Development of an Integrated Heuristic Model of Shame-Rage Cycle: A Narrative Review with Implications to Case Formulation

by

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Abstract

Anger and shame are individually explicated through intrapsychic, interpersonal, and emotional-motivational processes. The phenomenon of shame-rage, a common psychological defensive strategy, is described and illuminated as an unconscious avoidance mechanism that involves maladaptive expressions of anger and shame separately. Shame-rage strategies are empirically found in individuals who exhibit vulnerable narcissistic traits; this population is selected to discuss the development and consequences of shame-rage strategies. Compassion is suggested as a necessary therapeutic framework to support individuals suffering from shame-rage related afflictions. Affective neuroscientific concepts are embedded throughout this thesis to link shame-rage phenomenology to the evolutionary and empirical study of neuroscience in an effort to support therapeutic endeavours.

***Keywords**:* aggression; anger; compassion; shame-rage; vulnerable narcissism

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empathy, care, and compassion during my earlier developmental years. The required wherewithal to complete this program and thesis truly developed out of the compassion and intellectual attention offered by my parents and siblings while growing up; the continuation of this attention continues to enable me to move forward in other important areas of my life.

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List of Acronyms

ABT	Affective Balance Therapies
ACT	Acceptance and Commitment Therapy
ADS	Anger Disorders Scale
AEDP	Accelerated Experiential Dynamic Psychotherapy
CFT	Compassion Focused Therapy
CM	Childhood Maltreatment
CMT	Compassionate Mind Training
DID	Dissociative Identity Disorder
DSM	Diagnostic and Statistical Manual of Mental Disorders
EFT	Emotion Focused Therapy
ER	Emotional Regulation
ESS	Experience of Shame Scale
FFNI	Five-Factor Narcissism Inventory
ISS	Internalized Shame Scale
MSC	Mindful Self-Compassion
NPD	Narcissistic Personality Disorder
NSM	Narcissism Spectrum Model
PCTN	Perceived Control Theory of Narcissism
PNI	Pathological Narcissism Inventory
SCS	Self-Compassion Scale
SE	Somatic Experiencing
STAXI-II	State-Trait Anger Expression Inventory II
TOSCA	Test of Self-Conscious Affect

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Preamble

Research Becoming Re-Searching My Self

The process of writing this thesis began with an intuitively felt but also much circulated idea regarding the possible therapeutic benefits of self-compassion. Self-compassion must provide substantial healing for those dealing with distressing levels of anger, aggression, and rage. I began looking into research about angry rumination and eventually my pursuits moved towards how anger is often a resultant emotion from shame (i.e., shame-rage). This emotional dynamic has been empirically researched with individuals labelled as vulnerable narcissists. It occurred to me that self-compassion must therefore be apposite in reducing the subjective distress of those labelled with vulnerable narcissism. Although I did not recognize vulnerable narcissistic parts in myself at the time, I did observe this psychological typification in not only the people around me, but also in the sociopolitical stage during which I wrote this thesis, exemplified by particular political leaders. This observance of shame-rage in "others" eventually led to my own self-examination alongside my developing intellectual and scholarly knowledge.

My increased embeddedness in the research truly changed my outlook on the world. This process of writing brought me through deepened stages of self-awareness to face myself as a person, a researcher, and as a counsellor-trainee. While reading and researching into what is entailed by vulnerable narcissism (anger, shame, and self-compassion, in research terms), I became viscerally aware that I embody every one of these with some varying degree on the spectrum. In other words, I can be vulnerably narcissistic, ashamed, angry, and oftentimes need self-compassion. Hence, when I thought further into my research topic, I came to a lucid realization that I have personally experienced all these phenomena and I was able to perceive these constructs in a closer, more intimate, and real-life manner. An unexpected and most valuable bonus from my thesis research and writing is the increased experiential self-knowledge: myself as a certain constructed personality.

While learning that I am a constructed personality with vulnerable narcissistic traits (i.e., shame-rage) I was also practicing mindfulness and self-compassion – I subjectively felt positive intrapersonal and interpersonal changes from practicing these methods. The positive changes ascertained from practicing self-compassion and mindfulness provided the impetus to research more closely how self-compassion and mindfulness may be therapeutic for those suffering from the distress associated with vulnerable narcissism. Working in the mental health field simultaneously during my research, I also observed the stigmatization of those labelled as "narcissistic" and/or "angry."

Learning about these constructs and working with clients with acquired brain injuries and mental health concerns, I was able to recognize how stigmatized these constructs were, and still are, in various professional mental health fields. I observed that the word "narcissism" was often used with the intention to hurt the recipient and to suggest that they were "bad" in some way. Rather than seeing the person through a lens of common humanity, the *stigmatizer* was shaming the supposed "narcissist." The counterreaction of anger by the "narcissist" led to further stigmatization and they, consequently, received less support than individuals who did not react as frequently or intensely with anger. While working in the mental health field, empathy and compassion were lacking or non-existent in interactions with those who expressed anger. Thus, my hope is that through this research on vulnerable narcissism and the associated emotional reactions of shame-rage, by uncovering its psychosocial origin in the hyper or aggressive individualism that wounds the vulnerable young self, I would be able to not only destigmatize narcissism generally, and vulnerable narcissism specifically, but also help create a compassionate culture and society.

Writing this thesis has taken three years, from its conception to its final point. During this course of writing, I encountered the potential death of my father twice. I also married the love of my life and travelled to visit her family for the first time in Brazil. In the midst of being besieged by all of these major life events, I realized that it would be

impossible to remove oneself from the research one is involved in. In fact, in concordance with tenets of Buddhism— in which the practice of mindfulness and compassion is central— approaching ourselves and accepting how we are and how we change (since this is inevitable) and by allowing this perspective to enter our research, we begin to recognize and accept others' lived reality and sense of self. By accepting ourselves we are better able to accept and connect with others instead of inadvertently shaming those we wish to connect with. This may lead to better cooperation and improvement in overall mental, social and ecological health, and individuals may justifiably show economic health as well. I make this last statement based on the cardinal ecological principle that in the closed system of life phenomena on this planet, everything and every being, and every aspect of life are interconnected, influencing each other.

Mindfulness and Self-Compassion as Treatment Considerations

Bentz and Shapiro (1998) state: “The more ego you have in your inquiry, the more likely that your other is really a projection of your ego” (p. 52). These authors are highlighting the importance of recognizing our own ego and its influence on our perceptions of others. This is why practicing mindfulness and looking at the intervening of all of my preconceptions about narcissism, suffering, and psychological phenomena helped me recognize my own ego-injuries and insults. It also exposed how much I could relate to others’ feelings of shame-rage: a major theme of this thesis inquiry. I am part of the research as much as anyone who has been labelled with a psychological typification, such as vulnerable narcissism. I intend to elucidate the experience of the person behind the label - individuals with higher levels of vulnerable narcissism - throughout this thesis, to deepen the understanding of vulnerable narcissism, shame, and anger, and to allow my reader to access and learn about the reciprocal manners in which we affect and are affected by others; we are intersubjective beings whether purposefully or not. Currently, there is inadequate understanding of the suffering that those labelled as narcissists incur – demonstrated by negatively connoted psychological

conceptualizations of these individuals (Ronningstam & Weinberg, 2013). It is my hope that through this thesis research and writing, I will contribute to increasing the empathy and compassion towards those who have been labelled as narcissistic.

In terms of intervention and treatment of clients with vulnerable narcissistic traits and shame-rage reactions, my chosen modality is mindfulness and self-compassion. The latter combination allows clients to experience and accept all phenomenological occurrences afforded to humans, thereby enabling them to expand holistically their mind-heart-body-spirit; in short, the whole human being. This experience of expansion is an antidote to the experience of vulnerable narcissism and shame-rage – an experience connoted by feeling limited, constrained, concealed, and under pressure. There is a lack of psychic space from which to move within and without. The journey of enacting more self-compassion (Neff, 2003) begins to create more space for the real, unbarred, unmasked person underneath to come out of hiding from the vulnerable narcissistic defenses and to feel alive again, to get in touch with their inner experiences, memories, physical feelings, and emotions. They are able to experience themselves in the moment rather than experiencing themselves as their idealized image. This thesis explores how and why mindfulness and self-compassion are the most suitable treatment methods for those suffering from the vulnerable narcissistic defense of shame-rage.

The abovementioned focus is different from, say, an aim of *managing* shame-based rage. A management focus implies that the erupting rage and anger are to be dampened, controlled, or eradicated. This management focus is quite the opposite to self-compassion in that the latter explores the root causes that have led the individual to shut themselves in behind an idealized image of themselves; inevitably creating the preconditions for an outburst of rage in the "right" context. With the expanded sense of self, the sufferer will be able to feel a sense of spaciousness that allows them to experience their feelings and emotions without necessarily feeling the compulsion to act upon them or reacting to them (reacting to shame with rage). Henceforth, this thesis

hopes to flip the typical approach to anger and rage: from the management approach to what I may call the hospitality approach. This hospitality approach emphasizes moving towards suffering and pain, with compassion, to support the transcendence beyond any disproportionate focus upon any single emotion or defensive strategy. The minimal hope is that this thesis will galvanize researchers in psychology to extend their explorations deeper into the concepts discussed in this thesis with an aim of providing increased supports to those with shame-rage tendencies and vulnerable narcissism.

Methodological Considerations for My Thesis Research

Typically, a thesis is based on an empirical research involving research subjects and data collection and requires a separate chapter on research methodology that goes extensively into the details of data collection and other finesse concerning qualitative research. My thesis is not of this nature. Rather, it is a narrative review that synthesizes the literature regarding the constructs of anger, shame, vulnerable narcissism, and self-compassion (Cook et al., 1997). Moreover, it supports the synthesizing of constructs from two disconnected fields - clinical neuroscience and psychotherapy - for the purpose of developing a heuristic model of anger (i.e., shame-rage). Through the increased conceptual connection of disparate constructs (i.e., anger, shame, and vulnerable narcissism) and the lens of differing fields of research, the constructs become further illuminated. Possibilities for future cross-field research is simplified for the aforementioned constructs.

The research used in this thesis is primarily based on library findings, PsycINFO, Google Scholar, and SFU library databases. I used the following headlines to search for the appropriate peer-reviewed, scholarly articles: (1) self-compassion or compassion; (2) anger or aggression or rage or violence; (3) narcissism or vulnerable narcissism or narcissistic personality disorder; (4) emotional regulation or affect regulation or self-control or self-regulation; (5) shame or self-conscious emotions or embarrassment or guilt; (6) affective neuroscience or neuroscience of emotion or emotions. I also

combined these categories when searching for articles that united the constructs. Once a particularly useful article was discovered I used the snowball sampling method to glean other relevant literature. Moreover, the primary limiting qualifiers were that the article must be academic, English, and peer-reviewed. However, the use of published books, often authored by established researchers in psychology, also supported the acquisition of empirical research.

Another research method used in this thesis is autobiographical in nature. I have drawn from my own personal experience of the subject matter that is under inquiry and discussion in this thesis. Who can have a more intimate look, feel, and understanding of a psychological phenomenon than the experiencing subject, "me"? I strove for an intimate and illuminating understanding of vulnerable narcissism, anger, shame, and self-compassion, as well as insightful and comprehensive ways to work with these phenomena. However, this thesis is not a write up of an autoethnographic research. That would be a different research venture. As well, emphatically, no empirical data from the clients whom I have worked with are revealed in any ways in this thesis.

Structure and Format

In thinking long and hard about the matter, at some point, a sudden thought occurred to me that I could organize my thesis along a trajectory that resembles the progression of a client through therapy, from intake to termination. By organizing the thesis in this manner, it lends itself to being used for case formulation purposes and to support other mental health professionals in supporting those afflicted with the constructs discussed throughout this thesis. The first chapter represents the presenting issue and reported reason for suffering – anger. The second chapter presents the underlying source of the suffering – shame and shame-rage – and is explored by discussing individuals with vulnerable narcissism. The third and final chapter presents the pathway to healing – self-compassion. To give the reader a close feel of what this process is like, I have created a case vignette for each chapter that outlines the

characteristics, presenting issue, and current stage in therapy with a focus upon the discussed topics in this thesis: that is, anger, shame, and self-compassion. To note, they are fictional accounts that do not disclose personally identifying details of any real people. While reading through the chapters, the reader could keep the vignette in the back of their mind as they review the experiences of anger, aggression, and rage (Chapter 1); shame, shame-rage, and vulnerable narcissism (Chapter 2); and self-compassion (Chapter 3).

The first chapter outlines the nature of suffering itself; in the present case, anger, aggression, and rage. These are various reasons why someone may seek a mental health professional, as seen in the case vignette. I will be explicating anger, aggression, and rage – how they arise, differ, and are subjectively experienced. I will also describe and explicate the use of common empirically researched assessments for anger. I use examples from my own personal experience as well as examples from research to elucidate this phenomenon.

The second chapter outlines the root cause of suffering, which, in this case, is regarded as shame and shame-rage. I will discuss a psychological typification of vulnerable narcissism where the research has indicated that individuals with higher levels of this typification are more likely to experience instances of shame-rage. Therefore, I explain what constitutes this trait, how shame is involved and what the experience of these two phenomena are like subjectively. Assessment tools are also discussed for use in therapy. I use examples from my own personal experience as well as examples from research to elucidate this phenomenon.

The third chapter outlines the road to decreasing suffering, which in this paper is a road to self-compassion. I explicate the concept of self-compassion and describe my own personal experience of developing this concept within myself. I describe how self-compassion functions as the antidote to shame and shame-rage, and then discuss the overall use of mindfulness and self-compassion throughout the course of therapy with someone who initially presented with anger issues, specifically if unacknowledged

shame is hypothesized to be underneath the anger and contributing to the clients' suffering. As included in the other chapters, a scale for assessing self-compassion is discussed for use in therapy.

Moreover, throughout the entire thesis, I integrate propositions based upon affective neuroscience. These propositions are meant to provide a neurological basis for the emotional dynamics expressed throughout this thesis. This integration of neurological emotional-motivational networks with the other concepts found in this thesis link together the concepts in the chapters. It also provides for the promotion of important findings related to therapeutic pursuits in psychology. It is my interest and conviction that the findings, as explained in Panksepp and Biven (2012), are extremely relevant to human psychological processes. This idea of combining neuroscientific research with clinical psychotherapeutic practice is not new. However, it has not been widely accepted or promulgated (Holmes et al., 2014). By involving these concepts and propositions in this thesis, it is my hope that there is increased interest and research funding provided for similar lines of exploration.

Case Vignette: T.J.

T.J. is a forty-year-old white Canadian. He is a heterosexual cisgender male. He grew up in Vancouver, BC, Canada with his two parents and siblings – one older sister and one younger brother. T.J. was raised in a Catholic home: his father was raised Catholic and continued the faith of his family. T.J., however, reports as agnostic, and does not attend any religious meetings. He rejects any religious following, in part, because he does not want any affiliation with his emotionally abusive father. He is currently a bank teller but has had many different jobs in various fields ever since he graduated from high school.

He first sought counselling because of recurrent conflict he was having with his girlfriend, who he currently lives with. He mentioned that he would get angry and would throw things in the apartment, but, as he was discharging his anger in this manner, he felt like it was someone else who was performing these aggressive acts. He reported that he felt an "evil" presence in him, that was let loose, and was raging at times. He mentioned that he never hit his current or previous girlfriends, but he had visualizations of himself doing so while enraged. He further commented that he typically left his romantic relationships permanently after only a few months. The preceding pattern for parting from these relationships is that he typically became extremely angry about something his partner had done or said, and then he would withdraw and break all contact and communication. In order to elucidate the experiences of T.J., the following list contains examples of experiences of rage reported during his first session in therapy:

- T.J. reported that when his girlfriend came home from work on a Saturday afternoon, she asked him "Why didn't you put the dishes away like I asked?" T.J. said that he, seemingly immediately, yelled at her saying "You aren't the boss of me!" and threw a plate at the wall, shattering it all over the kitchen floor.
- T.J. said that he typically despised others disagreeing with him and could not control himself when others explicitly tried to correct his belief or assertion. He said that, however, when he was at work, he found it very difficult to

control his anger because when he disagreed with a particular co-worker, they were always ready to confront and challenge him. T.J. said he had erupted in rage more than once at this co-worker when they were discussing the best stocks to invest in.

- T.J. reported that his goal in therapy was to stop behaving angrily because it was "putting his job and romantic life at risk."

As evidenced through some of the reports by T.J. in his first counselling session, his experience of anger, and his lack of sense of control over his angry behaviour, caused him personal and interpersonal suffering. The following interview provides an excerpt from the second counselling session with T.J. This excerpt is meant to display the stage of therapy that T.J. was working in, as well as convey the direction that the therapy progressed during the early stages of his personal therapeutic work.

T: So, tell me about how you experience anger…

T.J.: I feel angry so much of the time and it is affecting my personal life and job. I just wish others would stop pissing me off.

T: Mm, I hear how distressing this must be for you, having such important parts of your life being disrupted from feeling angry. What goes on for you when others are pissing you off?

T.J.: I yell at them or throw something usually. I just can't stand when others tell me what to do or correct something that I do. Like who said they're the boss of me!?

T: I think I hear that you feel dismissed and that your opinion doesn't matter, is that right?

T.J.: Well of course my opinion is correct, it's them who doesn't have it right. That's why I get angry, to show them who is the REAL smart one!

T: Hmm, it seems difficult to feel the responsibility of having to tell others what is right, all the time. How do you experience this in your body?

T.J.: Why does it matter what is happening in my body? It's the other person who is the problem. How do I learn to deal with them effectively?

T: Mm, I understand your concern with wondering why your experience matters when you feel that the issue is with the other. I am wondering though, since feeling angry can be very distressing, that maybe it will help to understand how you experience anger (cognitively, physically, behaviourally, affectively) so that you are able to learn how to host your own symptoms of anger, and then maybe you will be better equipped to inform others of your opinion in a way that may be received differently by others. What do you think about that?

T.J.: I guess I can give it a shot. How do I do that?

T: First we can start by talking about your experience of anger. And then let's do some mindfulness exercises that may help us with this…

Case Summary

As can be observed, T.J. has difficulty explaining his own experience of anger. Rather, he attributes his anger to others (externalizes blame) and denies his part in the process. It seems to the therapist that T.J. has developed strongly entrenched defense mechanisms to avoid and deny his experience of anger, which also precludes any development of insight into his anger. Inevitably this leads to T.J. feeling a lack of control over himself and his emotions – he is unaware of why he is suffering. This would make any compassion-based interventions difficult to use at this time. A focus upon developing insight and mindfulness of his experience with anger and how it functions interpersonally may be most useful at this stage.

Chapter 1. Anger as suffering

1.1. Introduction

Violence tends to beget violence. In our hunter-gatherer days, violence occurred as quarrels between tribespeople for the acquisition of food and territory (Harari, 2015). Nowadays, violence seems to occur, in the Western world, more so from the striving for economic and social power combined with the need to appease our unfillable craving minds for the luxuries of the material and consumerist world. Basically, it seems that Homo Sapiens have been fighting, aggressing, and killing each other since our conception (Harari, 2015). There are surely, among others, biological, evolutionary, and sociological reasons for being violent. Because it is the duty of many mental health professionals to support those who have been violent, mental health professionals need to understand the reasons for violence and be able to empathize with those who participate in violent behaviours. This chapter will help to increase the understanding of the reasons for violence, implicated in emotional dynamics, as well as the intrapersonal and interpersonal suffering that often takes place for the individual who has been described as "violent."

Violence detrimentally impacts the lives of many. The World Health Organization (WHO, 2017) indicates that every year there are roughly 1.4 million people who lose their lives to violence and that millions more people suffer violence-related injuries. Beyond these direct consequences of violence, there is an increased risk to suffering innumerable health complications through exposure to violence. An increased risk of smoking cigarettes, abusing substances, suffering from mental illnesses and suicidality, chronic health diseases, contracting infectious diseases, and social problems such as crime and more violence are all possible indirect consequences of being exposed to violence (WHO, 2019).

In Canada, the rate of death by violence in 2017 was 1.77 per 100,000 for both male and females; for males it was 2.69, and for females, it was 0.84 (Statistics Canada,

2017). These rates represent a less violent situation for Canada when compared to global statistics. However, when looking at Canadian-specific numbers, the rates of violence are still egregious and deserve more attention – especially considering these statistics are the only incidences that are known and reported.

You are more likely to be harmed by someone you know than a stranger. Data from police reports of Intimate Partner Violence (IPV) in 2017, which includes violent offences between current and former legally married spouses, common-law partners, dating partners and other kinds of intimate partners, indicate that "IPV represented close to one-third (30%) of all police-reported violent crime in Canada, affecting almost 96,000 victims aged 15 to 89" (Statistics Canada, 2017, p. 1). Women were overrepresented by a majority – representing almost 79% of victims of IPV crimes (Statistics Canada, 2017). Overall, violent crime victims were subjected to violence by either an intimate partner as defined above, or by someone else who they knew, whereas 26% of victims were harmed by a stranger (Statistics Canada, 2017).

There were 933 IPV homicides, which typically occur within complex interpersonal contexts involving a history of violence, in Canada between 2007 and 2017 (Statistics Canada, 2017). Female victims represented the majority (79%) (Statistics Canada, 2017). Police reported that "the primary motive in these cases was most often an argument or quarrel (50%), frustration, anger or despair (24%) and jealousy (17%), a range of emotions typical of offenders exerting control over victims" (Statistics Canada, 2017, p. 7).

The aforementioned data relay the presence of violence even within the safe borders of Canada. Most importantly, for the purpose of this thesis: arguing, anger, frustration, despair, and at times jealousy were the most common antecedent experiences. What underlies the experiences of arguing, anger, aggression, rage, and violence, and how do mental health professionals support an effective violence prevention program for individuals who see a counsellor or mental health professional? By exploring in-depth anger, aggression, and rage – the oft-exemplified antecedents to

violence — this chapter aims to answer these questions. Understanding these experiences subjectively and objectively allows the individual sufferer and the clinician to support the *person*, instead of solely the emotion, more effectively.

1.2. Anger, Aggression, and Rage

There are many words to describe seemingly similar experiences and phenomena. Anger, aggression, rage, violence, and hostility are a few words encompassing the difficult-to-bear experiences that are perceived as harmful by the recipient. However, finding a coherent definition for these terms has been plaguing researchers for quite some time.

Creating a cohesive definition must rely on the common thread underlying these experiences – they are reflective of, or are related to, emotions. Emotions are evolutionarily derived experiences with cognitive, behavioural, and affective components which provide "moment-by-moment feedback information … and provide the impetus for motivation and action" (Gilbert, 2014b, pp. 13-14) to increase the likelihood of surviving. Essentially, emotions are required for anything to be considered important (Gilbert, 2014b). Gilbert (2014b) asserts that without emotions, nothing matters. Once individuals are consciously aware of their emotions, such as anger, they obtain a clearer idea of what they need and how to get it. They are able to regulate and utilize their emotions to their advantage instead of allowing the emotions to take over. However, emotions can also occur unconsciously and can conflict with one another, thereby leading to confusion, distress, and a perceived sense of lacking control (Greenberg et al., 1993). Throughout this thesis, the terms *emotion* and *affect* will be used interchangeably.

Anger is a difficult emotion to define due to its relationship with the experiences of aggression, rage, and violence. For instance, T.J. reported in one of his sessions that he was angry at his boss for not obtaining a promotion at his previous job. He threw a coffee mug at his boss when denied the promotion – a retaliatory aggressive response

preceded by feelings of anger. Anger, then, seems to be denoted by an assessment of transgression in the other with a consequent behavioural tendency to resist or retaliate in order to counter the transgression (Lazarus, 2000). This perception of anger emphasises the movement towards righting the wrong that has been done unto them (T.J. being denied the promotion) and is based on a cognitive-motivational-relational theory of emotion (Lazarus, 2000). Defining anger in this way seems to imply the requirement of an act of aggression due to its emphasis on *the behavioural tendency to resist or retaliate against the other*. This definitional integration of aggression and anger seems to be popular amongst researchers in the field.

Harmon-Jones et al. (2010) argue that anger *often promotes* approaching the perceived instigator of anger and discovered that anger functions as an approach motivation, primarily to support the destruction of the anger-producing source. For instance, T.J. felt angry at his boss when denied the promotion and threw his coffee mug, presumably to *destroy the anger-producing source* (i.e., his boss). Thus, anger was implicated with aggression. The above definitions imply a movement toward the other, but in reality, anger may be directed inward. I declare that anger, despite its preceding cause, can also be observed (intrapsychic) solely as the associated physiological, sensory, and cognitive phenomena – movement or action are not necessitated. Moreover, it seems that most often, the experience of anger occurs in more complex scenarios which involve the interplay of multiple conflicting perceptions and cognitions. Evidently, it is difficult to differentiate anger from aggression with the use of the above definitions as the terms are dependent upon one another. Therefore, I will use different definitions for each phenomenon to differentiate them.

Anger will be defined as an assemblage of particularly difficult subjective experiences constructed of cognitive, affective, autonomic (facial expressions, muscular blood flow), and interoceptive components (Volavka, 2013) that occur when the individual feels their intentions or goal-directed behaviours have been thwarted or hindered somehow. This definition excludes any necessary outward action or

movement towards resolving or overcoming the obstacle. Implied in this definition is the concept of relationality. Anger is a relational emotion – it occurs in relation to something (e.g., an object) or another living thing (i.e., someone else or oneself). Oftentimes, as exemplified with T.J., there is an *angerer* (i.e., the girlfriend of T.J.) – the person or thing that is the antecedent, seemingly causal, source of the experience of anger. Anger, then, is like a signal that alarms us to a situation when something we value, desire, or need is at risk of being taken away or not being fulfilled. Anger indicates and helps us physiologically, cognitively, and motivationally, to act urgently, actively, and directly to secure/protect what may be lost (i.e., what already was in our possession), or to seek out and secure what is at risk of being unattainable in the first place (i.e., what is not yet in our possession). For instance, it could be presumed that T.J. became angry at his girlfriend (he threw the plate at the wall) from perceiving that his sense of self as competent and helpful was taken from him, or that he felt rejected when asked about not doing the dishes. T.J. assumed that his girlfriend thought he was incapable of helping out and so felt interpersonally rejected. His sense of self as competent became precarious from both a personal and interpersonal perception.

Anger, as any emotion, can be seen as being adaptive or maladaptive. Anger, when experienced and expressed adaptively, supports the attainment of a certain goal that is in alignment with the values, desires, and needs of an angry individual. In extreme cases, it reflects the goal of self-preservation. It supports the resolution of an issue that was leading to personal suffering. For instance, adaptive anger might be observed when someone being physically abused feels anger towards their attacker and resolves the situation either in the moment by retaliating aggressively in self-defence to prevent the abuse from continuing or resorts to seeking other mediational supports, for example, informing the police (DiGiuseppe & Tafrate, 2007). Maladaptive or dysfunctional anger is when an individual may respond with anger “to nonthreatening stimuli as if one were threatened” (DiGiuseppe & Tafrate, 2007, p. 246). It is considered maladaptive anger when anger expression becomes excessive and results in aggressing against friendly or non-threatening individuals. For instance, excessive and chronic

anger have been regarded as clinically problematic when they interfere with or negatively affect health, judgment, caring for others, and sexual functioning, among other facets of life (DiGiuseppe & Tafrate, 2007).

Moreover, the definition of aggression has been stated as an outward action tendency (i.e., verbal or physical aggressive act) to cause harm to another person who does not want to be harmed (Allen et al., 2018). This definition by the authors of the General Aggression Model (GAM) also indicates that aggression is more "likely when specific individual differences interact with situational features to influence one's cognitive, physiological, and affective state" (Denson, 2013, p. 104). Therefore, in this thesis, *aggression* will be defined as an overt action tendency that is directed and intended to harm others, objects, or oneself via verbal, physical, emotional or any other form of abuse. As the aggressor's perception is affected by situational and individual factors (e.g., cognitions, affective state, behavioural action tendencies), the aggressor believes they were wronged in some way and thus the recipient of the aggressive act is perceived to deserve retaliation against them/it (Allen et al., 2018; Denson, 2013; Potter-Efron, 2015).

There are various types of aggression depending on its conceptualization. I will be focusing upon reactive (as opposed to instrumental) aggression, which is sometimes referred to as impulsive aggression (Swogger et al., 2015). This form of aggression pertains to shame-rage cycles, as seen with T.J., and is more frequently reported in the population to be discussed in Chapter 2.

Reactive aggression is considered impulsive and typically occurs with negative emotions such as anger, frustration, and sadness (Blair, 2018). Reactive aggression has been theoretically implicated in the frustration aggression hypothesis indicating that an individual with a deficit in emotional regulation skills and an increased hostile attributional bias will aggress when frustrated, perceives a threat, or is provoked (Berkowitz, 1989; Fite et al., 2016). The individual is hypothesized to respond to

negative affective states (e.g., shame) by aggressing against the other (Swogger et al., 2015).

In contrast, instrumental aggression, also commonly referred to as proactive aggression, typically denotes aggressive acts that were planned ahead of time. “The aggressor anticipates that the act will have a positive outcome (increased resources or social status or gratification of a perceived need)” (Blair, 2018, p. 1) and therefore plans the aggressive act to glean the desired outcome. Instrumental aggression is presumably learned through social experiences of reinforcement and acquisition of rewards after aggressing and frequently occurs without any experience of emotion (including anger) (Blair, 2018; Swogger et al., 2015). Whereas aggression is typically a conscious act that the aggressor remembers (although many arguments can be made against this), the experience of rage is one that seems to be more unconscious.

Rage, although similar to anger and aggression, differs in its experience. Potter-Efron (2015) has explicated a useful description of rage that will be used for the purposes of this thesis. He describes rage as “an experience of excessive anger (and often other emotions) characterized by partial or complete loss of: a) conscious awareness (blackouts not due to alcohol or other drug reactions); b) a normal sense of self; c) behavioral control” (Potter-Efron, 2015, p. 50). Potter-Efron remarks that some of his clients report feeling a Dr. Jekyll and Mr. Hyde type of experience, typically not remembering what they did while in a fit of rage. Therefore, *rage* will be defined more succinctly as “an experience of tremendous fury, far more intense than strong anger, which may be triggered by an immediate danger to one’s existence or identity, or by a longer-term sense of unbearable injury or injustice” (Potter-Efron, 2015, p. 50).

Although the definitions of anger, aggression, and rage differ, they are all uncomfortable experiences due to the perceived mistreatment of ourselves (verbally, emotionally, physically) and increase the likelihood of desiring to correct or retaliate against perceived wrongdoings. Anger and rage signify the phenomenological experience whereas aggression implies the act of retaliation. As much as it is helpful to

have an intellectual understanding of definitions of phenomena, it is equally helpful to understand the distinct experiential ways the anger sufferer subjectively experiences anger, aggression, and rage and how mental health professionals may observe these experiences in clients.

1.3. The Experience of Anger, Rage, and Aggression

This section outlines the subjective experience of anger through its entire spectrum (i.e., irritation to rage). First, I will begin to detail more observational indices of anger, often associated with the experience of aggression and rage as well. Lastly, I will explicate more subjective accounts of the visceral sensations of anger, taken from research studies using qualitative methodology. The importance of explicating the subjective experience of emotions has recently been advocated for due to the apparent lack of research exploring this area. Barrett et al. (2007) completed an annual review of the different theories of emotions and argued that "[d]escribing how emotion experiences are caused does not substitute for a description of what is felt, and in fact, an adequate description of what people feel is required so that scientists know what to explain in the first place" (p. 374). These researchers emphasize the need to understand the subjective experience of all emotions in order to effectively research therapeutic ways of supporting mental health.

Some of the earliest observations of angry behaviour and experiences were by Charles Darwin, the revered naturalist and biologist most known for his contributions to the science of evolution. Darwin (1872) states, "So a man may intensely hate another, but until his bodily frame is affected he cannot be said to be enraged" (p. 250). He therein implies the unequivocal cooccurrence of the manifestation of anger/aggression/rage in the body. For some of the objective experiences that Darwin observed with regard to humans and their experience of anger, indignation, and rage (Darwin, 1972) see Figure 1 – Objective indices of anger, indignation, and rage.

- The face appears red or purple and the veins on the forehead and neck become distended, however, sometimes the heart becomes quite hindered by rage that "the countenance becomes pallid or livid" (Darwin, 1972, p. 250).
- As per the forehead, Darwin (1872) reported that there is often a patent frown on the forehead. Sometimes though, "instead of being much contracted and lowered, remains smooth, with glaring eyes kept widely open" (p. 252).
- The eyes appear to be always bright and seem to stick out from their sockets (Darwin, 1872).
- The nostrils of the nose will be dilated and spasming (Darwin, 1872).
- The mouth is generally closed with firmness, showing fixed determination, and the teeth are clenched or ground together. However, in more intense levels of anger and rage the clenched teeth may be shown while the lips are retracted (Darwin, 1872).
- The chest of the individual may move in and out quite erratically or quickly; it heaves (Darwin, 1872).
- Generally, the body is observed to be held upright, but may be bent forward towards the perceived threat. The arms and legs will be quite rigid, and the fists are commonly clenched. Overall, the body may be trembling, especially if in intense rage (Darwin, 1872).
- Of interest to note is that when young children are expressing their rage they may "roll on the ground on their backs or bellies, screaming, kicking, scratching, or biting everything within reach" (Darwin, 1872, p. 251).

Figure 1. Objective indices of anger, indignation, and rage

Moreover, Retzinger (1995), an experienced clinician particularly regarding shame, anger, and their interrelatedness, explicates how anger is experienced and observed particularly in relation to shame since "anger is a common way to defend against shame" (p. 1106). The following information has been extracted from her own clinical experience as well as other interview-based studies that coded the interviewees for different ways of communicating their shame-related anger. These manners of communication are referred to as cues.

Firstly, Retzinger (1995) listed specific verbal cues used by an individual that indicate anger: aggravated, angry, bothered, enraged, fuming, furious, incensed, irate, irritable, pissed. Secondly, she listed statements that were found to indicate hostility (when in reference to self, other, animals, objects): abandoning, blaming, causing, criticizing, cursing, deprecating, destroying, dislike, harming, hating, mutilation, threatening, violence. The aforementioned words (not exhaustive) may be used by individuals when feeling angry or hostile toward someone (including themselves), something, or an animal.

Thirdly, Retzinger (1995) asserts that anger can be observed through verbal challenges. Challenges "involve a kind of acting out of hostile behavior rather than speaking directly about feelings" (p. 1109). Retzinger lists the observed challenges as: interruptions, sarcasm, blame, criticism, questioning (same question repetitively), presumptive attributions (likened to projection of thoughts, feelings, behaviours), prescriptions (requests, or demands to change others behaviour), and threats (Retzinger, 1995; Sillars et al., 1982). These challenges present as universal expressions and individuals display anger in differing ways with different intensities – they attempt to glean their needs with these socially understood and acknowledged behaviours. It is likely that individuals use them so regularly that they become unaware of the intention and emotion behind them. Additionally, the following paralinguistic gestures are reported in individuals experiencing anger: speaking loudly, increased stress and emphasis on certain words, staccato (breaks between sequential tones), repeated patterns of pitch and stress, and nasally sounding utterance of words (Retzinger, 1995).

The above-mentioned findings from Darwin (1872) and Retzinger (1995) present more objective indices of anger. These indices should be studied and tracked by mental health professionals as possible signs of shame-rage difficulties. The subjective experiences of anger are explained in the qualitative research completed by Tom Barber (2018). The article contains the phenomenological experiences of anger as obtained

through semi-structured qualitative interviews with six men between the ages of 20-25 years old. The key findings presented here were related to six subthemes.

Barber (2018) created the first subthemes regarding the relational component (interpersonal) and the visceral sensations related to the experience of anger. In essence, the experience of anger was always relational, involving someone else, and the perception individually influenced the arousal of anger in the individual. Barber highlights the relational importance of the experience of anger by indicating that anger "always began with the involvement of another person; someone else's disrespectful behaviour towards them "sets them off." Awareness of anger was triggered when participants observed the Other as not doing what was expected of them" (p. 336). Barber is asserting that the angered individual perceived negative or disobedient behaviour in the "other" and interpreted it as an attack against them. Consequently, the participants described feeling as if they were unjustly treated and reported frustration being approached this way.

Barber (2018) also recorded the participants' visceral sensations in the body: "rushing, tightening, tensing, pumping, building, shaking, boiling, clenching … numbing … pressure, hotness, dizziness and blacking-out" (p. 336). These sensations varied in speed of intensity, from gradual (like a wave) to rapid (sudden and uncomfortable), depending on the participant.

The third subtheme represents the participants' alteration of their metaphorical self during an experience of anger. Reporting on the participants' experience, Barber (2018) indicated that "[t]heir body size, strength and even colour … change as they morph into a different version of themselves, described as being like the character of the 'Incredible Hulk'" (p. 337). Thus, when the participants experienced extreme levels of anger, nearing the experience of rage, Barber emphasizes that they felt increased metaphorical pressure within themselves, expressed themselves with louder voices, and experienced themselves as embodying something larger and more powerful than how they typically imagined themselves to be, such as being like the "Incredible Hulk."

The fourth subtheme Barber (2018) introduced related to control and responsibility. The participants reported a felt loss of control as they became angry and seemed to lose their sense of self during the process. Retrospective statements of surprise were reported from the participants indicating an unawareness of their own anger (Barber, 2018). This is typical of individuals who experience bouts of rage (Potter-Efron, 2015). Essentially, when the participants were extremely angry, they felt a lack of responsibility for their actions as they experienced themselves as psychologically distant from their behaviour. The last two subthemes discussed in this study relate to the direction of the participants' anger.

As Barber (2018) explains, the participants directed their anger towards themselves, others (perceived to provoke them), and/or objects. Largely, the participants wanted to dissipate their anger and needed to channel it elsewhere (in some cases, towards themselves). As Spielberger (1999) reported, anger sufferers attempt to get rid of the anger by expelling it outwards – often towards the accused "other" or inanimate object in their way. Barber comments that "[o]nce the anger has been directed onto something or somebody else, participants experienced the urge to leave the scene in order to enable their sense of self to re-emerge" (p. 337). Barber also explicates that participants reported a need to expel their anger onto others and to escape the area in order to collect and express their former sense of self. I interject that the need to escape and reclaim a sense of self indicates a possible avoidance of the "angered self" due to a sense of shame or embarrassment.

I feel a certain resonance with the material when reflecting upon the above-mentioned descriptions of the experience of anger. Particularly, I resonate with feeling like "The Hulk." When going through middle school I was often the victim of emotional bullying. At the time of the bullying, I felt a lack of control and of being helpless. When arriving home from school, on a day when I was bullied, I became very frustrated and experienced a charged-up sense of physical and mental power. On the one hand, it was distressing and scary; I did not know what I was capable of. On the other hand, I enjoyed

the feeling of being powerful and strong. It never occurred to me at the time that my anger was a result of first feeling ashamed and socially rejected. At the time, I did what I felt was best with this new feeling of physical vigor, I began exercising in my room and at a local community centre. The habit of exercising greatly diminished my feelings of helplessness and lack of control and so I was able to sidestep the issue of feeling shamed for a while. Most importantly though, I was lucky to have had a supportive family and social network. My social network helped to preclude the development of any maladaptive behaviours, with love and attention, I could have adopted if I did not have this level of support from family and friends.

All of the above information describes the objective and subjective information regarding an experience of anger, from anger to rage, generally speaking. However, due to the complexity of anger, as well as any other emotions, researchers in this field have discovered that a psychologically-based theory is more likely to explain the experience and expression of anger that is necessary to bolster the understanding of how this phenomenon is experienced and therefore how to support its regulation and expression in a manner that is most useful to the individual sufferer.

1.4. Assessment of Anger

The specifications of differences in the experience and expression of anger have been thoroughly researched and form the basis of a widely used and empirically validated anger psychometric scale, the State-Trait Anger Expression Inventory-II: STAXI-II (Spielberger, 1999; Lievaart et al., 2016). Scales like this are imperative in the assessment of individuals who come to therapy indicating that anger is the root cause of their suffering.

There are many assessments for anger and aggression and/or rage. I will outline two assessments primarily indicative of anger but can be used to ascertain information regarding aggressive tendencies as well (Potter-Efron, 2015). First, the Anger Disorders Scale (ADS) will be described briefly. Then I will describe the scale by Charles

Spielberger, the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988) in more detail.

The Anger Disorders Scale is a 74-item self-report assessment that indicates different levels on 21 different facets of anger and aggression (DiGiuseppe & Tafrate, 2007). It can be used for clinical and non-clinical populations. Some of the items reported on include: reactivity, physiological arousal, impulsivity, rumination, suspiciousness, and revenge (DiGiuseppe & Tafrate, 2007). DiGiuseppe and Tafrate (2007) describe this scale as most useful for gathering an understanding of how the individual experiences their anger and aggression and in which ways they, and others, are affected by their experiences with anger and aggression.

Spielberger (1988), one of the eminent researches and contributors to the psychological study of anger, explained anger as either a momentary state (i.e., how people feel at the time) or as a trait (i.e., how people feel in general). Moreover, Spielberger also recognized the importance of individual expression or control of angry feelings. After his development of the first measurement tool, the State-Trait Anger Expression Inventory (STAXI), the associated State-Trait Anger Theory became widely empirically validated (DiGiuseppe & Tafrate, 2007). The second and most updated version of this measurement tool, STAXI-2, comprises six scales: State Anger, Trait Anger, Anger Expression-In, Anger Expression-Out, Anger Control-In, and Anger Control-Out (Lievaart et al., 2016).

The *State Anger Scale* assesses the intensity of anger as an emotional state. For instance, the intensity of feeling angry (i.e., from irritation to rage), the intensity of wanting to express anger verbally, and the intensity of wanting to express anger physically. The *Trait Anger Scale* assesses Angry Temperament (T-Ang/T) which is the measurement of the propensity to experience anger without provocation and Anger Reaction (T-Ang/R) – the measurement of the frequency that angry feelings are elicited in frustrating or negatively evaluated situations (Lievaart et al., 2016).

The *Anger Expression Scale* comprises two subscales: Anger Expression and Anger Control, each broken down into the following subscales (Lievaart et al., 2016). Anger Expression-Out (AX-Out) is defined as "a tendency to express angry feelings towards other persons or objects in a negative way," (Brodie et al., 2018, p. 5) whereas Anger Expression-In (AX-In) is "a tendency to suppress angry feelings" (Brodie et al., 2018, p. 5). Anger Control-Out (AC-Out) is defined as an attempt to regulate angry feelings by averting their expression towards the perceived source of the anger, whereas Anger Control-In (AC-In) is an attempt to regulate angry feelings by the engagement in relaxing or calming exercises, such as taking a deep breath (Brodie et al., 2018). Having described the STAXI-II assessment tool, the assessment results for T.J. are presented in Figure 2 – Application of STAXI-II to the case of T.J.

- State Anger Scale: T.J. feels anger intensely, usually on the end of the spectrum towards rage. He tends to want to express his anger physically more frequently and intensely relative to expressing anger verbally. T.J. discovered that he feels a decrease in rage and anger only after he expresses it physically.
- Trait Anger Scale: T.J. has low to moderate levels of angry temperament but has frequent and intense angry reactions when frustrated or perceived to be negatively evaluated by others.
- Anger Expression-Out: T.J. often expresses his anger outwards towards others and reported that he often blames others for causing his anger.
- Anger Expression-In: T.J. experiences negative thoughts about others and himself frequently.
- Anger Control-Out: T.J. attempts to regulate his anger by frequently expressing it outwards toward others and objects.
- Anger Control-In: T.J. rarely attempts to regulate his anger by using self-soothing or relaxation techniques.

Figure 2. Application of STAXI-II to the case of T.J.

T.J. was assessed to feel intense anger, often akin to the experience of rage. He usually prefers to express his anger physically, rather than verbally. However, at times, he expresses his anger in both ways. He typically is unaffected by feelings of anger,

except when he perceives someone to provoke him, in which case he reacts angrily or in a rage. Although he more frequently and intensely expresses his anger and rage outwards (toward others and objects), he still expresses it inwards, by way of angrily ruminating on personal negative aspects. As per controlling his anger, he more frequently regulates his anger by expressing it towards others, which does allow some relief. He rarely attempts to regulate his anger using relaxation or self-regulation strategies.

The assessment of T.J. provides an exemplification of the use of STAXI-II and parallels Spielberger's (1988) proposal of the experience and expression of anger. Spielberger suggested that anger can be experienced differently depending on the person, which can have potentially drastic outcomes for the individual depending on their experience of the intensity, duration, and frequency of anger as well as the manner in which they control and/or express their anger. Therefore, I assert that this assessment should be used throughout therapy by counsellors and mental health professionals to help inform the treatment of problematic anger, as experienced idiosyncratically, from which their clients suffer.

1.5. Neuroscience of Anger

The experience of anger can be elusive; when feeling wronged by someone, humans may in fact turn inwards and blame themselves for the outcome. Or perhaps humans feel shamed due to their perceptions of someone ridiculing or belittling them. Instead of stewing in the extremely uncomfortable experience of shame, they react with anger to "get back" at the individual perceived to shame them. Needless to say, the motivations and functions of anger and aggression can be maladaptive and lead to more long-term deficits and consequent anguish. Accordingly, this section will explain some of the evolutionary and neuroscientific-based functions and motivations of anger and its support in attaining our needs when used adaptively.

When I say that the reason for anger can be maladaptive or dysfunctional, it is not because I believe anger should be judged and depreciated. Rather, I imply that over time, individuals can learn through attachment experiences, modeling, and conditioning, maladaptive expressions of anger. Sometimes, the best course of action in pursuing our goals would be to preclude the use of anger and adopt a new approach to the situation, or to express anger in a manner that is congruent with our values. However, as anger researcher Potter-Efron (2015) has demonstrated, this can become difficult for individuals who have been tormented throughout their lives and have developed "angry brains" (p. 4). Potter-Efron discusses the research regarding neurophysiological differences in individuals who are chronically angry or seem to present with maladaptive anger issues.

In essence, "angry brains" are wired for survival and thereby perceive situations as more threatening than others (Potter-Efron, 2015). Individuals with brains that are more sensitized to perceiving threats (indicated through stronger neurophysiological pathways) have an increased propensity to react, relatively unconsciously, with anger (LeDoux, 1998; Panksepp & Zellner, 2004). This develops into a vicious cycle of anger, increased perceptions of being slighted, and of "not getting their way."

To elucidate the rise of anger and aggression in certain individuals it is necessary to explicate the purpose of anger and *why* it may arise. The purpose of anger is exemplified here through discussing the evolutionary basis of anger, and its primary function for homo-sapiens and other animals. Many contemporary researchers are using an evolutionary psychological theoretical basis for their conceptualization of psychological disturbances and their proposed therapeutic strategies and implementations. One of the most influential is Paul Gilbert, a prominent figure in shame and compassion research, and the founder of Compassion Focused Therapy (CFT). Gilbert (2014) argues that humans have developed different evolutionarily-based motivational systems, which he refers to as *social mentalities.* These social mentalities are neurologically based upon three affect-regulation systems.

Gilbert (2014b) defines the three main affect-regulation systems as:

> (1) alert to threats and activate defensive strategies; (2) provide information on the availability of resources and rewards and activate seeking-engagement strategies; and (3) provide information on safeness, allow for rest and digest and relative non-action in the form of contentment and openness. (p. 14)

The three affect-regulation systems are referred to as the: 1) Threat and self-protection system (for self-protection against threat to ourselves and our kin); 2) incentive/resource-seeking system (to achieve desires and needs such as food, sex, care), and; 3) Soothing and contentment system (to support play, digestion, feeling of calm and safety and caring for ourselves and kin). These affect-regulation systems provide the basis for many social mentalities. These mentalities, when activated through the related affect-regulation systems, "organize a range of psychological functions such as attention, emotion, cognition, and behaviour in pursuit of that motive or goal" (p. 11). Thus, the *threat and self-protection affect-regulation system* activates defensive social mentalities elicited in response to an attack on the self, such as, if an individual is perceived to be verbally insulted, for example, the girlfriend of T.J. makes a remark that leads him to feel angry and react aggressively. Anger, herein, is an emotion based within the threat and self-protection affect-regulation system – it supports T.J. in protecting against further injury to his sense of self (Gilbert, 2014b).

Gilberts' (2014b) three regulation systems seem to functionally parallel what current affective neuroscience has discovered as primary emotional processes in the brain. Panksepp and Biven (2012), affective neuroscientists, report on the discovery of seven primary-process emotional-affective systems, namely, SEEKING, FEAR, LUST, CARE, GRIEF/PANIC, PLAYFULNESS, and RAGE, that are reported to be homologous to other mammals studied in the lab and form the basis of our emotional systems, rooted

in mammalian evolution.[1] The use of explicating human behaviour through these neurophysiological substrates is controversial as the principal studies leading to the substrates (e.g., RAGE) was conducted in mammals, rather than humans (Panksepp & Biven, 2012). However, leading researchers in the field of emotion, neuroscience, and survival circuits, such as LeDoux and Hofmann (2018) assert that "because behavioral and physiological responses are important contributors to emotions, and the circuits underlying these are highly conserved, studies of animals have an important role in understanding how emotions are expressed and regulated in the brain" (p. 67). Nevertheless, I am examining and exemplifying the neurological substrates for the seven discovered emotional pathways in order to explicate the neurological and evolutionary underpinnings of anger, aggression, and rage, in short, the RAGE system introduced in this thesis. These pathways will also be discussed throughout this thesis in order to align the concepts discussed with neurological substrates.

Panksepp and Biven (2012) describe the seven primary-process emotions as emanating from the sub-neocortical regions of the brain (midbrain) and are responsible for the emotional experiences for each of the seven systems. Panksepp (2010) also indicates that there are secondary and tertiary emotional processes. The *secondary-process emotions* involve the learning of emotions (i.e., classical conditioning) and depend upon neurological substrates that are higher in the brain than the sub-cortical (midbrain) primary-process areas (Panksepp & Biven, 2012). The *tertiary-process* emotions constitute the ability to be aware of the affects as well as interlay executive functions, ruminations, and free-will and require the use of our neo-cortex (Panksepp, 2010). Antonio Damasio, another highly respected researcher in the area of neuroscience and neurology, also has found corroborating evidence for different neural

[1] The use of capitalization of the seven primary-process emotional systems by Panksepp and Biven (2012) is because these systems, and therefore the words to describe them, designate specific neurological structures in the subcortical brain that have been empirically researched in animals. Thus, the capitalized words are the names of primary-process emotional systems that imply the association with actual physical structures that are implicated in the emotional experiences that are created by them: that is, they are not just words attempting to describe phenomenological experiences in humans.

networks for emotions (fear, anger, sadness, happiness) in the brain (Damasio et al., 2000; Panksepp, 2010). I will describe the seven primary-process subcortical affective systems briefly as they appear throughout this thesis.

The first, implicating the six other systems, is the SEEKING system. Panksepp and Biven (2012) clarify that this system is often mistakenly referred to as "the reward system" in the brain, but it is more complex and important. The SEEKING system has been discovered to be implicated in any form of pursuit towards any cognitively or biologically based need, for instance, the SEEKING system combines with the LUST system in order to search for a mate to procreate. The experience of the SEEKING system is described as feeling akin to a state of euphoria and galvanizes animals and humans to search for whatever we need or want. Panksepp and Biven (2012) emphasize that the SEEKING system is constantly aroused in materialistic Western cultures.

The FEAR system is the experience of being afraid. It manifests into experiences of free-floating FEAR, similar to anxiety in that there is a FEAR of certain situations/objects or of things in general (Panksepp & Biven, 2012).

Panksepp and Biven (2012) implicate the LUST system in the search for sex as well as the search for romantic love. It is therefore, in evolutionary terms, based upon the need to procreate and to produce offspring to ensure that our genes continue on (Dawkins, 1989; Panksepp & Biven, 2012).

The CARE system is implicated in the urge to nurture and support others, particularly our children. However, it is also proposed to be implicated in the development of non-sexual friendships (Panksepp & Biven, 2012).

The PLAY system is generally regarded as the foundation for playing with others. It also supports learning how to interact with the environment and others in useful and affiliative ways (Panksepp & Biven, 2012).

The PANIC/GRIEF system is essentially responsible for indicating separation-distress when CARE (receiving and providing) has been taken away (Panksepp & Biven, 2012). This process acts as an alarm system to self and others when the need for care and support are not provided. Thus, the purpose of this system is to get the attention of others, particularly caregivers, to glean the necessary support, nourishment, and/or care. If this attention is received, the CARE system becomes activated once again (Panksepp & Biven, 2012).

Panksepp and Biven (2012) assert that the RAGE system is strongly connected, neurophysiologically, to the SEEKING system. The RAGE system is activated when the SEEKING system is thwarted. Since the SEEKING system is involved in all of the primary-process emotions, RAGE is activated when the pursuit of the other systems is thwarted. The thwarting of the SEEKING system, when in conjunction with any of the other primary-process emotions, is reported to be likened to the experience of hopelessness and lack of vigor – akin to the experience of shame in humans. For instance, if our human pursuit to glean CARE from others is rejected or dismissed then we may experience RAGE (Panksepp & Zellner, 2004).

A common proposed pathway, partially implicated in the development of an "angry brain," occurs when an individual needs CARE but results in RAGE; this is exemplified in the following situation. T.J., six-years old, wanted help from his mother to get ready for school the next day (SEEKING AND CARE were activated), but, his mom was on the phone and so dismissed his calls for help. T.J. then felt PANIC/GRIEF which was meant to demonstrate the severity of his need for help and ideally would have beckoned his mom over to him (T.J. was anxiously pacing around the living room and crying). After some time of being continuously ignored by his mom, T.J. then became FEARful of not being able to solicit his need for support. After some time, it became apparent that none of T.J.s expressions of FEAR would galvanize his mom into providing support for him. This resulted in a feeling of despair and hopelessness; this occurred due to a decline in activation of the SEEKING system (experience akin to shame). RAGE was

the last step in this sequence to secure what he needed – he began to hit his mom repeatedly on her legs until she hung up the phone. The mother of T.J. then responded to his urgent requests for help. If she had not, T.J. would have fallen into a despondent, hopeless, and depressed state – all attempts at soliciting help failed thereby his body and mind resorted to shutting down behaviourally and emotionally.

T.J. has experienced the above sequence throughout his entire life. When T.J. experienced a situation in adulthood where he felt his need was not being recognized or honoured, he skipped the in-between stages of PANIC/GRIEF and FEAR. He learned through his childhood that the PANIC/GRIEF and FEAR primary-process emotions did not help him receive what he needed. Instead, he reacted immediately with RAGE (Badenoch, 2018; Panksepp & Biven, 2012). When T.J. first went through the full process of SEEKING out CARE from his mother – CARE, PANIC/GRIEF, FEAR, decreased SEEKING, then RAGE – he was moving through progressive stages of emotions to seek what he needed. If T.J. was provided with the CARE he needed at the time, somewhere along this pathway before reaching RAGE, he may have been able to adaptively use other emotional-motivational processes to secure his needs. However, given his experience through life, he learned that the only way to attain his needs (albeit with other negative consequences) was to react maladaptively, with RAGE (Panksepp & Biven, 2012). The abovementioned exemplification of movement through progressive stages of primary-process emotional networks can be seen in Figure 3 – Soliciting support: Sequential activation of emotional networks.

Panksepp and Biven (2012) explain how the RAGE system is implicated in "affective attack" – a type of defensive or offensive attack – in mammals. It is proposed to consist of the amygdala, hypothalamus, and periaqueductal gray areas of the brain. This RAGE system is a part of the threat and self-protection affect-regulation system highlighted by Gilbert (2014b) – activating defensive social mentalities to protect oneself – which supports humans' ability to survive when confronted with a threat to our lives or at least something *perceived* to be a threat to our sense of self, livelihood,

social status, or safety (Gilbert, 2014b; Panksepp & Biven, 2012; Panksepp & Zellner, 2004).

The RAGE substrate implicates individuals who suffer from the maladaptive use of anger. It can become overused and can result in a vicious cycle of anger through neuroplasticity (the physiological and structural changes in the brain that occur from experience and learning). The expression, *neurons that fire together, wire together,* exemplifies this notion (Hebb, 1949). The more an individual becomes angry, the more easily and quickly they perceive situations as anger-inducing; they have a propensity to react with anger, so on and so forth. This behavioural and emotional sequence seems to have neuroplastic effects within the brain, thus increasing the likelihood that anger begets anger with increasing frequency (Damasio et al., 2000; Panksepp & Zellner, 2004; Potter-Efron, 2015).

1.6. Avoidance of Anger

Typically, problems with anger (frequency, intensity, duration) are reported for certain clients upon entering a mental health clinic. The individual, such as T.J, would like to stop behaving angrily due to its influence on his personal and/or interpersonal life. However, there are many unknowns about how the anger affects the client. Anger is exacerbated by the persons coping mechanisms; avoiding the severity of the issue or of denying its existence in the first place – as seen in cases where the individual is mandated for therapy (Potter-Efron, 2015). Denying or avoiding our emotional experiences often contributes to worsening mental health and “experiential avoidance” (Frank & Davidson, 2014).

There are multiple types of experiential avoidance. In fact, the concept of experiential avoidance has garnered much empirical research that it is now perceived as a common coping mechanism with deleterious effects. Frank and Davidson (2014) discuss various types of experiential avoidance which they argue are common ways that individuals respond to their own vulnerabilities in an effort to be rid of their problems.

Frank and Davidson (2014) explain the different forms of experiential avoidance as: avoidance and escape strategies, behavioural avoidance, cognitive avoidance, interoceptive avoidance, emotional avoidance, and emotion-driven behaviours. The transdiagnostic roadmap positively contributes to the ever-developing trend toward seeking diagnostic formulations which are at the root of individual suffering (Frank & Davidson, 2014). This way of conceptualizing and diagnosing came as a reaction to the continuous controversy and debates about the efficacy and utility of criteria-based diagnosing which has many issues including comorbidity – as evidenced through the use of the *Diagnostic and Statistical Manual for Mental Disorders 5 (DSM-5)* (American Psychiatric Association [APA], 2013; Frank & Davidson, 2014).

Avoidance behaviours are typical ways of responding to our own experiences, to escape them, lessen their impact on us, and/ or control them in some way. However, these manners of relating, or lack of relating, to our experiences create further problems and often a worsening of the issue; paradoxically making it more difficult to avoid the experience (Frank & Davidson, 2014). For instance, in a sample of criminal offenders, one study found that an inability to attend to emotional experiences in oneself was positively indicative of an extensive history with reacting aggressively compared to individuals who were able to be alone with their emotions (instead of suppressing or avoiding) (Roberton et al., 2015). By using experiential avoidance strategies, a positive feedback loop develops between the initial issues and cause of the problems – referred to as *vulnerability mechanisms* – and the ways people try to cope with (i.e., via avoidant responses) the resultant experiences and emotions – referred to as *response mechanisms* (Frank & Davidson, 2014).

Due to the potential worsening of symptoms by using experiential avoidance strategies it is important to learn other ways of coping with emotions, for instance, anger. An effective approach in supporting individuals who respond to their own experience through avoidance mechanisms is by increasing their awareness and acceptance of their experiences and consequently, of themselves. Therapeutic

approaches for anger and avoidance will be further discussed in Chapter 3. However, for a brief depiction of the abovementioned concept, see Figure 3 – Soliciting support: Sequential activation of emotional networks.

1.7. Summary

Anger, aggression, and rage can differ in regard to frequency, intensity, and duration. They appear due to differing contexts dependent upon the person and the function these phenomena may serve in their lives. They are difficult experiences and can become intricately involved in some individuals' lives. Anger, aggression, and rage experiences can negatively affect the personal and interpersonal lives of those who struggle with any one of these phenomena. T.J. exemplifies his personal and interpersonal struggle when he reacts to the question posed by his girlfriend, "Why didn't you put the dishes away like I asked?", with RAGE. Clearly, he is suffering interpersonally with a perceived disconnection and lack of support from his girlfriend. He is also suffering personally due to experiencing chronic anger and irritability, wherein there is often a consequent feeling of lack of control and physical arousal.

There are neuroscientific (i.e., RAGE) and physiological reasons for the subjective and objective experience of anger, which also influence the potential routes of therapeutic intervention. The reason for looking at anger in research and in therapy is not to eliminate it but to understand how it can be utilized most fruitfully for each individual. Anger is often assessed with individuals using the Anger Disorders Scale (ADS) or the STAXI-II measurement, helping to develop a thicker picture of the idiosyncratic ways in which anger creates suffering and how the individual copes with that suffering. Anger, aggression, and rage can precede one another and develop into a vicious cycle where the typical response to any situation or provocation is one of anger, aggression, and/or rage. This can create a brain wired to experience anger. When there is a maladaptive tendency to regulate anger there is an increased likelihood to have

anger appear without awareness and results in acts of aggression – as seen through avoidance coping methods.

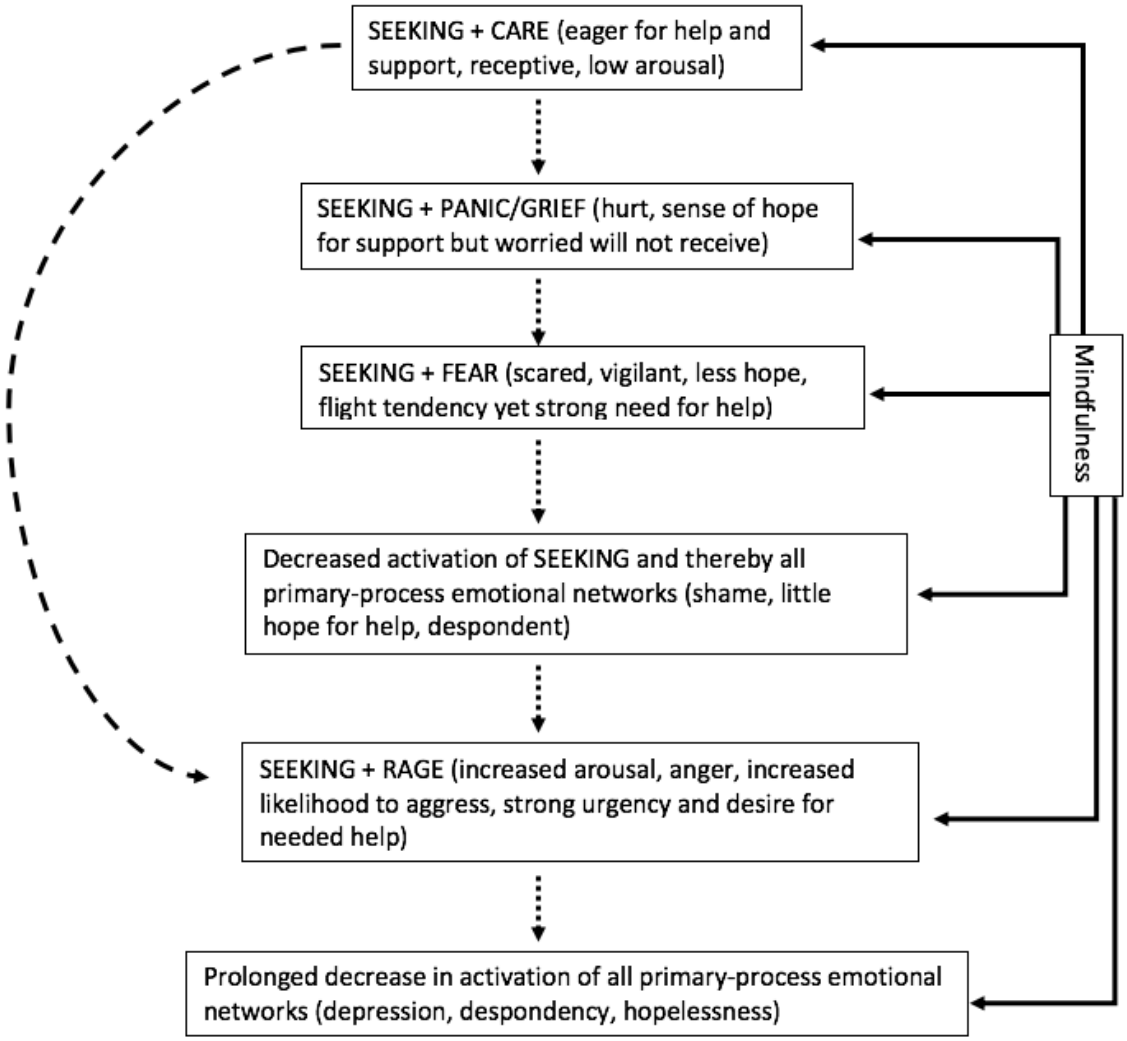

Figure 3. Soliciting support: Sequential activation of emotional networks

When requiring CARE and/or support of any kind, the individual progresses through various stages of primary-process emotional system activation. The dashed arrow indicates that if the above primary-process emotional system activation was not successful in obtaining the support needed, subjectively perceived as invalidation and rejection, the next sequential emotional network (below) will be activated. The curved dashed arrow from 'SEEKING + CARE' to 'SEEKING + RAGE' indicates that through continued conditioning of anger responses and invalidation of the other primary-process emotional systems the individual begins to avoid the other emotional systems and reacts with anger immediately after their needs have been invalidated at the first stage of the sequence (their initial request for help). The mindfulness box indicates that through increased mindfulness the avoided emotional systems become illuminated for the individual. The content in the brackets indicate the subjective experience of the individual.

Case Vignette: Bella

Bella is a Filipino 35-year-old bisexual cisgender female who immigrated to Canada with her family when she was 10 years old. She has since been living in Toronto, Ontario, Canada with her two parents and younger brother. Bella was raised Christian and still follows this faith. However, she does not regularly attend church anymore due to preferring to practice informally at her own discretion.

Before moving to Canada, she was sexually abused by one of her uncles on her maternal side of the family. She had not disclosed or processed this experience until she first began therapy when she turned 30. She first sought counselling because whenever she would become romantically involved with someone, she became irate and physically attacked them. She mentioned that this would happen without being aware of why she behaved like this. She automatically would resort with fury whenever the relationship became more intimately involved. She continued in therapy for 10 sessions, during which she discussed and explored her experiences of anger in greater detail.

During these sessions, she also became acutely aware of the shame she experienced when others would become close to her. She realized that when she felt herself opening up more to her partner, she became reminded of her experiences of being sexually violated as a young girl. She reported having nightmares of these traumatic events in various ways. She continued with therapy beyond the first ten sessions and began to explore the inextricable links between her shame and fits of fury. In order to elucidate the experiences of Bella, the following list contains examples of experiences of shame-rage events reported during her 11th to 14th counselling sessions:

- Bella reported that she felt a sudden hollowness in her body, she felt empty inside and reported having thoughts of worthlessness and disgust towards herself whenever she was in a more intimate setting. She experienced these sensations and thoughts whenever she had physical contact with her partner.
- Bella mentioned that this feeling of hollowness and associated self-despising cognitions always seemed to precede a strong visceral experience of

tightening fists and an urge to jump up and yell, punch, and kick her partner when engaged in intimate situations. She mentioned that she was only able to experience and acknowledge this process by first learning and practicing taking a time out when feeling angry and to pay attention to what was going on inside her before reacting in any particular way.

- Bella also reported during sessions that she threw a full cup of hot coffee at a barista when her order was not made correctly. She mentioned that she used to argue often with others and felt as if she pushed away people when she did not get her way.

As evidenced through the reports made by Bella during the abovementioned sessions it becomes apparent that she has become more aware of her own experience of anger and experiences the underlying shame. She became aware of her own discomfort when sitting with and feeling the emotion of shame and noticed the tendency of her body to gravitate towards feeling anger instead. The following interview provides an excerpt from the 15th counselling session with Bella. This is meant to display the later stage that Bella is in. In relation to T.J., Bella has become more aware of her anger during her earlier counselling sessions and has begun to deepen her awareness of the experience of shame, that is constantly underneath her anger. The therapeutic direction is indicated throughout the dialogue to convey suggested areas of movement in this stage of therapy while working with Bella.

T: So, we've been talking about your awareness of feeling ashamed when with others with whom you are romantically involved with. What goes on for you at the time?

Bella: I feel as if my insides are emptied out, that I am hollow and have no significance in this world. It's almost as if my whole self is worthless and that I have no reason to live, but then as if out of nowhere I feel my body starting to tense up, and I experience an urge to fight and yell chaotically.

T: Mm, I hear how terrible that experience is for you, and how confusing it must be as well to experience such seemingly differing sensations after one another. I wonder what types of thoughts or images you have during this process…

Bella: Well, sometimes an image appears of me being on my bed when I am a young kid. I am not sure how old I was though. This image or memory seems really associated with my feeling of being hollow and worthless, like I am ashamed and disgusted with myself. That whole experience just seems so hard to bear and I don't know what to do, so then I start to feel angry and have thoughts of killing someone, just anyone.

T: I imagine that is a seemingly intolerable experience to bear. I really commend you for working through this with me, it must take a lot of effort and courage! What is the first experience, shame, telling you? What do you think?

Bella: Hmm, it's hard to say, I really don't like feeling that way, so I think I usually just ignore it or try to change how I feel instead of being in it. But I guess, it is telling me of an experience I had that was terrible and where I did not have any control in the situation. I think it's to do with something that I have always had an inkling about but never wanted to acknowledge… that I was touched by my uncle when I was a kid…sexually I mean.

T: I'm deeply sorry to hear this, Bella. That must have been the most terrible experience. I can see how hard it is to even talk about this let alone acknowledge in any way. Sometimes it seems like it's easier to keep things stored away, but then we wouldn't be able to work through it, so I really feel honoured that you feel ready to tell me this.

Bella: It's definitely not something I like talking or thinking about. It is something I know I need to work on, though. Even in talking about it, I feel ashamed. I feel like I am a terrible person. I mean, it definitely is linked to me reacting angrily towards others, I think I recognize that now. It's something I have wondered about the last few weeks but have had difficulty with consciously reflecting on it.

T: Mm, I understand your pain and shame with bringing your experience with being sexually abused to consciousness. I imagine it is the hardest thing to think about. I think I hear you saying that you feel ashamed, disgusted, and that you feel responsible for what happened to you. I want to say that you are not to blame; it is not your fault. I wonder if it is time to discuss approaching yourself in a way that honours your strength and adaptability. A way to approach yourself which offers you the emotional acceptance and compassion that has been neglected

throughout much of your experiences. A way that the little girl who was abused would've wanted to be treated. How does this sound?

Bella: It sounds very hard but absolutely helpful. I'm in.

T: First we can start by developing a compassionate image…

Case Summary

Bella begun the process of deepening her awareness into her angry behaviour. Through the first ten sessions she became aware of underlying experiences that were based on shameful and traumatic incidents as a child. She became aware of how her sexually traumatic experiences as a child left her to feel ashamed, disgusted, and frozen when being intimate with others as an adult. With the help of the therapist, Bella became aware of reacting with fury, when intimate with others, due to her feeling of being shamed – she would begin to relive her sexual abuse history which was imbued with paralyzing shame and fear. Bella, through deepening her awareness and through being compassionately received by her therapist, began the work of healing and recovery. Future sessions would focus on more explicitly developing her own self-compassion to support her in the path to long-term healing.

Chapter 2. Shame Underlies Anger

After the client gained further insight into their experience with anger in the safety of a trusting relationship with the therapist or mental health professional, other experiences underlying the anger begin to rise to the surface of awareness. Emotional depth may deepen, often shining light on negative experiences that the individual has gone through and has hid from their own awareness through psychic mechanisms of denial and avoidance. As stated by many researchers (Greenberg, 2015; Johnson et al., 2006) representing the experiential side of psycho-therapeutic modalities, it is necessary to commence "exploring secondary or defensive anger in order to access underlying hurt, fear, or shame" (Paivio, 1999, p. 312). Hence, this chapter will explore the emotional dynamics proposed as the source of maladaptive anger. Avoidance mechanisms are indicated as the primary methods of hindering the capability to understand the root emotion that is underlying anger. Shame, implicated as the root emotion, and the interrelated dynamic of shame and anger (i.e., shame-rage) will be explicated through objective and subjective indices of these experiences. Furthermore, the consequences of avoiding these emotional experiences will be exemplified through an extensive discussion regarding people with higher levels of vulnerable narcissism. Overall, the elaboration of these psychological occurrences helps explicate the development and maintenance of the vulnerable narcissistic tendencies causing suffering to the individual. Elucidating these tendencies facilitates the exploration of therapeutic approaches.

2.1. Shame

Shame denotes a self-conscious emotion signifying a focus on the global self (Lewis, 1971) and "involves feelings of being exposed and devalued for one's deficiencies" (Krizan & Johar, 2015, p. 786). Gershen Kaufman (2004), an influential pioneer in the study of shame, describes it succinctly:

> Shame is the affect of inferiority. No other affect is more central to the development of identity. None is closer to the experienced self, nor more disturbing. Shame is felt as an inner torment. It is the most poignant experience of the self by the self, whether felt in the humiliation of cowardice, or in the sense of failure to cope successfully with a challenge. Shame is a wound made from the inside, dividing us from both ourselves and others. (p.16)

In evolutionary terms, shame signifies that an individual is "bad" and to align with their surroundings, and not be ostracized, something needs to change within them (Potter-Efron, 2015). Thus, shame has been regarded as an emotion that informs the individual that they require adjusting their behaviour in order to more effectively fit in with their social relationships.

The concept of feeling *hurt* could be argued to that of *shame*. Although there may be strong connections between *hurt* and *shame*, there is little to no research connecting or elaborating possible distinctions or connections between these two phenomena. I claim that the experience of being hurt is different from that of shame. Hurt is an experience wherein there still remains a sense of hope within the individual for reconnection and reconciliation with the emotional or physical executor of harm. The relationship or concern of the individual in question is deemed to be reparable. Whereas, with shame, the individual feels so disturbed with themselves that they do not want to be seen by others or themselves. There is a significant lack of hope and conviction in seeing themselves as reparable and any of their connections to others are also seen as irremediable. To extend this idea, I propose that experiences of being hurt, as long as repaired, may lead to personal growth, wisdom, and many other positive social and personal characteristics. Whereas, the experience of being hurt without subsequent repair, or with further invalidation, may lead to the development of shame regarding the issue at hand.

For instance, during childhood, there was a time when Bella reacted with sadness and tears when her dog died. Her mother responded to her sadness with disgust and rejection – she told her she could not bear to be with her if she was "going

to be a baby and cry." Bella felt hurt and believed that her expression of sadness was something to be disavowed. If her mother, instead, were to connect with Bella later on that day and apologize for her reaction and subsequently validate the expression of sadness Bella may feel able to express this emotion without fear of rejection. However, if her mother did not attempt to repair the hurt that Bella was feeling and, instead, continued over her lifetime to reject and invalidate expressions of sadness by Bella, sadness would then become an experience to be ashamed of and to be hidden. I propose that this example can be extended to other emotions and situations that we humans encounter on a daily basis.

The experience of shame, as mentioned above, has been reported by many authors to be the most disturbing, devastating and aversive experience people can have (Tangney, 2002). It is the experience of being naked and completely vulnerable, of being wounded from the inside where there is seemingly no resolution or way out. It has been called a self-conscious emotion for a reason (Thomaes et al., 2011). The experience of shame is typically associated with an inward focus of attention. The head hangs down, eyes are averted from the self, speech is thwarted and physical movement becomes awkward and unspontaneous due to the feeling of being exposed and watched by others and/or by oneself (Kaufman, 2004).

Kaufman (2004) explains this further:

> The excruciating observation of the self that results, this torment of self-consciousness, becomes so acute as to create a binding, almost paralyzing effect. This binding effect of shame is central to understanding shame's impact on personality development. The binding effect of exposure, of feeling seen, acutely disturb the smooth functioning of the self. Exposure binds movement and speech, paralyzing the self. (p. 18)

Kaufman explicates the fact that the experience of shame stops humans in our tracks; we feel immobile and physically rigid and awkward. The experience of shame, of being physically restrained, is often reason enough for individuals to want to escape experience through potentially harmful avoidance behaviours to the self (i.e., using

substances, distraction, self-harm) or others (i.e., reacting with RAGE at the other person, treating him/her as if they are an object). For an overview of the experience of shame, see Figure 4 – Objective indices of shame.

1) Face may be red (blushing – embarrassed) or colourless
2) Averted eyes and tilted head, behaviourally avoiding and body is pointing away from person (looking from the side of their head, eyes are turned toward them rather than facing directly)
3) Bottom lip may be pushed forward (biting indicates anticipation of shame and bracing of it or defending during experience of shame)
4) Chest is sunken and is experienced as a feeling of heart-sink.
5) Body is generally held frozen/paralyzed. There is a general experience of being hollow and empty inside. There is a lack of vigor and energy, often coinciding with hopelessness.

Figure 4. Objective indices of shame

Personally, similar to most people, I have experienced shame on many occasions. However, I only realized it after many years of reflecting upon my own experiences and behaviours. During my own intentional practice of mindful reflection upon my behaviour, I realized that I often experienced shame before becoming angry. I spent much of my life only thinking that I was angry and never thought that shame could be a part of it. I was able to recognize this with the support of my partner and my therapist. While paying closer attention, with non-judgment, I was able to feel the sensation of sinking in my stomach and heart with an overall weak and helpless physical state. I noticed this occur for only a brief moment before I suddenly felt a surge of blood to my muscles, reddening of my face, and fists closing. Thinking back to my middle school days, I can almost relive the experience of being bullied, returning home to hide in my room, and then avoiding and subjugating this experience of shame by becoming angry and exercising. Due to the weakening, heart-sinking, and hopeless feeling of shame, it is no wonder I wanted to avoid the experience at the time I was bullied and would rather

have felt angry instead. However, this avoidance was not without its consequences in later life.

Furthermore, Kaufman (2004) bases much of his psychological leanings on the proposed *Affect Theory* by Silvan S. Tomkins (1984). *Affect Theory* proposes that affect, that is, emotion, is the principal innate motivating mechanism and is biologically based. Silvan Tomkins also proposed *Script Theory*. This theory argues that personality is based upon the development of certain action patterns and scripts. *Action patterns* (i.e., reacting with anger) are contextually-based, learned ways of behaving and proved useful in the past. *Scripts* can be unconscious or conscious, and they describe the required stimuli, including the affect (e.g., shame), and the object/person perceived to cause the affect (e.g., shame-inducing parent). Scripts inform the individual when certain action patterns are to be utilized. The situation or context of a situation is labelled the scene. The *scene* contains all the information the individual may need to develop certain scripts, creating rules for prediction, interpretation, controlling, and responses to a set of scenes (Carlson & Carlson, 1984; Kaufman, 2004). The scene is where the script was learned initially and where action patterns may have been tried and tested. Scenes that have similar contextual information (e.g., there was a person with authority telling the individual that they were wrong) will enact the scripts the individual has for that scene and the corresponding action patterns.

The individual learns and remembers initial situations where the particular affect (in the present case, shame) was activated and what the contextual details of the situation were (e.g., parent deriding the individual). The individual then repeats these scenes in similarly structured situations in the future – when the individual perceives someone in authority to be deriding them, they enact their script and coinciding action pattern of reacting with anger. Thus, the affect (e.g., shame), with the contextual information (e.g., alone in a living room), and the object of affect (e.g., person with authority – parent) becomes a memory which is relived and re-enacted by the

individual. The individual then re-enacts, with the corresponding affect, the scene in similar ways as they did when they first encountered the situation.

For instance, when Bella was questioned about her first experience of feeling ashamed, she remembered an image of her mother berating her for not being feminine enough. She reported this was one of the first times she could remember, while envisioning it in her mind, the scenario of feeling shamed by her mother. Now in adulthood, she re-enacts this scenario, but instead perceives that others (not only her mother) are shaming her when in fact they may have a very different intention in mind. Her script of shame has incorporated itself into her beliefs and perceptions which predisposes her to act similarly (i.e., with anger) in many situations where she perceives to be shamed. She reacts with anger or rage, a defending script (i.e., action pattern) against the feelings of shame.

As Kaufman (2004) explicates, when the sense of self of an individual becomes tormented and infiltrated with the experience of shame, a common way of defending against this experience is through different *defending scripts*. *Defending scripts* are designed to help the individual sufferer escape from and avoid future experiences of shame. He describes eight different ways of defending against shame: *rage*, *contempt*, *perfectionism*, *striving for power*, *externalizing blame*, *withdrawing internally*, *humour*, and *denial* (Kaufman, 2004). In this thesis, I will discuss the defending script of *rage* although it could be argued that the defenses of *contempt*, *striving for power*, *externalizing blame*, and *denial* may also have strong relevance to the population used in this thesis – vulnerable narcissists.

The defending script of rage, also known as shame-rage, has been theoretically discussed at length by many notable authors in the psychological, psychoanalytic, and psychiatric domains, however, empirical research is lacking. The very first psychological theorizing of shame-rage was by Sigmund Freud, as cited in Krizan and Johar (2015). He proposed that self-preoccupation, as seen in narcissistic individuals, makes them vulnerable to narcissistic injury which can lead them to react aggressively towards

others. Narcissistic injuries, defined as threats to the narcissistic image or perception someone maintains, are the root of shame-rage reactions. Over the years, shame-rage has obtained various names. It has been referred to as humiliated fury (Lewis, 1971; Thomaes et al., 2011), narcissistic rage (Kohut, 1972) and entitlement rage (Krizan & Johar, 2015). Since its theoretical inception, shame-rage experiences were all observed clinically and empirically in individuals ranked as having higher levels of trait vulnerable narcissism.

2.2. Narcissism

Vulnerable narcissism and grandiose narcissism are subtypes of the umbrella term narcissism. Krizan and Herlache (2018) indicate that narcissism, generally speaking, implies the individual with this label has a strong sense of *entitled self-importance*. Vulnerable narcissism implies that along with an entitled sense of self-importance, the individual is also defensive, resentful, and anxious (Krizan & Johar, 2015). Grandiose narcissism describes someone who, in addition to being entitled, is boastful, outwardly arrogant, and assertive (Krizan & Herlache, 2018; Krizan & Johar, 2015). From the perspective of social psychologists, narcissism is viewed as a trait that exists on a continuum; everyone falls on it somewhere (Miller & Campbell, 2008). Since narcissism is viewed on a spectrum on which everyone falls, levels of vulnerable narcissism and grandiose narcissism can theoretically be found and exemplified through any human on this planet.

Bella has been exemplified as someone who has high trait levels of vulnerable narcissism, but this does not insinuate that she can only be defined in this way. Also, when discussing the accompanying behaviours and emotional attributes typically associated with the different subtypes of narcissism, it is important to note that these attributes are also on a spectrum. Understanding that all humans fall on the narcissism spectrum helps to provide a broader and contextualized perspective of Bella and anyone who has been labelled as narcissistic. By seeing everyone as having varying levels of

certain attributes, it may then be easier to perceive our individual lives as a part of a common humanity and to extend compassion towards those who have developed certain attributes which have generally been imbued with negative connotations by Western society (Ronningstam & Weinberg, 2013). Seeing the person as a whole, rather than their label, will support increased acceptance and compassion for all people.

For the sake of exemplifying the theoretical roots of suffering I describe more extreme levels of the vulnerable narcissistic subtype. For instance, Bella (and all case vignettes in this thesis) is someone who would be considered to be at the more extreme end of the continuum of vulnerable narcissism. Throughout the rest of the thesis I will refer to either subtype by its more simplified name, such as *grandiose narcissism* and *vulnerable narcissism.*

The term *narcissism* originally came from the Greek Hero Narcissus who died as a result of losing his will to live through his fixation with himself; he could not stop staring at his own reflection in the water. However, Sigmund Freud and Otto Rank, in psychiatry, were the first to use this term to describe psychodynamic processes demonstrated by extreme self-love and egocentricity (Rivas, 2001). Later on, Heinz Kohut coined the term Narcissistic Personality Disorder (NPD) through his work with a supposed narcissistic population while Otto Kernberg hypothesized that the characteristics of a narcissistic person were of self-interest and aggrandizement (Kernberg, 1975; Kohut, 1971).

Evidently, NPD as a psychological phenomenon was developed and popularized by the psychoanalytic community. Thus, the purported causes were of a psychodynamic theoretical nature. Consequently, unhealthy narcissism and the rarer case of NPD was reported to stem from this theoretical orientation and thought to arise from childhood abuse or neglect, often in relation to a narcissistic mother or caregiver, and from a defense against tremendous frustration with object relationships, more generally, during childhood (Kohut, 1971; Rivas, 2001).

Eventually, NPD made its way into the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III) in 1980, thereby initially validating it as a diagnosis of a mental disorder. The general qualities of having NPD are regarded as being pervasively grandiose, requiring admiration, and of lacking empathy for others (Rivas, 2001). Moreover, there has been multiple revisions to the DSM-III resulting in the current use of the DSM-5. Overall, the criterion to describe and diagnose someone with NPD has typically referred to grandiose narcissistic qualities (Weiss & Miller, 2018). However, the DSM-5 does mention "content that is indicative of vulnerability and fragility" (Weiss & Miller, 2018, p. 4) thereby alluding to the vulnerable subtype of narcissism.

2.3. Vulnerable Narcissism

There are different theories for classifying types of narcissism. This section will describe the delineation of the two subtypes of narcissism, grandiose and vulnerable, with a focus on explicating the latter. Individuals with high levels of *vulnerable narcissism* are typically described as self-centred, defensive, and resentful (Krizan & Johar, 2015; Miller & Campbell, 2008). Contrastingly, *grandiose narcissism* is the stereotypically imagined narcissism individuals conjure when they think of "narcissism" more generally. Individuals with high levels of grandiose narcissism have been described as being exploitative, exhibitionist, over-confident, egotistical, and assertive (Krizan & Johar, 2015).

Although there are multiple models and differentiations of the subtypes of narcissism, the Narcissism Spectrum Model (NSM) is helpful when describing the differences between the subtypes (Hermann et al., 2018; Krizan & Herlache, 2018). Krizan and Herlache (2018) assert that this model integrates clinical evidence, social, and personality psychology to formulate its hypothesis that differences in entitlement reflect two distinct functional patterns of influence. The functional patterns are based on approach-dominant (bold) and avoidance-dominant (reactive) personality orientations supported by reinforcing social experiences. The NSM theory argues that

individuals with grandiose narcissism (approach-dominant) seek out opportunities for rewarding experiences which boost their self-enhancement. These individuals will act boastful and arrogant, often speaking highly of themselves whenever they have the opportunity. Grandiose individuals have been found to experience more positive emotionality, extraversion, and assertiveness, with typically lower negative emotionality (Clark & Watson, 2008; Krizan & Herlache, 2018).

More pertinent to this thesis is the discussion of vulnerable narcissism. As per the NSM, Krizan and Herlache (2018) state that individuals with vulnerable narcissism are reactive, avoidant-oriented, and emotionally dysregulated. They are more focused upon fight-or-flight reactions and also experience higher levels of distress and negative emotionality. The term *anxiety* describes these individuals well, in that they are behaviourally inhibited, more neurotic, and less able to regulate their own emotions which become overwhelming and distressing (Krizan & Herlache, 2018; Scott et al., 2013). Krizan and Herlache (2018) emphasize that "heightened narcissistic vulnerability is strongly and positively linked with avoidance-oriented constructs such as high neuroticism, distress, anxiety, and angry rumination…vulnerability is strongly correlated with self-consciousness and depression, although it is broadly related to anxiety, anger, and personal distress" (pp. 14-15). Vulnerable narcissism, in contrast to grandiose narcissism, are likened to the conceptualization of vulnerable narcissism as an *internalized narcissism* whereby grandiose narcissism is an *externalized narcissism.* Essentially, the vulnerable narcissist has narcissistic beliefs and conceptualizations of their sense of self, but this is not immediately obvious to the outsider since they can often appear to be submissive and anxious. Grandiose narcissists, in contrast, are observed by outsiders to be boastful and arrogant and thus fit the stereotypical presentation of a "narcissist." Moreover, vulnerable narcissistic characteristics paint a picture of someone who engages in shame-rage action patterns.

2.4. Vulnerable Narcissism and Shame-Rage

Empirical research regarding the development, etiology, function, and phenomenology of vulnerable narcissism is severely lacking. However, existing evidence is primarily linked with the phenomenon of shame-rage; largely due to the fact that vulnerable narcissism is more positively associated, compared to grandiose narcissists and presumably other personality traits, with higher levels of entitlement rage (aka shame-rage) (Miller et al., 2013; Zeigler-Hill & Wallace, 2011).

The key ingredients implicated in shame-rage are evidenced through theoretical proposals and empirical studies with vulnerable narcissists. Krizan and Johar (2015) list the key ingredients as: anger and hostility, shame and inferiority, and reactive and displaced aggression. The traits of anger and hostility are additionally defined as "pervasive and dysfunctional anger coupled with hostile suspicions, presumably resulting in misdirected or disproportionate aggression in response to even minor provocations" (p. 786).

The components of shame and inferiority contribute to the shame-rage spiral due to the perceived need, asserted by the individual, to defend against further shaming, as discussed above (i.e., defending scripts of rage). It has been empirically discovered that shame and anger often accompany one another (Tangney et al., 1996). The literature regarding individuals who are prone to feeling shame (i.e., elevated shame-proneness), such as vulnerable narcissists, indicate an increased propensity to experience anger and, as a result, to conduct themselves in damaging ways (Bennett, et al., 2005; Harper & Arias, 2004; Krizan & Johar, 2015; Tangney et al., 1996). As per reactive and displaced aggression, Krizan and Johar (2015) identify that these experiences signify the minimal requirement of perceived provocation to reacting aggressively. This is correlated with the avoidant-oriented and defensive nature of vulnerable narcissists (Krizan & Herlache, 2018). The aggression displayed is typically displaced onto individuals who are perceived to stand in the way of vulnerable narcissists or who have proven to be disruptive in some way.

Narcissistic injuries are the root of shame-rage action patterns in vulnerable narcissists. As discussed above, Kaufman (2004) argued that defending scripts, such as the rage script, is often wielded as a defense against feeling shame. When a vulnerable narcissist perceives that they have been shamed, they experience themselves to be openly wounded, that their inner self — which they have so strongly attempted to defend and protect — has now been attacked. Thus, by reacting with anger, they are functionally pushing the person away and protecting their fragile inner selves. In this sense, they are adapting to the situation in order to protect themselves.

2.5. Shame-Rage: Experiential Avoidance

Kaufman (2004) emphasizes the deleterious effect that shame can have on the self and on the functioning of the self with others. It makes sense that individuals may seek to escape and protect themselves from experiences of shame. As alluded to in Chapter 1, escaping or avoiding experiences (i.e., experiential avoidance) is a common way of coping with the discomfort that typically accompanies many negative affects. When individuals suffering from negative affects have not learned functional ways of relating to these responses, avoidance may be the only way out of the discomfort. The way that shame is defended against, through avoidance, as seen with vulnerable narcissists, is of reacting with anger or rage (i.e., shame-rage cycle). With regard to shame-rage, the rage and/or anger is typically a secondary emotion in relation to the often fleeting, almost unrecognizable, primary emotion of shame (Greenberg, 2015).

Emotion Focused Therapy (EFT), a psychological theory focusing on increasing emotional intelligence, distinguishes between three different types of emotions: primary, secondary, and instrumental (Greenberg, 2015). Primary emotions are the direct and instantaneous responses to our environment that guides our attention and behaviour with unique action tendencies which serve us in a particular way. The emotion is considered adaptive if it supports the survival and thriving of the individual. Thus, in regard to anger, primary adaptive anger helps protect us from threats and

promotes “self-empowerment, assertive expression of need, and interpersonal separation and boundary definition” (Paivio, 1999, p. 312).

Secondary emotions are not the root emotion in a situation. These emotions come after the initial experience (typically unconscious or only mildly conscious) of primary emotions. The most often reported example is of anger being elicited by the principal reaction of feeling shamed. Sometimes feeling shame is much less desirable than that of anger (Greenberg, 2015).

The final set of emotions, instrumental emotions, are used for the purpose of fulfilling a personal goal. It can occur with personal awareness but usually goes without awareness. For instance, anger is often used as a way to control others and get what the individual wants (Krizan & Johar, 2015; Paivio, 1999; Tangney et al., 2014). Describing emotions with the abovementioned qualifiers, as primary, secondary, or instrumental, is helpful in explicating the purpose and function of the emotion.

Authors such as Lewis (1992) in their descriptions of shame-rage are able to explain the use of anger, within this emotional dynamic, more succinctly:

> On one hand, anger at others that shamed us may be initially adaptive, as it can help us to forget shame-based pain, to recast the blame for painful feelings on others rather than ourselves, or to eliminate the person that shamed us. (pp. 150–151)

The experience of shame can be so painful that it often goes unacknowledged (Lewis, 1971). Instead, the experience transforms into vague depressive or anger emotional experiences at the sources of shame – as explained through shame-rage theory (Lewis, 1971). In its most extreme form, lacking the ability to acknowledge the feeling of shame (i.e., avoidance of shame) is manifested in a psychodynamic perspective of splitting.

Essentially, the individual adopts a shame-based identity from their experiences of being shamed as a young child and begins to disown their shameful self; due to the unbearable nature that shame is phenomenologically experienced. Thus, the extreme version of disowning a part of oneself is of splitting. In other words, splitting is the

extreme version of disownment of a part of oneself, which in severe cases can be observed in individuals with Dissociative Identity Disorder (DID) (Kaufman, 2004). The individual splits off their shame-based part in order to function more effectively in their daily life. The individual adopts (rather unconsciously but can be consciously) a new sense of identity wherein, as Kaufman (2004) reports, narcissistic identities are ones that can emerge.

However, this discussion of splitting and of different selves is rooted in psychodynamic theories and are explained here to highlight some of the possible psychological mechanisms and functions for increased trait narcissism. Despite splitting the shame-based part of the self, the use of rage as a defense against shame and to functionally prevent those that are perceived to shame the individual can be adaptive whether there is a splitting or not.

The emotional-avoidance (i.e., splitting, denial) seen in shame-rage, in terms of transdiagnostic mechanisms, constitutes one of the experiential avoidance mechanisms outlined by Frank and Davidson (2014). I argue that present in shame-rage is the predominant use and interrelated function of the specific experiential avoidance mechanisms of *interoceptive avoidance* and *emotion-driven behaviours*.

According to Frank and Davidson (2014), emotion-driven behaviours are exemplified as behaviours of self-harm. Bella experiences emotion-driven behaviours when experiencing shame-rage. I contend these self-harming behaviours are driven by an emotion to avoid or escape an emotion (the experience of the emotion), and the act of reacting with rage at others parallels this process of self-harm as she is harming her own chance at reconnection with others by raging against them. For instance, by reacting with rage, Bella pushes her partner away and is less able to solicit desired intimacy due to this automatic emotional reaction – Bella, as well as her partner, are consequently confused and distraught. This behaviour could be seen as a self-handicapping behaviour, paralleling the function of self-harm. The function serving to avoid the experience of and prevent future occurrence of shame. This also reduces the

attention on the person experiencing shame and places the attention on the other who is being raged against.

Moreover, interoceptive avoidance is implicated with regard to shame-rage experiences as well. The experience of a specific subtype of alexithymia – difficulty in describing feelings within oneself – has been suggested as another transdiagnostic mechanism (Valdespino et al., 2017). I suspect it is linked to the interoceptive avoidance mechanism. The insula, brain area responsible for discerning interoceptive and associated affective information about ourselves and therefore others, has been found to have decreased gray matter in individuals with Narcissistic Personality Disorder (Schulze, 2013; Fan 2011). The insula is also associated with empathic abilities; less gray matter means a decrease in empathy. As empathy is based upon our ability to sense emotions and experiences in ourselves in order to "feel" them in others (Valdespino et al., 2017), the demonstrated lack of empathy in individuals with narcissism, including vulnerable narcissism (Vonk et al., 2013) seems to indicate alexithymia and decreased interoceptive abilities in these populations. More research is clearly needed, especially given that the main research regarding narcissism is conducted with NPD or grandiose narcissistic qualities.

Nevertheless, this line of research is intriguing since others have formulated parallel ideas in the past, albeit, without accumulating corroborating empirical research. Alexander Lowen (1985), the creator of Bioenergetics, proposed that narcissistic individuals experience a denial of their self, as instantiated through a physical denial of their body. I propose, in alignment with Lowen (1985), that this observed physical denial of the body is through decreased interoception, increased alexithymia, and a maintenance of a structural rigidity of the body. In my interpretation, Lowen (1985) was proposing a certain form of alexithymia or interoceptive deficit in individuals with narcissism.

Likewise, research regarding alexithymia and interoceptive difficulties corresponds well to other empirical findings with regard to traumatized individuals and

the use of physical therapies, presumably functioning by increasing interoception and an acceptance of being embodied, in alleviating and attenuating symptomatology associated with traumatic histories (Cozzolino, 2010; Levine & Frederic, 1997; Ogden & Minton, 2008). For instance, those who have experienced childhood maltreatment, such as individuals with vulnerable narcissism (Van Buren & Meehan, 2015), may also benefit from experiences that decrease alexithymia and increase interoceptive capabilities.

Schellenbaum (1988) succinctly highlights the consequences of avoiding/denying our embodied experiences for an idealized image of ourselves:

> Bodily being in the present moment is always a 'being in the world' and a 'being in relationship'…Conversely, someone who exiles himself to the past and future is absolutely cut off from relationship since he is fixated on the wound of being unloved. His life follows the traumatic trail. For such a person the ego becomes an overvalued idea. (p. 123)

As described by Schellenbaum (1988), shame-rage is an overall practice of experiential avoidance, particularly of emotion-driven behaviours, emotional avoidance, and interoceptive avoidance. Emotion-driven behaviours cause Bella indirect social disruptions and conflicts. There is also an avoidance/denial of bodily sensations as evidenced through alexithymia and interoceptive deficits. Moreover, the use of secondary emotions in the pursuit of avoiding primary emotions – emotional avoidance – is also an important factor in the shame-rage experience.

The use of emotional avoidance as a coping strategy, therefore, most likely arose due to the fact that the primary emotion was disavowed and/or punished by the caregivers during the developmental years of the child. For instance, the use of secondary emotions instead of primary emotions may have been more accepted (implicitly or explicitly) or even modelled by caregivers. I claim that children adopting the use of the secondary emotion, for example, anger, were more accepted when expressing the secondary emotion, and/or the secondary emotion seemed to support the attainment of the need of the child relative to the use of the primary emotion of shame. In this sense, the use of emotional avoidance mechanisms was adaptive to the child at the time. Although it was adaptive and served to protect the individual, this

does not belie the fact that shame-rage action patterns can be threat-inducing to those who are witnessing the expressed behaviour. Recognizing protection-based suffering and reactions are supportive to a better understanding of the suffering individual. Perhaps empathy and compassion will arise instead of fear and condemnation.

2.6. Experience of Shame-Rage

Describing shame-rage is the focus of this section. By explicating the experience of shame-rage, mental health professionals will be better fit to recognize possible shame-rage emotional patterns in their clients. To appropriately describe how to recognize shame-rage cycles, I will list terms that have been associated with describing shame-rage and the associated experience and feelings about it.

For this line of explication, the article and research by Retzinger (1995) is helpful. Retzinger studied the subjective accounts of shame-rage during her research with shame. She describes shame-rage to be similar to the experience of resentment, bitterness, being spiteful, and holding a grudge. Retzinger also describes certain verbal hiding behaviours, as seen in the list below, that are reported to be indicators of shame and anger. In essence, these are all ways in which someone may react or defend against their feelings of shame with anger when interacting interpersonally.

a) *Mitigation* – Saying a word or phrase that minimizes the experience of the speaker. For instance, saying “It’s okay, we don’t need to do what I suggested, it probably wouldn’t be that fun anyways.”

b) *Abstraction* – Speaking of referenced phenomena vaguely, such as using the words “they” or “it” instead of specifying the referenced person or object.

c) *Denial* – This could be an explicit or implicit statement that plainly denies the feeling.

d) *Defensive* – A reactive statement towards a perceived challenge by another.

e) *Indifference* – Maintain an external appearance of being cool or unaffected while in emotionally arousing contexts – such as asking someone on a date. It could be perceived as defensive and/ or hostile.

f) *Verbal withdrawal* – Silencing oneself, such as suddenly going from speaking verbosely to then either speaking in shorter sentences or single word format.

g) *Distraction* – Can be observed as changing the topic, joking about the topic in an effort to change the discussion towards issues that are less emotionally evocative, or personally exposing, thereby shame-inducing.

h) *Projection* – The exclamation that the other person feels a certain way, which is actually how the individual sufferer feels. For instance, saying "I think you're feeling humiliated right now" when in fact the speaker feels that way.

i) *Fillers* – Includes statements such as "I'm not sure" or "you know what I mean?"

These verbal hiding behaviours either reflect the use of anger or aggression to retaliate against the perceived shame-inducer or the use of minimization in order to reaffirm the bond between the relating individuals. These behaviours are used by almost all people; highlighting that all humans fall on the spectrum of shame-rage and vulnerable narcissism. These behaviours also act as functional parallels with some of the defensive scripts described by Kaufman (2004) such as externalizing blame, denial, withdrawal, humour, and rage. The above verbal hiding behaviours describe a protection or defense against shame. For instance, the use of *projection* and *filler* verbal behaviours indicate the speakers need for reassurance by the other person and indicate an attempt to reaffirm their bond with the other by including the person in their reference after having been felt ashamed. The speaker quells their own experience of shame, through the use of anger, to make an effort to reconnect with the other person (as they perceived a disruption to their connection). This most likely occurs unconsciously.

Overall, Retzinger (1995) describes the observation of the experience of shame-anger in the following way:

> If there are visual signs of anger but it is verbally being denied rather than being expressed directly, shame is likely to be present (seen in hiding behaviour). Often when anger takes overt form, shame is covert. When shame is overt, we are likely to find anger absent or covert. (p. 1112)

Retzinger was influential in formulating the objective indices of expressions that link shame and anger together. More recent evidence by Kaufman (2004) and others align with her research regarding shame-rage (Freis et al., 2015; Gilbert & Procter, 2006; Hermann et al., 2018; Krizan & Johar, 2015). Shame-rage defensive maneuvers help avoid the experience of shame. This maneuver inevitably requires the avoidance of vulnerability, due to the experience of shame as feeling exposed and open to others. Instead of reacting with anger, if an afflicted person were to learn how to feel safe, they may be able to approach their shame and allow the experience of shame to be present. Allowing the experience of shame is akin to approaching oneself and others with an openness— inevitably, letting others in. Revealing shame to others supports an acceptance of common humanity. This is presumably the ultimate fear of those who react with shame-based defenses, such as vulnerable narcissists. Due to the ways in which vulnerable narcissists have developed, reacting with shame-rage has been adaptive for them throughout their lives. In essence, reacting with rage, when feeling ashamed, is *protective*. It is enacting protection against the individual's vulnerability and sense of self. Accordingly, defensive strategies could alternatively be described as *protective strategies.*

The idea of shame-rage as an adaptive strategy supports a decrease in the stigmatized connotation of the term narcissism. In my experience, the term "narcissist" is often used pejoratively against others and typically denotes the harm or destructive behaviour that these individuals direct towards others; leading to empathy and compassion for the individuals who come in to contact with narcissists rather than the narcissists themselves. There is little empathy or compassion shown to individuals

diagnosed with the associated labels of narcissism, as demonstrated through diagnostic labels (Ronningstam & Weinberg, 2013). For instance, there has been disagreements into the utility of the criterion for Narcissistic Personality Disorder (NPD). Emphasis is frequently placed on describing outward negative connotations of narcissists' actions to others while negating any description of how the individual labelled with NPD may be suffering (Ronningstam & Weinberg, 2013).

Moreover, the terminology around narcissism seems to be a hot topic due to current (at the time of writing) powerful and influential individuals who have been labelled as being narcissistic. Levels of narcissism also seem to be rising (Twenge et al., 2008); the reasons for this are hotly debated. Moreover, there may be potential societal, ecological, economic, political, and overall socio-psychological consequences of this increase. However, this evidence is not without its opposers (Barry & Lee-Rowland, 2015).

Whether there is an increase in narcissism or not, it is particularly necessary to discuss vulnerable narcissism. Understanding the *why* may help support, with an empathic and compassionate attitude, those suffering with the psychological consequences resultant of the vulnerable narcissistic manners of relating to oneself and the world. Through understanding how and why a person may be the way they are – self-injurious and alienating – mental health professionals will be better suited to support vulnerable narcissists in attaining what they need and want; that is, human connection.

2.7. Development of Vulnerable Narcissism and Shame-Rage

The need for isolating and disowning parts of oneself, and of experientially avoiding certain aspects of common humanity, such as shame, leads me to hypothesize that the individual sufferer was not validated, or worse yet, disavowed and punished for the display and expression of their own human experiences and emotions. One study published in 2015 sought to research this line of thought.

Van Buren and Meehan (2015) used a sample of undergraduate students (*N* = 129; 77.5% female) from a large urban university. Their sample consisted of African American (34.9%), Asian (20.2%), Caucasian (18.6%), Hispanic (17.1%) and other non-specified races (8%). The participants self-reported on measures assessing for childhood trauma (childhood maltreatment), shame-proneness, and avoidance of self-object needs (Van Buren & Meehan, 2015). Self-object needs are the needs of a developing younger person throughout childhood that can be provided by caregivers, particularly during subjective times of distress (Kohut, 1984).

The self-object needs were described as the following constructs:

1) *Mirroring*: the attunement and resonance with another, of being seen and acknowledged (Kohut, 1971; Marmarosh & Mann, 2014).
2) *Idealization*: the caregiver is idealized and respected (Kohut, 1971; Marmarosh & Mann, 2014), and
3) *Twinship*: the need to belong, having a sense of being a fellow human (Kohut, 1971; Marmarosh & Mann, 2014).

When assessed for the avoidance of self-object needs, higher ratings implied that individuals avoided caring aspects and disavowed them through various manners (Van Buren & Meehan, 2015). Also, vulnerable narcissism was assessed using the Pathological Narcissism Inventory (PNI; Pincus et al., 2009) that contains subscales for grandiose and vulnerable subtypes of narcissism.

The aspect of childhood maltreatment (CM) pertains to physical, emotional or sexual abuse, or physical or emotional neglect during childhood (Van Buren & Meehan, 2015). The researchers of this study were testing the proposition, held by Kohut (1971), that childhood maltreatment can lead to shame-prone individuals through having their psychological human needs (mirroring, idealization, twinship) disavowed. They further proposed that CM may lead the individual to neglect and avoid these experiences independently and thus repeat the pattern they developed in childhood. The resultant

outcome being the development of pathological narcissism, another term for vulnerable narcissism (Kohut, 1984; Van Buren & Meehan, 2015).

Van Buren and Meehan (2015) found through mediational analyses of shame-proneness and avoidance of self-object needs, that shame-proneness was found to be a "partial mediator of the association between CM and vulnerable narcissism" (p. 558). They supposed that other emotional factors would mediate this link to vulnerable narcissism. They also indicated that the avoidance of self-object needs "fully mediated the relationship between CM and vulnerable narcissism" (p. 559). Van Buren and Meehan concluded that the mediating relationships between shame-proneness and avoidance of self-object needs, resulting from childhood trauma or maltreatment, indicates a clinically useful reason for assessing shame in individuals who have survived childhood maltreatment and trauma; for, they may be at increased risk for developing vulnerable narcissistic traits.

2.8. Psychodynamic Perspectives

The abovementioned evidence linking childhood maltreatment and vulnerable narcissism seems promising for delineating the possible development of vulnerable narcissistic traits. However, there are contrasting perspectives regarding the development of narcissism generally and vulnerable narcissism specifically. Psychodynamic theories (Kohut, 1971) emphasize that developing individuals acquire narcissistic traits in order to compensate for the deprived bonds (emotional, nurturing) between themselves and their parents especially when their parents are devaluing, indifferent or cold towards them. The children seek to obtain approval from others, since they were unable to obtain this from their parents (Thomaes & Brummelman, 2018).

Similarly, the proponents of the psychotherapeutic method of bioenergetics, developed to heal the body through direct physical means, explained the development

of narcissism as resulting from a lack of love and authentic idealization and empowerment by the caregiver (Lowen, 1975).

Lowen (1985), has the following clinically developed assessment regarding "special" treatment of children by caregivers and the associated consequences of this:

> The promise of specialness is the seductive lure put forward in the parent's effort to mold the child into his or her image of what the child should be…Parents tend to identify with their children and to project onto them their own unfulfilled longings and desires … the deal is that the child will be treated or regarded as "special" if he or she submits to the parent. (p. 105)

Lowen (1985) highlights that "special" treatment of children typically occurs with an agenda on the part of the parent. The parent may or may not be aware of this agenda. However, through subtle implicit or explicit interactions, it becomes evident to the child that he/she must submit his/her own desires and control to the will of his/her parent. By declining to submit to the parental demands to uphold a certain image (e.g., play a certain sport, attain a certain job), the child would lose the parental support they are completely dependent on. Thus, the child has no real option of declining; the child submits its own self, interests, and identity, in order to maintain the support from the parent, which is accompanied by being treated as special. The cost to the child is their own freedom: "For their part, children want to be free – free to grow up according to their own natures" (Lowen, 1985, p. 106).

Unfortunately, as Lowen (1985) argues, the ability to be "free" becomes impossible in these child-parent dynamics, and a denial of the self occurs in the child. This denial is similar to the disowning of the self (i.e., contemporarily labelled as experiential avoidance), as Kaufman (2004) discusses. However, Lowen (1985) emphasises a denial of our body and physical self – interoceptive avoidance and alexithymia. The physical self is denied and subjugated for an image of superiority.

2.9. More Recent Perspectives

Other predominant theories of the development of narcissism are based on Social Learning Theories (Millon, 1969). These theories propose that developing individuals learn to see and treat themselves how others have seen and treated them. Thus, the development of narcissism, typically first observed from age seven or eight onwards, occurs through *parental overvaluation* – treatment of children by caregivers that suggests that they are special and more entitled than others (Thomaes & Brummelman, 2018).

The empirical research seems to corroborate the findings implicated from the social learning theories. Correlational studies (Horton, 2011; Thomaes & Brummelman, 2016) and longitudinal studies, spanning two years, with children aged 7-11 years old (Brummelman et al., 2015) support the development of narcissism (grandiose) through parental overvaluation. A more recent theory proposes an explication for the differences in behavioural and emotional manifestations between the narcissistic subtypes. It is called the Perceived Control Theory of Narcissism (PCTN) (Hansen-Brown, 2018) and it helps to explain the development of the different narcissistic subtypes.

Hansen-Brown's PCTN theory (2018) proposes that grandiose narcissists have elevated perceived control over the behaviour of others, their own situations, and the world in general while vulnerable narcissists have low perceived control in all of these areas. Whereas the previously reported empirical research found that parental overvaluation of children has supported the development of individuals with high levels of trait narcissism, the narcissism they are referring to is of the grandiose type (Brummelman et al., 2015). The PCTN by Hansen-Brown (2018) reaffirms this finding and proposes that overvaluation and inflated feedback towards children may support the development of "high self-centredness, perceived control, and entitlement" (p. 32).

Hansen-Brown (2018) also proposed that, in contrast, vulnerable narcissism develops when parents act coldly and devalue the child while providing unpredictable

and inconsistent feedback that is contingent on the efforts made by the child (Miller et al., 2010; Otway & Vignoles, 2006). Consequently, developing individuals become more self-centered and entitled in order to compensate for the inadequate empathy, compassion, and idealization received by their caregivers. The aspect of compensation aligns with the proposed psychodynamic theories of narcissistic development. Clearly more empirical evidence is required to understand the etiology of vulnerable narcissism.

2.10. Combined Perspective

Overall, I concede that psychodynamic theories, social learning theories, and the PCTN all have merit. However, when these theories are applied in unison, the resultant description of the development of vulnerable narcissism appears more accurate. As per grandiose narcissism, it is apparent that the social learning theories are correct in their identification that consistent parental overvaluation will instill self-centred and entitled attitudes and traits in the child – particularly if the provision of feedback and overvaluation is consistent and unconditional (Brummelman et al., 2015; Hansen-Brown, 2018; Millon, 1969).

For the case of vulnerable narcissism, I generally agree with Hansen-Brown (2018). However, there are specific intrapsychic mechanisms occurring within the child that are missing from this theory. For the development of vulnerable narcissism, it seems that the development of entitled self-beliefs and self-centredness with the coinciding experience of emotional dysregulation and low perceived control develops through inconsistent overvaluation of the child (Hansen-Brown, 2018). I claim that any overvaluation of a child by caregivers will inevitably create a schism between how the child actually feels and what they believe they should feel like. The child experiences their parents' overvaluation as creating an image of the child that he/she cannot meet. As discussed in Lowen (1985), the child then denies/avoids their own sense of self (physically and emotionally). In essence, this overvaluation is an invalidation of the subjective experience of the child because it is not truly empathizing or meeting them

where they are. By the provision of inflated praise towards the pursuits made by children (especially when inconsistent), it may unconsciously place a level of expectation on the child to appear and or perform a certain way in order to receive acceptance from the caregivers. This would, in psychodynamic language, create two senses of identities, one of superiority and entitlement, and the other as the true sense of the needs, wants, and sense of identity the child holds. The latter having to take a backseat due to the implicit parental invalidation.

Experiences of shame or inferiority are invalidated in the parents' eyes and the child learns to keep this side of themselves hidden away – leading to disownment and denial of this inferiority and shame-based side of themselves. In this way, "the unloved think they've been abandoned by the entire world. They don't know that they abandon themselves" (Schellenbaum, 1988, p. 163).

I assert that a level of inconsistency truly differentiates the development of grandiose versus vulnerable narcissism since this catalyzes the development of a feeling of insecurity and of an inability to self-regulate, thereby having difficulty in emotionally regulating, which is a hallmark of vulnerable narcissists (Krizan & Johar, 2015). I concede that this inconsistency, as well as childhood maltreatment, which completely devalues and traumatizes the child, leads to a certain degree of feeling insecure about their identity; resulting in an overall denial/avoidance of their shame-based identities – any part of their self, emotion, or behaviour that was shamed or devalued during development and therefore disavowed expression and experience.

Inevitably, this leads to an experience of being out of control and of unpredictability – an experience that things happen to them instead of the individual having control (Hansen-Brown, 2018). It is also evident in the findings that vulnerable narcissists seem to be avoidance-oriented and more reactive (Krizan & Herlache, 2018). They try to maintain a status quo of stability and only react when something is broken or needs repair (i.e., their inflated sense of self, image) (Krizan & Herlache, 2018).

Whereas grandiose narcissists focus on improving or building an image of self, which aligns with approach-oriented behaviours (Krizan & Herlache, 2018).

2.11. Affective Neuroscience Conceptualization

The conceptualization of shame according to Panksepp and Biven (2012) is that shame is a tertiary-process emotion where one is elaborated in our neocortex after having been instantiated by affective subcortical brain networks. Panksepp and Biven state that as of now, the research is primarily based upon animal models and therefore the neurological substrates and emotional processes of shame cannot be elaborated upon or empirically based as of yet. I take this moment, however, to speculatively propose a possible affective neuroscience basis for shame-rage and vulnerable narcissism.

By thwarting the SEEKING system of an animal when attempting to obtain something it needs (e.g., nurturance, food, or sex) their RAGE system is aroused (Panksepp & Biven, 2012). Based on evolutionary principles, I claim that a similar situation arises as well in people. For instance, imagine Bella attempts to buy something online that she has been looking forward to (she is SEEKING the item). She enters her credit card information and clicks “Buy.” Then, imagine that she is told that the item is no longer available, at which point, she may react with RAGE at her plan suddenly being foiled. Add to this the fact that the SEEKING system, when aroused, typically creates an enhanced sense of self along with it (Panksepp & Biven, 2012). This phenomenon can be confirmed by anyone who has tried drugs that induce increased dopamine release – dopamine activates the SEEKING system (Panksepp & Biven, 2012). This finding lends itself seamlessly to narcissism research, such that narcissists may experience increased activation of their SEEKING system, depending on how they were treated, be it consistent parental overvaluation (grandiose narcissism) or inconsistent praise with inconsistent maltreatment (vulnerable narcissism). The individual may learn to SEEK

their needs to maintain and protect, as in the case of vulnerable narcissism, or improve and bolster, as in the case of grandiose narcissism, their self-image in the eyes of others.

Also, with experiences of childhood maltreatment, I assert a strong initial activation of the PANIC/GRIEF networks due to not receiving care, affection, or nourishment. Consequently, I claim that FEAR network activation occurs after PANIC/GRIEF activation, when the need of the child was not met in a certain amount of time (e.g., FEAR of not being able to survive alone). Panksepp and Biven (2012) indicate that FEAR and RAGE together seem to equate to aversion and defensiveness – very strongly associated experiences of those with vulnerable narcissism. Overall, I claim that vulnerable narcissists experience chronic PANIC/GRIEF and FEAR activation (i.e., aversion, avoidance), with often coinciding chronic RAGE activation (i.e., defensive and reactive). These emotional network activations are paralleled by inconsistent activation of the SEEKING system. It seems that the subjective suffering of vulnerable narcissists, caused largely by emotional dysregulation, may be explained by affective neuroscience patterns of primary-process emotional network activation (Freis et al., 2015; Panksepp & Biven, 2012). See Figure 3 for a diagram of the sequential patterning of the proposed emotional network activations.

The development and observation of emotional-network activation is in contrast to the development and proposed cause of grandiose narcissism – parental overvaluation and consistent striving of the child to perform. With grandiose narcissism, I propose a chronic activation of the SEEKING system with possible RAGE when sought goals are foiled, however, with little experience and activation of PANIC/GRIEF or FEAR systems. The consistent activation of the SEEKING system and of parental overvaluation in grandiose narcissism may then lead to a more stable sense of self in contrast to the vulnerable narcissist.

Finally, it seems appropriate to refer to shame-rage, in terms of affective neuroscience, as *thwarted SEEKING – RAGE*. Once the person has exhausted their SEEKING behaviours by attempting to glean CARE from others, they ultimately resort to

RAGE (see Figure 3). Accordingly, shame, experienced when our intentions or goals are thwarted, leaves us in a state of physical and emotional freezing, especially if we could not or do not behave otherwise (Kaufman, 2004). Therefore, RAGE is a natural behaviour that provides a path out of the devastating experience of being frozen with shame. The afflicted people also appear chronically ridden with PANIC/GRIEF and FEAR. Through the lens of their own subjective experience of chronic PANIC/GRIEF and FEAR, they would experience instability in self and relationships – hallmarks of vulnerable narcissists. It seems probable that the secondary-emotional processes, of learning and modelling, are strongly implicated in the differentiation of the individual idiosyncrasies of how the SEEKING and RAGE experiences are expressed to self and others (Panksepp & Biven, 2012). With regard to tertiary-processes (i.e., higher thinking abilities), vulnerable narcissists may experience being stuck within themselves and not knowing how else to react. They further avoid others and look outside of themselves for ways to escape (e.g., substances, self-harm, externalization of blame). Consequently, the process ends in anger and RAGE, as this is the learned route to acquiring the CARE or needs the individual requires.

Importantly, the SEEKING system and other emotional processes may become activated and deactivated inconsistently; this is especially the case with experiences of inconsistent attention, either through inflated praise and/or childhood maltreatment. Inconsistent activation of the SEEKING system with chronic activation of PANIC/GRIEF, FEAR, and RAGE leads the person to become suspicious, hostile, and reactive. These characteristics increase the likelihood that the individual perceives shame and attacks when the intentions of others are elsewhere (Panksepp & Biven, 2012).

I propose that vulnerable narcissists experience underdevelopment of the CARE system due to cold or indifferent caregivers, leading to decreased empathy for themselves and others. This manifests in an increased likelihood to aggress or RAGE against perceived shame-inducing individuals. As mentioned in Chapter 1, “angry brains” tend to beget anger more often, thus if a brain low in CARE system activation is

built alongside a strong and established RAGE system, RAGE is more likely to develop and be expressed relative to expressions of CARE (Panksepp & Biven, 2012; Potter-Efron, 2015).

In discussing vulnerable narcissism, all of these qualities and affective neuroscience propositions fit well with the current research regarding the development of vulnerable narcissists and with how they experience distress. Needlessly to say, much more research is needed to elucidate and confirm the above-mentioned findings, particularly regarding the affective neuroscience hypotheses.

Overall, there are common themes throughout the varying perspectives of the development of vulnerable narcissism and shame-rage. The theoretical perspectives described above concord that vulnerable narcissists have been mistreated during development and have learned to adapt to life in the best possible way they could. Their differing brain networks learned a set of patterns, what psychodynamic theorists call defensive strategies or action patterns, that enable the person to attain what they require – connection, nurturance, food. However, the strategies used (e.g., avoidance of shame for the expression of RAGE) are often met with RAGE and avoidance from others which further preclude a persons' needs being met. Vulnerable narcissists, or those who display shame-rage tendencies, are attempting to secure connection with others but the strategies they developed do the opposite. As Badenoch (2018) says, "[i]solation is more harmful for us than attaching, even in disorganizing ways" (p. 172). Evidently, vulnerable narcissists have a need to develop alternative strategies to SEEK their needs and wants more effectively.

2.12. Assessment of Shame-Rage and Vulnerable Narcissism

In order to support vulnerable narcissists, or those who struggle with shame-rage action tendencies, mental health professionals should understand how shame may underlie the anger their clients present. The experience of shame and the level of shame-proneness that an individual may experience can be measured using

assessments of shame. In the empirical research literature, there are three primary measurements that assess shame. The Test of Self-Conscious Affect (TOSCA; Tangney et al., 1989), the Experience of Shame Scale (ESS; Andrews et al., 2002), and the Internalized Shame Scale (ISS; Cook, 1994). These scales aim to measure the experience of shame and shame-proneness; however, they inquire into different aspects of the individuals experience of shame.

The TOSCA requires the individual to rate how likely they would react to certain hypothetical scenarios with feelings of shame; this assessment is now in its third version (Tangney et al., 1989; Tangney et al., 2000). The ESS measures the behavioural responses of shame as well as personal characteristics that may be sources of shame (Andrews et al., 2002). Finally, the ISS measures particular phenomenological aspects of the person In specified contexts (Cândea & Szentagotai-Tăta, 2018; Cook, 1994). The TOSCA and the ESS have been used in conjunction with the STAXI-II to indicate the associations between shame-proneness and reacting with anger (Elison et al., 2014; Hejdenberg & Andrews, 2011; Stuewig et al., 2010).

The use of these scales will be helpful for case formulation and therapeutic progress with the case vignettes. Once Bella and T.J. become aware of the underlying shame beneath their anger reactions, the use of these scales are helpful to illuminate their specific phenomenological and behavioural responses. These scales should also be used in conjunction with the STAXI-II – particularly the Anger Scale measurement – to determine how much shame is associated with behaviors of anger (Spielberger, 1999).

After assessing for the experience of shame and its effect on the client, specific knowledge of vulnerable narcissistic characteristics would further support the progression of therapy. There are two scales that are widely used for assessing levels of vulnerable narcissism: The Pathological Narcissism Inventory (PNI; Pincus et al., 2009) and the Five-Factor Narcissism Inventory (FFNI; Miller et al., 2013). Due to the recency and significant validity of the FFNI, I will describe the FFNI in more detail (Miller et al., 2013; Oltmanns et al., 2018). The FFNI entails 15 scales that were developed using the

facets of the Five-Factor model: “neuroticism (Reactive Anger, Shame, Indifference, Need for Admiration), extraversion (Exhibitionism, Authoritativeness, Thrill Seeking), openness (Grandiose Fantasies), antagonism (Cynicism/Distrust, Manipulativeness, Exploitativeness, Entitlement, Lack of Empathy, Arrogance), and conscientiousness (Acclaim Seeking)” (Miller et al., 2013, p. 749).

Vulnerable narcissists typically score higher on facets of neuroticism as well as the cynicism/distrust component of antagonism, relative to grandiose narcissists (Miller et al., 2013). For Bella and T.J., the use of this assessment may help to clarify the particular facets of the five-factor model that they characteristically associate with. By using all of the data accumulated from the aforementioned assessments (including those in Chapter 1), a clearer picture of how the individual suffers may become evident. Consequently, the information gleaned from the assessments will determine the most effective way to guide the client with transcending their shame-rage and maladaptive emotional-behavioural tendencies. This guidance, as long as it follows the path outlined by compassion-based therapies, will support the client in healing. For an explication of a proposed heuristic model for the purpose of case conceptualization when working with individuals deemed to suffer from vulnerable narcissistic and/or shame-rage tendencies, see Figure 5 – Development of vulnerable narcissistic and shame-rage tendencies. The model is functionally similar to the transdiagnostic model put forth by Nolen-Hoeksema and Watkins (2011); however, it does not use the same terminology and only provides one possible final trajectory, that of vulnerable narcissistic and shame-rage tendencies.

2.13. Summary

Shame is an unbearable and devastating emotion. The experience of shame itself is an experience of being alone and vulnerable, the behavioural symptoms, such as hanging the head low and gazing at oneself, only exacerbate the experience of self-consciousness. Shame is often a primary emotion, whereas anger is an often-reported secondary emotion to shame. The experience of anger helps to push others away from

further shaming us (perceived or real) and to protect our inner selves. Those with higher trait levels of vulnerable narcissism, a subtype of narcissism, seem to experience and demonstrate the shame-rage cycle more frequently and intensely than others.

Due to the typical childhood maltreatment and inconsistent parental identification vulnerable narcissists receive during their developmental years, their emotional suffering and mental health concerns are not surprising; especially when compared to those with higher levels of grandiose narcissism. Because of this, vulnerable narcissists will report to mental health professionals more frequently and regularly than grandiose narcissists.

Although there is many differing, yet seemingly compatible, conceptualizations of shame-rage and vulnerable narcissism that exist, the therapeutic ways to support the individuals afflicted with these concerns remains to be clearly established. Increased research into affective neuroscience may support the abstract claims made by other theorists and provide a framework for an effective therapeutic modality. Appropriate assessing of the individual will help delineate the most specific route to healing the idiosyncratic ways of coping that the individual uses. Approaches to supporting individuals with the aforementioned afflictions that emphasize compassion are the most effective. These will be explored and elucidated in the following chapter.

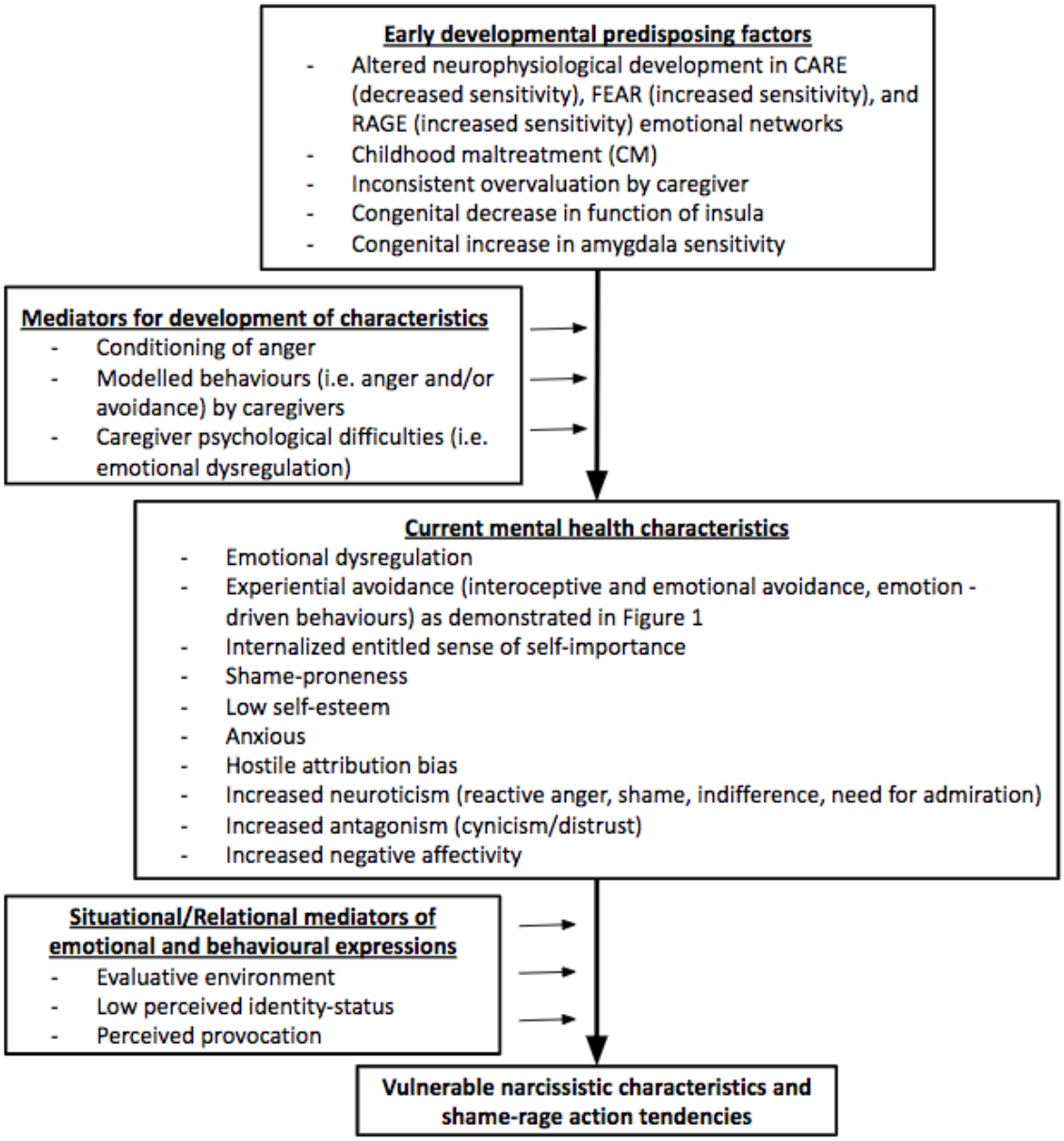

Figure 5. Development of vulnerable narcissistic and shame-rage tendencies

The rectangular boxes are organized temporally and in order of stages of required factors for the proceeding (lower) rectangular box. For instance, the top rectangular box, 'early developmental predisposing factors,' entails factors that occur prenatally and during childhood. The 'mediators for development of characteristics' interact with the 'early developmental predisposing factors' to create the 'current mental health characteristics.' Thus, each stage requires the factors of the stage above it for the expression of the content of the rectangular box in question.

Case Vignette: Juan

Juan is a 29-year-old white heterosexual cisgender male who was born in Vancouver, BC, Canada. His parents immigrated from Brazil when they were 22 years-old; two years later Juan was born. Juan is an only child and was raised without much guidance from his parents. Although his parents followed the religion of spiritism, they were not devout followers and never imposed any specific belief systems on Juan.

Juan indicates that he remembers his father always being angry about the difficulties with immigrating to Canada – often talking about how much harder he had to work compared to native born Canadians. In therapy, Juan talked about feeling distanced and estranged from his father – he could not relate closely to the lived experience of hardship and struggling to fit in to the Canadian society that his father went through first-hand. Juan often felt shamed by his father for not having to work as hard as him. He was berated frequently with comments such as "you should be grateful for everything … and not be a spoiled brat." The mother of Juan, frequently perceived by Juan as submissive and afraid of his father, was remembered to treat Juan as if he was a prince that could do no wrong. Thus, due to the conflicting self-identities experienced through his parents' differing relations with him, Juan grew up with conflicting belief systems regarding his self-identity.

Juan began studying at a local college to become an electrician when he was 18 years old. Through many negative interactions with others, due to their having "suspicious behaviour and reactions towards" him, he often resorted to aggressively reacting to others. He earned a reputation of relating to others aggressively. He did not trust others' actions – this affected his ability to find and maintain jobs. Juan reported in counselling that he felt he was a great person and deserved the best, so when others talked to him as if he was not the best, he became angry and "taught them a lesson."

Through the course of therapy, he began to tell stories of his father physically and emotionally abusing him. He could vividly remember instances of his father shaming

him even when he did well in school – it was still never good enough. Juan, during the sixth session with his counsellor, began discussing his experience of shame more overtly and, with support of the therapist, became more aware of his bodily and physiological experiences when feeling shame.

Juan begun to open up to his experience of shame without feeling an urge to react angrily. He felt less inclined to protect his shamed identities. He slowly began to discuss a lack of self-compassion for himself between session 18 and 22 with his counsellor. By about his 23rd session he felt more compassion for himself and others and recognized that this was something he had been severely lacking in his life. In order to illuminate experiences of Juan, the following list contains examples of his first-hand encounters with self-compassion reported during his 23rd and 24th counselling sessions:

- Juan reported that he felt an expansiveness throughout his entire body, particularly in his abdomen and chest. He mentioned that he could let go of some of his shame-based overidentification. However, he said this feeling did not last long. There was only a brief moment of peace and calm within himself where he no longer felt an inner struggle. At that moment he burst into tears in-session and reported an enormous amount of relief. Typically, his mind was full of ready-made statements to retort others' comments – comments that would be harmful to others – yet for a moment his mind went blank and open. He felt more reflexive.

- Juan felt a slight tingling in his extremities, not due to a lack of blood flow or anything discomfiting, but rather as if his muscles were allowed to relax and expand, instead of resting in their typical semi-constricted state. He mentioned that this feeling was akin to how he imagined being truly loved by someone would feel like. He envisioned himself being able to fully trust and accept someone else without feeling suspicious about their intentions.

- Juan also said that this experience of self-compassion was also scary for him when he experienced it for the first time in-session. Although it felt good, he believed that he would be punished afterwards. He said that whenever he felt good growing up, he was typically told that he was not good enough and that he now had to go and work even harder.

As indicated through the reports made by Juan during the abovementioned sessions it is apparent that he has begun the process of experiencing self-compassion,

particularly towards his previous shame-based memories. Throughout his course of therapy, he became more aware and accepting of his traumatic history. Juan, through mindful exploration, developed his ability to sit with his experience of shame and anger and consequently transcended it for a moment. He did this by developing feelings of self-compassion for himself. The following interview from the 26th counselling session with Juan conveys the later therapeutic stage that Juan is in, compared to T.J. and Bella. The process of moving towards self-compassion is elucidated throughout the interchange.

T: Throughout our sessions so far, we have begun to explore the many egregious experiences you have lived through. These experiences have left you with parts of yourself that you have suppressed and denied because of the extreme pain and discomfort, primarily shame, that accompanied them. I am wondering how you feel about approaching these parts of yourself with a compassionate frame of mind using some of the compassionate images we have developed before.

Juan: I mean, like we have talked about before, I am not accustomed to feeling compassion because I have never really felt it before from others – so I have some apprehension about it. But I can see how this could be helpful for me to relate to myself differently, especially parts of myself that I am really ashamed of – like when I feel that I am not good enough for anything or anyone.

T: Mm, from what I hear you saying, not having any experience of compassion makes it something new. It must be scary to try on a different way of being. But on the other hand, you see that it may be a way to help you experience yourself differently and treat yourself better than others have treated you.

Juan: Yeah, that about sums it up. So how can I start to look at my shameful parts differently? How do I just begin to accept them as part of me and allow them to be seen by myself and others? I know we have developed a compassionate image for myself, which helped to me to feel what compassion is like, but, approaching the shamed parts of myself seems so much different.

T: I really hear the uncertainty, fear, and confusion of how to enact a feeling of compassion towards such hurt parts of yourself. If you

are willing, we can begin to see how your compassionate image, Susan, may be able to help you through this process…

Juan: Yeah, sure let's give it a try.

T: So first I will invite you to close your eyes or find a comfortable gaze on something on the floor in front of you. Then let's take a few deep breaths together… inhale…exhale…inhale…exhale…inhale…exhale… Noticing what is going on in your body when you breathe in and out. Gently noticing where your body touches the chair, how your legs are positioned, where your hands are, just noticing these things with non-judgement. Now see if you can picture your compassionate image – Susan— the teacher from primary school. Allowing your image of Susan to unfold in your mind, try and see her in as much detail as possible. What does she sound like? What do you feel in your body when she is with you? Remembering that since this is your compassionate person, Susan wants to be with you right now… notice what it feels like for you to be in the room with her knowing that she wants to be in your company. Now bring to memory a time when you were recently feeling ashamed of yourself and wanted to punish the other person. See if you can allow Susan to speak to you in this moment. What would she say? What would you want to hear from her at that moment? What would you say in response to her? See if you can reflect on how Susan being there might change how you felt in the moment and how you might have reacted differently to the person who you perceived to cause you to feel ashamed. Would you react differently to the person? What would you want to say? Would you feel more open to experiencing your shame? How would you react with compassion towards the other person?

Juan: (Tears begin to drop from his eyes) Well, it was definitely hard to imagine this situation. I had some resistance to it. But because we have practiced mindfulness before and developed the image of Susan, prior to this, it wasn't as scary as I thought it would be. I was able to keep focused and return my attention to the scenario. I felt more accepted for who I am and freer to do what I pleased in the situation I was remembering. I was not as ready to defend myself as I typically would be, or rather, I felt more able to speak with my heart open, and less angrily. It felt calming, more engaged, and I felt that I could trust the other person more.

T: Mm, I hear that because this isn't something you're accustomed to, there was some resistance to it. The mindfulness practice we have done throughout our sessions helped you to hold on to the image longer. I really hear how much this exercise impacted you and provided an imagined scenario of compassion during distressing experiences that you, maybe, hadn't experienced before.

Juan: Yes, I liked doing this exercise. I feel that I have more control of my own actions towards myself and others when I am surrounded by Susan, my compassionate person.

T: That's wonderful to hear Juan, now we can focus on how to bring Susan into real-life situations in the moment when you feel distressed or in need of compassion to help you through the moment.

Case Summary

Juan progressed through therapy quickly; he developed insight into his anger within the first ten sessions. With the support of a compassionate, trusting, and authentic therapist, Juan was able to open up and expose his shamed parts. He was able to perceive them in a different light. He was able to access the underlying shame and perceive how shame and anger had been affecting him in many unconscious ways. Over time, he was able to adopt a compassionate image, Susan. He imagined Susan supporting him through distressing moments. Juan imagined Susan supporting the qualities he was ashamed of and allowed him to feel acceptance for them. Juan now had the space to express these previously shameful qualities. Overall, Juan was more accepting of his sense of self. He no longer, as frequently or intensely, felt he had to hide or defend certain aspects of himself in ways that worsened interpersonal relationships. In a sense, the emotional, cognitive, and behavioural experiences of Juan became integrated. He learned the skills to adapt his behaviour to different situations in regard to his feelings. Better yet, he felt more control over himself and his life.

Chapter 3. Self-Compassion

Compassion has been discussed for thousands of years; yet we cannot yet say the phenomenon of compassion is very well understood, let alone deeply practiced. Scientific fields (e.g., medicine, psychology, etc.) attempt to describe compassion in an empirical manner to help elucidate how it can be increased in individuals and society at large. Hitherto, important contributions and findings have been discovered. Compassion is a popular topic in positive psychology and has received empirical support for alleviating mental health concerns (MacBeth & Gumley, 2012). Accordingly, this chapter focuses first upon defining the construct of self-compassion as it is used in psychological research discourse; followed with a description of my own subjective experience of personally developing self-compassion. Next, I describe an assessment for self-compassion and exemplify the case of Juan through this assessment. Afterwards, I explicate how and why self-compassion, a developed emotional regulation strategy, is beneficial; particularly for those labelled as vulnerable narcissists struggling with shame-rage tendencies. Finally, implications for case formulation and treatment plans will be proposed for the abovementioned populations.

The construct of compassion and self-compassion derives from Buddhist psychology, wherein compassion (Sanskrit, *karunā*), as described by Shonin et al. (2015), means "the wish for all sentient beings to be free from suffering and its causes" (p. 1162). Kristin Neff (2003) has secularized the conceptualization of self-compassion and introduced it to psychological research discourse. Neff describes self-compassion as an extension of compassion. Compassion is shown towards oneself when suffering occurs from the external circumstances of life and when it "stems from our own mistakes, failures or personal inadequacies" (p. 4). Accepting suffering generates the desire to heal suffering with kindness. Neff is a vastly influential and important contributor to the construct of self-compassion and its related psychological benefits. However, Gilbert (2014a) provides a useful functional explication (see Chapter 1 for basic introduction).

Gilbert (2014a) argues that compassionate competencies have developed through evolution, via innate neurologically based motivational systems, allowing humans to experience affiliative motivations and emotions – typically emanating from our phylogenetically older brain systems which are found deeper in our brains (i.e., midbrain). Gilbert (1989) asserts that our ability to be compassionate to ourselves and others is from our evolutionarily derived ability to take care of our kin; this provided many survival advantages. These compassionate competencies (activated through the *contentment and soothing affect-regulation system*) and their associated neurological structures (i.e., CARE) are relatively distinct within mammals, including humans, when compared to the other affect-regulation systems (Gilbert, 2010).

The other two affect-regulation systems are seen in many other animals, including mammals, however, are phylogenetically older than the caregiving/compassionate system (i.e., contentment and soothing). These other systems entail the *threat and self-protection system* and the *reward and resource seeking system*. These two older systems are typically exemplified through differing motivational systems, such as the need to defend against a potential threat or the desire to seek out a reproductive mate, respectively. Gilbert (2014a) conceptualizes these different motivational systems (i.e., care for our kin, defend against threat, find a mate) as *social mentalities*. The affect-regulation systems function individually and/or together to form a myriad of possible social mentalities which affect our whole being. The combination of older brain systems (affect-regulation systems) provide for our emotional, affective, and behavioural experiences and evolved due to their protective, affiliative, and resource seeking purposes which benefit our lives.

Gilbert (2014b) contends that with our newer cognitive competencies (large neocortices) that allow us to imagine, anticipate, and have an objective sense of self, we are able to relate to others, use symbols, and develop new technologies. We are able to experience and reflect upon our identities, emotions, cognitions, memories, and futures. However, there is a downside to these newer evolved abilities, due to the need

to balance our new and old brain emotions and motivations (i.e., competition, sex and food acquisition). These downsides are demonstrated through our ability to stimulate older brain pathways, for example, through rumination, panic, self-criticism, and shame (Gilbert, 2010).

Essentially, as Gilbert (2014a) explains, "our evolved brain is therefore potentially problematic because of its basic 'design,' being easily triggered into destructive behaviours and mental health problems (called 'tricky brain')" (p. 6). Through activating the soothing and contentment affect-regulation system (i.e., CARE), we foster our affiliative motivational system to act as an emotional regulation system. It is impossible to be content and angry at the same time. By activating the affiliative motivational systems we are thereby regulating our threat detecting processes (including emotions of anger, disgust, anxiety) and consequently fostering empathy, self-care, well-being, and prosocial behaviour. Gilbert (2014b) put it succinctly with a maxim, "Self-care is central to life itself" (p. 9). Essentially, Gilbert is stating that in order for us to live psychologically healthily, we need to take care of ourselves, and one way to do this is fostering self-compassion.

CFT distinguishes between three directions that compassion can flow: compassion for others, compassion from others or ourselves, and compassion directed towards ourselves (self-compassion) (Gilbert, 2014b). Compassion is, according to Dr. Hooria Jazaieri et al. (2013), a Buddhist scholar who developed the *compassion cultivation training* out of Stanford University:

> a multidimensional process comprised of four key components: (1) an awareness of suffering (cognitive/empathic awareness), (2) sympathetic concern related to being emotionally moved by suffering (affective component), (3) a wish to see the relief of that suffering (intention), and (4) a responsiveness or readiness to help relieve that suffering (motivational). (pp. 1117-1118)

This definition by Jazaieri et al. (2013) is conceptually similar to the one by Neff (2003), except that Neff describes self-compassion with more specificity, as opposed to compassion broadly, and defines it in three, rather than four, components.

The definition by Neff (2003) is theoretically and empirically validated and is currently used in multiple countries and languages (Castilho et al., 2015; Garcia-Campayo et al., 2014). Neff (2003) delineates between three sub-components that are interrelated and necessary to describe self-compassion: self-kindness, common humanity, and mindfulness.

3.1. Components of Self-Compassion

Self-kindness (vs. Self-judgment) is one of the three sub-components of the definition of self-compassion by Neff (2003). Self-kindness denotes treating oneself with kindness and understanding with an active desire to soothe and comfort oneself. This is contrasted with a common way that we treat ourselves, through self-criticism and self-judgment. Common Humanity (vs. Isolation) is the second sub-component of self-compassion. Common humanity refers to our common humanness and our imperfect qualities. It involves seeing our "experiences as part of the larger human experience rather than seeing them as separate and isolating" (p. 85). Mindfulness (vs. Overidentification) is the third and final sub-component of self-compassion. Mindfulness is the paying attention in the present moment non-judgmentally (Kabatt-Zinn, 1994). In being self-compassionate, mindfulness means to hold painful thoughts and feelings in awareness rather than to overidentify and become swept up by them (Neff, 2003).

Although these concepts are each unique and distinct from one another, Neff (2003) reminds us that each "interact…to mutually enhance and engender one another" (p. 89). Without a degree of mindfulness, someone suffering is unable to distance themselves from their thoughts and feelings and thereby are less likely to relate to themselves kindly or to consider their experience as part of common humanity. This

becomes pertinent for those with shame-rage, for instance, due to the oft-reported presenting issue of anger. Without becoming mindful of their anger and how it is affected reciprocally, they will not be able to see the possible underlying shame – they will not be able to see their anger as an outgrowth of shame and will preclude connecting with others due to the externalized direction of their anger (i.e., externalization of blame). Likewise, if someone is able to stop themselves from self-criticizing, by enacting self-kindness, they will be more likely to hold a state of mindfulness in any moment as they are not overwhelmed by negative self-judgment. Similarly, by perceiving ourselves within a common humanity lens, we are able to put our experience into perspective, consequently increasing our ability to be mindful of our experiences (Neff, 2003).

For the case of Juan, in the beginning stages of therapy (also, see T.J. in Chapter 1), he expressed anger and resentment towards his father. Through mindfully (with a compassionate therapist) exploring his beliefs, behaviours, and emotions regarding his father he was able to broaden his awareness. He was able to come to an understanding into why he felt the way towards his father and was able to express and transcend some of the resultant anger. He then became closely involved with his experience of shame. Juan shifted from externalizing blame to his father, to a realization that this outward expression of anger was rooted in an inward disliking of himself that developed through his interpersonal relationships – rooted within dynamics he had with his father. Juan realized that although his father may have negatively affected his experience of himself (i.e., shame) he was able to experience a sense of common humanity. He recognized that like himself, his father must have also suffered during his upbringing. Juan expressed that this broader sense of suffering provided a more detailed contextual understanding of his upbringing, he began to feel in control of his own circumstances and began to let go of his self-blame. He realized that his mental health concerns are not his fault, in fact, they are the fault of no one. This insight enabled Juan to enact self-kindness with more ease; he believed he deserved it.

Nevertheless, despite the aforementioned authors' conceptually similar view of compassion and self-compassion (Gilbert, 2014b; Jazaieri et al., 2013; Neff, 2003), it is important to delineate between these two concepts because of the effect that self-criticism and other socially derived self-perceptions (our 'self' in the mind of the other) have on our psychological sense of love and security (Gilbert, 1989). The focus upon the self in self-compassion is not a narcissistic perception of oneself. Peter Schellenbaum (1988) helps to contradict this notion. He talks about mental massage (conceptually likened to self-compassion) as a way to heal ourselves from within. Mental massage is the bringing of gentle attention to ourselves in our mind and approaching our mind how we would with a physical massage – caring and aiming to heal the tensions and pains found throughout.

Schellenbaum (1998) further distinguishes the idea of narcissism from self-compassion and mental massage:

> Mental massage, which may at first sight have seemed to intensify narcissistic isolation, ultimately turns out to be a way leading to liberation from an ego that fearfully shuts itself off from a vital relationship with the outer world. Mental massage attains its natural conclusion in the experience of self-love merging with love of the other. (p. 150)

Mental massage or self-compassion, then, "is simply compassion directed inward" (Germer & Neff, 2013, p. 856), such as approaching oneself in a manner likened to someone supporting and caring for an injured friend. In fact, this inward compassionate focus will support the outward expression of compassion to others as well (Gilbert et al., 2017). Compassion, generally, is a broader term that has been defined as a "sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it" (Gilbert et al., 2017, p. 1). Therefore, both constructs are underpinned by a focus and consequent intention to alleviate suffering whereby self-compassion implies the focus is turned inward as opposed to compassions more outward and broad implication.

It is important to highlight the distinctions between self-compassion and self-esteem due to the typical confusion between them as interchangeable constructs in

layman conversations. Although the topic has been researched quite extensively, Neff (2011) describes the difference eloquently. She states, "while self-compassion is related to well-being because it helps people feel safe and secure, self-esteem is related to well-being in part because it helps people to feel superior and self-confident" (p. 7). She argues that self-esteem is interpersonally regarded, such that we increase our self-esteem through the approval or acceptance from others. Self-esteem is based on our experience with and through others; whereas self-compassion solely regards our own perception and approach to ourselves, implying that we can love and care for ourselves no matter how we are perceived in the minds of other people. It also implies that we are receptive of compassion despite possible wrongdoing or other perceived negative qualification from ourselves or others. Furthermore, self-compassion, which is a more robust negative predictor of social comparisons than self-esteem (Neff & Vonk, 2009), could therefore be used therapeutically when someone is low on self-esteem.

This is also important when discussing individuals with vulnerable narcissism due to their frequently observed low self-esteem (Freis et al., 2015). Attempting to directly increase self-esteem (i.e., focusing upon others' perceptions of them) will not be as helpful to vulnerable narcissists as they typically reflect on perceptions from others in a negative light, based on developmental histories of maltreatment. They would be hyper-focused on what others are doing while neglecting their own experience and needs.

By supporting their mindful and compassionate approach towards their shame, a self-focused emotion, they disconnect from their typical experience of being suspicious of others' intentions and access their own experience instead which could be much more therapeutic and transcendental. It is a rather pedantic differentiation, however, the focus on the self in a compassionate manner, which has been excluded from their mental and social life will be helpful in developing self-compassion. Theoretically, this will improve their self-esteem at the same time (Neff, 2011). It is a matter of working from *within* instead of from *without* which is pertinent with regard to vulnerable narcissists and those suffering from shame-rage tendencies. Schellenbaum (1988),

emphasises love (i.e., self-compassion) as a healing factor, particularly with those who have been wounded. He states: “Ultimately it is the love we give ourselves within the flow of mindful living that heals us of early deprivation, not the love offered by someone else” (p. 144).

3.2. Personal Experience of Compassion

Self-compassion parallels the experience of compassion generally. By activating a self-compassionate state, it is as if the “self” becomes less important. The “self” and others become equal and all deserving of attention. Compassion experiences have been alluded to by researchers, despite a gap in experiments or qualitative data. Thus, I report upon my personal experience with compassion to provide an example of the phenomenological account of this experience. My own experience of compassion has arisen, initially, during and following guided compassionate meditations. However, after much practice, with the support of a regular mindfulness regime, the experience of compassion has begun to arise in my life on a more spontaneous basis. Such that during the day, if I am in a mindful state, I spontaneously feel compassion towards others and myself.

Viscerally, the experience feels expansive, as if my internal organs and musculature suddenly grow and expand but without any discomfiting feeling of stretching or tension. It is as if my body is growing outward in all directions while consequently sensing spaciousness all around me; it is as if I could continue to “grow” and “expand” forever. There also seems to be a slight tingling sensation, almost like the outer edges of my body (e.g., torso, limbs, head etc.) have electricity flowing through them. Moreover, there is a feeling of physical lightness, less heavy, almost as if gravity has lessened to an extent where I developed a level of buoyancy that allowed me to float upon the earth, rather than being pushed down into it. Within the ebbs and flows of suffering that life offers, it is as if I am floating upon the surface of the ocean, where

the waves come and go, while I continue to ride them out, being a part of each wave just as much as any other.

This experience also parallels that of relationships. When in conversation, the unity of I and the other transcends all trivial matters. What is most significant in the moment is the recognition that we are all living beings and trying to do the best we can on this planet with what we have–- we are all travellers on parallel roads. There is a sense of ever-present connection and interrelatedness. Whether I am physically close in proximity to someone, or not, I feel connected to the world and its inhabitants; connected to all matter and phenomena.

On one occasion, while walking mindfully through a park near my home, I was acutely aware of the mark my footsteps left on the earth floor while the earth was also leaving traces of itself on my shoes. My attention focused upon my thoughts. I began thinking about how the marks I left in the ground might affect any insects living there and how this ripple effect could continue onwards infinitely. This was an experience of being interconnected, interdependent, and being something that is whole in itself, yet still part of another larger whole as well (e.g., Holon). The universe and I were both discrete and unified at the same time.

Mentally, the experience of self-compassion was similar to the visceral experience; there was a sense of freedom and expansiveness. My window of tolerance for all things was much larger when feeling compassionate for myself and others. It was easier to return to the plains of possibility when in this state (Siegel, 2012). For instance, if I sensed an expression of anger towards me, I found it easier to sit with the angered individual in non-judgment and compassion. Instead of narrowing my attentional focus (i.e., angry rumination, planning my revenge), I took into consideration the reason for their expressed anger and reacted compassionately towards them. Suddenly, it felt as if there was mental space to consider the situation of the other person and to respond more flexibly and compassionately.

On another occasion, while in a self-compassionate state, I thought back to times when I experienced shame in my childhood. I interpreted the shame-based context (i.e., *scene*) through a different lens. I provided compassion to my younger self in my mind and handled myself how I wanted to be approached at the time. Some of these memories, particularly the ones of being bullied, no longer imbued a repeating sense of inner shame. By renegotiating these memories with a compassionate lens, I was able to forgive myself and the perceived shame-inducer for any harm that was done. In this sense I felt more capable of transcending the shame-induced memory and colouring it with a sense of compassion instead. This held many benefits for me but one major benefit, still experienced presently, is that I no longer dwell negatively in my past as often. I am more adept at being compassionate and forgiving of myself, others, and I look forward optimistically.

These subjective experiences may sound like clichés and perhaps unattainable states to those who have experienced such egregious and terrifying maltreatment throughout their lives. However, I was only able to experience life, at times, in this way after my own practice of mindfulness and compassion – something which requires continuous and regular commitment.

Likewise, Gilbert (2010) contends that the intention of practicing and developing self-compassion is more important than the outcome. I personally corroborate this, since, much of the time during my own personal practice, it was difficult to bring forth compassionate images or experiences during formal meditation. But, the act of making time to try and access my inner ancestral parts (i.e., CARE) is what allowed for the possibility of these experiences to arise. By intending to practice and foster mindfulness and compassion the doorway to my neural brain circuits of CARE were opened, making it easier for me to experience compassion more frequently. The benefits accrued from this opening of the CARE doorway have been life changing.

Furthermore, as discussed, there is a limited amount of research regarding the subjective and experiential aspects of self-compassion. However, Neff (2016) developed

a scale that seeks to measure self-compassion. This can be used to assess the ability and skill with being self-compassionate that clients have developed. From the beginning of therapy through the varying stages, the use of this scale is helpful to track progress in therapy and glean an indicator of a fruitful type of emotional regulation skill that can be further developed and honed.

3.3. Assessment of Compassion

The Self-Compassion Scale (SCS), developed by Neff (2016), is currently considered valid and theoretically coherent. Supporting evidence from Castilho et al. (2015) indicates that "the SCS…is thus a reliable instrument to assess self-compassion and is useful for research and, in particular, clinical practice" (p. 856). The SCS has also been formatted to shorter versions and is translated for use with different native linguistic populations, such as Spanish, with valid and reliable results thus far (Garcia-Campayo et al., 2014). There is a high level of global consensus between researchers for using the conceptualization of self-compassion by Neff (2016) which increases its validity as a coherently defined concept (Arimitsu, 2014; Azizi et al., 2013; Castilho et al., 2015; Garcia-Campayo et al., 2014).

The SCS entails answering 5-point Likert-style questions regarding the six factors involved in the definition of self-compassion: mindfulness/over-identification, common humanity/isolation, and self-kindness/self-judgment. The overall score provides an indication of how self-compassionate the individual presents. The individual factors can be scored as well to assess specific areas for development (i.e., mindfulness) or attenuation (i.e., over-identification) (Neff, 2016).

Juan was assessed using the SCS in his 24th counselling session. He received a total score of 2.36/5.00. He was assessed to be higher in mindfulness (3.75) and thereby less in overidentification (2.25), most likely due to the numerous sessions in counselling and the practice between sessions that occurred. Since the most amount of time in the first 15 sessions revolved around discussing his anger and developing further insight into

the mechanisms of it, he became more mindful of the intricacies of his anger and began to experience the underlying shame. However, his results show high scores in isolation (4.0) and consequent low scores in common humanity (2.0). He also scored high in self-judgment (4.0) and low in self-kindness (1.4). Thus, supporting Juan in developing increased self-kindness and consideration of himself as part of common humanity, he would increase his total self-compassion score.

3.4. Benefits of Compassion

There is ample evidence, accumulated over the last 20 years, for the benefits and positive associations of compassion. Through the use of cross-sectional studies, compassion was discovered to influence positive alterations in our physiological health and genetic expression (Fredrickson et al., 2013). More relevant to psychological health, compassion has been positively correlated with mental health and emotional regulation (MacBeth & Gumley, 2012), and associated with positive interpersonal and social relationships (Yarnell & Neff, 2013). Frequently self-compassionate individuals are more prone to indicate higher life satisfaction, to have a higher emotional intelligence, to report using more effective coping skills, and are less likely to be self-critical, depressed, and anxious (Barnard & Curry, 2011; Neff, 2003). These studies demonstrate optimistic results and possibilities for the therapeutic use of self-compassion with regard to alleviating psychopathology in the general public as well as clients in counselling sessions. The related empirical research will be elaborated upon in this section.

Much of the evidence to date has been correlational and quantitative in nature. The studies and experiments themselves may be replicable, yet, the nature of self-compassion is more complex than any measurement tool can evaluate for, even when proposing that they have captured the essence of self-compassion. These experiments and measurement tools are subject to unrealistic generalizations to real life situations. Also, most of the studies used a comparative analysis of individual trait levels of self-compassion with levels of psychopathology or other negatively valued personal

attributes (Barnard & Curry, 2011; Fredrickson et al., 2013; MacBeth & Gumley, 2012; Yarnell & Neff, 2013). Thus, the data gleaned from correlational and quantitative research has its limits in external validity with real-world utility.

However, there are some qualitative studies which sought to explore the nature and experience of self-compassion. Two qualitative studies explored by Pauley and McPherson (2010) and Campion and Glover (2017) looked at the experience and meaning of self-compassion in depressed and anxious populations as well as the responses to self-compassion in a non-clinical sample, respectively. Pauley and McPherson (2010) conducted semi-structured interviews with clinically diagnosed patients who struggled with either depression or an anxiety disorder. These participants reflected upon their experiences of self-compassion. The results centered upon the discovery that "being self-compassionate would be difficult either because the concept itself felt challenging to enact or their experience of psychological disorder had negatively impacted on their ability to be self-compassionate" (p. 129).

Campion and Glover (2017) also conducted semi-structured interviews, however, with non-clinical populations. They aimed to understand the response of the general public to the idea of being self-compassionate. Overall, they found that participants believed in the benefits of being self-compassionate but that it would make them vulnerable and open to being judged by others. Essentially, they were afraid to be the first ones to be self-compassionate since they perceived that this way of relating to oneself was not acceptable, at least within the western culture where the study took place. The authors thereby concluded that the culture, specifically of western, educated, industrialized, rich, and democratic (W.E.I.R.D.) would have to first accept self-compassion in order for this way of being to flourish in western societies. Gilbert et al. (2012) have labelled this phenomenon as the *fear of compassion*. The above findings seem to point to a lack of acceptance and fear of compassion in western cultures. It is as if our negativity bias (Rozin & Royzman, 2001) makes it much harder to practice new

ways of being with ourselves and others – clearly there are personal and societal barriers to changing this mentality.

The amount of qualitative data is sparse and the concept of self-compassion in psychological literature is still young. More exploratory research is required to support its establishment and flourishment, most notably within the western world. However, researchers are encouraged by the current state of correlational and qualitative data. They have engaged in induction studies, attempting to increase the level of self-compassion in individuals and comparing the changes in individual self-compassion levels with their psychological functioning post-intervention.

Induction studies of compassion suggest that self-compassion can be increased and a likely outcome of this is an increase in well-being and improved processing of negative emotions (Leary et al., 2007). For instance, Jazaieri et al. (2018) found that compassion training "may help modulate specific affective states" (p. 290). This corroborates other findings that consider self-compassion to be a potential emotion regulatory strategy (Diedrich et al., 2014; Fresnics & Borders, 2017; Gilbert, 2014; Jazaieri et al., 2018; Neff, 2003). Therefore, if the individual is ready – they have explored, accepted, and integrated their negative past experiences through the support of a safe and compassionate environment – they can further develop their internal capacity (i.e., CARE) to be compassionate towards themselves and others and reap the many associated benefits.

3.5. Self-Compassion as Emotional Regulation Strategy

Gross (2015), a significant researcher in the area of emotional regulation (ER), situates ER under the umbrella of affective regulation. He specifies that *emotional regulation* "refers to attempts to influence which emotions one has, when one has them, and how one experiences or expresses these emotions" (pp. 4-5). Gross argues that emotional regulation is our own personal efforts to alter the way we experience our own emotions and how we make use of them. Effective emotional regulation has

been indicated to be “vital for mental health and that difficulties in emotion regulation are associated with a range of problematic behaviours and mental disorders” (Roberton et al., 2012, p. 73) such as deliberate self-harm, depression, and anxiety.

Correspondingly, self-compassion as an emotional regulatory strategy has been theoretically proposed by Gilbert, Neff, and other researchers (Diedrich et al., 2014; Finlay-Jones et al., 2015; Finlay-Jones, 2017; Gilbert, 2014; Jazaieri et al., 2013; Neff, 2003). Amy Louise Finlay-Jones (2017) completed a review of cross-sectional and experimental qualitative literature concerning self-compassion, emotional regulation, and mood disorders. In her review, she utilized the definition of self-compassion by Neff (2003), proposing that it is conceptually compatible to promote adaptive ER through the three related sub-components, or pathways, to foster ER. Finlay-Jones (2017) also contends that “the increased acceptance, greater positive affect and lower negative affect brought about by relating to oneself with compassion hypothetically mobilizes greater resources for regulating difficult emotions in an adaptive way” (p. 91). By relating to ourselves compassionately we improve our ability to recognize difficult and positive emotions that we experience. This consequently supports the regulation of these emotions, for instance anger, more adaptively and improves our ability to function more effectively in the world.

Additionally, the research evidence indicating the importance of secure attachment relationships in the development of self-compassionate abilities also underlines the potential for self-compassion to be a form of emotional regulation (Gilbert & Procter, 2006; Neff & McGehee, 2010). Individuals raised in emotionally supportive environments with nurturing and validating caregivers will more likely develop the capacity to be kind, nurturing and understanding towards the self (increased development of CARE networks) (Gilbert & Procter, 2006). Whereas, in abusive, neglectful, and unpredictable environments, individuals will more likely relate to themselves in self-critical and judgemental manners – as seen in vulnerable narcissists and those with shame-anger action patterns (Gilbert & Procter, 2006; Neff &

McGehee, 2010; Van Buren & Meehan, 2015). The abovementioned implications are the developmental possibility for individual self-compassion to be higher or lower depending upon the environment and attachment-based relationships a person was provided with during their developing years, self-compassion is thereby flexible, which is corroborated by induction studies (Jazaieri et al., 2013, 2018; Kirby, Tellegen, & Steindl, 2017).

Gross (2015) asserts that emotional regulation strategies include "both processes that are under deliberate control and processes that operate implicitly" (p. 5). He further suggests that emotional regulation strategies can be learned, and that "people may be maximally successful in pursuing their own idiosyncratic goals if they dynamically adjust the emotion regulation strategies they employ across situations" (p. 17). Gross also delineates between aspects and focuses of emotional regulation. Of specific importance here is of *intrinsic emotional regulation* – "the person who has the goal to regulate emotion is interested in regulating his or her own emotions" (p. 5). Gross emphasizes that emotional regulation can be consciously controlled, learned, and aimed at oneself in order to support our attainment of our personal goals. Based on the aforementioned self-compassion literature, it is evident that self-compassion can be learned, either in environments conducive and nurturing of compassion, or through induction studies. Moreover, self-compassion is theoretically and experimentally apposite to being conceptualized as an intrinsic emotional regulatory strategy.

In order to further explore the potential ER role of self-compassion, I will discuss a study that proposed self-compassion as an ER strategy to support individuals with regulating levels of stress. Finlay-Jones et al. (2015) explored the concept of self-compassion as an emotional regulation strategy in the context of stress in Australian workers. They found that "[s]elf-compassion significantly negatively predicted emotion regulation difficulties and stress symptoms" (p. 1). In this study, Finlay-Jones et al. extrapolated, within the context of the broad benefits associated with self-compassion,

that emotional regulation may be a strong contributing factor in the link between self-compassion and psychological health more generally.

Considering the ability to alter the *severity* and *duration* of our emotional response increases our ability to adapt during stressful situations, as opposed to altering the *type* of emotion (Gross & Jazaieri, 2014); self-compassion may be especially helpful at promoting a balanced perception of our negative emotions, such as anger or aggression (Neff, 2003).

3.6. Self-Compassion: ER strategy for Anger, Aggression, and Rage

Recently, self-compassion has been researched with regard to anger and aggression, albeit minimally. This is an area for future consideration due to the theoretical and empirical associations between the constructs. Nonetheless, a few studies have shown promising preliminary results. Neff and Vonk (2009) demonstrated that self-compassion, compared to self-esteem, "had a stronger negative association with social comparison, public self-consciousness, self-rumination, anger, and need for cognitive closure" (p. 23). This finding indicates that there is a definite link between self-compassion and anger.

Regarding relational dynamics between two people, Neff and Beretvas (2013) demonstrated that men and women participants (N = 104) in interpersonal relationships were more likely to be verbally aggressive to one another when they lacked self-compassion. Thus, theoretically by developing self-compassion the couple could put an end to the cycle of anger and see each other with a different perspective; perhaps approaching the others' angry suffering with compassion.

Lastly, a study by Barry et al. (2015) explored the relationship between levels of self-compassion, as defined by Neff (2003), and dispositional proactive and reactive aggression. Barry et al. (2015) found that self-compassion was negatively correlated with dispositional proactive and reactive aggression in at-risk adolescent males. They

also differentiated between the sub-components of self-compassion and discovered that self-kindness distinctively predicted less proactive aggression, while isolation and over-identification distinctively predicted an increase in reactive aggression. This corroborates the proposed therapeutic link between a lack in self-compassion and vulnerable narcissism (i.e., shame-rage). Reactive aggression, a common response tendency seen in vulnerable narcissists and those with shame-rage action patterns can be mediated through increases in a sense of common humanity and mindfulness. Further research in this area will prove especially useful if targeted towards individuals with vulnerable narcissism.

Unfortunately, there are many limitations to these studies, as the evidence comes from studies pursued by Neff (2003) and her colleagues, indicating a significant bias attributed to her findings as the founder of the Self-Compassion Scale (SCS) and otherwise embeddedness in the self-compassionate literature. More research is required. Still, the research by Fresnics and Borders (2017) solidifies an association between self-compassion, aggression, and angry rumination.

In Fresnics and Borders (2017) study, undergraduate students (*N* = 200) completed questionnaires assessing their level of self-compassion, mindfulness, angry rumination, anger and aggression. They found that "self-compassion was negatively associated with recent anger and aggression" (p. 559) and that "angry rumination statistically mediated the unique associations between self-compassion and anger and aggression" (p. 559). This research implies that self-compassion disrupts the negative, often causally interpreted connection, between angry rumination and aggression. They further noted that "these results suggest that one possible way self-compassion reduces anger and aggression is by decreasing angry rumination" (p. 559). Their research indicates a specific route, cognitively speaking, between mediating self-compassion and anger. This line of evidence is further corroborated with regard to aggression and emotional regulation research (Hagger et al., 2010).

Hagger et al. (2010) stated, in reference to emotional regulation strategies for aggression, that "self-control is a finite resource that determines capacity for effortful control over dominant responses and, once expended leads to impaired self-control task performance" (p. 495). These researchers are arguing that self-control emotional regulatory strategies, such as suppressing (e.g., avoiding) anger, often deplete our cognitive capacities and leave us low in mental energy and resources, thereby less able to effectively emotionally regulate for the proceeding event. The use of self-compassion as an emotional regulatory strategy would be effective and leave the person less cognitively fatigued, and as a consequence less likely to aggress again. It is no secret that compassion would be a fruitful area for further research with regard to anger and aggression, particularly regarding its use as an ER strategy.

Roberton et al. (2012) states, "empirical evaluation of the effect of emotion processing training (including emotion awareness and regulation) on aggressive behavior is ultimately needed" (p. 79). They further assert that "treatments aimed at increasing an individual's ability to regulate emotions deliberately and adaptively may benefit from a focus on increasing an individual's awareness and acceptance of emotions, while providing the individual with an increased variety of emotion regulation strategies" (p. 79). In this statement, many of the concepts (awareness and acceptance) are compared to the description of self-compassion by Neff (2003), specifically of mindfulness and common humanity. Hence, the research by Roberton et al. (2012) seems to support the development and research of self-compassion as an ER strategy.

Finally, Lee and DiGiuseppe (2018) concurs with Roberton et al. (2012) in that they perceive that most anger and aggression treatments are predominantly cognitive-behavioural in nature and thus require a broadening of horizons, especially due to the promising results with non-cognitive behavioural approaches (Lee & DiGiuseppe, 2018). Overall, it seems that the exploration of self-compassion as an emotional regulatory strategy regarding the regulation and acceptance of anger and aggression is a fruitful

avenue of research and supports the claim in this thesis that a therapeutic approach explicitly based around compassion proves therapeutically useful.

3.7. Supporting the Individual who Suffers

Self-compassion, I argue, is the primary therapeutic modality to alleviate the intraindividual suffering of individuals with maladaptive anger, aggression, and/or rage, specifically regarding shame-rage experiences. The utility of supporting the individual sufferer with increasing their own self-compassion and acceptance is, as I proclaim, a most important initial step in the therapeutic process. After this has been enacted and developed, other therapeutic strategies would be beneficial in supporting the client in relating to others with their newly developed understanding and acceptance of their own suffering (i.e., shame, anger, etc.). These next steps in the therapeutic process may involve developing interpersonal skills and learning to assert themselves non-violently when feeling angry. However, per this thesis, the focus is on the initial step of developing self-compassion. This section highlights the empirical research regarding the use of self-compassion for those suffering from specific concerns related to vulnerable narcissism and shame-rage action tendencies.

The phenomenological experience of self-compassion is, as I affirm, antithetical to the experience of anger, aggression, and/or rage whereby we are overridden with the associated feelings, thoughts, and behaviours which leaves us feeling out of control (overidentification/mindlessness). We feel alone and in need to protect ourselves (isolation) and are actively seeking harm and destruction upon ourselves (self-judgment and/or self-harm) and others. The use of mindfulness-based treatments (which are often embedded within compassion-based treatments) are fruitful therapeutic avenues when working with a client, similarly to T.J., who presents with “anger issues” and has yet to develop insights into the historical, cognitive, behavioural, and affective nature of how anger affects him. Unless the client initially recognizes the shame underlying their anger issues (perhaps from previous counselling or personal emotional exploration), we

must primarily support the client to elucidate the contextual and personal impacts of anger on their lives. This will be most helpful in the beginning stages of therapy before proceeding to any specific work with shame. Fundamentally, addressing overidentification and lack of awareness regarding the experience of anger will be supported through increasing mindfulness.

Mindfulness, acceptance, and compassionate techniques support the deepening of our insight and awareness of our emotional experiences (behaviourally, affectively, cognitively) (Germer & Neff, 2013). They support a deepened awareness of our primary-process emotions and how we enact these emotions (i.e., action patterns) in various scenes (see Affect Theory in Chapter 2) (Kaufman, 2004). Mindfulness contrasts with the mechanism of experiential avoidance. By intentionally enacting awareness of our experiences, we are, in essence, turning towards our pain and facing it head-on. Whereas, with experiential avoidance, we are turning away and doing what we can to forget/disown/avoid the pain (i.e., anger, shame).

Compassion and mindfulness-based therapies claim to support individuals with increasing their mindfulness and have extant positive empirical research (Kirby et al., 2017). Examples include: Acceptance and Commitment Therapy (ACT), Compassion Focused Therapy (CFT), Mindfulness Based Stress Reduction (MBSR), and Mindful Self-Compassion (MSC) among others (Byrne & Ní Ghráda, 2019; Kirby et al., 2017; Leaviss & Uttley, 2015; Smout et al., 2012; Zarling et al., 2015).

Compassion-based therapies highlight the importance of using experiential methods in therapy with clients, of facilitating acceptance of their experiences, and often emphasize (e.g., CFT and MSC) the ability of the client to experience their own emotions via compassion. According to CFT and its evolutionary basis, the physiological profiles of enacting a compassionate approach to ourselves and others facilitates an increased capability to regulate emotions that are often feared, such as shame and anger (Gilbert, 2014b; López et al., 2016; Yadavaia et al., 2014). Mindfulness is also implicated in decreasing stress and tension and improving distress tolerance (Khoury et

al., 2015). Improving these skills supports individuals who suffer from frequent, intense, and/or long duration episodes of anger (Khoury et al., 2013, 2015; Potter-Efron, 2015; Ruiz, 2010).

One explicit aspect of the compassion-based focus is exemplified through Compassion Focused Therapy (CFT), developed by Gilbert (2010) and its associated Compassionate Mind Training (CMT) (Gilbert & Procter, 2006). Essentially, Gilbert and the researchers behind the discovery of different emotional pathways in the brain have experimented with training the other neurophysiological pathways, such as the CARE or affiliative networks (Gilbert & Procter, 2006; Panksepp & Biven, 2012). In effect, this training results in changing the underlying neural structure of the brain which has resulted in consequent behavioural and emotional outcomes as observed in the clients who completed this training. The results have been promising thus far (Gilbert & Procter, 2006; Kirby et al., 2017; Leaviss & Uttley, 2015; Zarling et al., 2015).

In essence, the anger sufferer works with their mental health professional to learn and practice behaviours and activities which increase the strength of their other primary-process emotional and motivational pathways (e.g., CARE) which provides the sufferer with alternative ways of behaving, rather than always reacting angrily (i.e., with RAGE). This is one of the main tenets of CFT and CMT (Gilbert, 2014a, 2015; Gilbert & Procter, 2006).

Due to the focus upon the phenomena of shame-rage in this thesis, it is necessary to support the client with focusing initially on their anger as the problem. Emphasis on the development of mindfulness, initially, will support the client to increase their insight and understanding of their particular action patterns and scripts – the ways they react in particular situations. The emotion of anger is not inherently negative and thus imperative to understand the purpose of their anger. Emotions – anger – can be useful if acknowledged and integrated within our way of being and moving through the world so that we follow our emotions only in directions where our personal values are being honoured. “Anger — in particular — is a powerful emotion

that has a profound impact on self- organization and social relations" (Paivio, 1999, p. 312). Anger is often telling us something, even if it is in reaction to another emotion, such as shame. Emotions such as anger can also be at the core of the experience of anguish (Greenberg et al., 1993) which can lead individuals to seek therapy – as exemplified with T.J. in Chapter 1.

There are many psychotherapeutic approaches that seek to evoke emotional experiences, while in a mindful state, to support the client with experiencing and regulating these oftentimes difficult to experience emotional energies that emanate from subcortical brain regions. These types of approaches, labeled *Affective Balance Therapies* (ABT) (Panksepp & Biven, 2012), are at the forefront of psychotherapy and aim to integrate the body-brain-mind connection throughout therapy. Examples of these types of therapies include: Emotion Focused Therapy (EFT), Accelerated Experiential Dynamic Psychotherapy (AEDP), Somatic Experiencing (SE), Sensorimotor Psychotherapy, the Hakomi Method, and Attachment-Focused Family Therapy (Fosha, 2000; Greenberg, 2015; Hughes, 2007; Levine & Frederick, 1997; Ogden & Minton, 2008; Weiss et al., 2015). Particularly, use of the experiential and emotion-focused aspects of these therapies may help mental health professionals when assisting their clients to access and embody their RAGE, FEAR, and PANIC/GRIEF in order to mindfully attend and accept these experiences as a part of themselves. Afterwards, explicit self-compassion development will then help the clients to attend to themselves in more affiliative and helpful manners. Additionally, after embodying and experiencing RAGE mindfully, the underlying shame may be more easily accessible to therapeutic methods.

There is a definite lack in the treatment modality of shame (Schoenleber & Gratz, 2018). Research on shame has been more recent as it was referred to as the *master emotion* by Thomas Scheff (1990, 1994, 1997). Since then, there has been psychodynamic therapies focused on healing the experience of shame and its associated defenses (Kaufman, 2004). Cognitive-behavioural pursuits focus on altering the beliefs associated with shame-entrenched individuals and then targeting the behaviour

associated with these beliefs (Proeve et al., 2018; Schoenleber & Gratz, 2018). Experiential therapies (e.g., Emotion-Focused Therapy and Gestalt Therapy) aim to approach the emotion more directly and explicitly (Greenberg & Iwakabe, 2011). All of the above-mentioned forms of therapy have been completed in individual and group settings. With regard to compassion and mindfulness-based therapies, CFT has been a strong therapeutic modality which has focused much of its therapeutic and empirical efforts regarding the suffering from shame and self-criticism (Gilbert, 2014a; Gilbert & Irons, 2008; Gilbert & Procter, 2006).

Multiple studies have found positive results for the decrease in shame and increase in self-compassion through compassion focused therapies (Barnard & Curry, 2012; Ferreira et al., 2013; Gilbert & Procter, 2006; Woods & Proeve, 2014). While mindfulness-based therapies have been empirically found to result in increases in compassion and decreases in shame (Boellinghaus et al., 2014; Proeve et al., 2018) there is less known about the utility of mindfulness specifically regarding the treatment of shame relative to compassion-based therapies. However, it seems that all of the compassion-based therapies include aspects of mindfulness in the treatment interventions and style of therapy (Kirby et al., 2017). In using compassion-based therapies, such as CFT and MSC, the utility of mindfulness is still present.

Moreover, disowning parts of oneself, or in extreme cases of splitting parts off from our identity (see Chapter 2), seems to indicate an inability to experience parts of ourselves and of our identity (experiential avoidance) thus leading to forms of isolation from ourselves. By disowning and avoiding aspects of ourselves (i.e., shame-based parts), we are also disowning those parts in others. We may even reject and condemn those aspects of others and ourselves. This creates isolated and alienated selves and individuals, seeing as they are only able to cope with certain experiences through the use of experiential avoidance. I concede that experiential avoidance (i.e., emotional and interoceptive avoidance) is the opposite of an aspect of self-compassion – that of common humanity (Neff, 2003).

The definition of narcissism, entitled self-importance (Krizan & Herlache, 2018), is completely contradictory to a sense of common humanity. In essence, common humanity is the experience and knowledge that others suffer as well, and that others have experienced what we have experienced; we are not alone in our suffering. In a way, it is the acknowledgment and understanding that *others* are important too. It is the acceptance that others suffer alongside us, that we matter with those others, and that we are all human. Suffering is common among all humans. I concede that the idea of entitled self-importance is oppositional to the idea of common humanity. The upholding of the defenses (i.e., shame-rage), which maintain a sense of entitled self-importance, are also causing the debilitating consequences, as described in Chapter 2 with vulnerable narcissists. Therefore, by being supported to approach, with compassion, the disowned and avoided parts of themselves the individual may experience an inner integration of their disparate parts. Likewise, there may be a coinciding integration or connection with others due to their newfound ability to connect with themselves. Through compassion and integration with ourselves, we may find compassion and connection with others.

If we perceive vulnerable narcissism as a collection of defensive/protective strategies based around the experience of shame and anger, then we can see that many of their coping methods (e.g., emotional avoidance, interoceptive avoidance, externalization, rage) contribute to their psychological distance from their own experience of shame and ability to be compassionate. Anger functions as a defense to shame and instead focuses on the actions of the other. Self-compassion, in contrast, brings a deepening of awareness and acceptance towards anger. It brings mindfulness, kindness, and common humanity to the experience of anger and by exploring the roots, circumstances, and functions of the anger. Through this deepened self-compassion towards anger, the individual can transcend the anger in order to reach the shame. By accessing the experience of shame, a new sense of life and personhood can be expressed. The *denied self* may appear, the one who was shamed and maltreated throughout life (Lowen, 1985). The *denied self* (Lowen, 1985) will be avowed to awaken

and begin to experience compassion from the therapist and oneself more directly and openly. In order to truly support an individual like this (e.g., Juan), there will inevitably be hurdles and worsening of experiences through the journey. Through opening up and reaching under the thick skin of an individual, there will be, no doubt, repercussions and setbacks. This is inevitable due to the longstanding development and maintenance of the defenses built around protecting the inner sense of self.

Although minimal, there is research indicating direct links between self-compassion and vulnerable narcissism. Barry et al. (2015) assessed 251 at-risk adolescent males (*Age* = 16 – 18) in a residential program with regard to their level of self-compassion. They found that "[s]elf-compassion was inversely related to constructs that involve a sense of personal insecurity (i.e. vulnerable narcissism, internalizing problems)" (p. 121). Perceived in the other direction, self-compassion is related to concepts that provide an experience of security and safety – those people who have experienced isolation and maltreatment during developmental periods did not establish this security (Barry et al., 2015; Van Buren & Meehan, 2015).

Moreover, as mentioned in the first chapter regarding the inability to synthesize constructs of aggression with self-compassion (they are antithetical to one another), a similar finding was elucidated by Barry et al. (2015) with self-compassion and vulnerable narcissism. "Vulnerable narcissism was also positively associated with each of the attitudes thought to be contraindicative of self-compassion (i.e. isolation, self-judgment, overidentification)" (p. 121). It is pertinent to train or induce compassionate competencies (i.e., develop CARE networks) with vulnerable narcissists and individuals with shame-rage tendencies to provide a direct positive influence upon the limiting and detrimental psychological experiences of isolation, self-judgment, and overidentification (Gilbert & Procter, 2006; Jazaieri et al., 2013). Through developing the pathways for other primary-process emotions (i.e., CARE, PLAY, etc.), by training the soothing and contentment affect-regulation system, the vulnerable narcissist and individual with shame-rage action tendencies will be able to choose other ways of being. The

strengthening of more affiliative affect-regulation systems will consequently weaken the other systems (i.e., threat and self-protection system), developing a more balanced emotional-motivational network.

Essentially, self-compassion through all its necessary components (i.e., kindness, mindfulness, common humanity) supports the individual to feel expansive, to feel as if they have more control over themselves (Fatemi & Langer, 2016), to have an increase in emotional regulation, and to feel more reflexive with how they respond to distressing situations (i.e., whether asserting their needs to others or giving themselves words of compassion and care). By developing self-compassion, vulnerable narcissists learn how to create distance between their thoughts, feelings, and behaviours (i.e., reactions) in order to witness and find compassion for their own development and perceived inadequacies, to choose their own belief system of themselves, rather than adopt the beliefs of abusive parents, and to see themselves as part of the larger human picture. The hope is that they may begin to experience common humanity and experience themselves in the world as more connected and less condemned by shamed from others.

Overall, it is evident that the maladaptive use of anger, through shame-rage tendencies as observed in vulnerable narcissists, are strongly indicative of experiential avoidance mechanisms (Frank & Davidson, 2014; Krizan & Herlache, 2018). Self-compassion offers an approach to these avoided emotions and parts of ourselves. It provides for a less painful path. The process of becoming mindfully aware, accepting our common humanity, and developing increased self-kindness is akin to the process of first facing the closed door (through mindfulness), behind which is our avoided parts and emotions. This is the opposite of avoiding the door and the pain it holds inside. By developing our capacity to see ourselves as part of common humanity and by increasing our self-kindness (through activating our CARE networks) we are, metaphorically, opening the door to our hidden and avoided pain. With our increased ability for self-compassion, we are even more adept to walk through the doorway and approach our

pain directly. The impact of our pain becomes softened with self-compassion. By acknowledging and accepting our suffering, with compassion, we may then begin to transcend our pain and find new doorways (i.e., increased development of affiliative affect-regulation systems) and hallways in our lives that we never knew existed.

3.8. Progression of Therapy

The path to developing self-compassion in vulnerable narcissists may be difficult and lengthy. This section elucidates the possible trajectory and progress of therapy with vulnerable narcissists and those with shame-rage tendencies, including the discussion of hurdles that are likely encountered along the way. As mentioned above with Juan, it took many sessions of therapy before he was able to increase his mindfulness and acceptance of his anger in order to see through and find the underlying shame.

A similar finding was reported in the research by Kramer et al. (2018) when they explored the role of self-compassion and narcissism in patients with NPD over the course of more than 30 sessions. Kramer et al. (2018) found that there may be a "possible central role of shame in the therapeutic process of patients with NPD" (p. 3) and they hypothesized that one way for the client to resolve their shame is through accessing their underlying self-compassion. These researchers found in their study that, on average, between sessions 25 and 36 their clients reported decreases in the frequency that they experienced shame. These preliminary results are promising due to the evidently similar parallels they hold to this thesis. However, they completed the study with individuals with NPD and did not comment on any roles that vulnerable narcissistic subtypes may have influenced, negatively or positively, their results.

The research by Kramer et al. (2018) also adds to the knowledge that in working with those with narcissism (vulnerable and grandiose), the defenses against any inner vulnerabilities (i.e., shame, low self-worth) have been developed, practiced, and honed for much of the individuals life and so it may take time before conscious awareness of these injuries become available. Accordingly, it is important to firstly focus on increasing

mindfulness, particularly with anger, as it is often presented as the main concern for the client (i.e., TJ).

The proceeding step is a focus on the shame, assuming it becomes revealed, and explore the shame-based parts of the individual and support their healing and opening up throughout therapy. Since shame is an emotion of hiding and being self-focused, a primary goal for the therapist may be to provide a compassionate witness and co-experiencer of the shame the individual has felt throughout their life. Using compassionate reframing and re-scripting by building a composite image of a *compassionate self* or exploring the use of a *compassionate colour* among many other tools can often facilitate an increased acceptance of the shame-based identity and memories (Gilbert, 2010). This also provides a sense of safety that the individual may experientially retrieve throughout the day.

Once the anger and shame have been mindfully and compassionately attended to, the individual has already noticed major shifts in their experience of themselves, others, and the world around them. Through increased training in being compassionate towards themselves, and with others, the individual sufferer expands the compassionate part of their brain more directly – the CARE portion of their emotional-motivational neural network – which has been underdeveloped throughout their lives (Panksepp & Biven, 2012). They may expand their compassionate experiences and consequently reap the many benefits associated with increased self-compassion. For a heuristic model of how the proposed therapeutic process supports development of progress throughout therapy, see Figure 6 – Therapeutic implications for individuals suffering with vulnerable narcissistic and shame-rage tendencies.

It is much easier to present a linear model of supporting an individual through the course of therapy than enacting the therapy in real-time. The proposed use of specific modalities with the client is meant to underline the most useful interventions for the client at the time. If the client is primarily reporting about their concerns with anger towards others and have not mentioned any self-focused concern (i.e., shame),

perhaps focusing on anger with mindfulness will be the most useful at that phase. In this manner, the client would be met where they are instead of guided into realms they may not be ready to unveil. Whereas, if the client has become aware of underlying shame and begins to talk of these humiliating experiences, then a more explicit focus upon providing compassion-based interventions may be most helpful to the client at the stage.

Compassionate-based therapies and their intricately involved use of mindfulness are the most useful for clients who have experience with shame-rage and vulnerable narcissistic characteristics throughout the course of therapy. The order of which aspect of the therapy to use first is dependent upon what the client brings to the table during each session. This openness and acceptance of the moment-to-moment experience as primary would provide an overarching facilitation of trust, compassion, and empowerment in the therapeutic relationship. This allows for the therapeutic processes and the presenting concerns to unfold in the most effective order/pattern for the client.

3.9. Summary

Compassion enacted through competencies of contentment and soothing affect regulation are neurophysiologically based in CARE emotional-motivational brain networks (Panksepp & Biven, 2012). Conceptualization of compassion varies, however, the three components by Neff (2003) offer an empirical and widely used definition. Mindfulness (vs. overidentification), common humanity (vs. isolation), and self-kindness (vs. self-judgment) are three intricately intertwined concepts which combine to form the basis of self-compassion.

Self-compassion and compassionate based therapies support many positive psychological and physical health benefits (Kirby et al., 2017). The concept of self-compassion and its associated characteristics are conceptually antithetical to those of many characteristics of vulnerable narcissists as exemplified by their shame-rage action tendencies. Compassion-based therapies provide a theoretically coherent and

therapeutically useful modality when supporting individuals who present with vulnerable narcissistic characteristics, or more generally, shame-rage emotional patterns. The use of compassion-based therapies, with flexibility and clinical judgment regarding timing of interventions, over the course of therapy with these individuals, provides an environment where the individuals are able to transcend their anger, experience and accept their shame, and then to provide compassion to themselves and others.

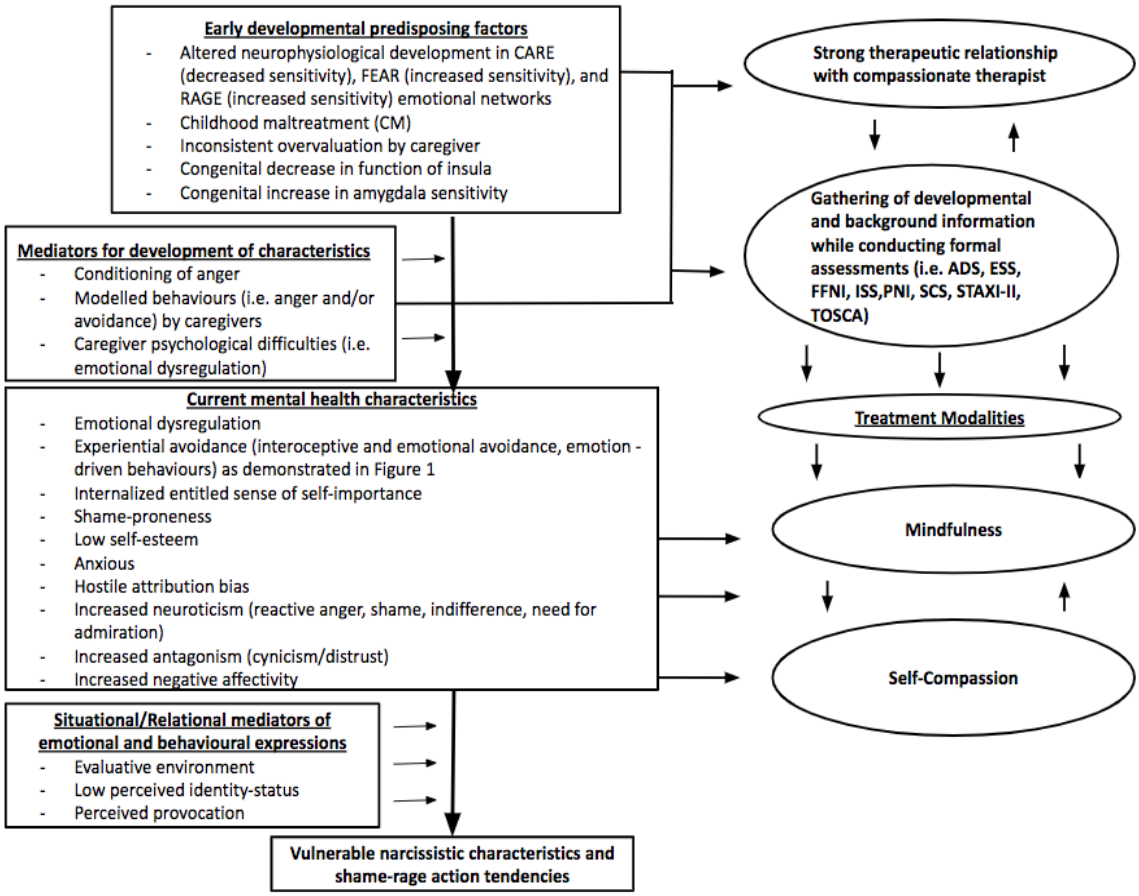

Figure 6. Therapeutic implications for individuals suffering with vulnerable narcissistic and shame-rage tendencies

The rectangular boxes are organized temporally and in order of stages of required factors for the proceeding (lower) rectangular box. For instance, the top rectangular box, 'early developmental predisposing factors,' entails factors that occur prenatally and during childhood. The 'mediators for development of characteristics' interact with the 'early developmental predisposing factors' to create the 'current mental health characteristics.' Thus, each stage requires the factors of the stage above it for the expression of the content of the rectangular box in question. The therapeutic implications (oval shaped boxes) are in temporal sequence from the top to bottom. The top two ovals explicate the dynamic interplay between developing a strong therapeutic relationship while gleaning relevant assessment and historical data that is described in the first two rectangular boxes on the left. After development of a strong therapeutic relationship with a compassionate therapist and formal assessments have been completed the therapeutic modalities can be decided. If the information from the assessments and background pertain to the top two rectangular boxes on the left, then mindfulness and self-compassion are the proposed principal therapeutic modalities to be used in therapy. Mindfulness and self-compassion, used individually and collaboratively (indicated by arrows in both directions), are proposed to alleviate any suffering associated with the 'current mental health characteristics.'

Postamble

This thesis explored the concept and experience of anger, shame-rage, and compassion with three vulnerable narcissistic case vignettes. There are myriad possible clinical implications from the conceptual syntheses outlined throughout this thesis. Of special importance is the fact that this thesis advocates for the understanding of individual differences with regard to emotions. It is evident that anger is much more multilayered and nuanced, and that emotions are generally expressed dynamically and become intertwined with other emotional experiences. I believe that a direction for future research lies within the integration of affective neuroscience findings with psychodynamic and psychotherapeutic constructs. This initial integration, as shown in this thesis, provides the impetus for further research into the possible connections between the specific emotions outlined above and how they develop and intertwine with other emotions throughout lived experiences. Appositely, this thesis highlights the empirically found nomothetic bases of emotions while simultaneously explicating the idiographic development and expression of affective experiences. The implications of this research aim towards further exploration of the aforementioned topics within various fields of study, such as evolutionary psychology, psychiatry, neuroscience, psychotherapy, and psychophysiology, for example.

There is also an abundance of possible transdiagnostic assessments and interventions that could be tested and developed based on the individual expression and function of each emotion discussed. Focusing on distinct emotions and the possible dynamics between them may present underlying functional and contextual information that could be useful in practical settings, such as psychotherapy. Emotion Focused Therapy (EFT) is one specific psychotherapeutic treatment that could benefit from this pursuit. Along this line of thinking, the conceptual dynamics between the emotions could be used, after testing, for case formulation purposes, particularly for psychotherapists, thanks to the ease with which the dynamic emotional concerns of the client can be envisioned and worked through in therapy sessions. In many ways, this

thesis provides a set of speculative guidelines and a framework to develop a heuristic model for supporting those suffering from difficulties with anger, shame, shame-rage, and/or vulnerable narcissistic tendencies.

More concretely, this thesis highlights the connections between shame and anger. To my knowledge, there are no extant assessments of anger that also inquire about experiences of shame. As these emotions are intricately intertwined, it would be helpful to develop assessments of anger and shame that include criteria of both of these emotions. An assessment with these criteria could increase the validity and applicability of assessments for the purpose of therapeutic treatment regarding emotional disturbances with anger and shame. Additionally, structural equation modelling may increase our understanding of the possible interconnectedness or trajectory of the activation of emotions within humans, for example, developmental processes of emotions and evolutionary purposes of emotions.

Speaking in terms of ethics, it seems to me that anger, and any emotion per se, is neither good nor bad. But rather, they are expressed for particular reasons, which need to be understood before further action is taken. This thesis has brought to light these axiological concerns and helped to explicate that the expression and development of anger within each individual is contextually and developmentally dependent upon each individual. This thesis has provided an opening in the realm of philosophical psychology to enable more in-depth and empathetic discussions around the expression of anger and possible ways of supporting the person, such as through forms of rehabilitation, rather than punishing the individual who reacted aggressively out of anger. Additionally, the use of subjective and objective data throughout this thesis supports the integration of varying research ideologies and methodologies, since it is the combined perspective that will provide the most help to those who are suffering. By understanding and researching more about the subjective experiences of emotional suffering, we may better understand how to best support those individuals who suffer.

Furthermore, the topics in this thesis were explored from an individualized and personal perspective. The perspective of myself, being from a W.E.I.R.D. cultural background, strongly influenced the ideas and concepts proposed throughout this thesis. As influential and important as these concepts may be, in terms of the definitions of mental health used in the modern western world (henceforth, just 'West'), they do not live and operate in a vacuum. That being said, as both a product and a producer of my environment, I see how much of the topics and conceptualizations presented here seem to contain important revelations for the broader social and political environment in the West. Historically, our modern western societies tend to advocate the ideal of "each person for themselves": that is, the ideal of individualism.

The rise of the rates of narcissism (Twenge et al., 2008) in the West is concerning, and I postulate that such rise is connected to the deepening of individualism. As I endeavoured to show, cultural practices of individualism and narcissistic wounds are connected. It is troubling that our cultural fabric seems to be indoctrinating our youth into a more egocentric and consequently less empathic society. Although all the ideas I present in this thesis may not be new in themselves, taken together for counselling purposes of advocating for increased compassion toward ourselves and others, they do point to the need for an increase in development and proliferation of cultural ideals that promote compassion, empathy, and solidarity as human ideals to be yearned for in these times of intensifying individualism.

Just like T.J., Bella, and Juan, who developed in an angry environment and developed an "angry brain", became immersed in the only culture and society they knew. Anger and competition were more accepted than compassion and caring. If there were a socially accepted perspective that promoted communal values, supporting one another, and of putting compassion before competition, they may have received more support from their community and developed less debilitating coping strategies.

All hope has not been lost, though. There has been an increase in teaching mindfulness in schools with promising results (Carsley et al., 2018). This is inspiring

news. The increase in mindfulness programs indicates changes are occurring in public policy that are more grounded in acknowledging and improving mental health. I, however, wonder if the dissemination of mindfulness is enough. Mindfulness in the West is often missing is the aspect of having a *sangha*. Sangha means a community of like-minded individuals who are also interested in and practicing together meditation or mindfulness-based activities (Chan et al., 2018). Becoming intersubjective through community is just as, if not more, important in practicing mindfulness. Instead, mindfulness and meditation are often implicated as ways to improve oneself, and the practices themselves are disseminated through apps and software that an individual can use on their own. In some ways, this allows for greater accessibility, but in others, it perpetuates the idea that we are each working to develop ourselves individually and are isolated from others. Meditating and mindfulness skills are a new fad to be sought and used for individual self-improvement, a skill that as individuals we are expected to develop in order to keep up with the fast-moving world. A sense of competition and "me vs. you" may develop. Perhaps a more explicit focus upon developing deep compassion for others, emphasizing the three components of self-compassion, would be more fruitful for the future of our individual lives and the health of the planet (Neff, 2003).

As a society and culture, we may prevent the negative experiences and implications of vulnerable narcissism, shame, and shame-rage through increasing the accessibility of compassionate supports and training. Explicit compassionate-based therapeutic treatment and implementation of compassionate training with younger individuals throughout their educational curriculums is promising and could glean results that are more appealing than the mindfulness-based programs alone. For the sake of our own generations, but also the generations to come, it is paramount to recognize the underlying experiences in those who present as narcissistic and emotionally dysregulated – especially those who hold a lot of power in positions of leadership — be they parents, teachers, directors in institutions, all the way up to the prime minister or president of a country. As discussed in this thesis, the anger and

difficult emotions that individuals express are often covering up for a history of trauma and negative interpersonal relationships.

In the years to come, I foresee major changes and adaptations to our lifestyles and belief systems; but only if we collectively wake up from the nightmare of hyper individualism and decide to take definite action to ensure the continuity of our planet and all its earthlings. My fear is that with an increase in narcissistic attitudes, which is antonymous with common humanity, our species may continue to mindlessly and selfishly destroy the planet with pollution, become more isolated through shaming and aggressing against others, and fuel a fire that leads to unprecedented disastrous ecological and health outcomes. My plea is that we promote and enact lived knowledge of compassion to ensure the viability, stability, health, and longevity of the world and all its inhabitants.

With this thesis, I have attempted to broaden the perspective of compassion research to include cultural aspects for those who have been stigmatized as narcissistic. As I attempted to show, we all are, by virtue of being part of an individualist culture, wounded and have become narcissists: it is only a matter of degree. My hope is that my research will not only support clinicians to look at their “narcissistic” clients with a deeper understanding of the psychosocial origin of narcissism but to create a culture of compassion, thereby softening individualism, which will contribute to mutual flourishing of all beings on the planet.

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