make it important from a social point of view. We also have all the issues to do with social disruption, the forensic scene.

Tony McHugh (04:30):

All really good points. It makes me think of what the literature refers to as the hedonics of anger, how important it is to talk with people about the benefits and the costs of anger, given what you've said.

Glen Bates (04:44):



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Well, I reckon that's going to be one of our core messages across these two podcasts. Clients come to us with anger problems. They find it very difficult to actually weigh up the pros and cons of what's going on. They're involved in the emotion, the arousal of what's going on, and they often don't see other alternative ways of managing things and the implications of what they do. So I think we need to talk about that from the beginning of therapy.

Tony McHugh (05:14):

Which leads very nicely to the second topic I'd ask you to comment on. That is the issues that are encountered in anger work can be very difficult for mental health professionals to work effectively with clients with dysregulated anger. Would you care to comment on what it's like and how might a client's effect on a mental health professional be thought about?

Glen Bates (05:38):

The key element I think is when you're working with someone who's got dysregulated anger, that there's much more arousal in the room than we often work with. And it's also going back to my earlier point about externalising, it's directed at other people and of course that means it can be directed at you as a therapist. So I think that puts a lot of pressure on us to be able to respond in situations when there's lots of arousal, lots of distress, less sort of cognitive sort of stuff going on and more able to accept that some of that is coming towards me. And on top of that, depending on the client, you also need to take into account safety. So I think you need to know a lot about the client's history and what safety practises you might need to implement.

Tony McHugh (06:33):

That leads very nicely to the next thing I'd ask you to comment on, and that is that often clients who are angry don't understand their own anger and its effect on them and others. How important is it to discuss the nature of anger with clients with dysregulated anger? And if that's important, what would be important to convey?

Glen Bates (06:52):

Discussing what goes on in an anger response is a really useful way to start with the client and it's almost neutral or respectful approach to the client that you take in terms of trying to understand what's going on for them. Now, as you say, they may not recognise what is happening, they may also be blocking what is happening. One client I remember who talked about seeing red was what happened during his anger episodes, and that was an umbrella term to avoid the fact that he was violent in those situations. So we're getting people who come into the situation, I think feeling like they've got a very narrow range of things that they can do about their anger, thoughts that their anger is justified, thoughts that there's nothing else that they can do and that this is something that just hits them. I saw red, I got hit by this. I think what we want to do is to, and this is hard, this is a process of therapy, is to get them to step back from that a bit and to look at what are the costs and benefits, and then you introduce the word of management. We're not going to take your anger away from you. We're interested in how you manage it. And management doesn't mean giving in, it just means working on what happens in the situation.



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Tony McHugh (08:15):

That sounds very much like a motivational question. And motivation for change in anger differs from client to client. What are some of the ways in which it differs and why might those motivational differences exist?

Glen Bates (08:30):

I think it differs in a few ways and you'll probably add to some of this because I know you've had a lot of issues with clients with motivational sort of issues. But I think it comes down to a bit to how voluntary the client is in coming to see us to do something about this anger. And I think we have to start from the point of view that clients with anger problems often come as involuntary situations. They're brought to us by the police, they've got ultimatums in the family that their partner will leave if they don't do something about the anger. They come in really feeling forced into that situation to work with you. So I think working on what's in it for you to do something about this anger and balancing that with it's not giving in and submission, it's about things that are going to be in your interests is really important. So in this therapy, I think we have to work towards people having experiential evidence that things can be different, that when I get into these situations that provoke me, I can actually be different, I can step back from that. And I guess that's part of any sort of work we do with clients is that idea of knowing that things can be different. And the motivation component I think is getting to a point where they'll at least accept that it's worth me looking at different ways of dealing with the emotion.

Tony McHugh (10:00):

And there are gains to be made.

Glen Bates (10:02):

Yeah.

Tony McHugh (10:03):

Good. Now I believe you may have a couple of questions just to flip the roll there for a minute that you'd like to ask of myself.

Glen Bates (10:10):

Yep. What I'm interested in is again, building a bit on what we were just talking about. I'd be interested in hearing from you a bit about who are the people that really get angry and where is dysregulated anger likely to occur. If we're talking, it occurs in situations where and when.

Tony McHugh (10:29):

So obvious questions. I think in the attempt to normalise anger, I think it's important to say that it's a natural human emotion that occurs in response to certain things like stress and traumatic stress in particular. So people who get angrier, those who have experienced those kinds of events. But we don't want to think that post-traumatic experiences are absolutely required stress around work, stress around life's busyness and similar things. The negative life events of everyday life will produce dysregulated



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anger if there are enough of them. What we know, however, around what's likely to increase that dysregulation of things like childhood experiences, particularly experiences of violence and sexual assault, there are certain occupations that are more likely to experience increased frequency, intensity and duration of anger. They would include, for example, first responders, military personnel. So there are some startling statistics or data around the close connection between exposure to trauma in a disorder like PTSD and anger.

(11:51):

So we know for military folk for example, early career anger is so predictive of later dysfunction. We know that they are up to four or five times as likely to experience problematic anger as people who don't belong to those professions. And of course, the more complicated or the more frequent as is the case with police who I would have to say are the most traumatised people occupationally that you could possibly find. And the things that then happen as a consequence of commands, inability to support people in their response to those traumas. We've had a couple of particularly troubling events in the last two or three weeks in relation to crimes against citizens and crimes against police. So I think where those things are in play, people are going to be more angry. The problem is then that the anger kindles those disorders, be they anxiety disorders or stress disorders like PTSD and adjustment disorder. So there's an inevitable kind of connection between the affect and the disorder.

Glen Bates (13:03):

So that's really the things that are getting people likely to have problems from the workplace from their earlier childhood. And so the vulnerability sort of factors. Can you talk a bit more about the situations in which dysregulated anger is likely?

Tony McHugh (13:20):

I would point to the classic example of people who are working in first responder organisations, and it's very common for them to say that I have given great service. I have seen things that most humans don't get to see and have had to deal with them. One of the things that they say are the worst things that you can possibly experience is the delivery of death messages. Now the public doesn't think about that. So there's the shock horror component. There's the distress of seeing other distressed people and they have an amazing resilience that they build up over time. But then what causes them to become irritable is feeling unsupported. I'm going out and doing all these things and the organisation does not seem to care. And I think whilst that's not a traumatic situation, it's the tipping point or the thing that kindles often the PTSD like reaction and anger is really front and central to that. I'm doing these things and you don't seem to care.

Glen Bates (14:26):

So it's sort of like an injustice thing that people have?

Tony McHugh (14:30):

Yeah, institutional injustice is very much part of the picture. And that can be true of ambulance officers, fire personnel, emergency services personnel, even ESTA call takers in the call centres who have to



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sometimes hear quite difficult things if they feel whether it's real or perceived, if they feel, I think that's very much part of the picture that makes their conditions worse.

Glen Bates (14:56):

And do you see that in clients, not so much in their occupational sort of issues, but in informal connections with other people, other workplace sorts of settings?

Tony McHugh (15:06):

I think it's like if you're in a club and then the club doesn't want you anymore, you leave the club, it's a very bitter thing. And then what tends to happen is that that gets transferred on to people who have got nothing to do with the club - partners, children, parents, siblings, community members, et cetera, et cetera.

Glen Bates (15:30):

I think that generalisation sort of factor is really important, isn't it? Because you'll get, and it connects a bit to what we were saying earlier about not knowing quite where your anger is coming from, and certainly talking to parents who find themselves getting very angry. They've come from an organisation in the way you've described it, and it's got transferred onto people who aren't that target.

Tony McHugh (15:51):

And I think I would emphasise that when one's head is fairly much full of things that have happened in work or in abuse from childhood or assault as an adult, when you have a busy mind, it's very hard to think clearly and dispassionately and there's a sense of mental chaos and pressure and anger is a very ham-fisted antidote to that.

Glen Bates (16:19):

I remember having a conversation with one stage where you came up with the elevator of affect.

Tony McHugh (16:23):

It was a long time ago.

Glen Bates (16:24):

Yeah, I still like it. Which the idea of as you go up, as the arousal goes up, the cognitive capacity to reflect on these things goes down.

Tony McHugh (16:34):

Correct.

Glen Bates (16:34):



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And the impulsivity sort of action comes up. Okay. So you've sort of addressed this, but the other thought I had is what's likely to increase anger's frequency, intensity, and duration and impact exposure to trauma?

Tony McHugh (16:49):

To summarise exposure to trauma? I think the sense of being let down is palpable. We know for example that in PTSD, there are three predictive factors or sets of factors, pre-trauma, life pre-traumatic experience, what was the trauma like? And thirdly, and most importantly, what happens after the trauma. So if people feel cared for by the employing organisation, by the system that is dealing with their traumatic or stressful experiences, including the employer, sometimes including the insurer in compensable schemes, if they feel cared for and understood, they will have better outcomes. Where the opposite applies, of course they don't have better outcomes.

Glen Bates (17:41):

Tony, I'm interested in hearing a bit more about what you're saying about the process characteristics of therapy and when they might be.

Tony McHugh (17:50):

Thanks, Glen. It's a crucial question. I think there is a natural sequence of events that take place in any therapeutic endeavour from assessment to completing with people. And what I'd say about process characteristics in relation to dysfunctional anger is to talk about them, help clients understand them. It's best that it's done early, very early. It's a session one, two or three kind of thing, I think. And what I'd say is also it's important as we'll talk more about it in podcast two in a fortnight, it's a stage process moving from development of awareness of the problem or establishing that is a problem that the client is willing to own through to active treatment. And I'd add that it's really important along those stages to tailor the interventions inverted to client's style. There are horses for courses and we need to enable people to follow their own treatment while mentoring, coaching, supervising, et cetera. And that they do it on the basis of a personalised model of how they're going to move forward. That involves them drilling the routines, drilling the intervention techniques that we think will be suited to them. So I think the importance of doing it cannot be overestimated. It's really important. It's a roadmap. And I think clients, when they're struggling with dysregulated anger, want a roadmap.

Glen Bates (19:37):

The other point I was reflecting on there is understanding the treatment process characteristics with the client. Do you think that's an important aspect of working with dysregulated anger?

Tony McHugh (19:49):

I can't place enough emphasis on this, Glen. I think it's critically important. You were saying before that people come for all kinds of different reasons. They reluctantly seek out treatment for this dysregulated anger or they understand that they need to do something or they're coming sometimes because they've got a crook gut and headaches and they don't understand why. So they can be there with all those mixed motivations wanting, I think to change in some respects, but fearing change in another respect.



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It's the old give them an inch, they'll take a mile, that sort of thing. And it's really, really important to walk people through what treatment looks like. It will be paced, it will be guided. It will involve evidence-based treatment interventions, which we'll talk more about next fortnight. But it's not something that is shapeless and formless. It's certainly not about creating aggravation in them to test them.

(20:51):

It's anything. But it's also not about endorsing worldviews. It's not about avoidance. We don't get better at dealing with anger and the things that lie below it, like anxiety and emotions like guilt and shame. By avoiding the anger it incubates, it gets worse. So to go down that kind of therapeutic path, people need to understand and be involved in and co-lead the process. So it's at their pace. It's going to involve challenge inevitably, but those challenges won't be beyond their capacity. It's really getting and helping clients to understand and know the process and know us and us know them.

Glen Bates (21:41):

Yeah, I reflect on that and think there's also this notion of getting across the client that they can still act effectively even when anger is aroused, that anger is, as you said earlier, it's a normal human emotion. It's not something we want to get rid of. It's actually quite a useful information for yourself. It can be quite adaptive in what you are doing. But what we're dealing with is problem anger when it goes too much further. And I think in that situation, as soon as people become aware, start to become aware of that anger, arousal, there's a big temptation to avoid. Avoiding takes the emotion away, but as you say very clearly, it makes it worse the next time. If you stay in the situation, that's where you get that I can actually function. I can do different things.

Tony McHugh (22:29):

I think there's a telling example of that Glen and I didn't necessarily anticipate talking to this and I have to talk to it sensitively. So it's not uncommon for people when they've been struggling with stress or and trauma related matters, the classic being PTSD, that they're angry and the anger gets in the way of recovery from the PTSD and they become isolated. They literally can live in isolated locations by themselves with a companion that is not a human because canine quadruped provide comfort, but the quadruped then becomes a barrier to actually meeting challenges and undertaking events that might lead to growth. I can remember when I was at a certain hospital and involved in treating folk who had PTSD, one of the reasons advanced for them not being able to come in for treatment was that they had to look after their canine friend. So that's where a device that seems like it might initially be very helpful actually becomes an impediment to wellness. So dogs, sorry to say, I've got two of the best dogs in the world. The dogs become an avoidance mechanism - isolated, apart from family, living with dog, not a good outcome.

Glen Bates (24:00):

Although being a dog person, I guess there's something you get from the dog. What your point to me is that it's something that is getting in the way of you taking the next step and reconnecting with people. And going back to our earlier point of that, one of the big problems of anger is that sense of isolation. And people get reputations, they get isolated, and there's this nasty interaction that occurs that, again,



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thinking of particular clients here, where you have someone who's a very powerful, strong looking character and everyone's scared of them and scared of their anger, and that gives them some sort of sense of integrity. But what it does is preclude any other interaction with people. And so they become more isolated. And I think a lot of what we see underneath the anger is that they haven't developed ways of interpersonal problem solving, engaging with other people, communication styles, all those sort of fundamental skills that I think anger gets in the way of them developing. So you get that isolation lonely sort of feeling.

Tony McHugh (25:09):

My thought in picking up on your idea is that humans are the great social animals.

(25:16):

They do best when they have adequate connection to other humans. And anger can be sufficiently alienating to cause that not to occur. And also I think when people have a sense of what's going on for them from an anger point of view, they can be self-critical and that doesn't help as well. So I think it's an amazing emotion. I've become more amazed about it the more I've thought about it and it has so many connections that other emotions don't necessarily have. But when it gets in the way of social connection, I think that that's really incredibly important and needs to be well raised more correctly with clients. So I think we've covered a lot today in this first episode of our podcast series. Thank you for joining us for this episode of MHPN. It presents a conversation about maintaining effectiveness and achieving outcomes for and with clients challenged by dysregulated anger.

(26:21):

You've been listening to me, Tony McHugh and -

Glen Bates (26:25):

Glen Bates.

Tony McHugh (26:25):

Today we've talked about the importance of addressing anger, some of the issues that might be encountered in anger work, the nature of anger, the importance of conveying that to clients, the importance of client insight and motivation for change, the prevalence of dysregulated anger, what increases it, and what makes understanding and sharing process characteristics important in working with anger. We've also touched on the sociality or the lack of sociality attached to anger and some things that make for greater anger control and lesser anger control. We hope this has been of value to you. If you want to learn more about Glen or myself, or if you want to access the resources we've mentioned, go to this episode's landing page and follow the hyperlinks. Join us again in a fortnight for the final episode in this series where we'll continue to conversation by exploring the problem of anger, rumination and existential circularity, the utility of explanatory theories or models of anger, the duality of anger and the problem of anger blindness, a very interesting concept, the signs of the need for anger focused work, proven anger interventions, and what support and resources there are for mental health professionals working with clients with dysregulated anger.

(27:46):



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Thank you for your commitment to ongoing learning and multidisciplinary mental health care. Bye now.

Host (27:54):

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