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Hypotheses and Study Methods

Anger as a Primary Phenomenon in Anxiety and Panic Symptomatology: A Gestalt-Phenomenological Psychotherapeutic Perspective

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ABSTRACT

This study explores the presence and role of retroflected anger in panic attacks and anxiety disorders, adopting a phenomenological-Gestalt perspective. The central hypothesis is that unexpressed anger may manifest in individuals through anxiety and panic symptoms, functioning as an "internal alarm" triggered by environmental factors or stressors. The research investigates the difficulty individuals experience in recognizing and expressing anger—often replaced, in their narratives, by terms such as "frustration" or "sadness", which they report within the therapeutic setting. A semi-structured interview specifically developed for this study was administered to a pilot sample, providing preliminary data that indicate the presence of anger—often unacknowledged—in situations where personal expectations or desires were unmet. The observation of results further suggests that once recognized, anger can be transformed into self-affirming awareness and assertive communication. The semantic analysis of the collected data aims to provide a phenomenological description of retroflected anger in anxiety disorders, highlighting the relevance of therapeutic interventions focused on emotional recognition and the effective management of related symptoms.

Keywords

Retroflexed anger, Anxiety, Panic attacks, Gestalt psychotherapy, Phenomenology, Contact cycle.

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ABSTRACT in ITALIANO

Questo studio esplora la presenza ed il ruolo della rabbia, quando è retroflessa, negli attacchi di panico e nei disturbi d'ansia, adottando una prospettiva fenomenologico-gestaltica. L'ipotesi centrale è che la rabbia inespressa possa manifestarsi nella persona attraverso sintomi ansiosi e di panico, agendo come un "allarme interno" innescato da trigger ambientali o stress. La ricerca indaga la difficoltà nel riconoscere ed esprimere la rabbia - spesso sostituita, nella narrazione, da termini come "frustrazione" o "tristezza" che la persona riferisce all'interno di un setting terapeutico. La somministrazione di un'intervista semi-strutturata costruita ad hoc ad un campione pilota ha fornito dati preliminari che indicano la presenza della rabbia, spesso non riconosciuta, in situazioni nelle quali non si è ottenuto ciò che si desiderava; l'osservazione dei risultati suggerisce inoltre che la rabbia, una volta riconosciuta, può essere trasformata in consapevolezza auto-affermativa e in comunicazione assertiva. L'analisi semantica dei dati mira a fornire una descrizione fenomenologica della rabbia retroflessa nei disturbi d'ansia, evidenziando l'importanza di interventi terapeutici orientati al riconoscimento emotivo e ad una gestione efficace dei sintomi.

Parole chiave

Rabbia retroflessa, Ansia, Attacchi di panico, Psicoterapia della Gestalt, Fenomenologia, Ciclo di contatto.

INTRODUCTION

Anger is a fundamental primary emotion, phylogenetically ancient: its presence indicates a discrepancy between the individual and their environment, linked to the function of territorial defense. From a Gestalt perspective, anger is considered useful for the individual to relate to, appropriate, and adapt to the external world, like other emotions, as it is an integral part of the contact cycle [1, 2].

However, in Western culture, anger may be regarded as a socially unpleasant and undesirable emotion, often devalued and discouraged. Due to an internalized prejudice that perceives it as dangerous, destructive, and negative, it is frequently unrecognized and inhibited by those who experience it: its expression tends to be denied and sometimes replaced by acting out, as anger is considered unfair or even illegitimate. When anger is introjected (retroflexed), it can generate anxiety and panic symptoms. Some Gestalt theorists attribute retroflection to a mechanism that blocks or stalls the healthy movement of "reactivity" toward the environment, occurring when one directs inwardly, rather than outwardly, what one wishes to obtain from others: "Retroflexion is the contact-avoidance mechanism whereby the individual 'turns upon themselves' the emotional or active manifestations that others have elicited, thus directing toward oneself what cannot be placed externally" [3].

As psychotherapists, and particularly within Gestalt Therapy, we continuously engage with all emotions, allowing them to flow through the experience cycle within the 'in-between' of the therapeutic relationship: each emotion functions within the organism's self-regulation process, thus anger also contributes to the overall functioning of the person. When anger is not contacted, acknowledged, and expressed as such, it can transform into extreme anxiety or panic [2, 4].

According to the WHO, during the first year of the pandemic, the incidence of anxiety and depressive disorders increased by 25% globally. There has been a rise in patients seeking psychotherapeutic interventions for the 'treatment' of anxiety disorders, often with a focus on symptom suppression [5]. By addressing the symptom solely for the purpose of eliminating or suppressing it, there is a risk of overlooking the underlying functioning that sustains and activates the symptom itself.

This study originates from clinical observations of clients presenting anxiety- and panic-related disorders, in whom difficulties were noted in recognizing and functionalizing the emotion of anger. Utilizing a phenomenological and Gestalt approach, the aim is to explore how this emotion, when inadequately expressed and directed outwardly, may turn against the individual (retroflexion), manifesting as anxiety symptoms. Our hypothesis is that, in many cases, what is experienced as fear may actually represent a secondary manifestation of unrecognized and unexpressed primary anger. This article provides a multidisciplinary theoretical analysis of the phenomenon, integrating Gestalt, phenomenological, systemic, psychoanalytic, cognitive, and neuroscientific perspectives, and subsequently proposes a research design aimed at empirically testing the proposed hypothesis.

Anger as a Primary Phenomenon

Many individuals undertaking psychotherapy report anger as a particularly problematic or "uncomfortable" emotion to manage. In common culture, the concept of anger is frequently conflated with violent or antisocial behavioural manifestations that may arise from it. However, it is essential to distinguish between the emotion of anger and aggression, understood not as violence but as a vital drive necessary for the active assimilation of the environment, as theorized by Fritz Perls [6]. Conversely, the acting out of anger constitutes a dysfunctional behaviour, enacted impulsively and without awareness, which can be harmful both to the individual and to those around them.

To deepen the understanding of anger's role within the Gestalt contact cycle, it is useful to consider the distinction between "antisociality" and "aggressiveness" proposed by Perls, Hefferline, and Goodman [2]. The authors emphasize that social factors hold crucial importance for the organism, even prior to the development of personality and language. In the strictest sense, "antisocial" behaviour is defined as conduct that compromises or destroys significant aspects of social norms, institutions, or personality patterns typical of a given historical and cultural context [2].

Drives or goals perceived as unacceptable, unconscious, or projected onto others are frequently experienced as potentially antisocial or threatening. From a Gestalt perspective, when an individual fails to integrate certain aspects of their personality—often due to social, moral, or internalized constraints—these elements are externalized through mechanisms such as projection or retroflection, resulting in dysfunctional emotional and relational consequences [2]. However, as Freud already hypothesized, it is legitimate to question whether the drive itself is antisocial, or whether it is rather the repression process that leads us to perceive it as such [7].

From a phenomenological-Gestalt perspective, the drive tends to be excluded from awareness when it is incongruent with the internalized ideal self-image, often shaped by authoritative figures from the primary social environment. Nevertheless, when the drive is recognized, accepted, and integrated as part of the self, it loses its antisocial connotation and reveals its adaptive potential [2, 8, 9].

Within the context of social pressure exerted by so-called "primary authorities," the process of introjection can lead to the passive and uncritical assimilation of external norms, rules, and prohibitions, without allowing the individual the opportunity to process them autonomously and personally. This phenomenon, termed "undigested introjection," may constitute the basis for the development of dysfunctional defense mechanisms, including neurotic repressions. In Gestalt Therapy, these processes are interpreted as forms of aggression directed toward the self. In particular, retroflection represents one of the principal modalities through which aggressive energy, or anger stemming from frustration, is internalized and turned against oneself, constituting a direct consequence of non-integrated introjections [2].

Anger is a complex and multidimensional construct encompassing interconnected emotional, cognitive, and behavioural components. The intensity of this emotional experience can manifest along a broad spectrum, ranging from mild states of irritation or frustration to more pronounced forms of rage or intense anger. Expressively, anger may be externalized through verbal or physical behaviours directed toward the external environment (anger-out) or inhibited and internalized through avoidance or suppression strategies (anger-in). These expressive modalities exist along an individual continuum, within which significant interpersonal differences are observed in terms of propensity, intensity, and regulation strategies of anger [10].

Empirical evidence indicates that individuals with high levels of anger-out tend to express anger directly toward the external environment, exhibiting reduced emotional self-regulation and an increased likelihood of engaging in aggressive or hostile behaviours, both verbal and physical. Conversely, individuals characterized by elevated levels of anger-in tend to inhibit or suppress the expression of anger, which becomes internalized and retained. Such inhibition may facilitate the emergence of dysfunctional emotional states, such as guilt, anxiety, or depressive symptoms, contributing to the exacerbation of intrapsychic conflicts and emotional and psychological difficulties [11].

From an evolutionary perspective, the inhibition or retroflection of anger may be associated with early experiences in which the expression of this emotion was punished,

inhibited, or inadequately contained by significant figures. In such relational contexts, the individual may internalize implicit beliefs that anger is a dangerous, unacceptable, or morally censurable emotion. Consequently, defensive strategies—often implicit and preverbal—may develop, oriented toward the avoidance or suppression of anger itself. These dynamic compromises the capacity to recognize, process, and consciously communicate the experience of anger, potentially resulting in negative repercussions on emotional and relational functioning [12].

Anger as a secondary phenomenon

The hypothesis advanced in the present study posits that retroflected anger, particularly in its chronic and unconsciously unrecognized forms, may constitute a significant psychopathological factor in the etiopathogenesis of anxiety disorders and panic attacks. From this perspective, the failure to process and the systematic inhibition of angry emotions would promote the establishment of a persistent state of physiological hyperactivation, which can be conceptualized as a latent internal alert condition. This baseline activation state would increase individual vulnerability to environmental stressors or specific triggering factors, which, in the presence of such predisposition, may act as catalysts for the onset of panic attacks.

Heinz Kohut already described reactions to experiences of rejection as intricate mixtures of anger and fear of retaliation, whereby the individual defensively withdraws, anticipating an inability to fulfill their own desires [13].

Our hypothesis is that chronic repression of anger may significantly contribute to a generalized emotional dysregulation profile, impairing the individual's capacity to adaptively modulate affective experiences. This regulatory deficit can trigger a vicious cycle characterized by an increasing tendency to inhibit angry emotions, motivated by fear of their potential behavioural or relational consequences, resulting in heightened anxiety states and internal psychophysiological tension.

Within this context, the theoretical concept of the "phenomenological configuration of anger retroflection" is proposed, according to which the individual develops a phobic response toward anger, perceiving it as a threatening, dysfunctional, or unacceptable emotion. This construct describes an internal dynamic of self-inhibition of emotional or behavioural experience, manifesting through avoidant behavioral patterns such as systematic avoidance of potentially conflictual situations, difficulty in assertively expressing one's needs and opinions, and the emergence of psychosomatic symptoms including recurrent headaches, gastrointestinal disturbances, or chronic muscle tension, which represent somatic expressions of unrecognized and unprocessed anger [4].

The onset of a panic attack is characterized by the emergence of intense somatic symptoms and a subjective experience of terror, phenomena commonly interpreted as manifestations of fear. However, these manifestations may actually derive from neurophysiological alterations underlying the repression of anger. In particular, amygdala hyperactivity has been associated with an amplification of threat perception and facilitation of panic states; nevertheless, this amygdaloid dysregulation may originate from processes related to unexpressed anger.

In summary, the panic attack can be conceptualized as a somato-cognitive "mask" of anger, representing a distorted mode through which this emotion manifests at the bodily and mental levels. From this perspective, fear would not constitute the primary cause of the panic experience but rather a secondary consequence of the physiological activation and neural alterations characteristic of panic disorder [14].

The intense reaction of anger can manifest in various ways: it may be repressed, giving rise to psychosomatic symptoms such as fatigue, migraines, or nausea; alternatively, it may be freely expressed or at least fully perceived; finally, it can translate into a refuge in unhappiness and self-compassion, where suffering becomes a means to communicate reproach. Anger and fear responses are closely interconnected, as both are activated in response to a wound to personal pride, perceived as a threat leading to profound feelings of self-contempt. The repression of these emotions may contribute to the emergence of specific symptom profiles, while the need to suppress feelings of fear and anger may represent a factor underlying a generalized state of emotional depletion [15].

Neural Network: Emotions, Anger, Fear and Panic

Understanding the neural networks underlying emotions represents a rapidly evol-

ving field of research that offers illuminating perspectives on the mechanisms underpinning panic disorder. Anger, an “approach” emotion oriented toward action, involves the amygdala for intense emotional processing, the insula for interoceptive awareness, the prefrontal cortex for regulation and control, the hypothalamus for “fight” physiological responses, and the limbic system for motivation; these activations guide the behaviour of the “angry” individual [16].

Fear, an “avoidance” emotion linked to survival, centers on the amygdala for rapid, automatic threat responses, the hippocampus for memory and learning of threatening experiences, and the thalamus as a sensory relay. Anxiety, characterized by apprehension and worry about the future, activates the amygdala, the prefrontal cortex (areas involved in planning and control), and the limbic system due to its emotional and regulatory components. During a panic attack, there is simultaneous hyperactivation of these areas, with particular involvement of the amygdala, which triggers intense terror, and the brainstem, which amplifies physiological responses such as tachycardia, sweating, hyperventilation, and sensations of suffocation [17].

In the case of anger, neuroimaging studies have highlighted the activation of a network that includes the insular cortex, implicated in emotional awareness, the amygdala, and specific areas of the prefrontal cortex. Trait anger, defined as the tendency to experience anger with some frequency and intensity, has been associated with reduced functional connectivity between the prefrontal cortex and the amygdala, suggesting deficits in emotional regulation mechanisms [18].

Particularly relevant is the distinction between the expression (anger-out) and suppression (anger-in) of anger: while expression correlates with increased left-lateralized prefrontal activity, suppression is associated with greater right prefrontal cortex activation, a lateralization pattern also confirmed through functional connectivity studies [19].

In panic disorder (PD), recent studies have revealed significant alterations within these networks. A particularly insightful finding emerged from the analysis of neural responses during emotional stimulus processing: individuals with PD exhibit reduced activation of the pregenual anterior cingulate cortex (pgACC) during subliminal processing of faces expressing both happiness and sadness [14].

Moreover, reduced functional connectivity has been observed between the pregenual anterior cingulate cortex (pgACC) and the right amygdala during the subliminal presentation of sad and fearful faces. This hypoconnectivity suggests an impairment in emotional regulation circuits, particularly at the preconscious level. Of particular significance to our hypothesis is that these neural alterations are consistent with a model in which retroflexed anger plays a primary role in the development of panic disorder (PD). The suppression of anger ("anger-in") is associated with increased activation of the right prefrontal cortex and altered connectivity with the amygdala, a pattern that significantly overlaps with the alterations observed in PD [20].

The subliminal emotional processing system, primarily mediated by subcortical structures, is hyperactivated in response to stimuli potentially evoking anger, although such responses are promptly inhibited at the cortical level. This dynamic leads to hyperactivation of the innate alarm system, a subcortical network involved in processing both supraliminal and subliminal fear-related stimuli [15]. This hyperactivation induces a selective attentional bias toward threatening stimuli, which manifests as autonomic symptomatology similar to that observed during panic attacks.

From this perspective, the panic attack does not primarily constitute a fear response but rather a somatic and cognitive manifestation of unexpressed anger, which, lacking adequate expressive channels, is reprocessed by neural circuits as an internal threat, thereby generating the characteristic symptomatology of the disorder. The fear associated with the panic attack thus appears as a secondary phenomenon, consequent to the primary activation linked to retroflexed anger [21].

Introduction to the Theoretical Examination

The present contribution aims to integrate the theoretical and clinical framework of panic disorder (PD) and anxiety disorders by emphasizing an emotional dimension beyond that of fear. The Gestalt perspective adopted here does not intend to oppose established pathogenetic models, but rather to enrich them through a fruitful dialogue, in full coherence with the phenomenological paradigm. In light of this, it

is methodologically necessary to provide a critical overview of the main existing scientific contributions on the subject. Following this examination, the article aspires to broaden the conceptualization of the emotional experience commonly associated with PD. Specifically, the role of anger, understood as an often-overlooked emotional variable, will be systematically investigated in the genesis and maintenance of anxious symptomatology. The ultimate aim of this exploration is to open up new, potential directions for therapeutic intervention and treatment, as previously hypothesized by the authors [4].

The following approaches will be presented in this order:

- Systemic approach;
- Psychoanalytic approach;
- Cognitive approach;
- Mindfulness perspective;
- Phenomenological approach;
- Gestalt approach.

Systemic Approach

Systemic and relational family psychotherapy conceptualizes the family as a complex system of interconnected individuals, wherein the actions of a single member influence the entire group. This approach focuses not on the isolated individual but on the interactions and relational dynamics established among family members, analysing how such exchanges contribute to the development and maintenance of psychological difficulties [22]. It is assumed that changes in one part of the system can induce transformations throughout the entire family system. Individual identity is constructed within the context of the family of origin, which conveys myths, rules, beliefs, habits, and behavioural patterns that profoundly influence personal development. Historically, the emotional dimension has been underrepresented in the literature; when prominently featured, emotion was often interpreted as a disorganizing factor for adaptation, an obstacle to rationality, and a potentially destabilizing force in everyday behaviour [23].

In recent years, there has been a renewed reconsideration or acceptance of emotion, now understood as a positive adaptive force. Emotions play a crucial role in decision-making processes, contributing to self-regulation and the organization of social interactions [24]. From a systemic perspective, emotion is not considered an exclusively intrapsychic phenomenon but rather an event emerging in the "between" of relationships, where the self and the system mutually influence and define each other. Within this framework, emotion serves as a vital element within any relational system and represents a key factor in the change process characteristic of couple and family therapy [24].

Panic or anxiety attacks may be experienced as purely emotional activations. The individual may ignore the neurovegetative components common to both conditions as they manifest as particular bodily sensations. Anxiety and anger often arise in response to parental relationships of which the patient is unaware; the symptom may be exacerbated by the reactions of family system members surrounding the patient. Therefore, conducting family sessions is necessary to assess the situation, reformulate, and establish new agreements based on the patient's needs and requests, promoting the well-being of the individual and the entire family system [25].

From a systemic viewpoint, retroflexed anger can be understood not only as an intrapsychic phenomenon but also as a relational response developed within a specific family context. In many families, the open expression of anger may be discouraged, punished, or deemed inappropriate. Consequently, the child learns to inhibit this emotion to maintain family system equilibrium and preserve fundamental attachment bonds. This pattern of retroflexed anger, learned early, may persist into adulthood, manifesting as anxious symptoms when the individual encounters situations that activate relational patterns similar to those of the original family [26].

The systemic approach aids in understanding how retroflexed anger may develop and be maintained within family dynamics, contributing to the formation of anxious or panic symptoms. This approach also suggests that therapeutic intervention should not be confined to the individual but may benefit from involving the entire family or relational system to promote deeper and more enduring changes [27].

Psychoanalytic Approach

As early as 1895, Freud referred to "anxiety neurosis," describing a form of acute anxiety, termed "actual" because it manifests in

the here and now of the body, characterized by a series of neurovegetative and cognitive symptoms such as dizziness, difficulty breathing, increased heart rate, nausea, cardiac symptoms, fear of losing control or dying, anticipatory anxiety, and avoidance behaviours [28]. Freud attributed the cause of anxiety attacks to an internal buildup of tension, which led to an increase in arousal that the individual needed to discharge through neurovegetative channels. According to classical psychoanalysis, anxiety neurosis could be explained as the result of a conflict between unconscious and unacceptable desires emerging from the Id and the punitive demands of the Superego, wherein the Ego mobilizes defence mechanisms to prevent access to unacceptable thoughts. For Freud, anxiety held a dual function: on one hand, it represented a symptomatic manifestation of an unconscious conflict, and on the other, it resulted from an insufficient repression of that conflict from consciousness. In this sense, Freud considered anxiety an emotion belonging to the Ego [28].

Subsequently, Freud shifted his focus from castration anxiety to separation anxiety, directly linking anxiety to the infant's sense of helplessness and early experiences of loss of the maternal object, occurring when the child is in a pre-Oedipal phase and language has not yet emerged.

With the work of Melanie Klein [29] and later Winnicott [30], psychoanalytic theories transitioned from an instinctual model to a relational model. For Winnicott, in fact, the adult's deep anxiety derives from a failure of the mother to provide containment for the child's psychophysical states of tension and need for caregiving, resulting in a breakdown of the maternal modulatory function that regulates recognition and mirroring of the infant's emotional states [31]. The child, lacking the possibility of mirroring and containment, silences their own emotional experience by substituting it with that of the mother [32].

Contemporary psychoanalytic theory conceptualizes the panic attack as an acute episode of anguish that reflects a complex disruption within the Self [33]. This anguish, which lacks the capacity for psychic representation, manifests directly through visceral bodily sensations. Accordingly, the panic attack can be understood as the breakdown of unconscious regulatory functions responsible for modulating emotional states and transforming affective experiences into representable mental content.

During a panic attack, the individual reenacts an early developmental incapacity to differentiate and regulate mental and somatic states. Panic is thought to originate within pre-Oedipal dynamics, in which the child employs splitting mechanisms that exclude mental states perceived as unacceptable to the mother. As a result, the body is recruited to express what the psyche is unable to symbolize. Splitting and dissociation thus take the place of symbolic functioning. This foundational vulnerability may later be reactivated in situations that evoke early developmental conditions under which it first emerged.

Recent psychoanalytic hypotheses, in conclusion, consider the panic attack as a complex suffering of the Self no longer linked to an unconscious conflict but to structural problems of the Self wherein the function of containing anguish has been lost [34]. According to many contemporary psychoanalysts, therefore, the panic attack is associated with a deficit in the structuring of the Self.

From the perspective of Kohut's self-psychology, narcissistic rage emerges when the Self experiences injury or humiliation. When this rage cannot be expressed or acknowledged due to introjects that devalue or condemn it, it may be retroflexed and manifest as anxiety or panic attacks. As highlighted in the quote from Kohut at the beginning of this article, the patient "withdraws defensively because they anticipate not obtaining what they desire and do not dare to allow themselves to know what they desire" [13]. This defensive withdrawal can be understood as a form of retroflection of anger, wherein aggressive energy, instead of being directed outward to assert needs and desires, is turned inward against the Self, generating anxious symptoms.

Cognitive Approach

Within the cognitive-behavioral theoretical framework, panic disorder, one of the most prevalent anxiety disorders, is characterized as an acute, intense, and transient episode of anxiety marked by affective symptoms such as fear, apprehension, and worry, accompanied by somatic manifestations (e.g., palpitations, tremors, sensations of choking) and cognitive symptoms (e.g., depersonalization, derealization). Subjectively, the experience is often described in terms

of helplessness, distress, and intense terror, with frequent fears of imminent death, loss of control, or insanity. The cognitive-behavioural model considers a multiplicity of internal and external variables that contribute to the activation and maintenance of mechanisms responsible for the vicious cycle characteristic of panic disorder [35].

Anxiety is conceptualized as a reaction to the perception of threat; a multidimensional response system involving cognitive, emotional, behavioural, and physiological domains. It is activated in response to particularly stressful life events, facilitating adaptive behavioural initiatives. It becomes dysfunctional when, endowed with autonomy, it manifests independently of external triggering causes, producing a high degree of suffering in the individual that impairs normal functioning, for example, through avoidance of situations perceived as potentially dangerous. This phenomenon is referred to as anticipatory anxiety, which consists of the fear of the possible occurrence of a panic attack [36].

The cognitive model of the panic vicious cycle is among the primary explanatory models of panic disorder [37]. It posits that panic results from catastrophic interpretations of normal bodily sensations. The individual is continuously engaged in self-monitoring of physical symptoms and the surrounding environment in anticipation of negative outcomes. This self-observation confines the subject to a persistent state of anxiety, entrapping them in a vicious cycle where symptoms of physiological arousal are misinterpreted as confirmation of catastrophic interpretations, thereby increasing anxiety. Indeed, the stimulus, interpreted in worrisome terms, triggers constant and selective attention and becomes salient through rumination. Increased attention, on the one hand, amplifies the intensity of physical sensations (tachycardia, tremors) and, on the other, overlays them with normal anxiety symptoms generated by danger interpretations.

From the perspective of the present study, it is highlighted that the traditional cognitive model of panic disorder primarily focuses on the vicious cycle between somatic sensations and catastrophic interpretations, neglecting the potential role of repressed anger as an etiological or maintaining factor of the disorder. It is hypothesized that the bodily sensations catastrophically interpreted may partially derive from retroflexed anger associated with a state of chronic physiological hyperarousal. Dysfunctional interpretations, therefore, would not pertain to “normal” bodily sensations but rather to those originating from an unrecognized and unexpressed emotion of anger. Furthermore, dysfunctional beliefs concerning the expression of anger—such as the notion that expressing anger is dangerous or that anger is an unacceptable emotion—may play a significant role in the development and maintenance of panic disorder. Such beliefs may lead the individual to systematically repress their anger, increasing the likelihood of emotional retroflection and, consequently, the emergence of anxious symptoms and panic attacks. By including the identification and modification of dysfunctional and secondary beliefs related to anger, in addition to fear and anxiety, a cognitive approach that considers the role of retroflexed anger as a primary phenomenon could expand the traditional model of panic disorder.

Anger as an antisocial disorder

According to the DSM-5, the essential feature of Antisocial Personality Disorder (ASPD) is a pervasive pattern of disregard for, and violation of, the rights of others, beginning in childhood or early adolescence and continuing into adulthood. Conduct Disorder (CD) involves a repetitive and persistent pattern of behaviours that violate the basic rights of others or major age-appropriate societal norms or rules. The specific behaviours characteristic of Conduct Disorder fall into one of four categories: aggression toward people or animals, destruction of property, deceitfulness or theft, and serious violations of rules [38].

Anger, a central characteristic of this disorder, is typically expressed without inhibition, leading to aggressive acts often followed by physical or verbal violence. This condition is widely observed in forensic populations and is interpreted as a manifestation of "willful capacity”, resulting from a lack of empathy and an inability to inhibit impulses in response to socially reprehensible behaviours [39].

Researchers at Leiden University and the Max Planck Institute for Human Development have proposed a possible explanation: the brain regions responsible for processing social information and impulse control are underdeveloped compared to typical development. Their study focused on incarcerated adolescents aged 15 to 21 in

the Netherlands diagnosed with Antisocial Personality Disorder. They found that antisocial adolescents showed reduced activation, relative to controls, in the temporo-parietal junction and the inferior frontal gyrus—brain areas implicated in perspective-taking and impulse regulation [40].

Contemporary neuroscience contributes significantly to the objective characterization of severe personality disorders such as ASPD through the use of Voxel-Based Morphometry (VBM). This neuroimaging technique allows for quantitative analysis of gray and white matter density and volume, facilitating the identification of structural brain alterations associated with specific psychopathologies [41].

In contrast, within anxiety disorders, anger manifests in a less destructive form, and affected individuals do not display the same propensity for violence or criminal behaviour. Although they may experience panic attacks, their responses to stressors do not result in harm to others but rather reflect internalized frustration.

This distinction between the externalized, disinhibited expression of anger in ASPD and the internalized, repressed anger in anxiety disorders underscores how the same emotion can follow markedly divergent pathways of expression. In the former, anger is immediately and often destructively discharged outwardly, whereas in the latter, it is directed inwardly, generating personal distress manifested as anxiety and panic symptoms.

The difference between these anger regulation modalities can also be understood in terms of neurocognitive development and social learning. While ASPD is characterized by deficits in impulse control and empathy, anxiety disorders often involve emotional overregulation and excessive concern about others' judgments, leading to suppression of anger expression [42].

This distinction carries important therapeutic implications: interventions for ASPD may focus on enhancing impulse control and empathy development, whereas treatment for anxiety disorders might emphasize recognizing and appropriately expressing anger, fostering assertive communication that is neither aggressive nor passive.

Mindfulness Perspective

Mindfulness, defined as the capacity to intentionally and non-judgmentally direct attention to the present moment, represents a promising therapeutic approach for managing challenging emotions such as anger and anxiety symptoms. Originally rooted in Buddhist meditative traditions, mindfulness is now integrated into various psychotherapeutic protocols, including Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT). Panic attacks are often characterized by a perceived loss of control and heightened emotional reactivity, which can be debilitating. The application of mindfulness may facilitate modulation of these experiences, promoting greater emotional awareness and regulation in the here and now [43].

Core principles of mindfulness relevant to interventions targeting anger and anxiety include: non-judgment, which involves observing experiences without assigning positive or negative evaluations; patience, understood as the recognition that change processes require time; the "beginner's mind," entailing openness and freshness toward each experience as if encountering it for the first time; trust, or the capacity to rely on one's intuition and feelings; non-attachment to outcomes, allowing engagement with the present moment free from expectation-driven bias; acceptance, characterized by receptive and non-defensive openness to experience; and finally, letting go, the ability to release dysfunctional or superfluous thoughts, emotions, and expectations [44].

Mindfulness practice may foster the development of a more compassionate relationship toward oneself and others, thereby reducing internal judgment that contributes to the amplification of anger. Empirical evidence suggests that individuals who express anger in response to provocative stimuli exhibit, on average, lower blood pressure values compared to those who tend to suppress this emotion, indicating potential physiological benefits associated with conscious and adaptive emotion regulation [45].

Phenomenological Approach

Phenomenology, by focusing on subjective experience, offers a unique perspective for understanding anger as an embodied and situated experience within the existential context of the individual. To analyze anger phenomenologically means to explore how it appears to the consciousness of the person experiencing it, situating it within the

concrete and embodied context of individual life. The phenomenological perspective emphasizes that anger is not merely a mental or anatomical event—i.e., related to the Körper (the physical body)—but an event involving the Leib, the lived body [46].

Unlike more traditional psychological approaches that tend to objectify emotions as quantifiable entities or diagnostic categories, phenomenological analysis is concerned with exploring the lived experience of an individual's affective atmosphere within their unique and unrepeatable experience [47].

Rather than questioning why anger occurs, phenomenology inquiries into how anger is experienced, examining how it alters one's perception of the world, of oneself, and of others during its occurrence. It is also pertinent to investigate what kind of intentionality, or orientation toward something, is connected with the emotion of anger—that is, what emotional "colour" the individual attributes to the world and to their embodied experience as intentional consciousness. Since consciousness is intrinsically intentional, always consciousness "of something," every act of consciousness is directed toward a specific content. This intentionality, according to phenomenology, is crucial for understanding the experience and self-awareness of what transpires, including the lived experience of anger [48].

From the phenomenological viewpoint, emotions such as anger do not represent merely emotional states but directly involve the body. The emotion of anger might be felt as a sudden warmth, muscular tension, an impulse toward action, or a tightness in areas such as the chest or jaw. In phenomenological analysis, the body appears not simply as a container but as a medium through which anger manifests spatially and temporally. The body is not merely something one "has," but something one "is." It constitutes the primary mode of being in the world, and for this reason, the body—as the very locus where lived experience occurs—allows for the identification of the meaning of experienced anger [49].

Phenomenologically, anger is also a relational emotion, arising in relation to the Other and serving a communicative and defensive function concerning the determination of personal and interpersonal boundaries. It is always intentional and aimed at effecting a change in perception and in the manner in which the world is presented to individual consciousness.

When anger is retroflexed (turned inward), the phenomenological experience transforms. The energy that would normally be directed outward is redirected inward, altering the quality of the lived experience. The body, rather than preparing for outward action (as in expressed anger), becomes the target of aggressive energy. This transformation can manifest through various physical sensations which, if not recognized as expressions of retroflexed anger, may be interpreted as signals of danger or threat. The reinterpretation of bodily experience can significantly contribute to the genesis of panic attacks, wherein the body itself is experienced as a source of threat and danger.

Thus, the phenomenological approach to retroflexed anger and its relationship with anxiety disorders offers a valuable perspective for understanding the subjective experience of individuals undergoing these phenomena, going beyond purely mechanistic or reductionistic explanations.

Gestalt Approach

The contact cycle in Gestalt Psychothera

zpy explains how the recognition and satisfaction of a need occur, and how therapy unfolds at the contact boundary between the organism and its environment. In Gestalt theory, it is also referred to as the experience cycle: it begins with sensation, excitation, appetite-impulse-need, a figure emerging from the background, and the prevailing present emotion; it then proceeds at the cognitive level, involving thought processes such as elaboration and generation of ideas, hypotheses, solutions, evaluations, and choices, which ultimately lead to an action coherent with the emergent need and aimed at its satisfaction. If the outcome is perceived as satisfactory, a cycle (or a Gestalt) can be considered closed or completed, thereby making space for the emergence of a new need [50].

Emotions serve as indicators of physiological and psychological alterations that the organism experiences in relation to the contingent situation, functioning as signals emerging from an undifferentiated background that focus attention on the here and now. They immediately reflect the state of the dynamic relationship between the individual and the environment during the present experience. In this way, the contact process enables the "discovery and realiza-

tion" of potential future solutions within the current moment. However, various defensive mechanisms—such as desensitization, deflection, projection, retroflection, confluence, egotism, and introjection—can interrupt the experiential cycle, hindering full emotional processing. The inhibition of action connected to the emergence of emotion or the disruption of contact with it contributes to the development of neuroses, psychosomatic disorders, and social maladjustments [51].

Perls asserts that every minimal excitation produced by the organism should, at any given moment, enable an adequate engagement with the present situation through the transformation of that excitation into emotion and functional action. However, if the excitation is directed against the self, its supportive function becomes inhibitory, inevitably causing the emergence of psychosomatic manifestations or symptoms [52].

In light of the above, the present study proposes the hypothesis that the retroflection of the emotion of anger may increase the risk of developing self-injurious behaviors, anxiety disorders, panic attacks, and depressive symptomatology. It is further hypothesized that even under apparent conditions of calm, the individual may be in a state of chronic activation characterized by a depletion of available emotional and cognitive resources, resulting in impaired regulation capacities and adaptive responses.

Within the framework of Gestalt psychotherapy, the assimilation process of experience involves fundamental survival mechanisms that allow the organism to grow and integrate new experiences. Among these is the annihilation process, a painful and cold impulse linked to frustration that represents a defensive response to pain or threat: it consists of rejecting and erasing an object from consciousness in order to complete a "Gestalt" without it. In parallel, destruction acts by breaking down a complex into fragments to assimilate them into a new structure. Initiative represents the transition from impulse to action; however, in neurotic contexts, it may manifest only verbally or through vague plans, thereby losing its transformative potential. Finally, anger integrates these mechanisms of annihilation, destruction, and initiative; although in extreme cases it may degenerate into fury or hatred—distorting reality perception and compromising awareness—if conscious and integrated, it can become a passion that unites desire and action.

The primary interruption mechanisms considered in Gestalt Psychotherapy are:

Desensitization: Interference during the Pre-contact phase (sensation). It interrupts the initial emergence of the need, preventing the existence of "joys and sorrows" and thereby disrupting the homeostatic equilibrium process.

Deflection: Interference during the Contact phase (awareness). It involves generalization or devaluation of the object which, while taking shape and becoming clearer, becomes pressing; the self, out of fear of contact with the need (or the Other), shifts attention away from the emerging need, diminishing the importance of the object.

Projection: Interference during the Full Contact phase (action). Seeing in others what is not recognized as one's own. Instead of moving toward the object overcoming obstacles, the self does not acknowledge unacceptable parts within itself.

Retroflection: Interference during the Full Contact phase (action). Turning back onto oneself what cannot be directed outward toward the object. Fear of disobeying the introject. Retroflexed anger becomes self-devaluation and fuels guilt.

Egotism: Interference during the Post-contact phase. Disruption of satisfaction through self-idealization. Instead of celebrating a completed achievement, the person is unable to enjoy and blocks spontaneity through control.

Confluence: Interference between Post-contact and Pre-contact phases of a new cycle. Loss of boundaries (the self exists within the boundary of the Other). Dysfunctional closeness, dependence.

Introjection: Interference during the Full Contact phase (action). Swallowing without assimilation. After recognition comes mobilization—emotional and physiological arousal—that leads to forming an idea of how to proceed; the self, blocked by duties, judgments, etc., swallows indigestible rules.

The ego predominantly constituted by introjects does not operate spontaneously and authentically, as it consists of self-related concepts, duties, norms, and externalized views internalized—often imposed by authority figures. These elements represent psychological contents that the organism has failed to fully process, constituting internalized relationships without adequate assimilation or conscious understanding by the individual [6].

Psychotherapist Mariano Pizzimenti emphasizes how the introjection of familial,

cultural, and religious concepts and models may limit the individual's capacity to "adgrade," i.e., to move and orient flexibly and openly toward the environment—an essential condition for the effective assimilation of novelty. In this context, anxiety is interpreted as a neurotic mechanism that tends to withdraw the individual from immediate experience, thereby blocking their evolutionary potential [53].

Aggressiveness, from this perspective, assumes a crucial adaptive function: it enables the removal from the background of rigid introjects and other obstacles that interfere with the organism's capacity to assimilate or reject new experiences, thereby fostering a more authentic and dynamic interaction with the surrounding environment [54].

Study Hypothesis

The present study hypothesizes that unexpressed anger plays a crucial role in the phenomenology of panic attacks and anxiety disorders more broadly. The phenomenological experience of these events may represent the expression of anger that, rather than being explicitly manifested, is turned inward by the individual. Retroflection, as a defensive mechanism interrupting contact at the transition between mobilization (pre-contact) and action (preliminary contact), may manifest as a panic attack or anxiety crisis—i.e., a transformation of an emotional experience into a visible and tangible physical symptom that subsequently limits the individual's functioning [4].

This hypothesis suggests that chronic, unrecognized retroflected anger may be a significant factor in the development of panic disorder. When anger fails to find adequate expression, it can trigger a persistent state of physiological hyperarousal, akin to an internal alarm poised to activate. This baseline condition may render the individual particularly vulnerable to stressful events or environmental triggers that serve as the "spark" for a panic attack. Furthermore, repressed anger can contribute to broader emotional dysregulation, impairing the individual's ability to manage emotions adaptively. This can lead to a vicious cycle in which anger is increasingly suppressed due to fear of its consequences, thereby exacerbating anxiety and internal tension.

An intriguing aspect of this dynamic is the so-called "anger avoidance model" [2, 6, 55, 56, 57, 58, 59] wherein the individual develops a phobic-like avoidance of anger, attempting to deny or evade it. This may be manifested through avoidance of potentially conflictual situations, difficulty expressing assertiveness, or even somatic symptoms such as headaches, gastrointestinal disturbances, or chronic muscle tension.

During a panic attack, physical symptoms and sensations of terror are often interpreted as fear; however, these may actually be consequences of neural and physiological alterations triggered by repressed anger. For instance, amygdala hyperactivity can amplify threat perception and contribute to panic experiences, yet its underlying cause may lie in unexpressed anger.

In summary, the central hypothesis of this study posits that panic attacks may function as a "mask" for anger—a distorted mode through which the emotion manifests somatically and cognitively. Fear, in this framework, emerges as a secondary consequence of physiological activation and neural alterations characteristic of panic disorder, rather than as the primary cause of the experience. The guiding research question is: how can individuals suffering from panic disorder or anxiety disorders more generally express their experienced anger and transform it into a form of self-affirmative awareness and assertive communication?

MATERIALS AND METHODS

Research Design

The study employs an exploratory qualitative approach through the use of a semi-structured interview developed in accordance with the dynamics of the Contact Cycle as described in Gestalt psychotherapy. This design enables an in-depth exploration of participants' individual experiences, focusing specifically on how they perceive and respond when they do not achieve their desired outcomes. The sample selection is carried out according to the analysis of the preliminary request for which the person contacts the clinical centre. People who report a request for help related to experiences involving panic or generalised anxiety are included in the study. From a phenomenological perspective, the inclusion of participants involves the person's first-hand experience rather than a diagnosis that fits pre-established criteria. The interview is con-

ducted within an individual therapeutic setting in which, in addition to the client, the Gestalt therapist and an observer are present, whose task is to conduct the interview in one of the first five sessions. The interview, lasting about 15 minutes, is conducted before the therapy session in order to facilitate or stimulate therapeutic work on the experiences that emerge during the session that follows. The subsequent phenomenological analysis is conducted based on the narrative data from the semi-structured interview. Phenomenology aims to describe the experience as the person lives it, without preconceived theoretical interpretations. This method is supported by semantic analysis using the Atlas.ti programme, which focuses on the common meaning of words and expressions in the narrative structures used by the various participants. The aim of this type of analysis is to understand: what it means for the person to experience panic and anxiety, how they perceive panic and anxiety in their body, what representations they construct and how they relate to their environment while experiencing it. Furthermore, it serves to understand what general meanings are attributed to this experience and how the person narrates and organises the episode in their story. This method can help to understand the experience "from within" and serves to: identify the units of meaning of an experience, group them together to reconstruct the essential themes, and identify the resources present in the narratives in order to establish an effective therapeutic intervention.

Participants

The sample will consist of approximately 40 individuals aged between 18 and 65, all undergoing psychological treatment at the Epsylon Clinical Center with Gestalt therapists in training, supervised by different professionals. Participants will be selected through non-probabilistic convenience sampling, including those who, within the first five psychological support sessions, exhibit difficulties or an inability to process the emotion of anger across various life contexts. Participant selection is based on the therapist's or supervisor's observations, which include self-reported information related to feelings of frustration, discomfort, emotional irritation, and difficulties in expressing refusal within affective relationships. These elements contribute to the hypothesis that retroflection constitutes the primary mechanism of contact interruption. Selection is further guided by the analysis of the individual's clinical request, and it includes subjects reporting experiences of panic or generalized anxiety arising within the past six months. From a phenomenological standpoint, inclusion is based on first-person lived experience rather than on a preliminary diagnosis [60].

The interview is conducted in an individual therapeutic setting, in the presence of the client, a Gestalt therapist in training, and an observer who administers it during one of the first five sessions, either in person or online; the primary therapist is also present. The interview, which lasts approximately 15 minutes, takes place before the therapeutic session in order to facilitate or stimulate the subsequent clinical work. With the participant's consent, the interview is audio-recorded, and all responses are transcribed by the observer on a designated form.

Phenomenological analysis is conducted on the narrative data derived from the semi-structured interview, with the aim of describing the experience as it is lived by the individual, avoiding predetermined theoretical interpretations. Semantic analysis, performed using Atlas.ti software, focuses on the shared meaning of words and on the ways in which participants articulate their narratives. This approach allows for an exploration of what it means for an individual to experience states of panic and anxiety, how these states are perceived bodily, what representations are constructed, and how the person relates to their environment during the experience. The analysis also makes it possible to identify the meanings attributed to the episode and the organizational structure of the narrative, while simultaneously identifying resources and core themes that may inform the design of an effective therapeutic intervention.

Instruments

Data collection will be conducted using a semi-structured interview comprising seven open-ended questions designed to trace the phases of the Gestalt-based Contact Cycle. The interview aims to identify the presence of unexpressed anger within participants lived experiences and will be administered to the sample of approximately 40 individuals.

The interview will be validated in the next step of the research.

The interview questions are as follows:

1. What do you feel when you do not get what you want?
2. What do you do when you do not get what you want?
3. What do you call this emotion/mood?
4. How would it be for you if we called this emotion "anger"?
5. What happens to you when you feel this way (using the term identified in question 3)?
6. What do you do when you feel this way (using the term identified in question 3)?
7. Write down all the words that come to mind related to the word "anger."

Procedure

Interviews will be conducted either in the rooms where psychological support sessions take place at the Epsylon Clinical Center or online for participants who have opted for the online pathway. Each interview will last approximately 30 minutes and will be conducted by the observer in the presence of the referring therapist prior to the scheduled session of the day. Each participant will receive detailed information regarding the study procedures and will participate only after providing informed consent.

Data Analysis

Data will be analysed using a semantic-phenomenological approach. Transcriptions will be coded to identify emerging themes, ensuring anonymity and secure data storage. The analysis will focus on identifying common experiences among participants as well as variations in how anger is expressed or repressed. The ultimate goal is to provide a phenomenological description of repressed anger in panic and anxiety disorders. Interviews will be audio-recorded and transcribed to allow for thorough and detailed processing. Data will be analyzed using ATLAS.ti software for semantic analysis, under the supervision and integration of the research team.

Observations

Preliminary insights gathered from pilot interviews and the clinical experience of our research group have revealed several notable trends warranting further investigation. When participants are asked what they feel when they do not get what they want (question 1), terms such as "frustration," "sadness," and "failure" frequently emerge, whereas the term "anger" is rarely used spontaneously. The emotion of anger tends to surface only later in the narrative, often after specific prompting.

Interestingly, when participants are explicitly invited to label this emotion as "anger" (question 4), many accept this designation but tend to associate or conjoin it with other terms such as "agitation," "frustration," "failure," or "sadness." This pattern suggests a possible difficulty in recognizing and expressing anger as a distinct emotion. We hypothesize that this may relate to cultural factors, beliefs, and family mandates that attribute a negative connotation to anger, framing it as an emotion to avoid or conceal. This hypothesis is further supported by responses to question 6, where many participants report managing the emotion through distracting activities or social withdrawal—for example, the recurring response "I distract myself so I don't feel it," indicating emotion-avoidance strategies.

A particularly relevant finding for our hypothesis is that when participants are invited to describe the physical sensations associated with the emotion not explicitly recognized as anger, they report symptoms closely resembling those typically associated with anxiety or panic attacks: sensations such as tachycardia, chest tightness, muscle tension, difficulty breathing, dizziness, tremors, heat sensations, sweating, nausea, and a lump in the throat are commonly described.

These preliminary observations appear to support our working hypothesis that there may be a significant correlation between the unexpressed anger and the manifestation of physical symptoms commonly linked to anxiety and panic. However, to confirm this relationship and fully elucidate its nature, it will be necessary to complete the study with the entire planned sample and conduct a systematic analysis of the collected data.

CONCLUSIONS

This study aims to explore the presence and role of retroflexed anger in panic attacks and anxiety disorders, adopting a phenomenological and Gestalt perspective. Our hypothesis is that unexpressed anger may mani-

fest through anxious and panic symptoms, functioning as an "internal alarm" triggered by environmental stressors or stimuli.

Preliminary observations suggest a difficulty in recognizing and expressing anger, which is often described by participants using terms such as "frustration," "irritation," or "sadness." Notably, when participants describe the physical sensations associated with the emotion not explicitly recognized as anger, they report symptoms closely resembling those of panic attacks: tachycardia, chest tightness, muscle tension, and respiratory difficulties. This finding supports the hypothesis that the panic attack may serve as a "mask" for anger—an alternative somatic and cognitive manifestation of the emotion when it cannot be adequately expressed.

By integrating perspectives from Gestalt psychotherapy, phenomenology, systemic therapy, psychoanalysis, cognitive-behavioral theory, and neuroscience, this study provides a multidimensional understanding of the relationship between retroflexed anger and anxious and panic symptomatology. Each theoretical framework offers a distinct yet complementary interpretive lens, contributing to a richer and more nuanced comprehension of the phenomenon.

The Gestalt approach allows us to conceptualize retroflection as a specific contact cycle interruption mechanism, whereby emotional energy is directed inward rather than expressed externally. The phenomenological perspective broadens this view by facilitating exploration of the subjective, embodied experience of anger. The systemic approach situates anger retroflection within a broader relational and familial context. Psychoanalytic theory aids in understanding the deep-rooted origins of difficulty expressing anger, often stemming from early attachment experiences and relationships with parental figures. Cognitive-behavioral theory elucidates the interpretative and meaning-attribution processes that transform the physical sensations related to repressed anger into anxious and panic symptoms.

This integrative approach yields significant clinical implications. Psychotherapeutic interventions for panic disorders may benefit from incorporating specific techniques aimed at recognizing and expressing anger. Mindfulness practice appears promising in fostering conscious and nonjudgmental engagement with anger, transforming it from a source of suffering into a resource for self-assertion and assertive communication.

Continuing this research will enable a more in-depth investigation of the hypothesis by collecting data from a larger sample and systematically analysing correlations between retroflexed anger and anxiety and panic symptomatology. If confirmed, these findings could have important clinical implications for the treatment of anxiety and panic disorders, suggesting the need to focus not only on managing anxiety and fear but also on the recognition and appropriate expression of anger.

Future research directions may include longitudinal studies to assess how anger recognition and expression influence the course of panic disorder over time, as well as mixed-method studies integrating qualitative and quantitative approaches for a more comprehensive understanding of the phenomenon. Moreover, it would be valuable to explore how cultural and gender differences affect the relationship between retroflexed anger and anxiety and panic symptoms, given the significant variation in social norms around anger expression across cultures and between men and women.

Ultimately, this study seeks to provide a focused contribution to understanding the emotional processes underlying panic attacks and anxiety disorders, offering a phenomenological explanation that integrates new perspectives and therapeutic possibilities.

Conflict of Interest

The authors declare they have no conflict of interest.

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