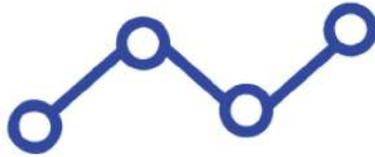


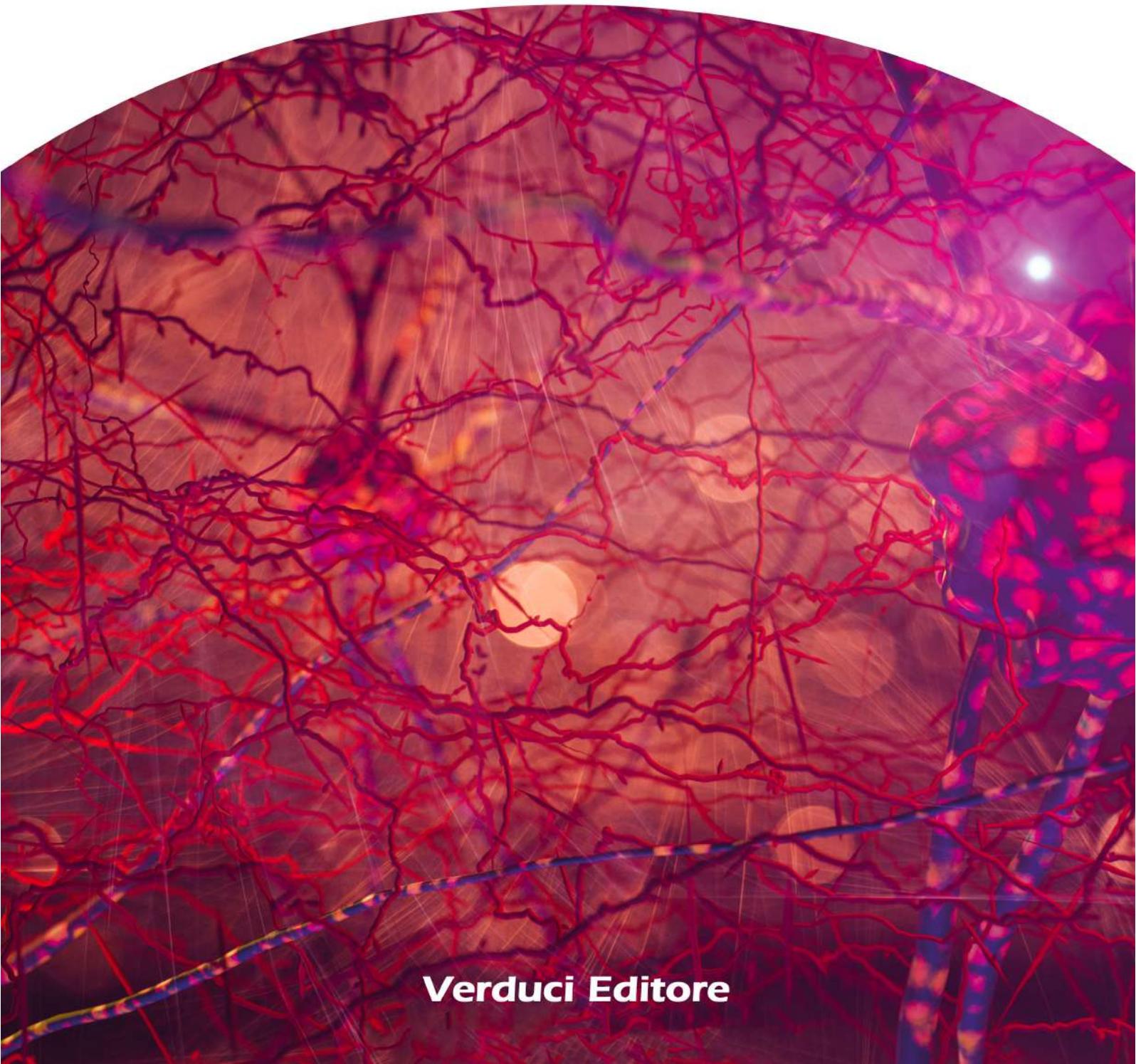
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Review

Quando l'amore diventa tossico: "Non posso vivere né con Te, né senza di Te"

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ABSTRACT

Che cos'è la dipendenza affettiva e quando possiamo parlare di amore tossico?

La dipendenza affettiva rientra tra le forme di dipendenza senza sostanza o *new addiction*, dove l'oggetto della dipendenza non è più la sostanza, ma un comportamento o un'attività illecita come ad esempio il gioco d'azzardo, la dipendenza da internet, la dipendenza affettiva, sessuale, lo shopping compulsivo.

La dipendenza sentimentale è la necessità estrema di carattere affettivo, che il soggetto prova nei confronti del proprio partner, diventando l'unica fonte di sostegno, di sicurezza per il soggetto dipendente. La necessità, l'insicurezza, la sottomissione, il bisogno dell'Altro, diventano gli elementi delle relazioni di dipendenza. Dipendere affettivamente significa amare troppo, amare male, confondere il desiderio con il bisogno costante e continuo dell'altro, rinunciando così alla propria autonomia, al proprio equilibrio e al proprio benessere personale.

La dipendenza affettiva colpisce soprattutto le donne, in quanto verosimilmente sono maggiormente attente ai bisogni degli altri e maggiormente disponibili ad esplorare la cornice relazionale.

Secondo gli ultimi dati pubblicati in letteratura, la prevalenza dell'amore patologico varia dal 3 al 10%, ma è probabilmente più elevata in alcune popolazioni (ad esempio, nel 25% degli studenti universitari).

In un rapporto di coppia si è alla ricerca di un sentimento sincero, di una base sicura nell'ottica di una condivisione, dove si struttura negli anni una relazione di interdipendenza.

La dipendenza affettiva, invece, rappresenta un asservimento unilaterale, che provoca disagio e sofferenza, alimentando un profondo stato di inquietudine e di insicurezza, generando, inoltre, un bisogno costante della presenza e della conferma dell'Altro.

Amare troppo significa annullarsi nell'altro, definirsi solo all'interno di un legame, che diventa vincolante e necessario per la sopravvivenza.

Il presente contributo costituisce una revisione narrativa della letteratura sulla dipendenza affettiva; verranno inoltre esplicitate le differenze presenti tra l'amore sano e patologico ed esaminate le motivazioni che inducono i soggetti a dipendere affettivamente.

Parole chiave

Amore patologico, Dipendenza, Fragilità emotiva.

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ABSTRACT in ENGLISH

What is emotional dependency, and when does love become toxic?

Emotional dependence is a form of substance-free addiction, or new addiction, where the object of the addiction is no longer the substance, but an illicit behavior or activity, such as gambling, internet addiction, emotional or sexual addiction, compulsive shopping, etc.

Emotional dependence is the extreme emotional need that a person feels for their partner, who becomes the dependent person's only source of support and security. Necessity, insecurity, submission, and the need for the other become the elements of a dependent relationship. Emotional dependence can be described as an excessive and maladaptive form of love, in which desire becomes an unceasing need for the other, leading to the loss of personal autonomy, emotional stability, and overall well-being.

Emotional dependence particularly affects women, as they are likely more attentive to the needs of others and more willing to explore the relational framework.

According to the latest data published in the literature, the prevalence of pathological love varies from 3 to 10% but is likely higher in specific populations (for example, in 25% of university students).

In a relationship, one seeks sincere feelings and a secure foundation, building an interdependent relationship over the years. Emotional dependence, on the other hand, represents a unilateral subjugation that causes discomfort and suffering, fueling a profound state of anxiety and insecurity, and also generating a constant need for the presence and validation of the other.

To love too much means to vanish into the other, to define oneself only within a bond, which becomes binding and necessary for survival.

This is a narrative review of the existing literature on emotional dependence. It will also clarify the differences between healthy and pathological love and examine the motivations that lead individuals to emotional dependence.

Keywords

Pathological love, Dependence, Emotional fragility.

INTRODUZIONE

Il concetto di dipendenza affettiva viene ad aggiungersi, in tempi abbastanza recenti, alle già note forme di dipendenza quali la tossicodipendenza, l'alcolismo, il tabagismo, già sanzionate dalla società per i profondi risvolti negativi connessi.

Uno dei motivi per cui verosimilmente la società non ha preso coscienza dell'esistenza di tale disturbo, è che in passato, i rapporti tra uomo e donna sono stati fortemente condizionati da percorsi obbligati in cui il matrimonio e, in genere, il rapporto di coppia avevano lo scopo di adempiere determinate "funzioni sociali" all'interno di ruoli abbastanza rigidi dai quali non si poteva uscire senza incorrere in critiche e giudizi.

Oggi le aspettative nei confronti del rapporto di coppia sono andate modificandosi: l'abitudine e il senso del dovere sono stati sostituiti dalla ricerca dell'amore, di una base sicura, della felicità e dell'intimità.

La dipendenza sentimentale nasce quando si perde la capacità di vivere la relazione come un equilibrio dinamico tra separatezza e fusione.

Quando l'altro non è più libero di essere se stesso, ma viene costretto ad assume-

re un ruolo o una funzione, l'amore smette di essere fonte di arricchimento e diventa una compensazione: un modo per colmare vuoti, paure e bisogni. In questo modo, il rapporto non è più un incontro tra due anime, ma una forma di co-dipendenza, una reciproca limitazione.

La dipendenza sentimentale è la necessità estrema di carattere affettivo che il soggetto dipendente prova nei confronti del partner, che si manifesta con comportamenti di sottomissione, con pensieri di tipo ossessivo e con una perenne paura dell'abbandono [1].

La necessità è l'elemento caratteristico delle relazioni di dipendenza ed è proprio dall'osservazione di questi aspetti, che possiamo andare a creare una scala immaginaria, come scrive Blasco [1], nella quale possiamo inserire il desiderio, l'amore o qualunque altro sentimento positivo, che sottolinea la volontà nel tenere una relazione sana con il proprio partner, come valore medio e considerare invece il concetto di dipendenza o necessità estrema ad un gradino superiore della nostra scala immaginaria, che ci consente già di fare una prima distinzione tra l'amore cosiddetto "normale" e l'amore "patologico".

Quando si parla di dipendenza, di necessità estrema, si va al di là di ciò che dovrebbe

essere una sana relazione di coppia, (dove il partner viene visto come l'oggetto del proprio amore, su cui poter contare nei momenti di difficoltà), poiché entra in gioco l'elemento puramente patologico nel quale il soggetto dipendente non riesce a vivere se non in presenza dell'altro, sviluppando una scarsa o nulla capacità di saper prendere iniziative, decisioni, poiché vive incessantemente nel timore continuo di venire abbandonato.

Dipendere affettivamente vuol dire amare troppo, amare male, confondere il desiderio con il bisogno, rinunciando così alla propria autonomia, al proprio equilibrio e alla serenità interiore.

Annullamento di sé, sacrificio, ansia e insicurezza sono alcuni dei sintomi delle relazioni in cui uno dei partner è in balia dell'altro.

Scrive Lia Inama, autrice del libro *Liberarsi dal troppo amore*: "Si ha dipendenza affettiva quando si è in balia di qualcuno di cui non si riesce a fare a meno e da cui non si sanno prendere le distanze" [2: p. 46].

Quando si dipende affettivamente, si mette in mano ad un'altra persona, che diventa essenziale, il proprio star bene e la conferma di meritare amore. Non c'è reciprocità: è un asservimento sbilanciato che crea disagio e sofferenza, fa sentire insicuri e fa vivere in questo senso di svalutazione [2].

La dipendenza affettiva colpisce soprattutto il genere femminile in tutte le fasce d'età, poiché le donne da sempre sono più attente ai bisogni degli altri e più disponibili a esplorare il campo delle relazioni; sono donne fragili che hanno difficoltà a prendere coscienza di loro stesse e del loro diritto di essere felici, che non hanno ancora imparato che amarsi non significa "amare troppo" ma poter stare in una relazione senza dipendere e senza dover elemosinare continue attenzioni e conferme.

Nelle donne che amano troppo, o per meglio dire che amano male, prevale il bisogno di essere amate rispetto a quello di amare, insaziabili nelle richieste di conferma, cercano di colmare da fuori il senso di insicurezza che sentono dentro, vivendo in funzione dell'altro, cercando di controllarlo e assecondarlo in ogni modo pur di ottenere attenzione e amore.

Alla luce delle trasformazioni sociali e culturali attuali, può essere utile rileggere questi dati con uno sguardo più ampio. Le dinamiche della dipendenza affettiva, infatti, riguardano entrambi i generi, seppur con modalità differenti, e suggeriscono l'opportunità di adottare una lettura più fluida e meno rigidamente normativa dei ruoli affettivi [3].

Che cosa significa amare troppo? Quando si ama, non si è un po' tutti affettivo-dipendenti? Non abbiamo tutti bisogno di amore, di accettazione, di riconoscimento?

Di certo non si nega il batticuore legato ai primi momenti dell'innamoramento e anche dopo anni di relazione sana, il desiderio della sua presenza, ma in questi casi si parla di interdipendenza, di uno scambio alla pari tra persone libere, che investono nella relazione sentimenti e risorse diverse che rendono vivo e naturale il rapporto.

La dipendenza affettiva viceversa è un asservimento unilaterale, pesante, che crea disagio e sofferenza, che fa sentire insicuri, bisognosi di un legame a qualsiasi costo e fa avvertire in questo un senso di svalutazione.

Amare troppo significa annullarsi nell'altro, definirsi solo all'interno di una relazione, spesso malata, che diventa ragione di vita.

L'amore vero regala fiducia, offre presenza e stimolo, lascia responsabilità e spazi, perché l'altro affronti in prima persona le proprie difficoltà; solo in questo modo il rapporto potrà risultare libero e non costrittivo per entrambi.

Spesso si confonde l'amore con la voglia di fusione totale, ma l'amore sano è capace di rispettare l'autonomia e gli spazi dell'altro; non è la simbiosi, ma l'accettazione serena della diversità, che permette al sentimento d'amore di continuare ad arricchirsi.

Scrive Di Maria: "se si riesce a vincere con consapevolezza il fantasma coattivo della simbiosi, il passo successivo diviene la ricerca di uno spazio emotivo (il Noi) che si pone essere 'nei' e 'tra' i due partner" [4: p. 11]. Solo in questo modo il rapporto di coppia diventando plurale (dalla simbiosi alla differenziazione) riesce a riempirsi di contenuti emotivi nuovi, stimolanti, proiettati nel futuro; in altre parole, un rapporto di coppia può nascere e non morire, ma crescere e svilupparsi se, e solo se, riesce a costituirsi paradossalmente di tre elementi: un IO, un TU e un Noi" [4].

Ma che cosa, dunque, spinge a mantenere in vita un legame patologico?

Una prima risposta "potrebbe essere un modo per quanto assurdo e disumano di aggrapparsi a qualcosa di conosciuto, sperimentato e provato, in un mondo che assiste ogni giorno di più al tramonto di ogni certezza. Un mondo che ci ha abituato a preferire certezze anche se imposte piuttosto che cercare di sperimentare nuove e migliori opportunità" [4: p. 11].

LE CARATTERISTICHE DELLA DIPENDENZA AFFETTIVA

Il "mal d'amore" nel suo aspetto di dipendenza affettiva ha molti elementi in comune con le altre forme di dipendenza, distinguendosi unicamente per il legame ad una persona anziché ad una sostanza o ad un comportamento.

Gli intossicati d'amore non sono capaci di prendere decisioni da soli, sono insolitamente sottomessi, hanno sempre bisogno di rassicurazioni e non sono in grado di vivere in modo soddisfacente a meno che qualcun altro non si prenda cura di loro.

L'amore per i soggetti affetti da tale dipendenza è ossessivo, inibito, manca di vera intimità, è parassitario, richiede l'assoluta devozione del partner, e risulta manipolativo e iperpossessivo.

Per Giddens [5], "la dipendenza è un modo di agire strutturato che viene praticato in maniera coatta e la cui eventuale rinuncia genera un'ansietà incontrollabile; anche se le dipendenze danno sollievo all'individuo perché alleviano l'ansia del momento, si tratta pur sempre di un effetto transitorio e di breve durata perché il meccanismo si innesca in modo continuativo e circolare".

Sempre secondo quest'autore la dipendenza presenta alcune caratteristiche specifiche:

- 1) "l'ebbrezza" (il soggetto affettivamente dipendente prova una sensazione di ebbrezza dalla relazione con il proprio partner, che gli è indispensabile per la propria felicità);
- 2) "la dose" (il soggetto affettivamente cerca "dosi" sempre maggiori di presenza e di tempo da spendere insieme al partner; la sua mancanza lo getterebbe in uno stato di smarrimento; il soggetto esiste solo quando c'è l'altro e non basta il suo pensiero a rassicurarlo; ha bisogno di manifestazioni continue e tangibili). L'aumento della dose di questa presenza non di rado esclude la coppia dal resto del mondo al punto che se la dipenden-

za è reciproca, entrambi i partner si alimentano di loro stessi.

L'unica cosa importante è il tempo trascorso con l'altro, perché attesta l'esistenza e la presenza del partner. Quando l'altro non c'è, il soggetto dipendente sente di non esistere, di non riuscire a pensare ad una vita senza di lui e questo spinge di conseguenza ad essere sempre più legati l'uno all'altro.

Una osservazione di Giddens sulla quale vale la pena riflettere è che "le dipendenze che hanno come oggetto degli obiettivi socialmente accettabili (lavoro, amore) sono meno facilmente riconoscibili come tali, sia da parte dell'individuo stesso che dagli altri". Ogni dipendenza sostiene il sociologo, è una reazione difensiva ed una fuga, un riconoscimento della mancanza di autonomia che getta un'ombra sulle effettive capacità dell'io.

Blasco [1] ha individuato le caratteristiche della dipendenza affettiva all'interno di tre aree tematiche, quali l'area della relazione di coppia, l'area della relazione legata all'ambiente interpersonale e infine l'area dell'autostima e dello stato d'animo.

Nell'area della relazione di coppia, otto sono gli elementi che contraddistinguono un legame di dipendenza:

- La necessità eccessiva dell'altro, che si manifesta con il desiderio di un contatto continuo con il partner;
- Il desiderio d'esclusività all'interno della relazione;
- La priorità della coppia sopra qualsiasi altra cosa;
- L'idealizzazione dell'oggetto amato;
- Relazioni basate sulla sottomissione e subordinazione al proprio partner;
- La storia di relazioni di coppia non equilibrate²;
- La paura per la rottura del rapporto³;
- L'assunzione del sistema di credenze della coppia⁴.

L'area legata al contesto interpersonale comprende tre elementi quali:

¹Per esclusività, Blasco intende la dedizione che i soggetti dipendenti hanno nel soddisfare qualsiasi bisogno ed esigenza del proprio partner, dedicando in tal modo tutto o gran parte del loro tempo alla relazione.

²La vita sentimentale del soggetto dipendente è quasi sempre una successione di relazioni di coppia tormentate e disequilibrate, che hanno origine nella adolescenza o all'inizio dell'età adulta.

³La paura della rottura corrisponde "all'ansia di separazione" di Bowlby, il soggetto dipendente vive la relazione con un perenne timore di essere abbandonato, che Blasco considera l'assillo principale delle persone affette da dipendenza affettiva.

⁴Il soggetto affetto da dipendenza affettiva crede nella grandiosità e superiorità del partner, considerandosi di conseguenza un essere inferiore, si sente colpevole di tutto ciò che avviene di negativo all'interno del rapporto, a tal punto da considerare tali elementi come veri e propri capisaldi del rapporto amoroso.

- il desiderio del soggetto dipendente di ricoprire un ruolo di esclusività rispetto agli altri (familiari, amici);
- l'esigenza di voler piacere, che si manifesta nel mettere in mostra le proprie caratteristiche fisiche e caratterologiche per paura di perdere il partner;
- la presenza di un deficit delle capacità sociali (i soggetti dipendenti sono spesso egoisti e poco empatici, mostrando una bassa o nulla capacità di ascolto nei rapporti interpersonali, in quanto concentrati esclusivamente sui loro problemi).

L'area dell'autostima e dello stato d'animo rivela come nei soggetti affetti da dipendenza sentimentale vi sia:

- Bassa autostima;
- Paura e intolleranza alla solitudine (i soggetti con mal d'amore si sentono prigionieri di sé stessi, poiché non riescono ad amarsi per quello che sono e credono di riuscire a vivere solo della luce riflessa del proprio partner;
- Stato d'animo negativo e comorbilità frequenti (i soggetti affetti da dipendenza affettiva sono sempre ansiosi, preoccupati e nervosi perché vivono con il timore di essere abbandonati dal proprio partner).

I MOTIVI CHE INDUCONO ALLA DIPENDENZA SENTIMENTALE

La dipendenza affettiva trova spesso la sua origine in bisogni infantili inappagati: i bambini i cui bisogni d'amore rimangono non considerati possono adattarsi imparando a limitare le loro aspettative, iniziando a credere che i loro bisogni non siano importanti e degni di essere amati e di ricevere attenzione dalle persone care.

Dal momento che nello sviluppo della loro crescita personale sono stati ostacolati nella vita, le persone con problemi di dipendenza sentimentale associano sé stessi all'identità del proprio partner.

Il bisogno di riconoscimento, cioè della reazione positiva degli altri, rientra nella normalità psicologica; se infatti l'accettazione o l'approvazione altrui manca o è negativa, si vive una frustrazione, perché il sentirsi criticati o, peggio ancora, ignorati significa non essere riconosciuti e rispettati nella propria individualità.

Per l'adulto dipendente il consenso altrui è una necessità, una specie di droga di cui

non può fare a meno; tale bisogno diventa decisamente patologico quando il soggetto rinuncia a pensare e a fare da solo e basa la sua autostima esclusivamente sull'opinione degli altri.

La persona dipendente è colui che ha bisogno necessariamente dell'appoggio altrui per colmare un profondo vuoto interiore, che ha le radici nell'età evolutiva. Il suo desiderio d'amore è infatti inversamente proporzionale al suo livello d'autostima; meno il soggetto si stima, più dubita di se stesso e più ha bisogno degli altri a cui spesso si affida con ingenuità.

Le conseguenze di una dipendenza psicologica sono il restare per tutta la vita legati ad un rapporto amoroso, per riuscire a colmare quel vuoto nevrotico, vivendo una dipendenza penosa e aggrappandosi alla persona amata, la cui presenza è vitale come quella materna.

Il soggetto dipendente vive quindi in un costante stato d'allarme sia per la paura di venire abbandonato sia perché, non riuscendo mai a soddisfare completamente i suoi bisogni affettivi, rimane perennemente "affamato" [6].

Numerosi studi mostrano come le cause di tali caratteristiche nei soggetti affetti da dipendenza siano da attribuire al nucleo familiare d'appartenenza; non di rado, infatti, queste persone hanno alle spalle famiglie problematiche; talvolta genitori con disturbi specifici di dipendenza da alcol o da droghe; nessuno di loro ha avuto un ambiente familiare "sufficientemente buono", né figure parentali che hanno potuto fungere da modello affidabile e valido [7].

Molto spesso persone con problemi di dipendenza hanno avuto genitori distanzianti e rigidamente superegoici che non hanno dato ai pazienti la possibilità di "esserci" nella propria individualità. La specifica patologia a volte sembra il tentativo disperato di cercare di individuarsi e di essere finalmente riconosciuti, anche se in negativo. In questo modo paradossale, il disprezzo del genitore sembra acquisire un significato e permette di mantenere inalterate, tramite la patologia, alcune parti "sane" di sé, anche se fragili e bisognose.

Alla luce di questi dati appare evidente come lo strumento ritenuto privilegiato da diversi autori per la cura di questa patologia sia il setting di gruppo, poiché grazie ai suoi fattori attivi, come la risonanza, il rispecchiamento (il mirroring), la condivisione della sofferenza, il soggetto dipendente si senta finalmente contenuto, protetto e pronto ai cambiamenti.

Il gruppo, quindi, si propone non soltanto come uno spazio mentale per rifondare la relazione, ma soprattutto come spazio di attraversamento e di superamento — "uno spazio senza" della matrice familiare e della cultura di coppia [4].

Rispetto agli interventi clinici degni di nota, sono i trattamenti integrati che lavorano non soltanto sulla consapevolezza corporea, sulla presenza nel momento presente e sulla regolazione delle emozioni, ma sono più efficaci rispetto agli approcci puramente cognitivi [8].

Negli ultimi anni, diverse ricerche hanno sottolineato l'importanza della regolazione affettiva e dell'attaccamento disorganizzato nei disturbi di dipendenza affettiva. Uno studio significativo di Musetti et al [9] ha evidenziato come la dipendenza affettiva sia correlata a stili di attaccamento ansioso, difficoltà di mentalizzazione e disregolazione emotiva.

Appare evidente, quindi, come la qualità degli attaccamenti primari dell'individuo nell'infanzia sia strettamente collegata ai modelli interpersonali, che intercorrono nel corso del ciclo vitale.

CONCLUSIONI

La dipendenza sentimentale è in qualche modo uguale alle altre forme di dipendenza, ma si contraddistingue dalle altre per il legame che il soggetto dipendente instaura con l'Oggetto in riferimento (Oggetto inteso come droga, cibo, giochi d'azzardo, comportamenti sentimentali).

Questa dipendenza si lega ad un'immaturità psico-affettiva, le cui cause vanno cercate nel rapporto del soggetto con la figura materna nei primissimi anni della sua vita.

È possibile definire la dipendenza affettiva come un rapporto in cui non si può fare a meno dell'altro e in cui vi è spesso la posizione di un altro dominante; le persone di-

pendenti vivono con la paura perenne di non essere amati e vedono l'altro come unico mezzo per il raggiungimento della propria serenità.

Il dipendente sentimentale è colui il quale mette in mano ad un'altra persona il proprio star bene, la propria serenità e felicità; da qui scaturisce l'impossibilità del distacco dall'altro che diventa anche qui figura essenziale per la propria sopravvivenza [2].

CONFLICT OF INTEREST

L'autrice dichiara di non avere conflitti di interesse con il presente articolo.

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Single Case Study

Supporting Athletes in Career Transition: The *Sport2Next* Protocol as a Model for Post-Sport Identity Reconstruction – A Single Case Study

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ABSTRACT

Background: This single-case study explores the application of the *Sport2Next* protocol to support an elite athlete in transitioning away from sport during the final phase of his professional basketball career. Developed within a multidisciplinary and preventive framework, this protocol integrates psychological, educational, and career development strategies to promote life after sport readiness, financial stability, and psychological well-being. Organized into four progressive phases – initial assessment, targeted training, job market preparation, and traditional working-world integration – the intervention can facilitate a smoother and more meaningful post-career transition.

Case Study: The participant had previously attended economic studies and stated that his target would have been to become a financial advisor. Nonetheless, because he was experiencing uncertainty and apprehension about his future after sport, he decided to pursue the *Sport2Next* pathway. Gradually, he was able to delve into himself, to better understand his potential, and eventually managed to shape his professional identity, which was confirmed as being adequate to the economic and financial fields. Psychological assessments revealed high levels of self-regulation, autonomy, and proactive learning, while also indicating areas for improvement, such as limited critical self-reflection and a tendency to assume excessive responsibility. Through structured support, the participant developed greater clarity, resilience, and motivation to pursue a career path aligned with both his personal skills and values.

Conclusions: This case study underscores the potential of the *Sport2Next* protocol as a replicable model for supporting athletes – regardless of their sport, age, or gender – through career transitioning. By emphasizing early preparation, personalized support, self-assessment, and interdisciplinary collaboration, the protocol addresses the complex emotional, cognitive, and practical challenges athletes face upon retirement, facilitating sustainable and meaningful reintegration beyond sport.

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Athlete career transition, *Sport2Next* protocol, Post-athletic identity, Psychological support, Career development, Sport psychology intervention.

ABSTRACT in ITALIANO

Contesto: Questo caso di studio esamina l'applicazione del protocollo *Sport2Next* nel supportare un atleta d'élite, durante la fase finale della sua carriera nel basket professionistico. Sviluppato all'interno di una cornice teorica multidisciplinare e di tipo preventivo, il protocollo integra strategie psicologiche, educative e di sviluppo professionale con l'obiettivo di promuovere la preparazione alla transizione di carriera, la stabilità economica e il benessere psicologico. Strutturato in quattro fasi progressive – valutazione iniziale, formazione mirata, preparazione al mercato del lavoro e integrazione nel mondo reale – l'intervento mira a facilitare una transizione post-carriera più fluida e significativa.

Presentazione del Caso: A fronte di incertezze e timori riguardo al proprio futuro, il paziente ha intrapreso il percorso previsto dal protocollo *Sport2Next* ridefinendo progressivamente la propria identità professionale e individuando potenziali sbocchi occupazionali nei settori della finanza e del management. Le valutazioni psicologiche hanno evidenziato alti livelli di autoregolazione, autonomia e attitudine all'apprendimento proattivo, unitamente all'evidenza di alcune aree di fragilità, tra cui una ridotta capacità di autoriflessione e una tendenza ad assumersi un eccesso di responsabilità. Grazie a un supporto strutturato e integrato, il paziente ha sviluppato maggiore chiarezza, resilienza e motivazione nel perseguire un nuovo percorso professionale coerente con le proprie competenze e i propri valori.

Conclusioni: Questo caso di studio conferma il potenziale del protocollo *Sport2Next* come modello replicabile per supportare gli atleti nella transizione dalla carriera sportiva a quella post-sportiva. Attraverso un approccio fondato sulla preparazione anticipata, sul supporto personalizzato e sulla collaborazione interdisciplinare, il protocollo affronta le complesse sfide emotive, cognitive e pratiche che gli atleti si trovano ad affrontare al momento del ritiro, favorendo una reintegrazione sostenibile e significativa oltre il contesto sportivo.

Parole chiave

Transizione di carriera degli atleti, Protocollo *Sport2Next*, Identità post-sportiva, Supporto psicologico, Sviluppo di carriera, Intervento di psicologia dello sport.

INTRODUCTION

We present a case study of a young athlete who participated in the *Sport2next* protocol at the end of his sporting career. In this life stage, the patient felt the need to start a new and concerned chapter in his life by entering the “traditional working world” in the most consistent way possible.

The intervention was based on the need to support post-sport athletes, using the *Sport2next* protocol as a guide. This procedure was used to develop targeted support strategies, including workshops, training modules, and individual psychological support sessions, each aimed to help athletes move through and beyond transition in a more positive and meaningful way.

This case is consistent with a body of research literature that identifies athletic retirement as a problematic and challenging psychological phase that involves uncertainty, disorientation, frustration, and difficulty adjusting to a new lifestyle [1-7]. The lack of early planning and the absence of awareness for an after-sport life have been identified as principal risk factors [8, 9].

In addition to emotional and psychological challenges, retiring athletes face the same practical issues of any career transition, such as financial insecurity, social isolation, inactivity, and loneliness [6,10-12]. However, there are other specific transitions to the élite levels of sport that athletes might consider, including loss of identity and difficulties in career redirection despite being professionally active by age [13, 14]. The intensity of athletic identity plays a crucial role. While it can be a source of motivation and resilience during this career, it can later become a barrier to adaptation and a risk factor for psychological distress [11, 15-18].

In this case, the intervention was positioned in an integrated context. The protocol itself is based on a developmental and preventive perspective, aiming to increase athletes' self-awareness and preparation for career transition. Psychological support was based on a life-design framework, focusing especially on meaning-making processes, identity reconstruction, and emotional consequences of leaving the athletic role.

This case demonstrates a successful use of the *Sport2next* protocol and its potential

to support athletes managing the complex emotional, cognitive, and practical challenges of retirement from competitive sport. By presenting this experience, the research provides a model for future programs on career transitions in athletic populations.

METHODS

The *Sport2Next* protocol was developed to create an integrated support system to assist athletes for life after sport. This protocol adopts a multidisciplinary and evidence-based approach, combining psychological, educational, and career-focused components. Its highest goal is to provide athletes with structured tools to transition out of a competitive sport while preserving their sense of identity and emotional well-being.

The intervention described in this single case study was not conducted by the authors whose role was exclusively observational and analytical, but by an external *Sport2Next* team composed of sport psychologists, HR specialists, mentors, and training experts.

The methodological robustness of the *Sport2Next* protocol is substantiated by the use of a multi-modal assessment architecture combining psychological tools, including validated psychometric instruments capturing constructs such as psychological wellbeing, identity restructuring, metacognitive functioning, and transition-related distress (ex. SF-36 for quality of life, Likert Scale for satisfaction, SWOT analysis for strengths, weaknesses, opportunities, and threats) and behavioral indicators, derived from systematic observational coding of performance, engagement, adaptive coping behaviors, and task-related regulatory patterns across the intervention such as simulations, measurable outcomes of successful job placement, financial self-sufficiency. This integrated measurement strategy enables high-resolution monitoring of both intrapsychic processes and externally observable change trajectories, thereby strengthening the empirical validity of the case analysis.

Objectives of the Intervention

The *Sport2Next* protocol was structured with the following purposes:

- identify and analyze the main challenges athletes have to deal with during the post-career transition;
- provide a personalized athlete-mentor

program, relying on the personal and professional experience as former athletes of *Sport2Next* teams;

- measure the program's impact on athletes' quality of life, psychological well-being, and career satisfaction.

The program was expected to last one year, a duration that ensures each athlete has sufficient time to complete all the planned activities of the protocol. Indeed, the actual duration very much depends on the athlete's attitude, approach, and pace.

Sport2Next Protocol's Structure

The *Sport2Next* protocol is organized into four progressive phases. The first phase is characterized by an assessment aimed at increasing self-awareness and finding out the athlete's current resources and strengths. This phase begins with a team workshop, followed by individual meetings with sport psychologists to develop a performance profile and frame their personality. These elements contribute to the creation of an initial report that would serve as the foundation for all phases that follow.

The second phase builds on the insights gathered in the first phase and focuses on specific training and the development of new skills. Based on the initial report, athletes may be recommended to specific courses or professional opportunities with specialized institutions and experienced figures. This allows the intervention to stay flexible and responsive to individual needs, updating the personal plan as soon as new goals and skills emerge.

The third phase, also called "career warm-up," shifts the focus from skills to job-market preparation. Athletes participate in dedicated sessions with work psychologists to refine and adjust their CVs, presentation letters, and interview skills. These sessions are followed by meetings with specialized HR specialists, who support them in updating their application materials and ensure they are ready to present themselves effectively in new professional contexts.

Finally, the fourth phase of the protocol proceeds to real-world integration. Athletes are guided through the process of finding internships, job placements, or further training opportunities. While also continuing to work on personal values, coping strategies, and identity transformation. The program concludes with a final review session, offering a

Supporting Athletes in Career Transition

space for feedback, a summary of achievements, and, ideally, a successful entry into a new career path. The *Sport2Next* protocol is organized into four progressive phases, as summarized in Table 1.

However, even when a new job is not immediately identified, athletes tend to value the protocol positively. They often describe the process as transformative, as it provides them with a deeper self-consciousness and concrete tools for professional transition. The generation of a personalized profile report, the guidance offered by a mentor, often an ex-athlete and with experience in sport transition, the possibility of specific training, and the opportunity to simulate job interviews all contribute to building resources and skills useful for the future, and that athletes often report as new in their educational path.

A strength and innovative point of the *Sport2Next* protocol is the mentorship program with a matching algorithm that associates each athlete with a mentor whose career trajectory aligns with their aspirations and psychological profile. This long-term relationship provides emotional support, career guidance, and a sense of continuity, which are proven to be essential for handling athletic retirement and identity restructuring.

In addition to the structured phases, athletes have access to a unique process of skill recognition and official certifications. Through a digital platform managed by an external provider, participants can identify their personal skills and take courses and lessons recognized by institutions such as universities and sports organizations to improve their CVs and strengthen their positioning in the traditional job market.

To minimize potential methodological biases, all operational phases of the *Sport2Next* protocol are supervised by an external professional not affiliated with the *Sport2Next* team. This supervisor verifies adherence to standardized procedures, coherence between goals and activities, and congruence of the collected materials, thereby reducing the risk of subjective or confirmatory interpretations.

In this case study, a multi-level triangulation strategy was also adopted, including:

- standardized psychological measures,
- clinical interviews conducted by psychologists not involved in the analysis,
- longitudinal qualitative observations,
- behavioral indicators (job interviews and placement outcomes),
- final participant feedback.

This approach strengthens the internal validity of the case by limiting dependence

Table 1. Four progressive phases of *Sport2Next* protocol.

Protocol's phase	Objective	Tools	Main result
Phase 1 - Assessment & Self-Awareness	Increase self-awareness; identify resources, strengths, and critical areas; construct the athlete's initial profile.	Team workshop; individual psychological interviews; personality and performance profiling; mentor's initial support.	Development of an initial report outlining personal resources, vulnerabilities, and transition needs.
Phase 2 - Targeted Training & Skill Development	Develop new skills aligned with the athlete's goals; enhance employability; strengthen identity beyond sport.	Specialized training courses; professional development sessions; mentoring; referrals to external institutions.	Acquisition of new competencies; updated personal development plan; emergence of new goals and learning pathways.
Phase 3 - Career Warm-Up & Job Market Readiness	Prepare the athlete for the job market; refine professional presentation; increase autonomy in job-seeking strategies.	Sessions with work psychologists; CV and cover letter revision; mock interviews; HR specialist meetings.	Updated application materials; improved interview readiness; clearer professional self-presentation.
Phase 4 - Real-World Integration	Facilitate actual entry into the professional world; support identity transition and emotional adaptation.	Internship/job search guidance; networking; real-world placements; final review session; ongoing mentor support.	Job interviews and placement opportunities; strengthened professional identity; transition plan finalized and enacted.

on a single data source. Furthermore, all four phases of the protocol follow predefined tools, checklists, and criteria that limit evaluator discretion, ensure replicability, and allow comparability across different cases.

Intervention's Goals

The primary goal of the *Sport2Next* protocol is to promote a successful and sustainable transition from sport to post-career life, with a particular emphasis on the search for a new personal identity after sport, professional reintegration, economic stability, and psychological well-being. We adopted a mixed-methods evaluation approach, combining quantitative and qualitative measures and participant feedback, to ensure the program's effectiveness.

Throughout the program, athletes were encouraged to reflect on their progress and share thoughts and considerations about the support they received, supported by measurable outcomes such as successful job placements or interviews, financial self-sufficiency, and improvements in psychological health.

On a psychological level, the program aims to reduce stress and anxiety typically associated with ending careers and identity transition, and to improve emotional resilience and self-efficacy [19, 20].

From a financial perspective, the intervention helps athletes gain awareness and control over their economic resources, supporting long-term stability and confidence in managing personal finances.

Professionally, the protocol is designed to open up new career opportunities, helping athletes strengthen their skills and actively pursue career opportunities aligned with their interests and values.

Case Selection Criteria

He was selected as the focal case because he represents an emblematic and methodologically relevant example of athletic career transition. His profile and circumstances allowed the research team to illustrate the protocol's full operationalization and assess concrete psychological and professional outcomes. Given these characteristics, his case serves as a paradigmatic lens through which the broader applicability of the *Sport2Next* model can be examined.

RESULTS

The participant's profile is characterized by high interpersonal energy, communicative tendencies and a vivid relational style, particularly evident in familiar and comfortable settings. He displays a proactive attitude and a moderate degree of self-confidence in approaching tasks, expressing his viewpoints assertively without adopting a directive approach.

In interpersonal exchanges, the participant demonstrated his ability to engage in meaningful dialogue, although he tends to adopt a conciliatory approach to avoid conflict. He is concerned with maintaining a positive self-image, even if he does not exhibit a strong drive for competition. From a relational point of view, the participant demonstrates a strong ability to recognize others' emotional states and responds adequately to both explicit and implicit requests for support. He usually behaves politely and exhibits selectivity in relationships, being cautious to trust individuals with whom he does not feel a natural affinity.

He performs more effectively in contexts that prefer order, sequential task management and multiple tasks at a time. He demonstrates determination in pursuing his goals, particularly when he receives positive feedback. He reports a preference for independent challenges and tasks, even if this requires more time.

Finally, he appears selective in his cognitive engagement, showing interest primarily in learning skills he perceives as practically applicable and aligned with his goals. He demonstrates moderate openness to novelty and tends to rely on previously acquired experience in familiar or structured environments.

Based on the interviews and assessments conducted by the *Sport2Next* team's psychologists, it emerges that the participant has personal resources and characteristics that make him well-suited for a professional role in the finance or management sector. These are fields where he could take on responsibilities that involve a good level of decision-making autonomy and accountability.

Although it remains uncertain whether a traditional office job involving computer work would be fully satisfying for him, the participant has expressed a desire to maintain a connection with the sports environment, which he still considers a part of his identity, and a connection with past expe-

riences actively. A reduction in competitive basketball commitments is also planned as part of the process to create space for this new professional phase.

The participant has demonstrated a strong capacity for self-directed action: when pursuing a goal, he is able to identify knowledge gaps and work to fill them, using a range of sources, including online tools, educational opportunities, and a well-established personal and professional network. This attitude, combined with self-consciousness and confidence in his own abilities, helps him remain resilient in the face of potential obstacles. The direction he has chosen appears to be consistent with his personal inclinations and abilities, forming a solid basis for the next stage of his career.

The participant had the opportunity to attend two job interviews with two different companies associated with *Sport2Next* Protocol as partners, both looking for someone with his professional and personal characteristics. Both job interviews ended with positive outcomes and the mentioned companies. Yet, right after the second interview, he signed a contract with a new team in a lower category, close to his wife's place, and then received, through a close friend, an offer to start an internship as a finance controller at an insurance agency near his new team's location.

Thanks to the protocol, the patient improves his skills, self-esteem, and awareness, factors that help him in this transitional phase of life and guide him in deciding to accept this job offer and to start a new professional role alongside his basketball career.

Limitations

Despite the promising findings, several limitations should be acknowledged. First, the intrinsic subjectivity of single-case designs restricts the generalizability of the results. Although a multi-level triangulation strategy was implemented, qualitative observations inevitably retain an interpretative component. The absence of standardized pre- and post-measures further limits the ability to quantify change over time. Moreover, broader longitudinal studies involving larger samples of transitioning athletes are needed to strengthen empirical validation and better capture inter-individual differences in career transition pathways.

CONCLUSIONS

This case is a valuable starting point for the potential effectiveness of the *Sport2Next* protocol in supporting elite athletes during the critical phase of career transition, and also for seeing it as a tool for accompanying them throughout their entire career.

The psychological assessments, combined with qualitative observations during all interventions, suggest that the participant demonstrated significant strengths, such as emotional self-regulation, autonomy in learning, and a structured goal orientation, which served as a protective factor amid the uncertainties of retirement from competitive sport. These personal resources enabled him to actively engage in the process of redefining his professional identity and to approach new career opportunities positively.

The challenges that emerged were in line with findings in the literature on athletic retirement: the participant's limited capacity for critical self-reflection and his tendency to assume excessive responsibility reflect common psychological characteristics and risks associated with a strong athletic identity [16, 17]. The *Sport2Next* protocol, thanks to its integrated and multi-phase design, encourages the identification and elaboration of these dynamics, providing targeted psychological support and mentorship to balance the participant's strengths and vulnerabilities. The participant's evolution throughout the program highlights the importance of a structured and yet flexible framework that combines self-exploration, skills development, and access to professional reintegration opportunities. Moreover, the ongoing mentorship component appears to have been a protective and key factor for the athlete's confidence and support for a realistic yet aspirational vision for his future beyond sport.

Taken together, the results of this case suggest that the *Sport2Next* protocol can be considered not only a valuable therapeutic and developmental tool but also a structured intervention model that addresses the multifaceted needs of athletes in transition. By addressing emotional, cognitive, and practical dimensions in an integrated tool, the protocol facilitates a smoother passage into post-sport life, fostering long-term wellbeing and career satisfaction.

Future Directions

The promising results emerging from this case encouraged the application of the *Sport2Next* protocol with other athletes undergoing post-competitive career transitions. Preliminary outcomes from these interventions have proven consistent with those observed in this case, suggesting a reproducible trajectory of psychological adjustment, identity redefinition, and professional reintegration. These converging outcomes contribute to building a coherent evidence base that supports the scalability of the model.

The following section outlines possible directions for the development, validation, and dissemination of the model within the fields of sport psychology.

- Empirical validation and comparative studies: conduct comparative analyses across larger athlete samples to identify recurring patterns, strengthen external validity, and map the relationship between individual characteristics (e.g., sport type, level, age, educational background, mental well-being) and transition outcomes.
- Enhanced athlete-mentor matching systems: develop a personalized matching algorithm integrating psychological, motivational, and career-related variables to optimize compatibility between athletes and mentors, thus improving intervention effectiveness.
- Long-term monitoring and structured outcome assessments: introduce standardized pre-, mid-, and post-intervention measures to track psychological well-being, identity development, and professional progress over time, enabling more robust evaluation.
- Digital infrastructure for implementation and scaling: create a dedicated digital platform where athletes can access personalized dashboards, monitor their progression throughout the protocol, update their reports and CVs, and participate in individual sessions, group meetings, trainings, and webinars.
- Institutional endorsement and dissemination: encourage national and international sport federations to adopt, support, and promote the *Sport2Next* protocol as a structured system for managing career transitions. Such institutional integration would not only provide athletes with a clear pathway beyond sport but could also contribute to shaping future generations of managers and sport professionals.

These directions collectively outline a roadmap for the continued development, validation, and dissemination of the *Sport2Next* model within the fields of sport psychology and athlete career development.

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INSTITUTIONAL REVIEW BOARD STATEMENT

This study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki and the Ethical Code for Research in Psychology of the Italian Association of Psychology (AIP), approved in 2015 and updated in July 2022 to comply with GDPR regulations (aipass.org). All procedures adhered to ethical standards to protect the participant, data confidentiality, and obtain informed consent.

INFORMED CONSENT STATEMENT

Informed consent was obtained from the subject involved in the study for the publication of this single case study.

DATA AVAILABILITY STATEMENT

The data supporting the findings of this study are not available from the corresponding author due to privacy and ethical considerations.

CONFLICTS OF INTEREST

The authors declare no conflict of interest. The authors were not directly involved in the implementation of the *Sport2Next* intervention. All activities were conducted by the official *Sport2Next* team. The authors contributed only to data analysis and scientific interpretation.

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Articolo di Opinione

Meccanismi di interruzione del contatto nella Psicoterapia di Coppia: l'esperienza del terapeuta come campo fenomenologico

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ABSTRACT

Il presente contributo esplora la psicoterapia di coppia da una prospettiva gestaltica, focalizzando l'attenzione sul ruolo attivo del terapeuta quale terzo elemento del campo relazionale. Il terapeuta, partecipa del processo intersoggettivo, contribuisce in modo incarnato e consapevole alla co-costruzione del contatto terapeutico, sostenendo ciascun partner e la coppia come entità dinamica. I meccanismi di interruzione del contatto – come introiezione, proiezione, retroflessione, confluenza – sono letti come difese che ostacolano l'emergere dei bisogni, la differenziazione e l'autenticità della relazione. Nel setting, il terapeuta osserva dove e come si interrompe l'esperienza di contatto relazionale, accompagnando i partner verso una maggiore consapevolezza affettiva, corporea e simbolica. Tecniche esperienziali come l'uso delle sedie, la verbalizzazione dei bisogni e l'immaginazione guidata facilitano la trasformazione delle impasse relazionali in processi evolutivi.

All'interno di questa cornice, è stato elaborato un questionario rivolto a psicoterapeuti di coppia (Q-PCOC), con l'obiettivo di indagare prassi cliniche, difficoltà operative, tecniche utilizzate e vissuto soggettivo del terapeuta nella conduzione delle terapie. Lo strumento, articolato in quattro sezioni (introduzione e obiettivi; profilo del terapeuta; aspetti metodologici e setting terapeutico; relazione terapeutica e dinamiche di coppia), è parte di un progetto di ricerca-intervento volto a favorire una riflessione clinica sull'efficacia degli approcci integrati e sul ruolo trasformativo del terapeuta nel campo di coppia.

Attualmente stiamo esaminando altri strumenti presenti in letteratura, con l'obiettivo di confrontare il nostro questionario con quelli già esistenti e approfondire ulteriormente il vissuto e le strategie adottate dai terapeuti nel lavoro con le coppie.

Parole chiave

Terapia di coppia, Terapeuta di coppia, Gestalt, Meccanismi di interruzione del contatto.

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ABSTRACT in ENGLISH

This contribution explores couple psychotherapy from a Gestalt perspective, focusing on the therapist's active role as the third element within the relational field. The therapist, as a participant in the intersubjective process, contributes in an embodied and conscious manner to the co-construction of therapeutic contact, supporting each partner and the couple as a dynamic entity. Contact-interruption mechanisms—such as introjection, projection, retroflexion, and confluence—are understood as defensive processes that hinder the emergence of needs, differentiation, and relational authenticity.

Within the therapeutic setting, the therapist observes where and how the experience of relational contact is interrupted, guiding partners toward greater affective, bodily, and symbolic awareness. Experiential techniques such as the use of chairs, need verbalization, and guided imagery facilitate the transformation of relational impasses into developmental processes. Within this framework, a questionnaire for couple psychotherapists (Q-PCOC) has been developed to investigate clinical practices, operational challenges, techniques employed, and the therapist's subjective experience in conducting couple therapy. The instrument, structured into four sections (introduction and objectives; therapist profile; methodological and therapeutic setting aspects; therapeutic relationship and couple dynamics), is part of an action-research project aimed at fostering clinical reflection on the effectiveness of integrated approaches and on the therapist's transformative role within the couple's field.

We are currently reviewing other tools in the literature to compare our questionnaire with existing ones and deepen our understanding of the therapist's experience and strategies in working with couples.

Keywords

Couple therapy, Couple therapist, Gestalt, Contact interruption mechanisms..

INTRODUZIONE

Negli ultimi anni le richieste di psicoterapia di coppia sono aumentate, spesso per motivi che, pur sembrando attuali, affondano le radici in dinamiche relazionali più profonde, evidenziando come i modelli relazionali appresi nell'infanzia influenzino i meccanismi di contatto e di distanza nella relazione di coppia. In questo quadro, il processo terapeutico diventa occasione per trasformare le dinamiche affettive disfunzionali attraverso un lavoro emotivo esperienziale e consapevole [1].

Il terapeuta come terzo elemento del campo relazionale nella psicoterapia di coppia

La psicoterapia di coppia si configura come un dispositivo clinico complesso, dove l'incontro tra due soggettività – quella dei partner – avviene sotto la guida di una terza presenza: il terapeuta. Quest'ultimo non è un osservatore neutro, bensì un partecipante attivo che, mantenendo una posizione asimmetrica e consapevole, funge da mediatore, catalizzatore e specchio dinamico del "noi" della coppia. La terapia di coppia, infatti, non si limita a contenere il conflitto, ma ne esplora le radici emotive e comunicative, sostenendo un processo di consapevolezza, differenziazione e riappropriazione delle responsabilità individuali [2].

L'intervento terapeutico, secondo un modello integrato gestaltico e sistemico, considera l'esperienza come fenomeno situato nel "campo" e nel "tra" relazionale, dove ogni emergenza è co-costruita dai soggetti coinvolti [3]. Le emozioni, in questa prospettiva, non sono semplici reazioni, ma vettori di significato che orientano il comportamento e lo stile relazionale. Il terapeuta, consapevole del proprio vissuto, del proprio ruolo e della propria corporeità, è chiamato a stare in contatto con sé, con ciascun partner e con la coppia come entità relazionale, facilitando la co-creazione di nuove configurazioni relazionali più funzionali [4].

L'immaginazione, la consapevolezza corporea, la verbalizzazione dei bisogni, la regolazione affettiva e la messa in scena simbolica delle dinamiche (es. l'uso delle sedie) sono strumenti privilegiati per esplorare e trasformare le modalità disfunzionali di stare in relazione [5]. L'integrazione tra i modelli consente di lavorare con le emozioni, con i pattern relazionali e con la struttura simbolica della relazione, accogliendo la complessità del vissuto di coppia e promuovendo un processo evolutivo che coinvolga l'intero sistema [6].

La mappa gestaltica nelle dinamiche di coppia: dal contatto interrotto all'incontro autentico

Il ciclo del contatto è una delle colonne portanti della psicoterapia della Gestalt.

Questo modello fenomenologico-descrittivo, ideato da Perls e Goodman [7], consente di comprendere il modo in cui un bisogno emerge, viene riconosciuto, agito e integrato nell'esperienza della persona. Le fasi del ciclo sono: precontatto, contatto, contatto pieno e postcontatto [8].

Nel contesto di coppia, le interruzioni del ciclo sono osservabili nei blocchi della comunicazione, nei pattern relazionali disfunzionali, nella difficoltà a differenziarsi e a tollerare l'altro nella sua alterità. Meccanismi come la confluenza, l'introiezione, la proiezione, la deflessione, la retroflessione, l'egotismo e la desensibilizzazione interferiscono con la possibilità di un contatto pieno e autentico [9]. Ad esempio, la proiezione reciproca impedisce ai partner di assumersi la responsabilità dei propri vissuti, mentre la retroflessione genera dinamiche di autosabotaggio e isolamento affettivo.

Il terapeuta, nel setting, può osservare in quale fase del ciclo si interrompe l'esperienza relazionale e con quale meccanismo.

Dal punto di vista gestaltico, la coppia rappresenta un incontro dinamico, in cui due persone si esplorano reciprocamente condividendo emozioni, progetti e desideri. L'intimità nasce dall'energia che li unisce – fatta di sintonia emotiva, sostegno, interessi comuni e desiderio sessuale – e trova compimento quando i partner sanno mostrarsi vulnerabili senza il bisogno di cambiare l'altro [10]. Tuttavia, nei momenti di conflitto o trascuratezza, questo processo si incrina e la terapia di coppia diventa uno spazio per riconoscere e accettare la realtà della relazione, nel “qui e ora” [11]. Il terapeuta della Gestalt lavora stimolando la creatività dei partner, radicandola nell'esperienza fenomenologica piuttosto che nell'interpretazione [12]. Attraverso il ciclo del contatto è possibile osservare come la crisi emerga in ogni fase [13]. Questa mappa dinamica permette di intervenire in modo mirato, sostenendo la consapevolezza e l'autoregolazione dei partner. Il contatto interrotto, se riconosciuto e significato, può trasformarsi in una nuova occasione di incontro e di crescita [10]. Nel precontatto, i partner possono perdere connessione con il corpo: non sanno più come guardarsi, parlarsi, toccarsi e l'intimità diventa vuota [14]. Nella fase di contatto, gli scambi diventano meccanici, privi di ascolto e vitalità. Nelle coppie in crisi, il contatto perde significato; le loro interazioni sono ridotte a scambi frettolosi, senza spazio per l'ascolto o il desiderio di incuriosirsi recipro-

camente. Nel contatto pieno, l'energia può risultare spenta (svanendo la dimensione del “Noi”) o esplodere caoticamente – gesti concitati, urla –, ostacolando l'incontro autentico e favorendo mobilitazioni all'azione volte a soluzioni frettolose o all'evitamento del problema [15]. Infine, nel post-contatto, manca l'elaborazione dell'esperienza e il ritiro si trasforma in ansia o frustrazione [13]. Quando la relazione non è fluida e creativa, subentrano i cosiddetti “disturbi al confine del contatto” [16]. Perls li descrive come resistenze che bloccano l'energia vitale, impedendo di accogliere pienamente sé stessi e l'altro. Tra i principali meccanismi di interruzione troviamo:

- Proiezione: attribuire all'altro intenzioni o giudizi senza verificarli.
- Introiezione: conformarsi a regole e aspettative, soffocando la spontaneità.
- Deflessione: deviare l'attenzione per ridurre l'intensità del contatto.
- Retroflessione: rivolgere a sé impulsi e bisogni, rinunciando alla condivisione.
- Confluenza: annullare le differenze individuali per evitare conflitti.
- Egotismo: privilegiare il proprio Sé, erigendo barriere di controllo e distanza [9].

Il lavoro terapeutico consiste nel riportare alla luce queste dinamiche, osservando sia il funzionamento del “Noi” di coppia sia quello individuale (“Io-Tu”). Ogni incontro diventa occasione per intrecciare i cicli personali e la storia comune all'interno del campo terapeutico, dove si crea un nuovo “Noi” che consente di rinnovare il contatto [17].

Q-PCOC: Il questionario per psicoterapeuti di coppia come strumento di indagine e osservazione clinica

Nell'ambito del nostro progetto di ricerca-intervento, abbiamo sviluppato un questionario strutturato rivolto a psicoterapeuti di coppia, con l'obiettivo di esplorare le prassi cliniche. Inoltre, intendiamo utilizzare i dati raccolti per sviluppare una riflessione teorico-clinica sull'efficacia degli approcci integrati e sulla funzione del terapeuta come figura regolatrice e generativa del cambiamento.

Il lavoro psicoterapeutico con le coppie rappresenta un ambito clinico complesso e in continua evoluzione, che richiede al terapeuta una competenza multidimensionale,

capace di integrare saperi teorici, metodologie operative e sensibilità relazionali. In un contesto caratterizzato da una crescente domanda di interventi rivolti alle relazioni di coppia, si avverte l'esigenza di comprendere più a fondo le pratiche adottate dai professionisti, le strategie impiegate durante il percorso terapeutico e le difficoltà che frequentemente si incontrano nel trattamento delle dinamiche relazionali disfunzionali.

Il presente questionario è stato concepito come uno "strumento di ricerca clinica" rivolto a psicoterapeuti che operano nell'ambito della terapia di coppia, con l'intento di esplorare le modalità concrete di conduzione del trattamento, le tecniche utilizzate e le osservazioni cliniche emerse nella pratica. Per garantire una visione completa e approfondita, il questionario è articolato in quattro sezioni principali.

La prima sezione fornisce una breve introduzione allo strumento stesso, illustrandone gli scopi e il contesto di utilizzo. L'intento è quello di chiarire il razionale alla base della raccolta dei dati, evidenziando la necessità di analizzare il lavoro clinico con le coppie alla luce delle molteplici variabili implicate.

La seconda sezione si concentra sul profilo del terapeuta, raccogliendo informazioni relative al percorso formativo, all'orientamento teorico di riferimento e all'esperienza maturata in ambito di terapia di coppia. Questo passaggio è fondamentale per comprendere l'influenza del background professionale sulle scelte metodologiche e sull'impostazione della relazione terapeutica.

La terza sezione entra nel merito delle scelte metodologiche e dell'organizzazione del setting terapeutico. Vengono approfonditi aspetti quali la disposizione fisica dei partecipanti all'interno dello spazio clinico, la presenza o meno di più terapeuti durante la seduta, la possibilità di includere osservatori o supervisori nel processo terapeutico, nonché la struttura temporale degli incontri (durata, frequenza, durata complessiva del trattamento). Particolare attenzione è riservata anche alla definizione delle fasi del percorso terapeutico, alla stipula di eventuali accordi terapeutici formalizzati con la coppia e alla gestione degli obiettivi.

Inoltre, si indaga la possibilità di svolgere incontri individuali con i singoli partner, esplorando le finalità e le tempistiche con cui questi vengono inseriti nel percorso, nonché le modalità di conclusione della terapia, con eventuale previsione di follow-up.

Infine, la quarta sezione è dedicata alla relazione terapeutica e all'osservazione delle dinamiche di coppia. In questa parte si esplorano le motivazioni che spingono le coppie a intraprendere un percorso psicoterapeutico, gli elementi relazionali che emergono sin dalle prime sedute e le modalità con cui vengono definiti e condivisi gli obiettivi terapeutici.

Vengono inoltre analizzate le tecniche e le strategie ritenute più efficaci nel trattamento delle problematiche di coppia, così come le aree su cui il terapeuta tende a focalizzare maggiormente l'attenzione clinica. La sezione prende in considerazione anche il ruolo delle osservazioni cliniche nella gestione dei conflitti, l'emergere di eventuali momenti di impasse nel processo terapeutico e le strategie messe in atto per superarli. Si riflette, infine, sul ruolo che il terapeuta assume nella relazione terapeutica e sul suo impatto sull'andamento del percorso, nonché sulle modalità con cui viene valutato l'esito del trattamento.

CONCLUSIONI

La raccolta delle informazioni tramite il presente questionario non si configura unicamente come un esercizio esplorativo, ma si propone come un contributo metodologico volto a generare riflessione critica e confronto costruttivo tra professionisti. Attraverso l'analisi delle prassi operative, delle scelte metodologiche e delle strategie cliniche adottate, si intende promuovere una maggiore comprensione delle dinamiche che caratterizzano il lavoro terapeutico con le coppie, promuovendo un dialogo virtuoso tra teoria e prassi, favorendo l'evoluzione di modelli terapeutici sempre più efficaci, integrati e sensibili alla complessità dei legami affettivi contemporanei. Nella creazione del nostro questionario ci si è resi conto che attualmente in letteratura non vi sono altri strumenti che indagano le medesime aree. L'unico parallelismo potrebbe essere condotto con il questionario TRQ che indaga le dimensioni controtrasferali del terapeuta in fase di contatto [18]. Con questo quesito si è aperta, dunque, una nuova prospettiva di ricerca che sarà presto esplorata.

L'obiettivo è quello di costruire una panoramica dettagliata e articolata sulle prassi operative e sui modelli teorici di riferimento, ponendo particolare attenzione all'approccio integrato, sempre più presente nella formazione e nella clinica contemporanea.

CONFLITTO DI INTERESSI

Gli autori dichiarano di non avere nessun conflitto di interessi.

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Scoping Review

Brain tumor aphasia: the role of speech therapy

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ABSTRACT

Objective: The term “aphasia” refers to an acquired language disorder resulting from damage to brain structures involved in the processing of various aspects of linguistic competence. It manifests as a partial or total loss of the complex processes of language comprehension and production, due to focal brain damage affecting a wide network of cortical and subcortical structures in the language-dominant hemisphere, which is left in most individuals.

Among the different etiologies, brain tumors represent a cause of particular clinical relevance, both for the progressive characteristics of the underlying pathology and for the associated rehabilitation implications.

This work aims to systematically analyze the available scientific literature on brain tumor-related aphasia, with particular attention to the role of speech therapy, in order to provide a clear and structured overview of the current state of knowledge.

Methods: The review was conducted following the PRISMA-ScR guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) to ensure methodological transparency and reproducibility. The bibliographic search was performed on the PubMed database using a search string combining the keywords “Aphasia” and “Brain Neoplasms,” with pre-defined inclusion criteria.

Results: Three studies, all case reports, were included. They describe heterogeneous aphasic patterns, related to the tumor’s nature, location, and progression, as well as the effects of surgical and oncological treatments. In all cases, speech therapy played a central role through direct rehabilitation interventions, compensatory strategies, long-term monitoring, and support for neuroplasticity, particularly in pediatric patients.

Conclusions: Despite the limited number of available studies, the evidence suggests that speech therapy is a crucial component in the management of patients with brain tumor-related aphasia. Rehabilitation should be personalized, multimodal, and integrated throughout the clinical pathway. However, current literature highlights a significant lack of systematic studies on this topic; future research with larger samples, standardized protocols, and longitudinal follow-ups is therefore needed to establish more robust rehabilitation approaches.

Keywords

Aphasia, Brain neoplasm, Speech therapy.

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ABSTRACT in ITALIANO

Obiettivi: Il termine “afasia” si riferisce a un disturbo acquisito del linguaggio, conseguente a una lesione delle strutture cerebrali coinvolte nell’elaborazione dei diversi aspetti delle competenze linguistiche. Essa si configura come una perdita, parziale o totale, dei complessi processi di interpretazione e formulazione del linguaggio, dovuta a un danno cerebrale focale che interessa un’ampia rete di strutture corticali e sottocorticali dell’emisfero dominante per il linguaggio, che nella maggior parte degli individui è quello sinistro.

Tra le diverse eziologie, i tumori cerebrali rappresentano una causa di particolare rilevanza clinica, sia per le caratteristiche evolutive della patologia di base, sia per le implicazioni riabilitative.

Il presente lavoro si propone di analizzare in modo sistematico la letteratura scientifica disponibile in merito all’afasia da tumore cerebrale, con particolare attenzione al ruolo della logopedia, al fine di restituire un’immagine chiara e strutturata dello stato attuale delle conoscenze.

Metodi: La revisione è stata condotta seguendo le linee guida del metodo PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) per garantire trasparenza e riproducibilità metodologica. La ricerca bibliografica è stata effettuata sul database PubMed, utilizzando una stringa di ricerca che combinava le parole chiave “Afasia” e “Neoplasie cerebrali”, con criteri di inclusione predefiniti.

Risultati: Sono stati inclusi tre studi, tutti case report, che descrivono quadri di afasia eterogenei, in relazione alla natura, alla localizzazione e all’evoluzione del tumore, nonché agli effetti dei trattamenti chirurgici e oncologici. In tutti i casi, la logopedia ha svolto un ruolo centrale attraverso interventi diretti di riabilitazione, strategie compensative, monitoraggio a lungo termine e supporto alla neuroplasticità, in particolare in età pediatrica.

Conclusioni: Nonostante il numero limitato di studi disponibili, le evidenze suggeriscono che l’intervento logopedico rappresenti un elemento cruciale nella presa in carico del paziente con afasia da tumore cerebrale. La riabilitazione dovrebbe essere personalizzata, multimodale e integrata lungo tutto il percorso clinico. Tuttavia, la letteratura attuale evidenzia una significativa carenza di studi sistematici su questo argomento; sono quindi necessari studi futuri con campioni più ampi, protocolli standardizzati e follow-up longitudinali per definire approcci riabilitativi maggiormente consolidati.

Parole chiave

Afasia, Tumore cerebrale, Logopedia.

“It is impossible not to communicate.

Action or inaction, words or silence all convey a message: they influence others, and others, in turn, cannot avoid responding to these communications and thus, communicating themselves”.

P. Watzlavic

INTRODUCTION

Imagine that suddenly everyone around you, from your loved ones to strangers, speaks an unknown language. You do not understand what they are saying, and you cannot express what you want to say.

Imagine no longer being able to read your usual newspaper or favorite magazine.

Imagine no longer being able to write a shopping list or a love note.

And again, imagine that you can no longer see well; that you can no longer move your arm or leg freely.

Only gradually do you realize that you have changed. You don't know it yet, but you have become aphasic [1].

Aphasia is an acquired language disorder resulting from damage to brain structures involved in language processing. It involves

a partial or total loss of the ability to understand and/or produce language, due to focal damage to a complex network of cortical and subcortical structures, mainly located in the left hemisphere, which is dominant for language in most individuals [2].

Aphasia disorders can affect all levels of linguistic competence – phonological, morphological, syntactic, semantic-lexical, and pragmatic – and manifest themselves in both production and comprehension, in both oral and written form [2].

The most common causes of aphasia include ischemic or hemorrhagic strokes, head trauma, and brain tumors [2]. In particular, aphasia caused by brain tumors is a clinical condition of growing interest, both because of the progressive nature of the clinical picture and because of the challenges it poses in terms of diagnosis and rehabilitation.

Unlike acute-onset aphasia, aphasia caused by neoplasms can have a slower and more insidious progression. Clinical expression is influenced by multiple factors, including the location of the lesion, the nature of the tumor (benign or malignant), the rate of growth, and any complications arising from cancer treatments such as surgery, radiation therapy, or chemotherapy [3].

In this context, speech therapy plays a central role in the process of assessing and treating language deficits, as speech therapy aims not only at the functional recovery of impaired abilities but also at promoting compensatory strategies and improving the patient's quality of life.

This study aims to conduct a scoping review of the available scientific literature on brain tumor aphasia, with a particular focus on the role of speech therapy in this field. The objective is to map and synthesize existing evidence, providing an up-to-date, critical, and structured overview of the current state of knowledge to identify gaps and guide future research.

MATERIALS AND METHODS

The research was conducted following the PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) guidelines [4]

Table 1. Search strategy.

("Aphasia"[Mesh]) AND "Brain Neoplasms"[Mesh]

to ensure a transparent, systematic, and reproducible methodology for the identification and selection of scientific literature.

Specifically, the bibliographic search was carried out on the PubMed database, using a search string that combined the keywords "Aphasia" and "Brain Neoplasms" (Table 1).

For eligibility purposes, articles published up to 2025, in English, investigating the role of speech therapy in cases of brain tumor aphasia were considered. In addition, the various study designs included: case reports, clinical studies, clinical trials, comparative studies, controlled clinical trials, and observational studies (Table 2).

Initially, 120 articles were identified in the PubMed database. Following the inclusion criteria (Table 2), based on titles and abstracts, a total of 113 articles were excluded. Furthermore, after reading the full text, four articles were excluded. The remaining 3 articles were included in the Scoping Review, as they met the inclusion criteria (Figure 1).

The protocol for this scoping review was defined a priori in order to ensure methodological transparency and scientific rigor.

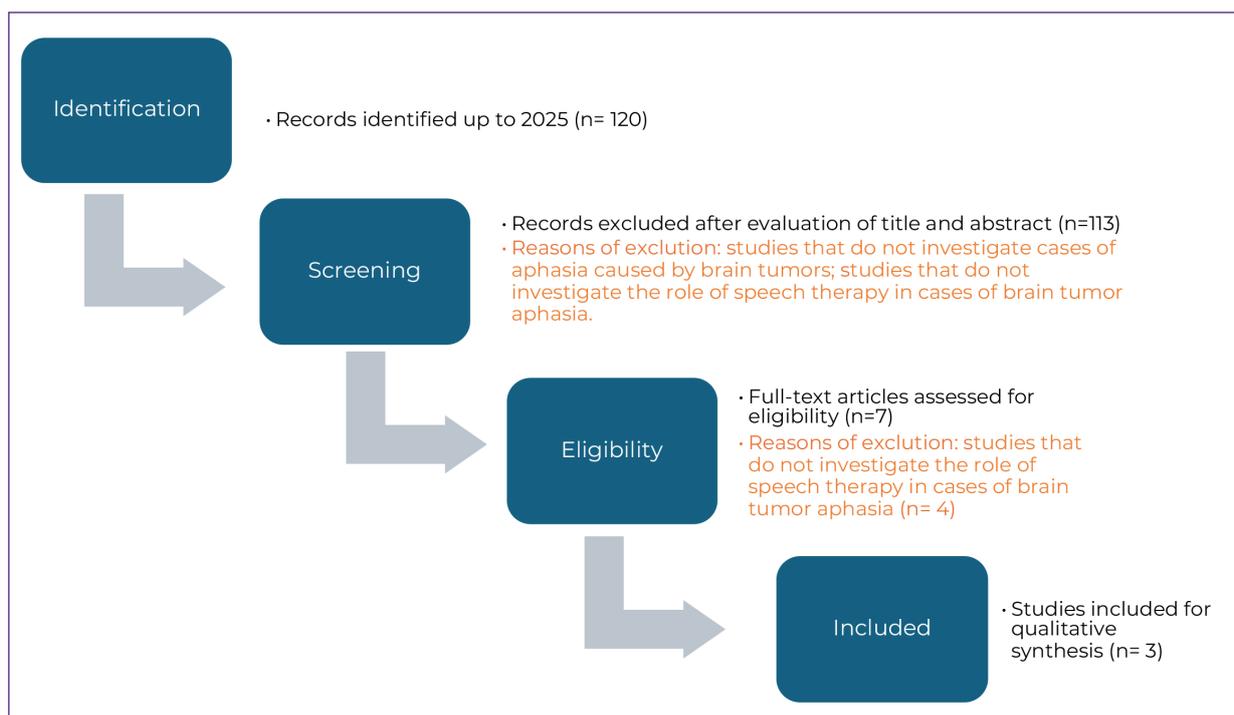


Figure 1. Flow chart of the article selection process.

Table 2. Eligibility criteria.

Inclusion criteria	<ul style="list-style-type: none"> - English language - Studies published up to 2025 - Study designs: clinical case, clinical study, clinical trial, comparative study, controlled clinical trial, observational study - Studies investigating the role of speech therapy in cases of aphasia caused by brain tumors
Exclusion criteria	<ul style="list-style-type: none"> - Studies that do not investigate cases of aphasia caused by brain tumors - Studies that do not investigate the role of speech therapy in cases of aphasia caused by brain tumors

Although not formally registered in databases such as PROSPERO or Open Science Framework, the review was conducted following the model proposed by the PRISMA extension for Scoping Reviews (PRISMA-ScR), published in 2019. This framework includes 20 mandatory criteria (plus 2 optional ones) that guide researchers in the design, description, and framing of their work within the category of scoping reviews. In accordance with this model, the objectives of the review, the eligibility criteria, the databases to be consulted, and the main categories for data extraction and synthesis were defined in advance.

The selection of studies was conducted independently by the author, based on previously defined eligibility criteria. When doubts arose about the inclusion of specific studies, a discussion with the academic supervisor was held to reach a shared decision. This procedure contributed to minimizing the risk of bias during the study selection process.

RESULTS

The characteristics of the selected studies have been summarized in Table 3, which provides information on the author, title, year of publication, study design, sample, cause and type of aphasia, and main results.

Overall, three studies that met the pre-defined inclusion criteria were included. All three selected articles are clinical case studies describing patients with aphasia resulting from brain tumors who were treated or followed up with a speech therapy approach. The results are heterogeneous in terms of age, tumor location, clinical manifestations, and rehabilitation

strategies adopted, but they offer relevant insights into the role of speech therapy in the management of aphasia in this specific clinical context.

Study 1 (Pogson & Halmagyi) [5]

In this study, the authors describe the case of a 57-year-old man with inoperable gastroesophageal adenocarcinoma, treated with chemotherapy and radiotherapy. The patient presented with verbal deafness, characterized by a selective inability to understand verbal language, despite normal perception of pure tones and the ability to recognize voices, environmental sounds, and musical instruments.

An MRI scan revealed a metastatic brain lesion, which was subsequently treated with stereotactic radiotherapy. The rehabilitation team, including speech therapists, introduced the use of a voice-to-text translator on a smartphone as a compensatory strategy to facilitate communication with the family.

Three months later, the MRI showed a reduction in the mass, and language comprehension was restored. This case highlights how language comprehension can be impaired despite normal auditory function and shows how technological solutions, when integrated into a rehabilitation program, can support communication in patients with aphasia [5].

Study 2 (Satoer et al.) [6]

Satoer and colleagues describe the case of a patient (KO) with recurrent glioma in the left hemisphere, located anteriorly and laterally to the supplementary motor area. The patient underwent awake craniotomy, pre-

Table 3. Summary of selected articles.

Author, Year	Title	Study design	Sample size	Cause of aphasia	Type of aphasia	Main Findings
Pogson and Halmagyi, 2022 [5]	Hearing but not understanding: word deafness from a brainstem lesion	Case report	A 57-year-old man, with a history of inoperable adenocarcinoma.	Metastatic brain lesion compressing both inferior colliculi.	Word deafness, in which there is a specific inability to understand speech, despite intact hearing of pure tones.	Language comprehension may be compromised, even though hearing is normal. In such cases, technological devices can support communication.
Satoer et al, 2013 [6]	Dynamic aphasia following low-grade glioma surgery near the supplementary motor area: A selective spontaneous speech deficit	Case report	A patient (KO) with slight pre-morbid reduced spontaneous speech.	Recurrent left hemispheric glioma anterior and lateral to the supplementary motor area in the left frontal lobe, treated with awake craniotomy.	Pure dynamic aphasia, in which spontaneous speech is reduced, whereas naming, repetition and comprehension are intact. Also, there is an impairment of verbal fluency and there are executive disorders.	Resection in the fronto-medial lobe, in conjunction with slight pre-morbid difficulties in the spontaneous speech could increase the risk of cognitive disturbances at long term, especially language.
Peru et al, 2007 [7]	Suggestive Evidence for an Involvement of the Right Hemisphere in the Recovery from Childhood Aphasia: A 3-Year Follow-Up Case Study	Case report	A 11-year-old girl, previously healthy, right-handed girl with acquired childhood aphasia.	A cerebral hemorrhage into a left hemispheric brain tumor.	Moderately severe nonfluent aphasia with a good recovery of comprehensive components but persisting severe impairment in expressive language.	After a 3-year follow-up period, all tests demonstrated a clear left hemispheric advantage in many different language tasks. So, the right hemisphere plays a functional role in the reorganization of language after brain lesions.

ceded and followed by a series of neuropsychological and linguistic assessments up to one year post-surgery.

KO already had mild difficulties with spontaneous speech prior to surgery. After surgery, he presented with a picture consistent with pure dynamic aphasia: reduced spontaneous speech with preserved naming, repetition, and comprehension. In addition, deficits in verbal fluency and impaired executive functions were observed.

The study highlights the potential impact of resections in the left medial frontal lobe on long-term linguistic and cognitive functions and suggests the importance of prolonged speech therapy monitoring, especially in the presence of premorbid difficulties [6].

Study 3 (Peru et al.) [7]

The third study presents the case of an 11-year-old girl, right-handed and previously healthy, who developed acquired aphasia following a cerebral hemorrhage associated with a tumor in the left hemisphere.

During a three-year follow-up, a progressive recovery of comprehension skills was observed, while expressive language remained severely impaired. The patient continued to exhibit moderate to severe non-fluent aphasia. An experimental investigation revealed a functional advantage of the right hemisphere (left visual and auditory field) in various linguistic tasks, suggesting a process of neural restructuring.

This case confirms the importance of childhood brain plasticity in post-lesion recovery and highlights the crucial role of speech therapy in supporting language development by exploiting hemispheric compensation mechanisms [7].

DISCUSSION

This review highlights how aphasia caused by brain tumors represents a complex, variable clinical condition that has yet to be thoroughly investigated in the literature. Although the three cases selected are heterogeneous in terms of age, etiology, and aphasic manifestations, they offer significant insights into the role of speech therapy in the management of these patients.

The first element that emerged is the clinical variability of aphasic manifestations associated with brain tumors. The cases de-

scribed include verbal deafness, dynamic aphasia, and non-fluent aphasia, confirming that neoplasms can selectively compromise linguistic components depending on the location, extent, and progression of the lesion. This implies the need for in-depth and individualized linguistic assessments conducted by experienced professionals, such as speech-language pathologists.

From a rehabilitation perspective, the importance of multimodal and adaptive approaches emerges. For example, in the case described by Pogson and Halmagyi [5], the introduction of technological support (voice-to-text translator) was a valuable temporary compensatory tool to facilitate the patient's communication. This highlights the role of the speech-language pathologist not only in the direct rehabilitation of linguistic functions, but also in the functional management of everyday communication through alternative strategies.

The case described by Satoer et al [6] highlights the importance of pre- and post-operative assessment, especially in patients undergoing tumor resection of brain areas involved in language. Speech therapy can contribute significantly to monitoring language development, preventing deficits, and planning targeted interventions based on individual neuropsychological profiles.

Finally, the pediatric case reported by Peru et al [7] draws attention to childhood neuroplasticity and potential hemispheric reorganization, particularly of the right hemisphere, following early lesions. In these cases, speech therapy plays a crucial role not only in language recovery but also in supporting communicative and academic development, with long-term interventions adapted to the developmental age.

Limitations

This review presents several limitations that should be acknowledged. The search was conducted using a single database (PubMed), which may have limited the breadth and comprehensiveness of the studies retrieved. Furthermore, the entire study selection and analysis process was carried out independently by the author, with input from the academic supervisor in cases of uncertainty, potentially introducing subjective bias. Another significant limitation is the small number of included studies (n=3), all of which were case re-

ports—a type of evidence that is methodologically limited and offers low generalizability. These factors reduce the possibility of drawing broad conclusions, although they provide useful insights for future research on a larger scale.

CONCLUSIONS

Despite the limitations arising from the small number of studies currently available, the data emerging from this review suggest that speech therapy intervention in cases of brain tumor aphasia is a crucial element throughout the entire clinical pathway. In particular, the rehabilitation approach should:

- be present from the early stages, continuing through follow-up, adapting to changes in the clinical picture;
- be tailored to the linguistic and cognitive profile and specific communication needs of each patient;
- integrate technological tools (e.g., voice translation apps, augmentative and alternative communication) and compensatory strategies to promote effective communication in daily life;
- play a central role, especially in childhood, when greater brain plasticity can promote recovery, provided that intervention is early, intensive, and continuous.

Furthermore, the importance of the active presence of speech-language pathologists within multidisciplinary teams involved in the care of patients with brain tumors is reiterated. An integrated, person-centered approach that considers not only the clinical management of the disease but also the maintenance of communication skills and quality of life is a fundamental goal of contemporary rehabilitation.

However, current literature highlights a significant lack of systematic studies on this topic. Therefore, further research with larger samples, longitudinal follow-ups, and standardized assessment protocols is needed to

verify the effectiveness of speech therapy interventions in this specific context.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

DATA AVAILABILITY

All data supporting the findings of this study are available within the article.

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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

Retroflected 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 retroflexion 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 anti-social 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 retroflexion, 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, retroflexion 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 retroflexion 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 retroflexion” 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 emotio-

nal 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 exclusi-

vely 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 re-enacts 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 retroflected 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 retroflexion 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 retroflected 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 retroflexion 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 retroflected 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 at-

tention 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 inquires 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 retroflected (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 retroflected 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 retroflected 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 Psychotherapy 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, retroflexion, 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 retroflexion 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.

Retroflexion: 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 "ad-grade," 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 Epsilon 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 retroreflection 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 Epsilon 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 retroflected 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 retroreflection 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 retroreflection 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 retroflected 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 retroflected 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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Brief Research Report

Eros as Awareness: A Field-Phenomenological Model of Contact in Psychotherapy

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ABSTRACT

Moments of therapeutic change often emerge subtly within the relational atmosphere – through shifts in breath, silence, or embodied resonance. Understanding these transformations requires attending to the shared organism-environment field rather than to individual intrapsychic processes. Grounded in Gestalt field theory and informed by a phenomenological stance, this brief research report introduces the Transformational Field Model (TFM), a descriptive framework identifying five recurring textures of transformation: concealment, containment, symbolization, integration, and stillness. Three clinical vignettes illustrate how these textures become discernible through embodied and relational cues in psychotherapy. Across clinical situations of groundlessness, inhibition of Eros, and prolonged grief, change emerged when the therapeutic field could hold vulnerability without prematurely defining or directing it. The TFM supports clinicians in cultivating field sensibility and recognizing qualitative shifts through which awareness moves toward contact, offering a phenomenologically precise vocabulary for the micro-movements of transformation.

Keywords

Eros, Awareness, Aesthetic Field, Field Theory, Phenomenology, Transformation, Contact, Gestalt Therapy.

ABSTRACT in ITALIANO

I momenti di cambiamento terapeutico spesso emergono in modo sottile nell'atmosfera relazionale—attraverso variazioni del respiro, del silenzio o della risonanza corporea. Comprendere tali trasformazioni richiede un'attenzione al campo organismo-ambiente condiviso, piuttosto che ai processi intrapsichici individuali. Radicato nella teoria del campo della Gestalt e informato da una prospettiva fenomenologica, questo breve report di ricerca introduce il Transformational Field Model (TFM), un quadro descrittivo che identifica cinque trame ricorrenti della trasformazione: occultamento, contenimento, simbolizzazione, integrazione e quiete. Tre vignette cliniche illustrano come queste trame diventino riconoscibili attraverso segnali corporei e relazionali nella psicoterapia. In situazioni di perdita di appoggio, inibizione di Eros e lutto prolungato, il cambiamento è emerso quando il campo terapeutico è stato in grado di accogliere la vulnerabilità senza definirla o orientarla prematuramente. Il TFM sostiene i clinici nel coltivare una sensibilità al campo e nel riconoscere i mutamenti qualitativi attraverso cui

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la consapevolezza si muove verso il contatto, offrendo un vocabolario fenomenologicamente preciso per i micromovimenti della trasformazione.

Parole chiave

Eros, Consapevolezza, Campo Estetico, Teoria del Campo, Fenomenologia, Contatto, Trasformazione, Psicoterapia della Gestalt.

INTRODUCTION

Therapeutic encounters unfold within an atmosphere that begins before words. A pause, a shift in breath, a subtle tightening or expansion in the room—experience moves between therapist and client before either can grasp its contours. Gestalt and contemporary field perspectives view such movements not as exchanges between two inner worlds but as expressions of the organism-environment field, the dynamic relational medium through which experience takes form. Broadly defined, the field is the total situation of forces, tensions, and conditions that co-create experience in the moment [1-3]. Following Lewin's foundational description of the field as a system of interdependent forces [1], and consistent with classical formulations in PHG [2] and later developments by Parlett [3], therapeutic situation is approached as a single, continuously forming process.

A phenomenological stance provides methodological grounding for this perspective. Phenomenology prioritizes attending to how phenomena appear prior to interpretation or explanation, staying close to lived experience as it unfolds [4]. Within psychotherapy, this involves cultivating a sensibility for subtle, pre-reflective shifts, those changes in silence, rhythm, posture, or density that reveal how the field reorganizes before meaning becomes articulable. This view resonates with Merleau-Ponty's understanding of the body as the locus of pre-objective knowing [5]. In this framework, the field is not merely observed; it is *sensed* as atmosphere, impulse, or the quiet emergence of a new figure.

A phenomenological orientation also highlights the intrinsic difficulty of describing micro-transformations in psychotherapy. Much of what reorganizes the clinical situation unfolds in liminal spaces—before language, before explicit knowing, and often before either participant can articulate what is shifting. Although Gestalt therapy has long emphasized awareness at the contact boundary, the fine-grained qualities of this

movement remain underdescribed. Husserl's call to return "*to the things themselves*," together with Merleau-Ponty's view of perception as embodied and relational, suggests that therapeutic change must be approached through its immediate, lived textures rather than through explanatory constructs [4, 5]. Within this lineage, the present work aims to clarify how subtle atmospheric changes signal reorganization in the organism-environment field. By offering a descriptive vocabulary for these shifts, the TFM contributes to ongoing efforts to articulate the micro-phenomenology of clinical change in a way that remains faithful to lived experience.

Within this embodied, relational ontology, Eros refers to the vital movement toward coherence, contact, and meaning. It is not understood as intrapsychic desire but as a field-dynamic movement expressing the organism's tendency toward connection. Francesetti's articulation of the *aesthetic field* emphasizes how transformation becomes possible when the relational medium supports the emergence of new meaning [6, 7]. Robine highlights the co-constituted and pre-reflective nature of this emergence [8], while Spagnuolo Lobb describes how vitality contours of the *body-in-relation* communicate field movements before they can be verbalized [9].

Across therapeutic practice, transformation often manifests through recurring atmospheric qualities – moments when experience tightens, thickens, articulates, settles, or becomes still. These qualities can be recognized as five recurring textures: concealment, containment, symbolization, integration, and stillness. Together they form the Transformational Field Model (TFM), a descriptive framework for understanding how lived experience shifts from diffusion to articulation, from fragmentation to coherence, and from effort to rest.

The aim of this paper is to introduce the TFM and illustrate its five textures through three clinical vignettes. In keeping with phenomenological methodology, the model is

grounded in careful attention to lived experience in the therapeutic field rather than on explanatory or interpretive frameworks. The following sections outline the phenomenological orientation guiding this inquiry, describe the development of the model, and present the clinical material through which these textures become sensibly present.

METHODS

Phenomenological Orientation

This study adopts a phenomenological orientation, which involves attending closely to how experience presents itself in the therapeutic encounter before interpretive or explanatory frameworks are applied. In keeping with Husserlian descriptive phenomenology and its application within contemporary aesthetic field practice, the emphasis remains on lived experience as it unfolds in the shared therapeutic situation [4, 6]. Interpretive and diagnostic lenses are *bracketed* to maintain clarity about what is directly given.

Within this framework, the therapeutic field is understood as a shared relational situation rather than two separate internal domains. What arises in one member of the dyad often belongs to both, expressing the organization of the relational medium in that moment. Subtle changes in breath, silence, rhythm, warmth, or tension are therefore treated as indicators of how the field reorganizes itself.

The methodological approach follows established phenomenological research practices in which attention to lived experience is supplemented by the identification of recurring qualitative textures across situations. Observational notes were recorded immediately after sessions and later compared to identify common atmospheric and embodied patterns. Through this comparative method, recurrent experiential structures of these moments were identified. This procedure is consistent with phenomenological inquiry, which seeks descriptive regularities in experience rather than causal explanations. Transformation is thus understood as revealed rather than produced, emerging when the field is held with sensitivity and without premature definition. This procedure aligns with phenomenological research in contemporary Gestalt therapy, which treats the clinical situation as an observable field and identifies recurring field phenomena through disciplined attention to lived experience [11-13].

In alignment with descriptive phenomenology, the comparative process relied on the disciplined use of *epoché* – the suspension of theoretical, diagnostic, and interpretive assumptions that might obscure how experience presents itself in the shared field [4]. Practicing *epoché* redirected attention from conceptual meaning-making to the immediate, lived qualities of the clinical situation, consistent with Merleau-Ponty's emphasis on perception as an embodied and relational event [5]. This stance was followed by a sustained phenomenological reduction, through which atmospheric, embodied, and relational shifts were approached as phenomena of the *phenomenal field* rather than as intrapsychic reactions. Returning repeatedly to the descriptive material with this reduced attitude allowed the emerging textures to reflect qualities inherent to the field rather than the therapist's implicit frameworks or biases. The combined movement of *epoché* and reduction was essential for maintaining methodological rigor and ensuring that the model arose from disciplined attention to what was sensibly given, rather than from theoretical imposition.

The Transformational Field Model (TFM)

The Transformational Field Model (TFM) offers a descriptive framework for understanding how therapeutic change becomes perceptible within the organism-environment field. Rather than locating transformation inside the individual, the model situates change in the aesthetic field, the dynamic relational medium through which experience takes form. Moments of therapeutic significance arise through shifts in this shared atmosphere, expressed as variations in tension, density, rhythm, and coherence.

The conceptual grounding of the TFM draws from classical Gestalt field theory, phenomenology, and contemporary aesthetic field developments. Lewin's description of the field as a dynamic system of forces illuminates why experiential shifts appear as tightening, thickening, opening, or settling in the relational situation [1]. Merleau-Ponty's emphasis on embodied and pre-reflective perception clarifies how such shifts become sensibly available before they can be verbally formulated [5]. Parlett's principles of field theory highlight the systemic nature of these processes [3], while contributions by Fran-

cesetti, Robine, and Spagnuolo Lobb elaborate how vitality contours and atmospheric intentionalities shape the emergence of meaning within the aesthetic field [6-9].

The TFM identifies five recurring textures of transformation: concealment, containment, symbolization, integration, and stillness. These textures are not intrapsychic states or countertransference reactions, but qualitative shifts in the relational field that can be sensed before they are conceptualized. Each texture reflects a distinct phase in the movement of experience toward or away from contact, consistent with PHG's articulation of figure formation at the contact boundary [2].

The model emerged inductively through phenomenological comparison across multiple clinical encounters. Observational notes captured atmospheric qualities, embodied shifts, and relational configurations present at moments of change. These descriptions were examined for recurrent patterns independent of diagnosis or technique. Through this process, the five textures were identified as qualitative invariants reflecting how the field transitions from opacity to articulation, from fragmentation to coherence, and from movement to rest. Instead of prescribing interventions, the TFM provides a vocabulary and conceptual structure for recognizing how the aesthetic field signals the emergence of new meaning.

The Five Textures of Transformation

TFM conceptualizes transformation as emerging through five recurring textures of lived experience. These textures describe pre-reflective, embodied shifts in the relational field as contact reorganizes. Each texture articulates a distinct qualitative movement within the aesthetic field.

Concealment

Concealment refers to moments when the field contracts and an emerging figure becomes opaque, veiled, or unavailable to awareness. In Lewinian terms, concealment reflects heightened field tension [1], while in PHG's description of fore-contact it corresponds to the earliest stirrings of experience before differentiation [2]. The atmosphere may subtly withdraw or thicken, signaling that something is forming but not yet arti-

culated. This opacity is not repression but a field-level obscurity inherent to early phases of emergence.

Containment

Containment describes the field's capacity to hold emerging intensity without fragmentation or premature closure. Where concealment tightens, containment stabilizes: the atmosphere becomes denser and more grounded. Francesetti describes this as aesthetic thickening [6], and Spagnuolo Lobb's notion of embodied attunement clarifies that containment is not the therapist holding the client but the field itself acquiring the capacity to support heightened affect [7]. The field becomes the vessel in which experience can remain present without dispersing.

Symbolization

Symbolization marks the transition from pre-reflective sensing to articulated form. In Gestalt terms, the figure becomes distinct against the background [2]. Through words, gestures, images, or shifts in posture, previously undifferentiated experience becomes expressible. Symbolization is not symbolic representation in a psychoanalytic sense, but a lived articulation grounded in embodied field movement. The atmosphere reorganizes as meaning becomes present.

Integration

Integration describes moments when differentiated aspects of experience reorganize into a coherent whole. Parlett's principle of mutual influencing situates this as a systemic reordering in which organism and environment re-establish equilibrium [3]. Integration manifests as alignment, continuity, or renewed agency – not through cognitive insight but through a field configuration that now supports coherent contact.

Stillness

Stillness is the texture of aesthetic suspension—the spacious pause in which the field settles and possibilities widen. This corresponds to PHG's notion of creative indiffe-

rence, the fertile midpoint from which new figures may emerge [2]. In Francesetti's description of the fertile void [6], stillness represents the moment when nothing is demanded and multiple directions of becoming are possible. The atmosphere may feel quiet, resonant, or expansive. Stillness is not withdrawal but a threshold of potential.

Data and Ethics

The clinical vignettes represent recurrent field phenomena in therapeutic practice. All identifying details have been altered so that no individual client can be recognized. Informed consent was obtained prior to the use of clinical material in this study.

RESULTS

To orient the reader before turning to the clinical material, Figure 1 provides a visual depiction of the five textures as movements of awareness toward contact. *Concealment* indicates the first inward stirrings of vitality; *containment* expresses a growing readiness in the field; *symbolization* marks outward articulation; *integration* signals the reorganization of meaning; and *stillness* (fertile void) offers a resting ground from which new experience may arise. The waveform highlights that the transformation is rhythmic rather than linear. The crosses (x) on the curve mark points at which a texture becomes phenomenologically discernible moments when a shift in the quality of contact becomes perceptible.

The figure illustrates how these textures become sensibly present in clinical practice through distinct reorganizations of the relational field.

Groundlessness

A woman enters therapy describing a persistent sense that “*the ground is not there.*” Her movements are careful, and a slight tension seems to surround the encounter – an instance of *concealment*, where experience is forming but not yet articulable. As she reaches for her bag, she unexpectedly loses balance and falls. The moment is brief, yet the relational field reorganizes noticeably.

The fall appeared to mark a momentary interruption of field coherence, allowing an emerging figure to reorient the atmosphere.

After she sits again, her breathing settles. The room feels steadier, and a sense of containment becomes perceptible. The field is now able to hold what had been unformulated. She begins to speak, haltingly at first, about longstanding fears connected to instability in her family. This marks *symbolization*, as previously opaque experiential pressure gains initial form.

Near the end of the session, she says, “*I can feel my legs now.*” The atmosphere stabilizes, and a renewed sense of groundedness appears. This reflects integration, where fragmented experiential elements reorganize into coherent support for contact. What had been diffuse becomes expressible within the relational field.

This vignette illustrates how the field shifts from *concealment* toward *integration* through small but significant reorganizations.

Containment and the Return of Eros

A choreographer arrives feeling empty and uninspired. Her tone is careful, her posture controlled. Beneath this composure, the atmosphere carries a muted strain – an instance of concealment, where intensity is

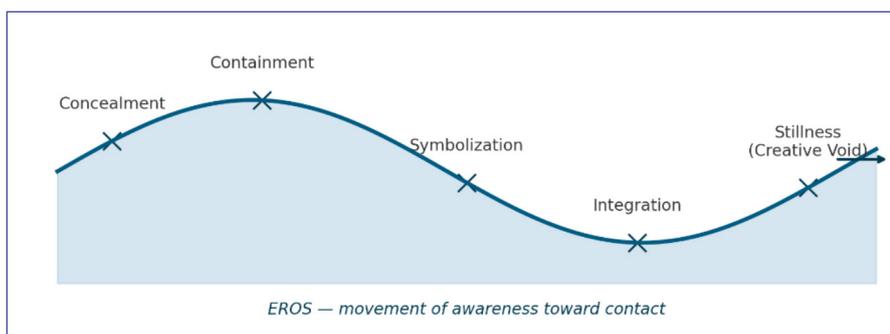


Figure 1. The five textures of the Transformational Field Model (TFM).

present but unexpressed. As she begins speaking about erotic bondage fantasies that disturb her, the room becomes charged. A quickening in breath and a trace of shame appear – not as personal reactions to manage but as part of the field's activation.

She pauses and then says quietly, “*It isn't about sex—it's about feeling alive.*” The atmosphere steadies, and the previously compressed intensity begins to circulate, marking the field's transition into *containment*.

In subsequent sessions, she resumes choreographing and begins exploring themes of restriction and release. Experience that had been constricted begins to loosen and move, expressing itself through gesture and creative process – an instance of *symbolization*. She sometimes traces arcs in the air with her hands. These movements carry meaning not yet verbalized. A warmth and coherence spread in the room, signaling *integration*, where new vitality becomes part of her ongoing organization of experience.

Interpretation was not the driver of change. Rather, what had stagnated began to circulate as the field regained its capacity for movement and expression.

This vignette highlights how *containment* and *symbolization* support the return of Eros as a field phenomenon.

Ashes Dream

A woman grieving her husband sits in extended silences. The atmosphere feels muted, as if sound itself has thinned; an instance of *concealment*, where grief is present but without form. After several sessions, she brings a dream: “*I'm sweeping ashes, and it never ends.*” The room grows denser yet steadier, reflecting *containment*, where overwhelming experience becomes possible to bear.

That night, a dream appears in the therapist's experience: raking ashes in a garden touched by early sunlight. Within a phenomenological framework, such imagery is understood as part of the field's unfolding rather than as personal material. When the dream is shared, the client begins to cry. The shared imagery offers *symbolization*, giving shape to grief that had remained unarticulated. The atmosphere becomes fuller and more resonant.

A few sessions later, she brings a small clay pot and says, “*I planted something.*” The imagery has shifted from ashes to soil – an

instance of *integration*, where grief reorganizes into a form capable of supporting new meaning.

The room becomes quiet, settled, and spacious. This reflects the texture of *stillness*, an aesthetic suspension in which potentiality gathers.

Nothing about the loss is resolved, yet grief now breathes differently in the field – shared, sensed, and carried with new coherence.

The vignettes demonstrate how the five textures of the TFM recur across clinical situations, offering a descriptive basis for the comparative analysis presented in the following discussion.

DISCUSSION

The three clinical vignettes show how the phenomenological textures become perceptible as shifts in the organism-environment field. Although their narrative contents differ, a consistent phenomenological pattern is evident. Across cases, experience reorganizes through the five textures of the Transformational Field Model (TFM): *concealment* as atmospheric opacity, *containment* as a stabilizing thickening of the relational field, *symbolization* as the movement from pre-reflective sensing to articulated form, *integration* as restored coherence, and *stillness* as an aesthetic suspension in which potentiality gathers. The textures illuminate how vitality becomes constrained, how it regains movement, and how the field reconfigures itself to support new forms of contact [1, 2].

TFM develops within the Gestalt field tradition while expanding its phenomenological precision. Lewin's conception of the field as a dynamic constellation of forces clarifies why therapeutic shifts appear as variations in tension, density, or rhythmic flow [1]. PHG's articulation of figure formation at the contact boundary aligns with the observation that each texture marks a phase in the emergence of figure from background [3]. Parlett's principle of mutual influencing further emphasizes the systemic reciprocity that shapes these movements. Contemporary contributions in aesthetic field theory support this orientation: Francesetti's articulation of field sensibility [1] and Spagnuolo Lobb's account of embodied attunement [7, 8] show how experience becomes co-organized before it can be verbally expressed.

Recent clarifications by Francesetti and Roubal regarding the differentiation of the

phenomenal, phenomenological, and psychopathological fields provide additional conceptual grounding [10]. Their emphasis on atmospheric intentionalities corresponds to the TFM's focus on qualitative shifts within the phenomenal field, while the therapist's disciplined awareness reflects the phenomenological field. This distinction explains how experiential pressures are sensed before formulation and supports the TFM's characterization of textures as pre-reflective field movements rather than intrapsychic or countertransference reactions.

Clinically, the TFM encourages an orientation centered on the evolving relational field rather than on individual states. The textures help clinicians discern whether the field is tightening, stabilizing, pausing, or opening toward articulation. Containment, for example, is understood not as something the therapist performs, but as a property of the field. Symbolization reflects the field's shift toward form rather than interpretive insight. The texture of stillness—often subtle and easily overlooked—plays a crucial clinical role. As an instance of aesthetic suspension or creative indifference, it constitutes the fertile interval in which new experiential contours may gather before articulation.

Beyond its descriptive contribution, the TFM also has implications for clinical training and supervision. Because the textures offer a vocabulary for subtle field movements, they may support trainees in developing perceptual sensitivity to atmospheric and embodied cues that precede explicit narrative content. Supervisors may find the textures useful in helping clinicians articulate micro-events that shape therapeutic direction yet are difficult to name within conventional diagnostic or interpretive frameworks. The model also resonates with contemporary developments in embodied cognition and enactive approaches to psychotherapy, which understand meaning as emerging relationally through coordinated movement, gesture, posture, and affective resonance. Foundational work in enactive cognitive science describes cognition as a dynamic, relational process grounded in sensorimotor coupling with the environment [14], while phenomenological accounts of intercorporeality and interaffectivity emphasize that experience unfolds through shared bodily rhythms and atmospheric attunement [15]. By framing transformation as a rhythmic reorganization of field qualities, the TFM provides a conceptual bridge between phenomenological psycho-

therapy and interdisciplinary research concerned with pre-reflective processes. This perspective highlights the importance of attending not only to what becomes articulated, but also to how the clinical field quietly prepares the ground for articulation, integration, and the emergence of new meaning.

The capacity to discern these textures rests not only on relational sensitivity but on the therapist's cultivated perceptual discipline. Within a phenomenological framework, such discernment is neither introspection nor the management of personal resonance; rather, it reflects a disciplined orientation to what becomes manifest in the shared field. In this sense, the therapist's embodied presence functions as an instrument of phenomenological observation, supporting the emergence of meaning without imposing interpretive structure. Although described separately, the textures often overlap or oscillate in clinical practice. Their unfolding is rhythmic rather than sequential: concealment may return after symbolization, or stillness may arise momentarily within containment. Acknowledging this fluidity prevents the model from becoming prescriptive and underscores its descriptive intent, preserving fidelity to the phenomenological complexity of lived experience.

This model does not prescribe techniques or interventions. Instead, it clarifies how meaning becomes possible through sensitivity to qualitative field shifts. Such attunement can support therapeutic presence in situations marked by fear, inhibition, emptiness, or grief. By naming these textures, the TFM provides a framework for recognizing atmospheric and relational conditions that precede the emergence of experience.

As with all phenomenological frameworks, the TFM has limitations. Its precision depends on the clinician's capacity to notice subtle atmospheric changes, a sensitivity shaped by training and embodied experience. The model is based on qualitative observation rather than empirical measurement. However, the textures appeared consistently across cases. Further research is needed to evaluate their reliability across therapeutic modalities, cultural contexts, and clinical presentations. The TFM does not claim predictive value; rather, its contribution lies in offering a descriptive structure that supports clinical attunement and enhances theoretical rigor. Future work may explore intersubjective reliability in identifying textures, examine their relevance to specific psycho-

pathologies, or consider convergences with neurophenomenological accounts of relational processes.

Despite these limitations, the TFM provides a coherent and clinically accessible framework for recognizing how transformation becomes sensible in the therapeutic field. By attending to subtle shifts in rhythm, tension, resonance, and suspension, clinicians gain access to the pre-reflective movements through which experience organizes and reorganizes at the contact boundary [5]. The textures illuminate how vitality becomes constrained, regains movement, and reconfigures itself to support new forms of contact and meaning.

CONCLUSIONS

The clinical material presented here demonstrates that therapeutic change often begins before words—through subtle reorganizations of the organism–environment field. The five textures of the TFM—*concealment, containment, symbolization, integration, and stillness*—describe these reorganizations as they unfold in lived contact. Rather than offering causal explanations, the model provides a phenomenological account of how experience becomes articulate: how opacity shifts toward visibility, how intensity finds a place to settle, how pauses in the field permit reorganization, and how meaning emerges through shared sensing [1, 5].

By naming these textures, the TFM clarifies dimensions of the aesthetic field that have long guided Gestalt clinical practice but lacked descriptive precision. The framework complements existing field theory by highlighting the micro-phenomenology of transformation and offering clinicians a framework for attending to atmospheric and relational conditions that precede articulation [1, 2, 8]. These textures bring conceptual clarity to subtle experiential shifts that frequently shape the direction of therapeutic movement.

The unformulated field does not disappear; it reorganizes. When this field is met with sensitivity and care, new meaning becomes possible to bear. In this sense, the process of change mirrors the rhythms of the body itself, emerging through alternating movements of tightening and opening, expression and rest, reflecting the organism-environment through which becoming unfolds. The TFM provides a vocabulary for these rhythms and

supports a form of clinical attention attuned to the moment-to-moment emergence of experience in the relational field.

CONFLICT OF INTEREST

The author has no conflict of interest to declare.

ETHICS APPROVAL

This study reports anonymized, non-identifiable psychotherapy vignettes. According to institutional guidelines, formal ethics committee approval was not required.

INFORMED CONSENT

Informed consent was obtained from the patients before conducting the study.

AI DISCLOSURE

AI tools were used only for grammar checking, figure & bibliography formatting; the human researcher authored all intellectual content.

AUTHORS' CONTRIBUTIONS

V.K.: Conceptualization, Methodology, Data Curation, Writing – Original Draft, Writing – Review & Editing.

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Scoping Review

Problem behaviors in nonverbal autistic individuals: the role of alternative augmentative communication

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ABSTRACT

Objective: This Scoping Review aims to analyze the correlation between problem behaviors and communication deficits in non-verbal individuals with autism spectrum disorder (ASD), evaluating the role of Functional Communication Training (FCT) and Augmentative and Alternative Communication (AAC) as evidence-based tools for reducing dysfunctional behaviors and enhancing communicative autonomy.

Materials and Methods: A systematic search was conducted following the PRISMA-ScR guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews), including articles published in English between 2015 and 2025. The databases consulted were PubMed and Google Scholar, using the following keywords: "Autism", "Problem behaviours", "Augmentative and Alternative Communication", "Non-verbal", with predefined inclusion criteria.

Results: From the initial search, 742 articles were identified, but only 8 met the inclusion criteria and were included in the final scoping review. The data confirm that the absence of functional communication channels is a primary risk factor for the emergence of dysfunctional behaviors. The implementation of FCT, even via telehealth, and the use of AAC tools (PECS, digital devices, gestures, images) have been shown to significantly reduce the frequency and intensity of problem behaviors, improving communication quality and reducing family stress. However, the literature remains limited and fragmented, with little focus on the systematic and formal integration of FCT and AAC.

Conclusions: The review highlights the need to develop early, multimodal, individualized intervention models that formally integrate AAC into FCT protocols, not only as an expressive support but also as a diagnostic and therapeutic tool for the functional analysis of behavior.

Keywords

Autism, Problem behaviors, Alternative augmentative communication, Nonverbal.

ABSTRACT in ITALIANO

Obiettivi: Questa Scoping Review si propone di analizzare la correlazione tra comportamenti problema e deficit comunicativi negli individui non verbali con disturbo dello spettro autistico (ASD), valutando il ruolo del Functional Communication Training (FCT) e della Comunicazione Aumentativa e Alternativa (CAA) come strumenti evidence-based per la riduzione dei comportamenti disfunzionali e il potenziamento dell'autonomia comunicativa.

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Materiali e Metodi: È stata condotta una ricerca sistematica secondo le linee guida PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews), includendo articoli pubblicati in lingua inglese tra il 2015 e il 2025. Le banche dati consultate sono state PubMed e Google Scholar, utilizzando le seguenti parole chiave: *Autism, Problem behaviours, Augmentative and Alternative Communication, Non-verbal*, con criteri di inclusione predefiniti.

Risultati: Dalla ricerca iniziale sono stati identificati 742 articoli, ma solo 8 hanno soddisfatto i criteri di inclusione e sono stati inseriti nella revisione finale. I dati confermano che l'assenza di canali comunicativi funzionali rappresenta un fattore di rischio primario per l'insorgenza di comportamenti disfunzionali. L'implementazione del FCT, anche tramite telehealth, e l'utilizzo di strumenti CAA (PECS, dispositivi digitali, gesti, immagini) hanno dimostrato di ridurre significativamente la frequenza e l'intensità dei comportamenti problema, migliorando la qualità della comunicazione e riducendo lo stress familiare. Tuttavia, la letteratura rimane limitata e frammentaria, con scarsa attenzione all'integrazione sistematica e formale tra FCT e CAA.

Conclusioni: La revisione evidenzia la necessità di sviluppare modelli di intervento precoci, multimodali e individualizzati, che integrino formalmente la CAA all'interno dei protocolli di FCT, non solo come supporto espressivo ma anche come strumento diagnostico e terapeutico per l'analisi funzionale del comportamento.

Parole chiave

Autismo, comportamenti problema, comunicazione aumentativa alternativa, non verbale.

INTRODUCTION

In the clinical and scientific context of autism, non-verbal individuals are among the most vulnerable and the least represented in research and therapeutic practice [1]. The absence of verbal and vocal language is one of the most significant limitations, profoundly affecting the quality of life of both autistic people and their caregivers [2]. This communication barrier not only hinders the expression of needs, emotions, and intentions, but can also contribute to the emergence of dysfunctional behaviors [3].

The impairment of the verbal channel is a crucial variable in the development of problem behaviors, such as aggression, self-harm, avoidance, escape, and opposition [3]. These behavioral manifestations, often misinterpreted as mere oppositional conduct [3], are in fact adaptive strategies through which the individual attempts to interact with their surroundings.

In the absence of alternative means of communication, behavioral repertoire can become the only means of expression available, taking on a primary communicative function [4].

Although problem behaviors have significant clinical importance and impact in the clinical and non-clinical lives of autistic individuals, they do not receive the same attention and relevance in treatment protocols and even in scientific literature.

Such problem behaviors are not seen for their true nature and meaning, but rather as elements to be curbed and contained. These actions lead the autistic individual to be-

come entrenched in and to consolidate the problem behaviors they identify as natural communicative practices. This approach is directly associated with therapeutic ineffectiveness, an increase in problem behaviors, and deterioration in caregivers' quality of life.

A fundamental element that provides support and objective, replicable results is the use of Augmentative and Alternative Communication (AAC) [5]. AAC is a resource that is still not adequately integrated and undervalued. This communication tool consists of a set of strategies, technologies, and symbolic systems that aim to support or replace verbal language, offering individuals concrete tools to express themselves, interact, and actively participate in social life.

AAC systems [e.g., PECS (Picture Exchange Communication System), personalized visual interfaces, digital voice devices] have allowed scientific researchers to demonstrate in various studies that their use significantly reduces the intensity and incidence of problem behaviors [6] improving the quality of communication and life for autistic individuals and their caregivers.

The purpose of this article, and the decision to focus on key points relating to non-verbal autistic individuals and their relationship with AAC, stems from the difficulties we continually encounter in clinical practice with regard to the rehabilitation of autistic individuals. This study stems from the need to raise awareness among the scientific community and caregivers about the importance of observing the autistic individual as a whole. This is the key to future rehabilitation success, represented by the

relationship between communication and behavior skills.

This scientific contribution aims to offer a dynamic, up-to-date, and multidisciplinary perspective on the transformative potential of AAC in addressing unexpressed communication needs that can lead to problem behaviors.

MATERIALS AND METHODS

To identify all articles related to our study, a systematic search was conducted using a Scoping Review of ethical and evidence-based interventions that value communication as a fundamental right and as the key to understanding and reducing problem behaviors.

The decision to conduct a Scoping Review arose from the desire to demonstrate that there is very little literature on this topic and from the desire to raise awareness among two types of categories: the scientific community (doctors, therapists and researchers) and the group of people who revolve around the routine of autistic individuals (caregivers, teachers, educators, communication assistants).

Scoping reviews are an excellent tool for identifying the existence of a sample of literature on a given topic and providing a detailed overview of its focus; they are useful for examining emerging evidence when it is not yet clear what other, more specific questions can be asked and addressed by a systematic review [7].

Table 1. Keywords.

Autism
Problem behaviours
Augmentative and alternative communication
Non-verbal

To conduct this review and ensure a transparent, systematic, and reproducible methodology in the identification and selection of scientific literature, the authors followed PRISMA guidelines, in the extension specifically developed for Scoping Reviews, the PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) [8].

To answer the research question of this scoping review, articles were included that focused on nonverbal autistic patients exhibiting problem behaviors for whom functional communication training was necessary. Specifically, studies published in English over the last ten years were selected. The review of scientific articles was carried out using two electronic databases: Google Scholar and PubMed, using keywords such as: autism, problem behaviors, augmentative and alternative communication, non-verbal (Table 1).

Initially, 742 articles were identified, of which 661 were found in PubMed and 81 in Google Scholar. Following the inclusion criteria (Table 2), based on titles and abstracts, a total of 732 articles were excluded. In addition, after reading the full text, two more articles were

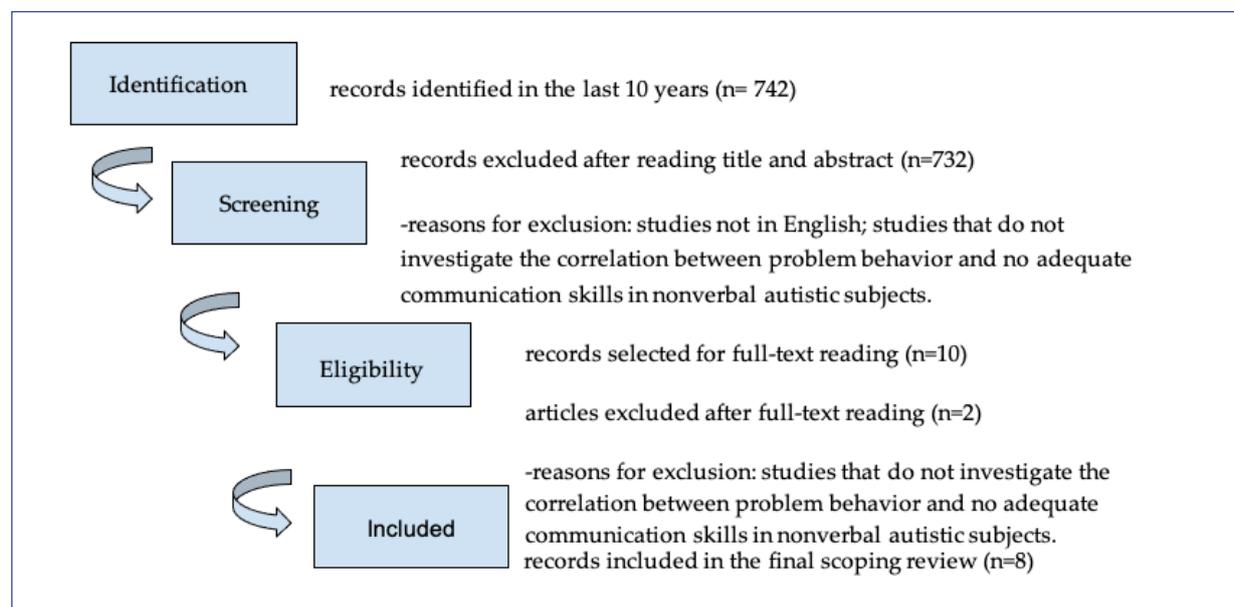


Figure 1. Flow chart of the articles' selection process.

Table 2. Eligibility criteria.

CRITERION	INCLUSION	EXCLUSION
Year of publication	2015-2025	Studies prior to 2015
Language	English	Other languages
Focus of the study	The correlation between problem behaviour and lack of adequate communication skills in non-verbal autistic individuals	Verbal subjects; adequate communication skills; absence of problem behaviours; absence of autism spectrum disorder.
Study sample	Non-verbal autistic individuals with problem behaviours	All other categories of patients and disorders
Type of article	Scientific articles	All others

excluded. The remaining eight articles were included in the Scoping Review, as they met the inclusion criteria (Figure 1).

RESULTS

The characteristics of the selected studies have been summarized in Table 3, which provides information on the author, title, year of publication, purpose, data collection method and tools used, sample size, and study design.

The articles selected are the result of a careful, systematic, and rigorous selection process based on specific criteria (paragraph 3).

The literature recognizes the ABA approach [9] and Functional Communication Training (FCT) (even when conducted via telehealth) as evidence-based treatments for reducing problematic behaviors and improving the communication skills of children with ASD. It is based on three fundamental points:

- 1) Functional analysis of dysfunctional behavior: the function of the problem behavior is identified;
- 2) Choice of an alternative communicative response: the child acquires an alternative and functional way to satisfy his needs;
- 3) Reinforcement of functional communication: when the child uses functional communication, he immediately achieves what he requests.

Strategies such as using daily materials in realistic, naturalistic environments and involving parents increase the likelihood of success and the transferability of techniques to environments beyond the tre-

atment setting, promoting the generalization of new communication skills.

Furthermore, younger children seem to benefit more from early intervention, as their development and brain plasticity favor learning in natural environments without the need for targeted generalization programs. At the same time, reducing parental stress can contribute to a more positive family environment that is conducive to children's learning and growth [10-14].

The need to adopt systematic and individualized assessment methods is also emphasized in order to improve the effectiveness and durability of Functional Communication Training (FCT) interventions: the assessment and identification of preferences and, above all, the choice of command type play an extremely crucial role. The results show that preference for a response can vary individually, and choosing a preferred option can increase motivation and the effectiveness of communicative learning. For example, individuals with good vocal imitation skills respond better to verbal instruction, while others may benefit from responses using visual symbols or manual signals.

The choice of delivery methods depends on several variables, such as:

- individual factors: physical abilities, existing communication skills, ease of prompting, and compatibility with the subject's current abilities;
- environmental factors: the social recognizability of responses in different environments or social contexts, and the costs for caregivers or ease of access.
- response characteristics: preferences because of compatibility with problem behaviors, continuous accessibility, and ease of control by the clinician.

Research shows that teaching different types of commands reduces problem behaviors because it increases flexibility and communicative independence, allowing for more precise responses and facilitating changes in preferences over time. Techniques such as delayed reinforcement are shown to be effective methods for increasing tolerance for waiting, promoting the acquisition of more complex responses, and reducing the risk of problem behaviors. In addition, the transition between different response topographies can be strategic in promoting the generalization of responses in different environments. To facilitate more functional communication, it is important to plan a gradual transition from generalized responses to more specific ones, while carefully assessing the patient's cognitive, visual, and motor skills.

The most effective and commonly used responses in nonverbal individuals include:

- gestures or signs (e.g., simplified sign language);
- pictograms or images (e.g., PECS – Picture Exchange Communication System);
- electronic devices (tablets with communication apps, voice buttons);
- physical indication (pointing, touching, handing over an object) [3].

Similarly, actively involving the patient in determining which type of reinforcement program is most acceptable or preferable, can improve the intervention's effectiveness and social validity and reduce problem behaviors [16].

DISCUSSION

In this perspective, it is essential to identify the problem behaviors exhibited by patients with ASD, the cause from which they arise (antecedent), and the function they perform in the absence of verbal language. This is made possible by functional behavior analysis, an observation methodology used to understand the function of a behavior by identifying the relationships between antecedents, the behavior itself, and consequences, using the ABC model:

- Antecedents (A): events, situations, people, or activities that occur immediately before the behavior and may trigger it.
- Behavior (B): the observable response or specific action that the person performs in response to the antecedents.

- Consequences (C): what happens immediately after the behavior and which can reinforce it, maintaining it over time, or, conversely, weaken it.

This tool enables planning targeted interventions to replace problem behaviors with more adaptive ones.

Adaptive behaviors are the set of conceptual, social, and practical skills that a person learns to function in daily life, respond to environmental demands, and meet social and cultural expectations.

Communication is one of the key components of adaptive behavior, including the ability to understand and produce verbal and nonverbal language, which is essential for interacting effectively with others and adapting to social contexts. In this sense, according to scientific literature, the treatment of choice involves early, individualized Functional Communication Training, carried out in naturalistic and real environments, with the involvement of the parents and/or caregivers of patients with ASD. In fact, several studies show that when parents are adequately trained to implement Functional Communication Training, significant benefits are observed in both the behavior and emotional well-being of the family as a whole. Furthermore, the use of FCT *via* telehealth has shown promising results in terms of accessibility and effectiveness, representing a valuable resource for local areas with limited availability of specialist services.

Another recurring theme is the personalization of the *mand*, that is, the choice of the type of communicative response to teach. Some sources show that taking individual preferences into account when selecting the topography of the communicative response (for example, vocalizations, gestures, picture exchange, use of devices) can increase the subject's motivation, improve learning, and make the results of the intervention more lasting.

However, it emerged that explicit attention to the integration of Augmentative and Alternative Communication (AAC) tools, such as PECS, digital voice devices, and other symbolic aids, was scarce. This highlights a gap in the literature, where FCT is frequently treated as a stand-alone method, without systematic reflection on its integration with AAC technologies and symbolic systems.

Finally, the review confirmed that early intervention is particularly effective in younger children, thanks to greater neuroplasticity.

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Table 3. Overview of selected records

	Author	Title	Year	Purpose	Data collection method/ tools	Sample size	Study design
1	Kodak T, Bergmann S [9]	Autism Spectrum Disorder: Characteristics, Associated Behaviors, and Early Intervention	2020	Provide an overview of ASD characteristics, associated behaviors, and early intervention strategies based on applied behavioral analysis (ABA)	Review	-	-
2	O'Brien MJ, Pelzel KE, Hendrix NM, Schieltz KM, Miller K, Call NA, Tsami L, Lerman DC, Berg WK, Kopelman TG, Wacker DP, Lindgren SD. [10]	Parent Ratings of Generalized and Indirect Effects of Functional Communication Training for Children with Autism Spectrum Disorder	2022 (Epub 2021)	Evaluate the effects of Functional Communication Training on target and non-target behaviors outside the training context, as well as parental stress	Intervention via telehealth, indirect measures (parental assessment scales), and direct observations of problem behaviors	30 children with ASD and their parents (aged 29-83 months)	Pre-/post-treatment study
3	Ruppel KW, Hanley GP, Landa RK, Rajaraman A [11]	An Evaluation of "Balance": a Home-Based, Parent-Implemented Program Addressing Emerging Problem Behavior	2021	Evaluate the effectiveness of a home-based program, implemented by parents, to prevent emerging problem behaviors in young children with ASD	Biweekly coaching for parents by a BCBA; direct measures of behavior and use of the Aberrant Behavior Checklist (ABC)	4 children with ASD and their parents (aged 3-4 years)	Pre-/post-treatment study
4	Lindgren S, Wacker D, Schieltz K, Suess A, Pelzel K, Kopelman T, Lee J, Romani P, O'Brien M [12]	A Randomized Controlled Trial of Functional Communication Training via Telehealth for Young Children with Autism Spectrum Disorder	2020	Verify the effectiveness of Functional Communication Training (FCT) provided via telehealth, compared to "usual treatment"	FCT implemented by parents with real-time coaching via telehealth; direct observation of problem behaviors	38 children with ASD (aged 21-84 months)	Randomized controlled trial
5	Kunnavatana SS, Wolfe K, Aguilar AN [13]	Assessing Mand Topography Preference When Developing a Functional Communication Training Intervention	2018	Reducing arbitrary selection of mand topography during functional communication training by assessing individual preference for mand topography to improve long-term effectiveness of intervention	Preference assessment, functional communication training, and enhancement of the chosen topography	2 adults with ASD	Experimental study
6	Gerow S, Hagan-Burke S, Rispoli M, Gregori E, Mason R, Ninci J [14]	A Systematic Review of Parent-Implemented Functional Communication Training for Children With ASD	2018	Evaluate the empirical literature on Functional Communication Training (FCT) implemented by parents for children with ASD	Descriptive and social validity analysis in different studies	26 studies	Systematic review
7	Houck EJ, Dracobly JD, Baak SA [15]	A Practitioner's Guide for Selecting Functional Communication Responses	2022	Provide practical guidance to help professionals choose functional and effective communication responses during Functional Communication Training (FCT) interventions, with the aim of reducing problem behaviors	Review	-	Applicative theoretical research
8	Briggs AM, Akers JS, Greer BD, Fisher WW, Retzlaff BJ. [16]	Systematic Changes in Preference for Schedule-Thinning Arrangements as a Function of Relative Reinforcement Density	2018	Examine which type of reinforcement schedule is most acceptable or preferable for the patient, as reinforcement conditions vary	Experimental study with reinforcement schedule	1 patient with ASD	Case report

ty and the possibility of preventive interventions compared to the consolidation of dysfunctional behaviors.

CONCLUSIONS

This Scoping Review has highlighted the central role of Functional Communication Training (FCT) in managing challenging behaviors in non-verbal autistic individuals. The collected data confirm that the absence of functional communication channels represents a primary risk factor for the emergence of dysfunctional behaviors, and that the introduction of alternative communication tools can significantly reduce the frequency and intensity of such behaviors.

However, the scientific literature available on this topic remains limited and fragmented. Studies published over the past decade are scarce and do not clearly systematize the integration between FCT and Augmentative and Alternative Communication (AAC). This misalignment among theoretical evidence, clinical practice, and the communication needs of nonverbal individuals underscores the urgent need to develop intervention models that formally incorporate AAC into FCT protocols—not only as an expressive support but also as a diagnostic and therapeutic tool for functional behavior analysis.

Both the literature review and clinical experience converge in showing that early, multimodal, and individualized approaches are the most effective in reducing dysfunctional behaviors and fostering communicative autonomy. The scarcity of available studies should not be interpreted as a limitation but rather as an opportunity: the scientific community must invest in more comprehensive and systematic research capable of filling this gap and translating what is already observed in daily clinical practice into operational protocols. It is desirable that the scientific and clinical community recognize the urgency of early, structured, communication-based interventions that are capable not only of reducing dysfunctional behaviors but also of valuing individuals' alternative expressive modalities, thereby promoting rehabilitation pathways that are genuinely inclusive and respectful of communicative diversity.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

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Editoriale

Salute mentale in Italia: recap 2025 e prospettive 2026

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Il 2025 si chiude con un dato che non possiamo ignorare: il 28% della popolazione italiana soffre di disturbi mentali, con un incremento di sei punti percentuali rispetto al 2022 [1]. Siamo di fronte a quella che il Ministro della Salute Orazio Schillaci ha definito una “vera emergenza silenziosa” [2], un’onda lunga che la pandemia ha innescato ma che affonda le radici in trasformazioni sociali più profonde. Tra i giovani la situazione appare particolarmente critica: oltre 700.000 under 25 convivono con problemi di ansia e depressione [3], mentre il rapporto OCSE 2025 conferma che la prevalenza di questi disturbi tra gli under 20 è cresciuta del 20% tra il 2018 e il 2022 [4]. Il suicidio rappresenta la seconda causa di morte tra i 15 e i 29 anni nei paesi UE [5], un dato che da solo dovrebbe orientare le priorità delle politiche sanitarie.

In questo scenario si inserisce l’approvazione, il 3 dicembre 2025, del cosiddetto DDL Validara con 151 voti favorevoli e 113 contrari [6]. Il provvedimento introduce l’obbligo del consenso informato dei genitori per la partecipazione degli studenti ai corsi di educazione sesso-affettiva nelle scuole secondarie, vietando tali attività nelle scuole dell’infanzia e primarie [7]. Il dibattito che ha accompagnato l’iter legislativo ha messo in luce fratture profonde: da un lato chi rivendica il primato educativo della famiglia sancito dall’articolo 30 della Costituzione [8], dall’altro chi denuncia un “passo indietro clamoroso” che rischia di escludere dalla formazione proprio quegli studenti più vulnerabili [9]. L’Italia rimane uno dei sette paesi europei senza un programma obbligatorio di educazione sessuale nelle scuole [10], nonostante la ricerca internazionale documenti come programmi strutturati contribuiscano alla prevenzione della violenza di genere e delle infezioni sessualmente trasmissibili [11]. Il 2026 vedrà il passaggio del provvedimento al Senato, con esiti ancora incerti ma con implicazioni significative per il benessere psicologico di intere generazioni.

Sul versante delle politiche sanitarie, il Ministero della Salute ha trasmesso alla Conferenza Unificata il nuovo Piano di Azione Nazionale per la Salute Mentale 2025-2030 [12]. Il documento rappresenta un tentativo di riorganizzazione sistemica attraverso un modello assistenziale su quattro livelli a intensità crescente, con particolare attenzione all’integrazione tra servizi e all’introduzione della figura dello “psicologo di base” a livello nazionale e non più regionale [13]. Le sei aree di intervento prioritario includono promozione e prevenzione con alfabetizzazione emotiva nelle scuole, potenziamento dei servizi per l’infanzia e l’adole-

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scenza con équipes dedicate alla transizione, integrazione con l'ambito penale, gestione del rischio clinico, integrazione socio-sanitaria attraverso il Budget di Salute e innovazione digitale [14]. Il Piano dedica particolare attenzione alla salute mentale perinatale, prevedendo screening precoci e unità madre-bambino per i casi complessi [15]. In Italia, infatti, il suicidio è stato identificato come una delle principali cause di morte materna entro il primo anno dal parto, eppure metà delle donne note per alto rischio suicidario nel postpartum non erano state inviate ai servizi di salute mentale [16]. La prevalenza della depressione perinatale si attesta intorno al 12,4% durante la gravidanza e al 9,6% nel postpartum [17], rendendo urgente l'implementazione di protocolli di screening sistematici.

Il Bonus Psicologo, introdotto nel 2022 come risposta al disagio post-pandemico, racconta una storia di domanda enormemente superiore all'offerta: a fronte di oltre 360.000 domande nel 2025, solo circa 7.000 beneficiari hanno potuto accedere al contributo [18]. Lo stanziamento di 9,5 milioni di euro si è rivelato drammaticamente insufficiente [19]. Per il 2026 il finanziamento potrebbe ridursi a 8,5 milioni [20], mentre a partire dal 2028 la misura diventerà strutturale con 8 milioni annui [21]. Il divario tra bisogno e risorse rimane il nodo irrisolto che impone un ripensamento sistemico dei servizi di salute mentale nel SSN.

Guardando al 2026, emergono trend destinati a trasformare il panorama della psicoterapia. Le Digital Therapeutics (DTx) rappresentano una delle innovazioni più promettenti: interventi terapeutici basati su software che forniscono trattamenti evidence-based per disturbi specifici [22]. Uno studio pubblicato su Nature nel 2025 ha dimostrato l'efficacia di interventi DTx gamificati e personalizzati attraverso algoritmi di reinforcement learning nel ridurre sintomi di depressione e ansia [23]. La Germania è pioniera in Europa con il sistema DiGA per il rimborso delle terapie digitali [24], mentre l'Italia sta ancora definendo i propri percorsi regolatori. Le DTx offrono vantaggi significativi in termini di accessibilità, scalabilità e personalizzazione, ma permangono sfide relative alla validazione clinica e alla privacy dei dati [25]. Gli esperti prevedono che il 2026 vedrà un'accelerazione nell'adozione di strumenti AI-powered per la gestione amministrativa degli studi, la personalizzazione dei piani di trattamento e il supporto tra le sessioni [26].

L'integrazione dell'intelligenza artificiale nella pratica psicoterapeutica solleva però questioni etiche cruciali. Uno studio della Brown University presentato nell'ottobre 2025 ha identificato 15 categorie di rischio etico nei chatbot LLM utilizzati per il supporto psicologico, evidenziando violazioni sistematiche degli standard dell'American Psychological Association [27]. Le problematiche includono mancanza di adattamento contestuale, collaborazione terapeutica inadeguata, gestione inappropriata delle crisi e creazione di falsa empatia [28]. La questione dell'accountability rimane aperta: quando un chatbot commette errori, chi è responsabile? [29] Il futuro della psicoterapia sarà probabilmente ibrido, con clienti che desiderano flessibilità tra sessioni in presenza e online [30], ma la relazione terapeutica autentica rimane insostituibile.

Un altro trend destinato a ridefinire il campo è la psicoterapia assistita da psichedelici. Le ricerche del 2025 mostrano risultati promettenti: il 71% dei pazienti con PTSD trattati con terapia assistita da MDMA riporta sollievo duraturo a 12 mesi [31], mentre il 58% dei pazienti con depressione raggiunge la remissione con psilocibina [32]. La FDA ha concesso la designazione di "breakthrough therapy" alla psilocibina per la depressione maggiore resistente al trattamento e all'MDMA per il PTSD [33]. Se i trial di fase 3 di Compass Pathways avranno successo, l'approvazione FDA della psilocibina potrebbe arrivare nel 2026 [34]. Gli Stati Uniti stanno conducendo studi pionieristici sui veterani [35], mentre in Europa il quadro regolatorio rimane frammentato. Per l'Italia, dove mancano ancora framework normativi specifici, il 2026 potrebbe rappresentare l'anno del primo dibattito istituzionale su questi approcci innovativi. Significativo in questo senso è l'avvio, a gennaio 2026, del primo corso italiano di alta formazione in Terapie Assistite con Psichedelici, promosso dall'Associazione Illuminismo Psichedelico [36]. Il percorso, accreditato ECM con 50 crediti formativi, si rivolge a medici, psichiatri, psicologi e psicoterapeuti e prevede 300 ore di formazione distribuite su 18 mesi, coprendo neurobiologia e farmacologia degli psichedelici, stati espansi di coscienza, trauma e PTSD, aspetti legali ed etici e feno-

menologia dell'esperienza psichedelica. L'American Psychological Association ha inserito le terapie assistite con psichedelici tra le 10 tendenze più significative per il futuro della psicologia, sottolineando la necessità di formare professionisti competenti in questo ambito emergente [37].

Sul fronte degli adolescenti, i dati dell'OMS Europa mostrano che l'uso problematico dei social media è aumentato dal 7% nel 2018 all'11% nel 2022, con percentuali più alte tra le ragazze [38]. L'Accademia Tedesca delle Scienze Leopoldina ha descritto la situazione come parte di una "crisi globale della salute mentale" giovanile [39].

In conclusione, la prevenzione e l'identificazione precoce stanno diventando priorità strategiche: attraverso dati analitici, screening di routine e modelli predittivi, le organizzazioni stanno costruendo sistemi capaci di identificare i segnali d'allarme prima che i pazienti raggiungano il pronto soccorso [40].

CONFLICT OF INTEREST

L'autore non ha alcun conflitto di interessi da dichiarare.

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