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EXAMINING FEARS OF COMPASSION AS A POTENTIAL MEDIATOR BETWEEN SHAME AND ANGER

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MASTER'S THESIS

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ABSTRACT

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To date, there is a great deal of research supporting the correlation between experiences of shame and struggles with clinical anger. What has received less attention is the nature of this relationship. The current study sought to explore the nature of shame's correlation to clinical anger by analyzing fears of compassion—the reluctance or inability to experience compassion for others, to accept compassion from others, and fear of directing compassion to the self. It was hypothesized that fears of compassion would function as a mediating variable between shame and anger. Participants were administered self-report questionnaires measuring levels of anger, shame, fear of compassion for others, fear of compassion from others, and fear of compassion for the self. The results revealed that the fears of compassion, although significantly related to both shame and anger, did not significantly reduce the correlation between shame and anger, and therefore, did not function as a mediator. Future research regarding the nature of the shame-anger relationship might benefit from exploring other related areas such as attachment, trust, and resisting self-attacks as possible mediator.

Examining Fears of Compassion as a Potential Mediator Between Shame and Anger

Psychology research on emotional difficulties has placed a strong emphasis on depression and anxiety. However, although understudied, research suggests that anger is another emotion that can have significant implications for individuals as well as society. Social media and news reports reflect much hostility in the recent United States presidential election, with presidential debates deteriorating into disparaging comments and name-calling and political rallies escalating into violent aggression and destruction of property. We could point fingers at the current cultural and political climate, but the truth is, anger has been around for as long as humanity.

Although anger may often be regarded as an unhealthy emotion, it originates from a healthy drive for self-preservation in the face of perceived threats (Gardner & Moore, 2008; Kolts, 2012). According to Denson, Grisham, and Moulds, people get angry when they feel that something is getting in the way of their goals (2011). This healthy drive, however, can become problematic when it is applied to situations in which it isn't adaptive. The Diagnostic Manual of Mental Disorders, 5th Edition does not currently have a category for anger as a clinical diagnosis. However, it is clear that clinically significant levels of anger exist, often presenting as a symptom of other diagnosable psychopathologies such as the various depressive disorders, bipolar I and II disorder, and PTSD (American Psychiatric Association, 2013). When anger becomes maladaptive to the point that an individual experiences "heightened intensity, frequency, and duration of anger [that leads to] a variety of interpersonal, health, occupational, and legal difficulties" (Gardner & Moore, 2008, p. 898), it is considered by some researchers to be "clinical anger" (Gardner & Moore, 2008).

When someone is swept up in a pattern of clinical anger, it tends to be accompanied by a variety of other problems. Additionally, many individuals who struggle with clinical anger also tend to have similar environmental backgrounds. Some of these include child maltreatment and highly critical or shaming style of parenting (Bennett, Sullivan, & Lewis, 2005; DiGiuseppe & Tafrate, 2007).

Clinical anger is also associated with problems with physical health. Ailments such as hypertension (Spielberger, 1992), coronary heart disease (Suls & Bunde, 2005), and other illnesses of the heart (Anderson & Smith, 2003) have all been linked with elevated anger. This becomes extremely relevant because heart-related diseases are "the leading cause of death in the United States (Anderson & Smith, 2003) and other developed countries" (World Health Organization, 2003, as cited by DiGiuseppe & Tafrate, 2007; p. 246).

In addition to physical problems, anger can cause a variety of social and emotional strains on a person's functioning. If a person struggles with recurring anger problems, it can have a very hurtful impact on the people close to them. Many of the behaviors of the person with clinical anger can result in strong guilt, remorse, or shame after an episode of anger. There can be a great deal of regret over bad decisions made during the experience of anger, and this can contribute to further negative emotions, fueling a cycle of toxic relationships (Kolts, 2012). Unfortunately, these behaviors often escalate to aggressive behaviors or violence (Roberton, Daffern, & Bucks, 2015). Oftentimes, these behaviors can lead to legal problems (Gardner & Moore, 2008) and even ending up with the individual being sentenced to prison time (Gardner & Moore, 2008; DiGiuseppe & Tafrate, 2007).

The Anger Experience

Though everyone has experienced anger in some form and could probably describe its nature, it is helpful to give an overview of the progression of anger. The most obvious aspect of anger is felt emotional experience. This tends to manifest itself through physical signs such as a muscle tension (Ax, 1953) racing heart, heightened breathing, and a feeling of being hot (Scherer & Wallbott, 1994). Attention, the brain's capacity to filter information, is also affected with the onset of anger (Eckhardt & Cohen, 1997). The attention will be focused only on the source of the perceived threat and therefore prevents the person from absorbing other unrelated information. This plays into a person's thinking and reasoning. Since the person's attention is so intent on his or her experience of anger, he or she will begin to view things through a "lens" of anger by way of automatic thoughts, rumination, and generalization (Eckhardt & Kassinove, 1998; Jones & Trower, 2004; Takebe, Takahashi, & Sato, 2016). Angry imagery or fantasy feeds into the maintenance of the angry feelings by causing a person to play images in his or her mind of perceived threats, whether real, imagined, or potential (Foster, Smith, & Webster, 1998). The normal reaction of anger serves the purpose of self-preservation. Therefore, the motivation driving anger is to protect the self (or others) from perceived threat (Gilbert, 2015). This motivation drives a person's behavior—which is the final and outward manifestation of a person's anger. The behavior of anger can be quite diverse, ranging from overt aggression to subtle withdrawal (DiGiuseppe & Tafrate, 2007).

State vs Trait Anger

This leads us to discuss the distinction between state versus trait anger. In the case of state anger, a person has a temporary experience of anger, typically for a relatively

short period of time. It manifests in physiological experience of anger—characterized by sympathetic nervous system activation and experiences such as muscle tension as well as the felt experience of angry emotion, with associated feelings of urgency that subside over time (DiGiuseppe & Tafrate, 2007). Trait anger, however, is a more steady and chronic characteristic comparable to a personality trait. This reflects a person's tendency and level of anger over the long-term course of his or her life (Roberton et al., 2015).

Anger vs Aggression, and Violence

It is also important to distinguish anger from aggression and violence. While some people might struggle with anger, they might not exhibit aggression or violence. Although they can sometimes manifest similarly, anger and aggression are distinctly different. For example, a person exhibiting violence might not always be dealing with anger. According to Roberton et al., aggression is "behavior directed toward another individual with the immediate intention of causing harm" (2015, p. 74). Violence is "aggression with extreme harm as its goal" (2015, p. 74). Anger, on the other hand, is "a subjective emotion accompanied by experiential and physiological responses that unfold in response to specific stimuli" (2015, p. 74). Anger is expressed in a variety of ways and tends to be a more broad-spectrum emotion, which may or may not be expressed through violence or aggression. While violence and aggression may be related to anger, it may also stem from more specific purposes, such as in instrumental aggression, which is performed to achieve a specific goal (Roberton et al., 2015). While there is frequently a correlation between anger and aggression or violence, this study seeks to focus particularly on anger and some of the potential contributors to clinical anger.

Models of Anger

Cognitive content specificity model.

There have been different theoretical models regarding the development of clinical anger. The most common model, according to Gardner and Moore, is the cognitive content specificity model (2008). This model conceptualizes anger as an emotional response to irrational beliefs, perceptions, or expectations about the behaviors of others. This model attempts to explain the correlation between anger and aggression by viewing aggression as a way to dispel intolerable feelings of anger. Additionally, the aggressive behavior is also perceived as achieving a means to a desired end. The results achieved by aggression positively reinforce the aggressive behavior as a response to anger. For example, if aggressive behavior (pushing someone) causes them to retreat and leave you alone (desired result), the aggressive behavior becomes reinforced because the desired end was accomplished (Gardner & Moore, 2008).

However, recent evidence suggests that the cognitive content specificity model may be founded on some problematic assumptions (Santanello, Gardner, & Moore, 2008). For one, it assumes that anger is an unhealthy emotion in and of itself. On the contrary, anger can be a healthy human response to perceived injustices. It is only when it has become maladaptive that it warrants therapeutic intervention. Another problem is that many of the current anger interventions based on this model have not demonstrated the expected results. Finally, the cognitive content specificity model has not incorporated more recent research into its core presuppositions (Gardner & Moore, 2008).

Anger Avoidance Model.

A newer conceptualization of anger has been suggested by Gardner and Moore, called the Anger Avoidance Model (2008). This theory draws ideas from another model designed by Clark and Watson (1991), referred to as the Tripartite Model of Anxiety and Depression. This theory proposes that most psychopathologies come from different variations of three factors: negative affect, positive affect, and autonomic arousal. The variations within these three types of symptoms are all seen as manifestations of the same phenomena, referred to by Barlow (2004) as negative affect syndrome (NAS). For example, depression is seen as a manifestation of low positive affect, moderate to high negative affect, and low levels of arousal. Anxiety is characterized by moderate to high positive affect, moderate to high negative affect, and moderate to high arousal. But these would each be considered a subset of NAS. Therefore, when looking at anger through the clinical construct of NAS, it would be viewed as demonstrating low levels of positive affect, moderate to high levels of negative affect, and moderate to high arousal (Gardner & Moore, 2008)

Biological and Psychosocial Contributors to Anger.

This view of the development of emotional disorders suggests that the development of these psychopathologies depends on three interacting processes. The first is the person's genetic and biological predispositions. A person's genes will influence his or her unique strengths and vulnerabilities, which interact to create the person's overall temperament. These biological predispositions have an impact on the development of an individual's tendency toward experiencing varying levels of physiological arousal, which

influences whether the person has a relative resilience or are at risk for the development of problems with anger (Gardner and Moore, 2008).

The second process is a psychological one. A person's upbringing and psychosocial experiences will lead to tendencies to view the world in certain ways. Individuals who struggle with anger often develop a view of the environment as uncontrollable. This sense of a lack of control can then contribute to general affective states that are organized around experiences of threat. This tendency is seen in patients who struggle with anxiety as well, but the two have been shown to respond differently, with anxious patients reacting with "flight," whereas anger patients respond with "fight." Both of these responses are seen as resulting from the combination of the individual's biological and psychosocial makeup (Gardner and Moore, 2008).

Finally, the third process is a union of both the biological foundation and the influence of psychosocial history. From Gardner and Moore's perspective, these two variables combine to create a dysfunctional process called information processing bias (2008). Information processing bias develops in people with clinical anger and occurs when their view of the environment is colored with an expectation of violation or harm from situations or people. As mentioned earlier, a person's thinking and reasoning becomes distorted by their anger bias, which leads him or her to expect that other people mean them harm. Gardner and Moore have coined the term "hostile anticipation [to describe] the angry patient's perseverative hypervigilance for signs of hostile intent and personal violation" (2008, p. 905). In this way, the individual's biology, psychosocial environment, and the interaction between the two can lead to a lifestyle that is organized around anticipation and experiences of threat.

Overregulation

Research has explored different ways that people try to regulate their anger. One of the most problematic methods is overregulation. Overregulation, also known as emotional suppression, is essentially a neglect or avoidance of one's emotions. This strategy attempts to hide or inhibit unpleasant thoughts or emotions, rather than experience them fully as they come. While employing this emotional inhibition in small doses for situations which promote an individual's personal goals can be adaptive (such as concealing anxiety during a job interview), if this becomes a person's regular response to any emotional distress (avoiding thinking about an impending school assignment because of the anxiety this provokes), this avoidance strategy becomes a rigid cycle that furthers the individual's distress (Kashdan, Barrios, Forsyth, & Steger, 2006). According to Roberton et al. (2015), this attempt to regulate anger has generally shown to increase aggressive behavior and comes with a host of other problems. This suppression actually leads to an increase in general negative affect as well as an increase in physiological arousal. Additionally, it can cause people to become so fixated on their avoidant thinking that they lose their capacity for goal-directed thought, which is needed for them to act with positive goal-directed behavior. In other words, suppression limits a person's ability to tap mental resources, which might assist decision-making and problem-solving processes even in the face of anger activation. This can cause problems in interpersonal relationships as this unhealthy dysregulation of anger results in lack of resolution of the problem initially causing the anger, further fueling the anger (Roberton et al., 2015).

Controlling Aggressive Behavior

There have been a variety of interventions designed around helping people to control their anger as an attempt to prevent aggressive and violent behavior. However, research shows that a more effective way of helping people manage their anger is to emphasize the ability to control their behavior in the midst of the experience of anger rather than trying to avoid the emotion itself. Attending to one's emotions (as opposed to suppressing them) appears to be an important aspect of learning to control one's behavior in the face of anger. Part of attending to one's emotions is recognizing that they serve a function, one of which involves recognition of one's personal values. For example, examining the reason for a person's anger may highlight something that he or she personally values that is currently being blocked or threatened. This awareness can help individuals to control their anger and prevent resulting aggression (Roberton et al., 2015).

As I will discuss later, having an ability to be aware of and attend to one's personal distress has an impact on a person's ability to deal specifically with anger as well as some of the possible links to anger. The specific links this study seeks to explore involves the relationship anger has with shame, compassion, and fear of compassion. A body of research shows that early childhood shaming, strong experiences of shame, or traumatic shame experiences appear to be linked with clinical anger later on in life (Shanahan, Jones, & Thomas-Peter, 2010; Bennett et al., 2005; Milligan & Andrews, 2005; Hejdenberg & Andrews, 2011; Harper & Arias, 2004; DiGiuseppe & Tafrate, 2007). Additionally, research has suggested a relationship between shame and a lack of or fear of compassion (Gilbert, 2009; Kelly, Carter, Zuroff, & Borairi, 2013; Gilbert, 2014; Gilbert & Procter, 2006), which itself may interfere with soothing processes that might

assist individuals in working with anger. The goal of this study is to examine how these constructs may be connected in ways which may contribute to the experience problematic of anger. I will begin by examining shame, how shame develops, and research suggesting how shame may be a perpetuator of anger.

Shame

Benjamin Franklin said "Whatever is begun in anger ends in shame" ("Quotes about Anger", n.d., http://www.quotestreasure.com/topics/anger). While there may be some truth to this, research is beginning to paint a picture of just the reverse: when a person's early years are entrenched with shame, this may lead to a cycle of anger.

Shame is the experience of the self as bad or the belief that others view the self as bad. As Matos & Pinto-Gouveia put it, shame is "the internal experience of the self as undesirable, unattractive, defective, worthless and powerless" (2009, p. 300). Shame has been hypothesized to take external or internal forms (Gilbert, 1998). In the case of external shame, the feelings of shame are a result of judgment or perceived judgment occurring from others in the environment. External shame comes from ideas that an individual perceives others have about them. Internal shame, on the other hand, is an internal perception that the self, or aspects of the self, are bad. This can take many forms—for example, a view of the self as disgusting or deserving of hate (Kelly and Carter, 2012).

Shame is thought to result from the formation of beliefs about the self which develop from early experiences with a significant other. Shame is thought to occur following the development of primary emotions, because it requires the development of certain cognitive capabilities first. It is thought that in order for people to have a sense of

shame, they require the capacity for self-awareness, self-evaluation, and a sense of evaluation by others (Matos & Pinto-Gouveia, 2009). The ability for such self-awareness emerges around age 2 ½ to 3 years. This self-awareness produces the capacity to experience self-evaluative emotions such as shame, guilt and pride. The child develops the ability to have beliefs about themselves and a sense of self-worth.

These types of emotions become especially apparent when the child is faced with failure. The child's emotional response to personal failure provides an indication of their self-beliefs and expectations (Bennet et al., 2005). Research has shown that, in general, girls tend to experience more shame than boys. It has been suggested that boys tend to manifest their shame through displays of anger. This may also explain the trend in which girls tend to have more internalizing problems whereas boys experience more externalizing problems (Bennett et al., 2005).

It is possible that early experiences of shame or shaming from others may result in a predisposition to develop psychopathology. One study examined individuals with early experiences of shame and found that these memories functioned similarly to the way early trauma memories function in the development of psychopathology (Matos & Pinto-Gouveia, 2009. Individuals who experienced early shaming had symptoms consistent with trauma experience such as intrusive memories, attempts to avoid reminders of the experience, and increased physiological arousal. These researchers also found that shame and traumatic shame memories explained a large portion of the depression variance found in the research sample. In sum, "individuals who experienced shame as more traumatic are the ones who show more depressive symptoms" (Matos & Pinto-Gouveia, 2009, p. 308).

Shame vs. Guilt

In understanding shame, it's important to make the distinction between shame and guilt. Though they can occur simultaneously, shame and guilt stem from different experiences of the self. Guilt is associated with the view that one has *done* something bad, whereas shame is a deeper, more pervasive, sense that the self *is* bad (Parker & Thomas, 2009). While guilt can be a very painful emotion, it can provide the impetus for repairing the perceived wrong. Shame, on the other hand, is a more global and inescapable experience because it is based on views of self-identity. If someone believes that they are at their core "bad", this is a much more emotionally damaging experience than the temporary experience of guilt (Tangney, Wagner, Fletcher, & Gramzow, 1992).

Problems Linked to Shame

Shame is linked with a variety of interrelated problems. People struggling with shame commonly come from socio-emotional backgrounds of abuse or rejection. Internalized pathological shame also appears to be related to a variety of other social or emotional issues such as recidivism, depression, eating disorders, and problems with emotion regulation. I will discuss a few of these now.

Child Maltreatment.

One pattern that has been consistent in the research literature is that people who struggle with shame may come from abusive backgrounds. A study conducted by Bennet et al. (2005) revealed that children who had been physically abused tended to have high levels of shame. Another study showed that harsh or rejecting parenting techniques during childhood also lead to higher levels of shame during adolescence. Of the varying

types of abuse, maltreatment colored with a fundamental sense of rejection or harshness appeared to be the strongest contributor to shame (Stuewig & McCloskey, 2005).

Recidivism.

Shaming has been linked with recidivism. A study completed by Murphy and Harris examined stigmatic disapproval, a type of shaming used in the rehabilitation of criminals. This method of rehabilitation shamed the criminals for their crimes and tended to use disparaging labels identifying the individual with their crime. This type of shaming did not offer opportunities for forgiveness and reconciliation and tended to result in higher rates of recidivism than when a less degrading method of rehabilitation was used (2007).

Depression.

Another pervasive problem linked with shame is depression. Some studies found depression to be more strongly related to shame than to guilt. In a study using the Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002) and the Tests of Self-Conscious Affect (TOSCA), results showed that shame played a significant role in the onset and maintenance of depression. The same result was found even when controlling for general experiences of negative affect measured in any of the scales (Andrews et al., 2002).

Self-criticism.

One of the most common correlations with shame found in the literature is self-criticism. Research suggests that one of the underlying commonalities of people who struggle with feelings of shame is a generalized self-criticism. Self-criticism is "a personality trait characterized by an excessive focus on achievement, harsh self-

evaluation, and strong fears of failure and rejection, and has been linked to early experiences with critical, controlling, and/or insufficiently warm carers" (Kelly & Carter, 2012, p. 150).

Eating Disorders.

Kelly and Carter found evidence to support the theory that shame mediates the relationship between self-criticism and eating disorders (2012). In general, research suggests that the relationship between shame and eating disorders is entirely explained by the function of self-criticism. Another study of eating disorders suggested that self-criticism is actually used as a way of trying to control behavior in order to avoid shame. However, this self-criticism tends to lead to the development of unhealthy behaviors resulting in eating disorders such as anorexia nervosa and bulimia nervosa (as well as other psychopathology) which then results in compounding the experience of shame (Kelly et al., 2013).

Insecure Attachment.

One study found self-criticism to be strongly correlated with insecure attachment styles, including fearful, dismissing, and preoccupied styles of insecure attachments. This same study also compared parenting style and their relationship to level of self-criticism. Facets of self-criticism were positively associated with parental rejection and somewhat with overprotection. Given self-criticism's role in the experience of shame, one might speculate that early shaming or rejection may have perpetuated the development of an insecure attachment in the first place (Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006).

Self-reassurance.

An important finding from the above study was that while self-criticism had a strong influence on a person's self-evaluation, the ability to self-reassure had an even stronger influence. This suggests that cultivating a person's ability to direct warmth or compassion toward the self will go farther than simply eliminating self-criticism (Irons et al., 2006).

This research suggests the presence of a positive affect regulation system which gives people the ability to self-reassure. Studies show that affiliative emotions and the cultivation of warmth toward the self tend to develop within the context of caring relationships. These warm and supportive relationships promote activation of oxytocin, vasopressin, and the opiate brain systems, parts of the brain which help us to feel safe, secure, and connected to other people. The implications of this study are that if therapeutic methods for promoting self-warmth can be developed, it is possible that people can work toward creating self-soothing to help combat their experience of self-criticism (Irons et al., 2006).

Self-soothing.

Much of what underlies peoples' shame and self-criticism seems to be related to problems within their ability (or not) to engage with soothing. This soothing affect-regulation system, which will be discussed later, is thought to develop in conjunction with the attachment system and involves a person's ability to respond to distress by directing kindness or warmth toward the self in order to alleviate unpleasant feelings. According to attachment theory, this ability to self-soothe would ordinarily develop naturally with the presence and nurturing of a loving attachment figure. In the absence of

such a relationship, however, a person struggles to develop the necessary foundation for dealing with his or her emotions independently or for benefiting from compassion offered by others. One of the interventions thought to help with this process in people with high levels of shame and self-criticism is compassion-focused therapy (Gilbert, 2009).

Self-compassion.

Many studies support the idea that shame is a precipitator and maintainer of many types of psychopathology (Matos & Pinto-Gouveia, 2009; Kelly & Carter, 2012; Andrews et al., 2002). It follows then that targeting shame in the therapeutic context may help to alleviate some psychopathologies. Gilbert (2005) suggests that the best way to help people work through shame is to help them nurture self-compassion. Self-compassion has been summarized as "a response to suffering characterized by self-kindness rather than self-judgment, a mindful rather than ruminative stance, and the perception that one's problems are part of the human condition rather than isolating" (Kelly et al., 2013, p. 253). If self-compassion can help a person work with shame, it is important to look at the process occurring behind compassion--a process I will discuss in the section on affiliation and the safeness system.

Anger and Shame

In this project, I'm particularly interested in exploring the relationship between shame and anger. The literature has shown a definite link between shame and anger and researchers have attempted to determine what the nature of that relationship might be.

Child Maltreatment.

One definite factor seems to be child maltreatment. Though not always the case, research suggests that individuals who experienced child maltreatment and constant

shaming in childhood have a tendency to develop behavior problems as children and anger problems later on in life. While shame was not found to be directly associated with behavior problems, it was found to be indirectly associated through anger. In other words, child maltreatment led to shame, which led to increased anger, which mediated the relationship between shame and behavior problems (Bennett et al., 2005)

Irrational Beliefs.

Another quality of both anger and shame is a tendency to get caught up in irrational beliefs and thinking patterns. A person inundated with messages of shame and criticism as a child will often internalize many of these negative messages about themselves (Shanahan et al., 2010). Additionally, these negative thinking patterns can manifest themselves though anger (Martin & Dahlen, 2004). As discussed in the section describing the experience of anger, one of the major facets of anger is an information bias toward viewing a situation through an angry lens. A person caught up in anger can twist their perception of a situation (for example, by attending to some aspects of the situation while neglecting others) so that it fits his or her anger schema, thus leading to patterns of irrational beliefs (Kolts, 2012).

Self-esteem.

One of the strongest commonalities found in people who struggle with both anger and shame is a lack of self-esteem. One study found that individuals with clinical anger also had low self-esteem and a strong negative evaluation of the self (Jones & Trower, 2004). Beck holds that people who are angry may have negative beliefs about themselves. They assume that others hold the similar views, and that this can be a contributing factor to their anger (1999). As a way of trying to distract or defend against

their negative self-beliefs, they will instead engage in other-downing thoughts, which lead to anger at the other person. This may shed some light onto how anger appears to develop from a foundation of shame-related thinking (Shanahan et al., 2010).

Self-soothing.

Both shame and anger have been related to difficulties with self-soothing. Shame and constant self-criticism can have a powerful shutting-down effect on a person's emotion-regulation. "To experience 'self' as 'living in the minds of others' as a rejectable person…can have a powerful inhibitory effect on information processing" (Gilbert & Procter, 2006, p. 354). It is proposed that powerful experiences of shame can inhibit people's ability to understand their own feelings and of how to soothe their pain. When this shame becomes internalized, a person experiences the world as unsafe—both inside and out. The individual basically views the world through a lens of self-condemnation in which he or she cannot, and do not, deserve to direct kindness and warmth to the self as a means to calm these overpowering feelings of threat (Gilbert & Procter, 2006).

There are a variety of studies documenting the relationship between difficulties with self-soothing and maladaptive anger. According to Martin and Dahlen, people with clinical anger tend to resort to rumination, catastrophizing, and other-blaming as a means of coping (2005). In a study by Besharat, Nia, and Farahani, maladaptive emotion regulation strategies were positively correlated with clinical anger symptoms. Anger was also found to be related to depression through the mediating role of impaired emotion regulation (2013). In a study looking at female-perpetrated psychological aggression, emotion-regulation difficulties were linked to psychological aggression because of the mediation of trait anger (Shorey, Cornelius, & Idema, 2011). Clearly, many aspects of

both anger and shame seem to be related to difficulties with emotional self-soothing. The question we now turn to is, where is this difficulty arising from? What functions as the catalyst of self-soothing difficulties?

Compassion

So far, I have addressed many factors which appear to contribute to the link between shame and anger. The current study seeks to examine compassion as a possible mediator between shame and the development of clinical anger. Before looking at this relationship, however, I will clarify what compassion is and look at what research suggests happens when a person develops an aversion or fear of compassion.

The Dalai Lama, quoted by Gilbert, McEwan, Matos, and Rivis (2011, p. 239) described compassion as "an openness to the suffering of others with a commitment to relieve it." Recent research has focused on compassion, and on attempting to operationalize what compassion looks like when it is experienced and manifested. For example, compassion involves the motivation to care for someone, sympathy for suffering, an ability to withstand difficult emotions, and the capability to relate with empathy and/or acceptance (Gilbert et al., 2011).

Research has examined compassion and how it can be directed. Gilbert has specifically discussed three different "flows" of compassion. The idea is that compassion can flow outward from oneself toward others; it can be accepted from others toward the self; and it can be directed internally toward the self. There has been growing attention on how the presence of self-directed compassion (called "self-compassion"), or lack thereof, can influence individuals' affect and ability to self-soothe in times of crisis (Gilbert et al. 2011).

Compassion for Others.

With regards to compassion directed toward others, this emotion tends to be elicited in response to another person's suffering and is accompanied by a desire to help or to alleviate it. Compassion for others has been shown to be correlated with prosocial behavior and even psychological and physical well-being, as reflected in increased activation of the vagus nerve and heightened overall parasympathetic autonomic nervous system activity (Stellar, Cohen, Oveis, and Keltner, 2015). This type of compassion is thought by some researchers to have evolved as an adaptive survival response, prompting caregiving behavior, such as that required for the survival of human infants, who are essentially helpless for a significant amount of time after they are born (Stellar et al., 2015). Compassion for others has also been associated with a higher likelihood of accepting social support from others and thus a greater protection against sickness (Cosley, McCoy, Saslow, & Epel, 2010).

Compassion from Others.

When a person can accept compassion or support from others, it provides a buffer against many mental ailments, and some evidence suggests that it can help avert certain physical illnesses as well (Cosley et al., 2010; Broadhead et al., 1983). It is part of being human to need and desire positive and warm feelings from others. This compassion or warmth helps us to feel connected and like we belong. It also helps us to feel safe. Compassion given from others communicates that we are loved and safe and that support is available to help us handle any unpleasant emotions we might experience. Problems develop for a person if he or she does not experience this compassionate warmth at a young age (Gilbert & Procter, 2006). The literature on secure versus insecure attachment

provides a significant example of the important role of caregiving responses to distress in the course of human development.

Compassion for the Self.

When looking at compassion directed toward the self, Neff (2003) discusses the three aspects of self-compassion, which echo the response of compassion one might direct toward or accept from another. The first is a willingness and ability to extend kindness to the self. This includes an ability to express empathy for personal suffering or failure instead of harshness or self-criticism. The second component is common humanity. This is the understanding that everyone goes through experiences of human suffering, and that these shared experiences are part of what it means to be human. This is accompanied by a sense of connectedness or of solidarity, rather than of isolation or separation.

The final component of Neff's operationalization of self- compassion is mindfulness, or an ability to view one's own cognitive or emotional experience from an objective stance, along with a non-judgmental acceptance of these thoughts and feelings. This requires a balance between accepting and fully experiencing the range of one's emotions while also viewing them with empathy and understanding. Mindfulness protects people from over-identifying with their negative emotions. When people over-identify with their emotions, they become so overwhelmed and entrenched with these feelings that there is a sense that they *are* their emotions. They feel as though these feelings are somehow intrinsic to who they are and thus, rather than being a temporary experience, they are perceived as a permanent state of being, which can create a real sense of helplessness within the individual (Neff, 2003).

Self-compassion vs. Self-esteem.

Self-compassion and self-esteem, though similar, are driven by different motivations. Self-esteem goes up when we are doing well, whereas self-compassion comes into play when we experience failure. Self-esteem focuses on how well we are doing, often in comparison to others. Self-compassion, however, focuses on ways we are all similar and commonalities of the human experience (Gilbert, 2009). Self-compassion is characterized by unconditional positive regard or warmth toward the self despite the experience of failure. Self-esteem, on the other hand, is a sense of personal value and self-efficacy that is more dependent upon a person's experience of success and how they have achieved in comparison to others. In the face of failure or suffering, a person with high self-compassion accepts and validates themselves as opposed to shaming themselves. This self-compassion serves to soothe and reassure the self in a way that might reduce the sting of shame (Kelly & Carter, 2012).

One study compared people with high versus low levels of self-compassion apart from self-esteem. Results showed that individuals with higher levels of self-compassion experienced less frequent and less severe psychopathology and had higher levels of subjective well-being and social connectedness. In other words, trait self-compassion was a protective factor distinct from any positive effects from self-esteem (Kelly & Carter, 2012).

Fear of Compassion

Work with clients through compassion-focused therapy has revealed that some people can experience fears of compassion—reluctance to direct compassion toward themselves or to accept it from others. Research suggests that these individuals

commonly feel that their self-criticism is helpful in preventing them from becoming undesirable or unpleasant people. Such beliefs, along with a less-than-optimal attachment or interpersonal history, may cause them to have difficulties feeling safe through experiences of affiliation in the way that other people do (Gilbert, 2009).

In clients with depression, this fear of self-compassion seems to be associated with an upbringing that communicated disapproval of pleasure or happiness. These individuals described a sense of fear whenever they felt happy or had good things happen to them. Many explained that when they experienced happiness, there was always a sense that something bad was going to happen in the future. In contrast, these same individuals claim that during times of depressed feelings, they are never bothered by these thoughts and feelings of fear or dread (Gilbert et al., 2011).

Research has shown that positive emotions can actually become cognitively associated with an expectation of negative outcomes (Gilbert, McEwan, Gibbons, Chotai, Duarte, & Matos, 2011). Unfortunately, these associations lead many people to develop a general fear of happiness. Affective experiences of compassion or affiliation are important positive emotions, particularly for self-soothing, and their absence can prevent a person from being able to direct compassion toward themselves (Gilbert et al., 2011).

Research suggests that individuals with eating disorders also struggle with experiencing self-compassion. Interestingly, when looked at separately, people with eating disorders and people with low self-compassion both tend to have similar psychosocial histories (Kelly et al., 2013). In many cases, they were victims of childhood abuse or neglect. It is also common to see high levels of critical parenting and shaming. It is possible that, as a result of these early experiences of shame and abuse, these

individuals struggle to express compassion toward themselves (Kelly & Carter, 2012; Kelly et al., 2013).

Compassion and the Safeness System

When discussing compassion and fear of compassion, it is important to consider how compassion works from a psychological and physiological standpoint. How does the capacity for compassion develop in a person's mind and emotions? It is helpful to begin by looking at the individual's capacity for affiliative emotions. According to Paul Gilbert, affiliative emotions are "emotions that are basically friendly, with caring interest, and indicate prosocial intent" (p. 6, 2015). Relationships built on affiliative emotions are essential for developing the ability to self-soothe in the face of threat. These affiliative relationships stimulate oxytocin through the amygdala and the parasympathetic system. Research shows that oxytocin helps us to experience trust and warmth in relationships (Gilbert, 2009).

The Three-Circles Model of Emotion.

In the compassion-focused therapy model (CFT; Gilbert, 2009), this capacity for affiliative emotions is conceptualized as being rooted in one of three types of emotion regulation system. Based in evolutionary psychology, these three core regulation systems are organized according to adaptive functions that evolved to keep us safe and provide us with motivation to pursue and attain the resources needed for survival and the maintenance of adaptive relationships.

The first system is the threat and self-protection system, which involves emotions such as panic and anger, and functions to help us identify and respond to things that threaten us. This is the most dominant system and is driven by our survival instinct.

While adaptive in the face of physical danger, this system can become maladaptive when mobilized during harmless situations, and being oriented around fight-flight-freeze response tendencies, is ill-suited to many modern stressors. Unfortunately, this system is also related to problematic experiences such as the negativity bias, which causes us to be more likely to remember negative events than positive events. It serves to protect us, but can result in negative thinking and a threat bias that can make it difficult for individuals to feel safe if they get caught up in habitual patterns of threat-related thinking and behavior (Gilbert, 2015).

The second system is the drive/seeking and resource acquisition system. This system is involved with acquiring the resources needed for survival and reproduction, and involves emotional and motivational states centered around orienting us toward goals, fueling our pursuit of goals, and the experience of rewarding emotional states once they are achieved. This system is exemplified by our sex drive and our need for achievement and competition. Like the threat system, it has its adaptive functions, but can result in dysfunctional patterns of behavior when this motivation turns into problems like workaholism, addictions, or other psychopathology (Gilbert, 2015, p. 4).

The third system is the contentment, soothing, and affiliative focused system, or safeness system for short. This system organizes the mind very differently than the other two systems, which are associated with feelings of urgency and a narrowing of attention and thinking onto perceived threats or goals. When this system is active, the person experiences a sense of safeness, comfort, peacefulness, and soothing supportiveness. They are no longer consumed by a need to combat threat or acquire resources, and as such, this system serves to balance out threat activation. In humans, these feelings of

safeness commonly occur within contexts of affiliation, states of contentment, and connectedness with loved ones (Gilbert, 2015).

Problems can develop for people who are unable to access their safeness system. If they are unable to feel a sense of safeness and connectedness with others, it may impair their ability to self-soothe in the face of perceived threats. This is where affiliation comes into play with compassion. Part of affiliation is the ability to accept compassion from others or to direct it to oneself. If individuals cannot accept soothing and support from others or direct it toward themselves, this may impair their ability to self-soothe when facing a perceived threat (Gilbert, 2009). This inability to accept compassion from self or others may actually result from a developed fear of compassion (Gilbert, 2015). Research shows that some people can actually be afraid of the feelings brought about by affiliation or more specifically, compassion (Gilbert, 2009).

The Current Study: Fears of Compassion as a Potential Mediator Between Shame and Anger

This paper has laid out some of the challenges people with clinical anger face and many of the consequences associated with it. Research is laden with examples of how clinical anger can be harmful emotionally, interpersonally, and sometimes physically. In extreme cases, clinical anger has lead to aggression, violence, and legal action. There is a definite correlation in the literature between anger and shame. This study seeks to explore the nature of this relationship. Shame tends to permeate people's views of themselves and of the world outside of them. How is this ultimately related to the development and maintenance of clinical anger? This lens of shame has shown to affect a person's ability to process difficult emotions in general. This difficulty with emotional processing and

self-soothing in the face of distress (especially perceived failure) can cause some people to struggle particularly with anger.

Given the function of compassion in helping a person develop an ability to regulate his or her emotions and self-soothe during times of distress, this study suggests that the reluctance or inability to accept compassion may represent a process by which shame can lead to anger problems. If an individual fears or is reluctant to experience compassion from others or to direct compassion toward his or herself due to internalized shame, he or she may be unable to self-soothe in the face of obstacles or perceived threats, leading to ongoing problems with anger. Hence, I hypothesized that fears of compassion may function as a mediator between shame and anger.

Method

Participants

Participants in this study were students from Eastern Washington University (N=381).

Ages ranged from 18 to 58 years, with an average age of 21.4. In terms of gender, the sample was made up of 75.2% females and 24.8% males. Ethnic/racial breakdown included 75.6% Caucasian/European American, 10.2% Latino/Mexican American, 3.7% Asian, 2.1% African American, 1.3% American Indian, and 7.1% Other. Within the sample, 90.9% identified themselves as heterosexual, 6% as bisexual, and 2.4% as homosexual.

Procedure

Participants completed measures of self-compassion, fear of compassion, shame, and anger. These self-report scales were completed through Qualtrics online survey-administration software. Most students received extra credit in their courses for participating in the study. The tracking of each person's participation was done anonymously and gave each student credit through SONA systems. All procedures were approved through the Institutional Review Board (IRB) of the sponsoring university. Results were then input into SPSS for analysis.

Measures

The measures used for the current study include the Self-Compassion Scale (SCS; Neff, 2003), the Fear of Compassion Scale (FOC), the Multidimensional Anger Inventory (MAI; Siegel, 1986), and the Experience of Shame Scale (ESS, Andrews, Qian, & Valentine, 2002).

Anger.

The Multidimensional Anger Inventory (MAI) was the first reliable anger measure to view anger as a multidimensional construct. The dimensions considered in the MAI include the frequency, duration, magnitude, mode of expression, hostile outlook, and range of anger-eliciting situations. This measure is composed of 38 Likert-type items, many of which were incorporated from existing anger measures. Statements were designed to measure each of the 6 dimensions. For example: the frequency dimension was assessed using statements such as "I tend to get angry more frequently than most people"; the duration dimension, "When I get angry, I stay angry for hours"; magnitude, "People seem to get angrier than I do in similar circumstances"--reverse scored; hostile outlook, "People talk about me behind my back"; and range of anger-eliciting situations, "I get angry when someone lets me down" (Siegel, 1986, p. 192). The mode of expression dimension was subdivided into four interrelated categories: anger-in, "I harbor grudges that I don't tell anyone about"; anger-out, "When I am angry with someone, I let that person know"; guilt, "I feel guilty about expressing my anger"; brood, "Even after I have expressed my anger, I have trouble forgetting about it"; and anger-discuss, "I try to talk over my problems with people without letting them know I am angry" (Siegel, 1986, p. 192) Participants were instructed to provide a rating for how well each statement described them on a scale from 1, "completely undescriptive", to 5, "completely descriptive" (Siegel, 1986, p. 192).

The MAI has a test-retest reliability of 0.75, which is the highest of any anger or hostility scale, as well as a strong internal consistency (.88). A test of validity comparing the MAI to other anger measures demonstrated strong validity within the MAI anger

subscales (ranging from .16 to .59, with correlations of .17 or higher being significant) (Siegel, 1986).

Shame.

The shame measure I used was the Experience of Shame Scale (ESS). The ESS, in contrast to the more commonly used Test of Self-Conscious Affect (TOSCA), asks participants direct questions about the experience of shame. Scores are based on their responses to a series of questions about real life personal behaviors or characteristics and whether they have experienced shame as a result of them (Andrews et al., 2002).

The ESS examines four areas of characterological shame, three areas of behavioral shame, and one for bodily shame. The characterological areas include "shame of personal habits, manner with others, sort of person you are, and personal ability" (Andrews et al., 2002, p. 32). Behavioral shame includes "shame about doing something wrong, saying something stupid, and failure in competitive situations" (p. 32). Bodily shame involves "feeling ashamed of your body or any part of it" (p. 32). The questions in this measure address each of the eight areas from three different perspectives: "the experiential component, in the form of a direct question about feeling shame…, a cognitive component, in the form of a question about concern over others' opinions,...and...a behavioral component, in the form of a question about concealment or avoidance" (Andrews et al., 2002, p. 32). Participants respond based on how much each item applies to them on a scale from 1 (not at all), to 4 (very much). Examples of items include questions such as "Have you felt ashamed of any of your personal habits?", "Have you worried about what other people think of your manner with others?", "Have you tried to conceal from others the sort of person you are?", "Have you avoided people

because of your inability to do things?" (characterological shame), "Have you tried to cover up or conceal things you felt ashamed of having done?", "Have you avoided people who have seen you fail?" (behavioral shame), and "Have you wanted to hide or conceal your body or any part of it?" (bodily shame) (Andrews et al., 2002, pp. 41-42).

A study looked at whether the results of the TOSCA, a well-established shame measure, could be replicated using the ESS. The data found that not only did the ESS successfully replicate the findings of shame found in the TOSCA, but it was also able to identify shame as an ongoing trait, rather than just as a generic temporary negative affective state. The ESS total scale was found to have high internal consistency (Cronbach's alpha=.92) as well as high test-retest reliability r (88) = .83 over 11 weeks. For the subscales characterological shame, behavioral shame, and bodily shame, internal consistencies of .90, .87, and .86 were found and test-retest reliabilities of r (90-93) = .78, .74, and .82 respectively (Andrews et al., 2002).

Self-Compassion.

The Self-Compassion Scale (SCS) is a 26-item measure that assesses a person's level of compassion directed toward the self. This scale has three parts related to positive aspects of self-compassion and three focused on negative aspects, referred to as Self-Coldness. The three positive parts include Self-kindness, Common humanity, and Mindfulness; the three negative parts are Self-judgment, Isolation, and Over-identification. In this scale, participants rate each item on a Likert scale from 1-5, with 1 indicating "almost never" and 5 indicating "almost always" (Neff, 2003, p. 228).

Examples of items on the Self-kindness subscale include, "I try to be understanding and patient towards those aspects of my personality I don't like" and "I'm

kind to myself when I'm experiencing suffering" (p. 231). Items on the Self-judgment subscale include statements such as "When I see aspects of myself that I don't like, I get down on myself" and "I can be a bit cold-hearted towards myself when I'm experiencing suffering" (p. 231). Examples of items on the Common humanity subscale are "When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people" and "I try to see my failings as part of the human condition" (p. 231). Items on the Isolation subscale include statements like, "When I fail at something that's important to me I tend to feel alone in my failure" and "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world" (p. 231). On the Mindfulness subscale, participants are presented with items such as "When something upsets me I try to keep my emotions in balance" and "When something painful happens I try to take a balanced view of the situation" (p. 232). Finally, the Over-identification subscale contains items such as "When I'm feeling down I tend to obsess and fixate on everything that's wrong" and "When I fail at something important to me I become consumed by feelings of inadequacy" Neff, 2003, p. 232).

The SCS has an overall internal consistency of .92. Each subscale had adequate internal consistency reliability—.78 for Self-Kindness, .77 for Self-Judgment, .80 for Common Humanity, .79 for Isolation, .75 for Mindfulness, and .81 for Overidentification (Neff, 2003). Additionally, the SCS has been shown to have consistent psychometric validity (Neff, 2015) and is able to discriminate between self-compassion and other related constructs such as self-esteem (a correlation of .59 was found between the Rosenberg Self-Esteem Scale and the SCS—a correlation low enough to show a definite discrepancy between the two constructs) (Neff, 2003).

Fear of Compassion.

A measure of fear of compassion was developed by Gilbert, McEwan, Matos et al. (2011). This scale was designed to measure fear of compassion for others, fear of compassion from others, and fear of compassion for the self. All three domains took the form of self-report questionnaires. The scale for fear of compassion for others was comprised of 13 items with statements such as "Being too compassionate makes people soft and easy to take advantage of" (p. 245). The scale for fear of compassion from others had 15 items with statements such as "I try to keep my distance from others even if I know they are kind" (p. 245). Finally, the scale for fear of compassion toward the self contained 17 items such as "I worry that if I start to develop compassion for myself I will become dependent on it" (p. 245). In all three scales, participants rate themselves on a Likert scale ranging from 0 ("Don't agree at all") to 4 ("Completely agree") (p. 245). This scale has been shown to have an internal consistency of .72 for fear of compassion for others, .80 for accepting compassion from others, and .83 for fear of self-compassion (Gilbert, McEwan, Matos et al., 2011).

Results

Data Screening

Although the original dataset consisted of 527 cases, numerous cases contained missing data for one or more measures. Because the mediation analysis involves making comparisons between correlations involving different measures, I used listwise deletion, including only cases without any missing data, which reduced the total *N* to 381 for all analyses.

Data was screened for outliers, and one case was removed for falling greater than 3 standard deviations above the mean for the dependent measure (MAI total score of 236). Examination of test statistics for skewness and kurtosis as well as examination of scatterplots revealed that the dataset met assumptions of linearity, normality, and homoscedasticity.

Measures

Table 1 below provides means and standard deviations for all measures included in the study.

Table 1

Means and Standard Deviations for Scores on the FOC (For Others and From Others), the SCS, the MAI, and the ESS Measures[a]

Measure	Mean	Std. Deviation
FOC for Others	28.7	7.7
FOC from Others	30.5	10.4
SCS/FOC for Self	32.5	13.65
MAI	103.4	22.1
ESS	64.44	16.8

Note. FOC = Fear of Compassion; SCS = Self-Compassion Scale; MAI = Multidimensional Anger Inventory; ESS = Experience of Shame Scale
[a] $N = 381$

Regression Analysis

A regression analysis was performed to explore the overall ability of the predictor variables to predict anger scores, a regression analysis was performed. Anger scores were predicted from a linear combination of measures of shame and fear of compassion for others, fear of compassion from others, and fear of compassion to the self. The overall

model significantly predicted anger scores, $F\ (4, 376) = 43.122, p < .001$. The proposed model also explained just under one-third of the variance in anger scores, $R^2 = .31$.

Correlational Analyses

Prior to conducting mediation analysis, correlations were calculated between all variables to allow examination of relationships between them. Significant relationships were observed between all variables included in the study. Table 2, on the following page, presents the observed correlations.

Table 2

Correlations between Scores on the FOC (For Others and From Others), the SCS, the MAI, and the ESS Measures

Measure	1	2	3	4	5
1. FOC for Others	—	—	—	—	—
2. FOC from Others	.489**	—	—	—	—
3. FOC for Self	.344**	.755**	—	—	—
4. MAI	.392**	.455**	.417**	—	—
5. ESS	.200**	.517**	.538**	.444**	—

Note. FOC = Fear of Compassion; SCS = Self-Compassion Scale; MAI = Multidimensional Anger Inventory; ESS = Experience of Shame Scale

** $p < 0.01$, two-tailed

Testing for Mediation: Baron & Kenny's Criteria

In order to establish mediation, the results must meet four criteria according to Baron & Kenny (1986). First, there must be a significant relationship between the proposed independent variable (shame) and the mediators (fears of compassion). Second, the mediating variable (fear of compassion) must be related to the dependent variable (anger). Third, the proposed independent variable (shame) must be related to the dependent variable (anger). Finally, the relationship between the independent variable (shame) and the dependent variable (anger) must be decreased when controlling for the mediating variable (Baron & Kenny, 1986).

Mediation Analysis for Fear of Compassion for the Self

In order to assess the potential for fears of compassion for the self to act as a mediator between shame and anger, I examined the data with regard to Baron and Kenny's (1986) criteria using Pearson product-moment correlation coefficients. Meeting the first condition of Baron and Kenny's (1986) requirement for mediation, a significant relationship was observed between the proposed independent variable (shame) and the proposed mediator (fear of compassion for the self), $r = .54 (p < .001)$.

The data also met criteria for the requirements of mediation through the observation of a significant relationship between the proposed mediator (fear of compassion for self) and the dependent variable (anger), $r = .42 (p < .001)$.

The next condition was met through the observation of a significant relationship between the proposed independent variable (shame) and the dependent variable (anger), $r = .44, (p < .001)$.

The final condition required for mediation to be met is for the relationship between the independent variable (shame) and the dependent variable (anger) to be decreased when controlling for the proposed mediating variable (fear of compassion for the self). This condition was met in the data examined, as seen in a reduction in the shame-anger relationship as reflected in the partial correlation controlling for fears of compassion from the self: $r_{xy.z} = .29, (p < .001)$. However, the analysis failed to demonstrate full mediation of the shame-anger relationship by fears of compassion for the self, as the shame-anger correlation maintained significance even after controlling for the proposed mediator.

Mediation Analysis for Fear of Compassion for Others

In order to explore the potential mediating effect of fear of compassion for others on the relationship between shame and anger, I used Pearson product-moment correlation coefficients to test the data against Baron and Kenny's (1986) criteria for mediational relationships. The first condition of Baron and Kenny's (1986) requirements for mediation was met with regard to fear of compassion for others. A significant relationship was observed between the proposed independent variable (shame) and the proposed mediator (fear of compassion for others), $r = .20 (p < .001)$. The second condition was also met in that a significant relationship was observed between the proposed mediator (fear of compassion for others) and the dependent variable (anger), $r = .39 (p < .001)$. The data also met criteria for the third condition, through the observation of a significant relationship between the independent variable (shame) and the dependent variable (anger), $r = .44 (p < .001)$.

As noted above, the final condition required for Baron and Kenny's (1986) requirements for establishing mediation is for the relationship between the independent variable (shame) and the dependent variable (anger) to be decreased when controlling for the proposed mediating variable (fear of compassion for others). This criterion wasn't fully met, as seen in the minimal reduction in the shame-anger relationship as reflected in the partial correlation controlling for fears of compassion for others, $r = .41 (p < .001)$.

Mediation Analysis for Fear of Compassion from Others

To examine the potential mediating effects of fears of receiving compassion from others, I once again tested the data using the criteria based on Baron and Kenny's (1986) model for mediational relationships employing Pearson product-moment correlation coefficients. The first condition for mediation was met when a significant relationship was observed between the independent variable (shame) and the proposed mediator (fear of compassion from others), $r = .52 (p < .001)$. The data also revealed a significant relationship between the proposed mediator (fear of compassion from others) and the dependent variable (anger), meeting the second criteria for mediation, $r = .46 (p < .001)$. The third condition was also met, as evidenced by the significant relationship found between the independent variable (shame) and the dependent variable (anger), $r = .44 (p < .001)$.

As mentioned above, the final condition required for mediation to be met is for the relationship between the independent variable (shame) and the dependent variable (anger) to be decreased when controlling for the proposed mediating variable (fear of compassion from others). This condition was met in the data examined, as seen in a reduction in the shame-anger relationship as reflected in the partial correlation controlling

for fears of compassion from others: $r = .27$ $(p < .001)$. However, the analysis failed to meet the criteria for full mediation, as the shame-anger correlation, while decreased, maintained statistical significance even when controlling for the proposed mediator.

Finally, a partial correlation was calculated between measures of shame and anger after controlling for all three fears of compassion scores simultaneously. Similar to the previous analyses, the correlation was reduced to $r = .27$ $(p < .001)$, lower than the zero-order correlation of .44, but still statistically significant.

Conclusion

Research shows that clinical anger leads to a variety of emotional, interpersonal, and physical problems. The empirical research on anger also provides much evidence suggesting a strong correlation between shame and the development of anger problems. The specific hypothesis this study set out to examine was whether fears of compassion, including fears of having compassion for others, fears of accepting compassion from others, and fears of directing compassion toward oneself, would function as mediators between shame and anger, by potentially interfering with social- and self-soothing processes.

As corroborated by previous research, the data revealed a significant correlation between shame and anger. Additionally, the results revealed significant correlations between anger and fears of compassion for others, fear of compassion from others, and fear of having compassion for the self. Also as predicted, significant relationships were observed between shame and fear of compassion for others, fear of compassion from others, and fear of compassion for the self.

Then, analyzing the data using Baron and Kenny's (1986) criteria, tests for mediation were employed. These tests for mediation revealed that both fear of compassion for the self and fear of receiving compassion from others resulted in partial reductions to the relationship between shame and anger. Though the shame-anger relationship was still significant this indicates that being able to direct compassion to the self and to receive it from others may reduce the likelihood that shame will translate into problems with anger. This finding adds credence to the idea that perhaps a person's inability to lend compassion to the self and accept compassion from others can compound the effects that shame has on a person's development of problems with anger, although it clearly does not support the idea that compassion (or lack thereof) is the primary pathway through which shame may lead to anger.

There are a variety of implications of these findings. If a person not only is unable to accept compassion from others, but fears accepting this compassion, the question arises, where might this fear come from? If a person has developed some sort of aversion toward compassion from others, it may be possible that this results from the occurrence of negative past experience with close relationships. One way to consider this is through the lens of attachment theory (Bowlby, 1969). It is possible that a close other who should have been a source of comfort and emotional soothing during a time of distress responded instead with neglect, shaming, or even abuse. Perhaps a close other may even have expressed compassion at a time in the past, and once the individual's guard was let down in the hopes of receiving emotional support again, support was withdrawn, or they may even instead have been put down or shamed. Thus, such individuals may have learned that people cannot be relied upon for consistent support, and thus cannot be trusted. They

might even generalize the idea that people offering compassion are not to be trusted, and in fact will hurt them in the future. The expectation that compassion is not authentic, possibly may lead a person to even expect that compassion leads to pain, thereby resulting in the development of a fear or aversion of compassion from others.

Since people's views of themselves are shaped so much by how others treat them, this view that compassion from others cannot be trusted, may have much to do with a person's self-concept. These people's self-concept may shape how they respond and relate to themselves during crisis and distress. If they do not believe compassion from others is safe or can be trusted, or if it simply hasn't been modeled to them in their development, it may make it difficult for them to understand how to direct warmth and compassion toward themselves. In fact, if they have a history of being shamed during times of distress, they may not view themselves as worthy or deserving of comfort or soothing during emotional pain. They may feel that they deserve to simply stew in their unhappiness and fear, and may perhaps take little action to help themselves. Even if they may not consciously view themselves as worthless or undeserving, they simply may not know how to help themselves, and thus the idea of directing warmth or compassion toward themselves may be foreign or even frightening.

I have discussed some possible suggestions for how shaming may develop into a fear of compassion, but this study also considers how fear of compassion translates into problems with anger. If fear of compassion at least partially explains anger's relation to shame, what might the role of fear of compassion in the relationship between these two variables look like? It is possible that fears of accepting compassion from others and directing compassion toward the self inhibits people's ability for empathy around what

they are feeling as well as toward the person to whom they are expressing their anger. This may impact both emotional self-soothing and an ability to mindfully view distressing situations objectively (both of which are necessary for self-compassion and successful working with anger). If people are unable to soothe their distress enough to reframe their distressing situation objectively, their default response may be an overriding frustration. This built-up sense of helplessness or exasperation may swell into something stronger, such as anger or rage, when combined with common but unhelpful cognitive strategies such as rumination on the source of the anger. On the surface, a person dealing with these overwhelming feelings may feel superficially "soothed" by the idea of blaming others for their situation, even as this avoidance effort fuels the anger in turn.

The third component of self-compassion perhaps lacking in people who struggle with anger might be common humanity. Feeling their situation is unique from what others might experience, they cut themselves off from the idea that their experience of disappointment is a commonly felt experience of the human condition. Their view of themselves may transform into one of being unfairly persecuted, serving their perspective of self-justified anger and outward blame, further fueling the anger lens discussed earlier in this study. This may provide a way of temporarily coping with these distressing and frustrating emotions that have built up. This manifestation of anger (lack of common humanity/blaming of others) in some way may give the individual a false sense of control or self-justification. If others are at fault and they perceive that they are the victim, then they may feel temporarily affirmed or justified. Obviously there is much need for further research before the shame-anger relationship can be more fully understood, but these ideas may be some possible suggestions for how underlying shame can inhibit the

individual's ability or willingness to lend care or compassion toward his or her distressing emotions, developing instead into difficulties with emotion regulation, but more specifically a dysfunctional cycle of anger.

Though fears of compassion from others and for the self revealed significant reductions in the relationship between shame and anger, controlling for fears of relating compassionately to others resulted in only a modest reduction. It is interesting that a person may still strongly experience a linkage between the experiences of shame and anger, separate from their experience of compassion for others, or at least not struggle with the fear of it. Why might this particular type of fear not be as involved in the development of anger? This finding may suggest that the process in which one soothes or cares for the self and accepts warmth or care from others is distinct from the process by which one lends care or compassion toward others outside the self. Since shame is primarily anchored to how one experiences (and perceives that others experience) the self, it makes sense that the shame-anger relationship is primarily effected by fears of compassion related to the self.

Relatedly, the finding that while fears of directing compassion toward the self and receiving it from others seemed to play a role in the shame-anger relationship, the minimal decrease in that relationship when controlling for fears of compassion *for* others seems to be consistent with the view that shame may lead to an inability to be soothed (by accepting kindness from others and directing it toward the self), which exacerbates anger problems, rather than the idea that those who struggle with anger have a generally hostile orientation (or reluctance to direct kindness) toward others. This may be important for understanding those who struggle with anger—for although it may seem that their

problems lie around directing harshness toward others, these data seem to indicate that they struggle even more greatly in relating kindly to themselves.

Finally, even after controlling for all three types of fears of compassion, the relationship between shame and anger was still statistically significant. Based on the evidence, fear of compassion does not fully mediate the relationship between shame and anger. However, the ability to accept compassion arguably may help reduce the effect of shame on the development and maintenance of anger problems. Further research is needed to clarify the involvement of fears of compassion in the relationship between shame and anger. It may also be beneficial to examine other possible mediators involved in the progression from shame to clinical anger, such as self-reassurance (Irons et al., 2006), self-advocacy/resisting self-attacks (Kelly, Zuroff, & Shapira, 2008), and other types of compassion-related emotion regulation.

Areas for Future Study

There are a number of other factors which may be valuable to explore in terms of the shame-anger relationship such as attachment, trust, and resisting self-attacks. Though briefly touched on in the shame section and again in the affiliative emotions section, a person's attachment style has an influence on his or her self-concept and how they function within interpersonal relationships (Bowlby, 1969; Pietromonaco & Barrett, 1997) and thus may be a possible mediator meriting further attention in research analyzing anger's connection to shame. Insecure attachments can lead to a variety of problems with closeness in relationships. Research also supports a relationship between attachment style and both anger (Babcock, Jacobson, Gottman, & Yerington, 2000; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Mikulincer, 1998) and shame

(Claesson & Sohlberg, 2002). It would be interesting to test this further, exploring attachment style as a mediating variable between shame and clinical anger. Troubles with attachment appear to closely align with a person's capacity for self-soothing during distress (Bowlby, 1969), a process which could potentially influence a person's emotional-processing in general, and anger-processing in particular.

Another variable which might be worth researching, though not specifically mentioned in this study, is trust. Though trust may vary relationally and situationally, it may be interesting to explore the influence of trust in close relationships (as compared to fear of accepting compassion from others). Might people's ability to trust those with whom they are in close relationships impact the relationship of shame to anger? If people dealing with internalized self-criticism and feelings of shame cannot trust close others enough to let down their guard, accepting and internalizing emotional support, then it would be interesting to study whether these built up emotions might possibly develop into a dysfunctional cycle of anger.

A process analyzed in a study by Kelly, Zuroff, and Shapira (2008) that may be a potential area for further research is resisting self-attacks. The study compared resisting self-attacks and self-soothing in their effectiveness in reducing depression. While both techniques were helpful, resisting self-attacks was particularly effective in reducing both depression and shame, especially for those with highly self-critical tendencies. This strategy for resisting self-attacks or self-criticism was designed to nurture a person's resilient self-relating. This involves challenging a person's inner criticism by separating themselves from their inner critic and learning to essentially advocate for themselves by resisting these internal attacks. Because this was shown to help with depression and self-

criticism in this study, it would be interesting to analyze this method for helping those struggling with anger, particularly in light of the current study's findings regarding the anger-shame link being related to participants' reluctance to direct compassion toward themselves or receive it from others. If a person's anger is potentially rooted in a deeper struggle with shame and self-criticism, research examining specific intervention strategies targeted at building self-compassion and reducing self-attacking in this population are warranted.

There are a number of limitations with the present study, the first of which is the small sample size. Due to missing data, a large portion of the sample needed to be excluded from the data analysis. This limits the reliability and generalizability of the results. Additionally, the participants were all college students at a single public university. Even if the entire sample had been used, the results may not have been generalizable to other populations. Secondly, all data was derived from self-report questionnaires, which may contain biased responses. Participants may have responded in ways they felt the researchers expected them to respond or could possibly have simply not understood certain questions. All of this can lead to biased responses which may skew the results. Thirdly, the nature of the study itself is correlational. Though correlations can give us helpful information, we cannot assume that the results found within this dataset reflect underlying causal relationships between the variables studied.

Clinical anger can lead to a variety of consequences for those who struggle with it. It is clear that for many people, the development of clinical anger is facilitated by their experiences of shame. The aim of this study was to examine the nature of this relationship between shame and the development of anger problems. Further research is

needed to determine the progression of this relationship. This study revealed that the process by which shame can translate into problems with clinical anger cannot be fully explained by fears of compassion. Though compassion and fear of compassion are important areas of study, in terms of understanding anger, different avenues of study will better aid researchers in developing methods for therapy and treatments to help those caught up in clinical anger. Perhaps through examining possible connections to attachment, trust, resisting self-attacks, and other related areas of study more resources might be developed which can be used to help those struggling with shame-based clinical anger.

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