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Repression of Aggression and Psychosomatic Functioning in Women with Breast Cancer: An Integrative Psychosomatic Approach

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Abstract
Breast cancer is a life-threatening condition that involves profound psychological adjustment processes. From an integrative psychosomatic perspective, this study explores the relationship between aggression repression, psychosomatic functioning, and mentalization capacities in women diagnosed with breast cancer. The aim was to examine how these psychological processes influence patients' experience of the disease and their psychological adjustment.
This qualitative multiple-case study involved three women aged 40, 43, and 47 years receiving psychological support in a public hospital in Bouira Province, Algeria. Data were collected through semi-structured clinical interviews and analyzed using a clinical approach based on Pierre Marty's psychosomatic framework.
The findings revealed a common pattern of inhibited aggressive affects, relational overadaptation, and marked emotional control, although the participants differed in their mentalization capacities and modes of psychosomatic functioning. Somatic manifestations appeared to be closely associated with difficulties in emotional processing and symbolization, without suggesting any causal relationship between psychological factors and the onset of breast cancer. Psychological support progressively enhanced emotional expression, strengthened mentalization capacities, and improved psychological adjustment to the disease.
These findings highlight the clinical relevance of an integrative psychosomatic approach in psycho-oncology and emphasize the importance of addressing psychological functioning as part of comprehensive supportive care for women with breast cancer.
Keywords: Breast cancer; Psychosomatics; Aggression repression; Mentalization; Psycho-oncology; Case study.

Répression de l'agressivité et fonctionnement psychosomatique chez les femmes atteintes d'un cancer du sein : Approche psychosomatique intégrative

Résumé
Le cancer du sein constitue une épreuve susceptible de mobiliser d'importants processus d'adaptation psychique. Dans une perspective psychosomatique, cette étude examine les liens entre la répression de l'agressivité, le fonctionnement psychosomatique et les capacités de mentalisation chez des

femmes atteintes d'un cancer du sein. L'objectif est d'analyser la manière dont ces processus interviennent dans l'expérience de la maladie et dans l'adaptation psychologique.
L'étude repose sur une méthodologie qualitative de type étude de cas multiples. Trois femmes (40, 43 et 47 ans), suivies dans un établissement public hospitalier de la wilaya de Bouira (Algérie), ont bénéficié d'un accompagnement psychologique. Les données ont été recueillies à l'aide d'entretiens cliniques semi-directifs et analysées selon une approche clinique inspirée de la psychosomatique de Pierre Marty.
Les résultats mettent en évidence, chez les trois participantes, une inhibition marquée de l'expression de l'agressivité, associée à une tendance à l'hyperadaptation relationnelle, à un contrôle émotionnel important et à des capacités de mentalisation variables. Les manifestations somatiques apparaissent étroitement liées aux difficultés d'élaboration des affects, sans pour autant établir un lien causal entre les facteurs psychiques et la survenue du cancer. L'accompagnement psychologique a favorisé une meilleure verbalisation des émotions, un renforcement des capacités de mentalisation et une amélioration de l'adaptation psychologique.
Cette étude souligne l'intérêt d'une approche psychosomatique intégrative dans l'accompagnement des femmes atteintes d'un cancer du sein et met en évidence l'importance de prendre en compte les dimensions psychiques dans les soins de support en oncologie.
Mots-clés : cancer du sein ; psychosomatique ; répression de l'agressivité ; mentalisation ; psycho-oncologie ; étude de cas.

1. Introduction

Breast cancer is the most frequently diagnosed malignancy among women worldwide and represents a major public health challenge due to its high incidence, the complexity of its therapeutic management, and its profound psychological consequences. Beyond its biological manifestations, the disease confronts patients with substantial emotional, identity-related, and interpersonal disruptions, requiring the mobilization of complex psychological adjustment processes. In Algeria, where breast cancer remains the leading malignancy among women in terms of incidence, these challenges are further compounded by barriers to early detection, disparities in access to specialized oncology services, and the limited availability of structured psychological support. Within this context, the present study was conducted among women receiving treatment at a public hospital in the Wilaya of Bouira, with the aim of exploring the psychological processes underlying their adaptation to breast cancer.

Research problem:

Contemporary psycho-oncology research has consistently demonstrated that adjustment to cancer is shaped by multiple psychological factors, including emotional regulation, coping strategies, perceived social support, and capacities for symbolic elaboration. From the psychosomatic perspective developed by Pierre Marty, insufficient mentalization may compromise the psychic processing of affects, thereby weakening psychosomatic functioning and limiting adaptive responses to emotional distress. Despite the growing body of evidence concerning psychological adjustment in oncology, the interplay between aggression repression, mentalization capacities, and psychosomatic functioning remains insufficiently investigated, particularly within the Algerian socio-cultural context. Accordingly, the present study addresses the following research question:

How do aggression repression and mentalization capacities influence psychosomatic functioning and psychological adjustment among women diagnosed with breast cancer and receiving care at a public hospital in the Wilaya of Bouira, Algeria?

2. Theoretical framework

The present study is grounded in an integrative theoretical framework that brings together Pierre Marty's psychosomatic model, mentalization theory, and contemporary developments in psycho-oncology. Within Marty's psychosomatic perspective, mentalization constitutes a fundamental psychological function through which emotional experiences are transformed into symbolic representations and integrated into psychic life. When this capacity is impaired, affects are less likely to undergo adequate psychological elaboration, increasing the likelihood that emotional tension will be expressed through somatic channels.

Mentalization theory, as developed by Peter Fonagy and colleagues, extends this perspective by emphasizing the capacity to understand one's own and others' mental states as a central mechanism underlying affect regulation, interpersonal functioning, and adaptation to stressful life events. Effective mentalization promotes psychological flexibility and resilience, whereas deficits in this capacity are associated with impaired emotional regulation and heightened psychological vulnerability.

Within the field of psycho-oncology, contemporary research has consistently highlighted that patients' quality of life and psychological adjustment depend largely on the psychological resources mobilized in response to the illness, including emotional processing, adaptive coping strategies, and social support. Importantly, these approaches do not posit a causal relationship between psychological factors and the development of cancer itself; rather, they emphasize their significant role in shaping patients' psychological adaptation, subjective well-being, and capacity to cope with the challenges imposed by the disease and its treatment.

Against this theoretical background, aggression repression is conceptualized as a clinically meaningful indicator of underlying psychic functioning. Rather than being viewed as an etiological factor in breast cancer, it is understood as a defensive process that may influence affective regulation, psychosomatic functioning, and the individual's capacity to achieve adaptive psychological adjustment throughout the cancer trajectory.

3. Methodology

3.1. *Study design*

The present study employed a qualitative clinical research design based on a multiple-case study approach. This methodology was selected to facilitate an in-depth exploration of aggression repression, mentalization capacities, and their integration within the psychosomatic functioning of women diagnosed with breast cancer. The study was conducted with patients receiving oncological care at a public hospital in the Wilaya of Bouira, Algeria, as part of their routine clinical management.

3.2. Participants

Three women diagnosed with breast cancer were recruited through purposive sampling to represent distinct stages of the oncological trajectory: the period immediately following diagnosis, the remission phase after treatment, and disease recurrence. Rather than seeking statistical representativeness, this sampling strategy was intended to capture variations in psychosomatic

functioning across different phases of the illness, thereby providing a richer understanding of the psychological processes involved in adaptation to breast cancer.

3.3. Data collection and analysis

Data were collected through individual semi-structured clinical interviews conducted within an appropriate therapeutic setting that ensured psychological safety and confidentiality. The interviews explored participants' subjective experiences of the illness, emotional functioning, interpersonal relationships, and coping processes.

The data were analyzed using a qualitative clinical approach informed by Pierre Marty's psychosomatic framework. Particular attention was devoted to the participants' capacities for mentalization, patterns of aggression repression, defensive functioning, affective processing, and the psychosomatic manifestations emerging throughout the clinical narratives. The analysis sought to identify the dynamic organization of psychic functioning rather than to establish causal relationships, thereby preserving the interpretative and idiographic nature of clinical inquiry.

3.4. Ethical considerations

All participants received comprehensive information regarding the objectives, procedures, and voluntary nature of the study before providing written informed consent. To ensure confidentiality and protect participants' privacy, pseudonyms were assigned and all potentially identifying information was removed from the research corpus. The study was conducted in accordance with the ethical principles governing clinical psychological research, including respect for participants' autonomy, confidentiality, beneficence, and professional integrity.

Table 1. Descriptive characteristics of the participants

Variable	Mrs. A	Mrs. B	Mrs. C
Age	40 years	43 years	47 years
Marital and familystatus	Married, mother of two children	Married, mother of one child	Married, mother of three children
Employmentstatus	Unemployed	Unemployed	Unemployed
Medicaldiagnosis	Breast cancer	Breast cancer	Breast cancer
Stage of the oncological trajectory	Recentlydiagnosed	Remissionfollowingtreatment	Diseaserecurrence
Psychological care	Individualclinical follow-up	Individualclinical follow-up	Individualclinical follow-up

3.2. Clinical procedure

Data were collected within the framework of individual psychological support provided to women diagnosed with breast cancer at a public hospital in the Wilaya of Bouira, Algeria. Semi-structured clinical interviews were conducted in a confidential therapeutic setting that respected each participant's psychological pace and emotional readiness. The interviews explored participants' lived experience of the illness, bodily changes associated with the disease and its treatment, family relationships, coping strategies, and patterns of emotional expression, with particular attention to anger, frustration, perceived injustice, and aggressive feelings.

Beyond the verbal narratives, clinical observation encompassed nonverbal behavior, periods of silence, emotional reactions, and bodily expressions, in accordance with Pierre Marty's psychosomatic framework. These observations provided valuable insights into participants' mentalization capacities, emotional regulation processes, and the evolution of their psychosomatic functioning throughout the course of psychological follow-up.

3.3. Data generation

The empirical material consisted of clinical interview transcripts, observations recorded during psychological follow-up sessions, and clinical notes documented after each encounter. Together, these complementary sources provided a comprehensive account of the participants' medical trajectories, psychological experiences, interpersonal relationships, changes in body image, and psychosomatic manifestations observed throughout the clinical process.

From a clinical perspective, these data are understood as the co-constructed product of the therapeutic encounter between participant and clinician. Their scientific value lies in the integration of verbal discourse, emotional expression, and systematic clinical observation, thereby allowing an in-depth understanding of the psychological processes mobilized in response to breast cancer.

3.4. Data analysis strategy

The data were analyzed using an interpretative clinical approach grounded in Pierre Marty's psychosomatic theory. Each clinical case was initially examined independently in order to elucidate the dynamics of individual psychosomatic functioning. Subsequently, a cross-case analysis was conducted to identify both shared patterns and distinctive characteristics across the three clinical situations.

The analytical process focused on several interrelated dimensions, including patterns of aggression repression, capacities for mentalization and symbolization, characteristics of operative thinking (*pensée opératoire*), psychosomatic manifestations, and the processes of psychological disorganization and reorganization observed throughout clinical follow-up. Interpretations emerged through a continuous dialogue between the empirical clinical material and the theoretical framework, without assuming any causal relationship between psychological factors and the onset or progression of breast cancer.

4. Presentation of the clinical cases

The three clinical cases presented below illustrate distinct patterns of psychological adaptation to breast cancer, corresponding to three major stages of the oncological trajectory: the initial diagnosis, remission following treatment, and disease recurrence. The objective is not to establish statistical comparisons among participants but rather to examine, from a clinical and interpretative perspective, the processes of mentalization, the mechanisms of aggression repression, and the psychosomatic manifestations characterizing each individual trajectory.

Each case is first analyzed independently to capture its unique psychodynamic organization before being integrated into a comparative cross-case analysis aimed at identifying both convergent and distinctive patterns of psychosomatic functioning across the three clinical situations.

4.1. Case A

4.1.1. Clinical presentation

Mrs. A, a 40-year-old married woman and mother of two children, unemployed at the time of the study, was referred for psychological support shortly after receiving a diagnosis of breast cancer at a public hospital in the Wilaya of Bouira, Algeria.

During the initial clinical interviews, her discourse was coherent and organized but predominantly focused on the disease itself and its medical treatment. Emotional experiences were only minimally expressed, and psychological distress remained insufficiently elaborated. She reported persistent fatigue, diffuse musculoskeletal pain, sleep disturbances, and chronic bodily tension, all of which intensified during periods of heightened emotional stress.

Deeply invested in her maternal and familial responsibilities, Mrs. A consistently minimized her own suffering in an effort to protect her family members from additional emotional burden. She tended to avoid interpersonal conflict and experienced considerable difficulty expressing anger or frustration. These initial observations revealed restricted emotional expression, a pronounced tendency toward relational overadaptation, and a predominance of bodily manifestations in the regulation of psychological distress.

4.1.2. Personal history and illness context

Mrs. A described a life history characterized by a longstanding commitment to family responsibilities, consistently prioritizing the needs of others over her own. She portrayed herself as a patient, accommodating individual who habitually avoided conflict and suppressed emotional expression in order to preserve family harmony. This relational style, largely shaped by sociocultural expectations associated with traditional female caregiving roles (Helgeson & Tomich, 2005), appears to have fostered enduring emotional inhibition and limited self-assertiveness.

The diagnosis of breast cancer represented a profound psychological rupture, generating intense fear, feelings of injustice, and persistent concern regarding the future of her children. Despite this emotional upheaval, her narrative remained primarily centered on medical examinations, treatment protocols, and practical aspects of care, while emotional experiences proved difficult to verbalize. This predominance of factual and concrete discourse is consistent with the concept of *operative thinking* (*pensée opératoire*) described by Marty (1990) and with alexithymic characteristics reported in the literature (Taylor et al., 1997).

The bodily changes associated with the disease and its treatment also undermined her feminine identity, contributing to heightened vulnerability and disturbances in body image (Fobair et al., 2006; Paterson et al., 2016). At the somatic level, persistent fatigue, diffuse pain, sleep disturbances, and muscular tension fluctuated according to periods of emotional stress, illustrating the complex interaction between psychological functioning and bodily experience (Andersen et al., 2014; Holland & Weiss, 2015).

4.1.3. Analysis of psychosomatic functioning

The clinical analysis revealed limited emotional elaboration, reflected in marked difficulty identifying and verbalizing anger, frustration, and feelings of injustice. These affects remained insufficiently symbolized and were frequently displaced by descriptive accounts centered on the practical constraints of illness and treatment, a pattern characteristic of the *operative thinking* described by Marty (1990).

The repression of aggressive affects emerged as a central organizing principle of Mrs. A's psychological functioning. In her effort to preserve family relationships and maintain interpersonal harmony, emotional control became the dominant mode of regulation, while unresolved psychological tension was expressed predominantly through bodily symptoms. Within the present psychosomatic framework, this pattern should not be interpreted as suggesting a psychogenic origin of breast cancer, but rather as reflecting limitations in mentalization and affective processing.

Over the course of psychological follow-up, therapeutic support facilitated a gradual recognition and verbalization of previously inhibited emotional experiences and internal conflicts. This psychological evolution was accompanied by a subjective reduction in emotional tension and an improvement in functional somatic complaints, consistent with evidence supporting the benefits of psychosocial interventions in psycho-oncology (Carlson &Bultz, 2003; Faller et al., 2013).

4.1.4. Clinical course during follow-up

Longitudinal clinical follow-up demonstrated a gradual transformation in Mrs. A's psychological functioning. Whereas her initial discourse was almost exclusively focused on the medical aspects of the disease, it progressively became more reflective, enabling her to establish meaningful connections between her personal history, habitual relational patterns, and the emotional experiences elicited by breast cancer. Her growing ability to recognize and articulate anger, frustration, and feelings of injustice reflects a progressive strengthening of mentalization capacities (Fonagy et al., 2002).

Concurrently, Mrs. A developed greater awareness of her longstanding tendency to prioritize the needs of others at the expense of her own, gradually acquiring a more adaptive capacity for self-assertion. At the somatic level, she reported improved sleep quality, reduced diffuse pain, and a more manageable level of fatigue. These clinical changes should be interpreted within the broader context of comprehensive oncological treatment and ongoing psychological support rather than as evidence of a direct causal effect of psychotherapy on disease progression or medical outcomes (Holland & Weiss, 2015; Faller et al., 2013).

Overall, the clinical follow-up revealed enhanced emotional regulation, strengthened mentalization capacities, and a reduction in psychosomatic manifestations, underscoring the value of integrating psychological care into the multidisciplinary management of women living with breast cancer.

4.1.5. Interpretative synthesis from Marty’s psychosomatic perspective

Mrs. A's clinical presentation reveals a psychosomatic organization in which the repression of aggressive affects functions as a predominant mode of psychological regulation. Her life history, relational patterns, and the changes observed throughout follow-up suggest an adaptive style centered on preserving family relationships, often at the expense of her own emotional needs. This defensive organization appears to have progressively constrained the elaboration of emotional conflicts, particularly when their expression threatened interpersonal equilibrium.

From Pierre Marty's psychosomatic perspective (1990), such a configuration extends beyond the mere repression of discrete affects. Rather, it reflects a temporary reduction in the psyche's capacity to process and symbolize emotional excitation. When representational activity becomes compromised, internal tensions are less likely to undergo symbolic elaboration and are more readily expressed through bodily experience. Accordingly, the psychosomatic manifestations observed in Mrs. A should not be interpreted as direct consequences of intrapsychic conflict, but as expressions of a

psychosomatic regulatory system operating under transient limitations in mentalization and symbolic processing.

This interpretation is further supported by the characteristics of her initial clinical discourse, which was dominated by factual descriptions, limited affective differentiation, and a primary focus on the practical demands of illness. Marty (1990) associated this pattern with *operative thinking* (*pensée opératoire*), while emphasizing that it should not necessarily be regarded as a stable psychological organization. The clinical course supports this view: the establishment of a secure therapeutic environment progressively promoted richer associative processes, improved recognition of emotional states, and a more coherent integration of psychological, relational, and bodily experience. From the perspective of Fonagy et al. (2002), such changes reflect the strengthening of mentalization capacities, enabling patients to attribute greater psychological meaning to their lived experience.

Overall, the clinical findings indicate that the chronic repression of aggressive affects formed part of a broader adaptive pattern characterized by emotional overcontrol, persistent self-sacrifice, and the prioritization of others' needs. Psychological support contributed to a gradual flexibilization of these defensive processes, facilitating greater affective integration and a concomitant reduction in psychological tension. This interpretation is consistent with evidence demonstrating that psychological interventions enhance emotional adjustment and quality of life in individuals living with cancer by fostering more effective emotional processing (Faller et al., 2013).

This case therefore illustrates the heuristic value of Pierre Marty's psychosomatic model for understanding the dynamic relationships among affect regulation, mentalization, and psychosomatic manifestations in women with breast cancer. Conducted within a public hospital in the Wilaya of Bouira, Algeria, it also highlights the clinical relevance of integrating psychosomatic assessment into psycho-oncological care in order to identify early difficulties in emotional elaboration and support processes of psychological reorganization. As with all qualitative clinical research, these interpretations remain explanatory rather than causal and should not be construed as evidence that psychological functioning contributes to the onset of breast cancer. Instead, they underscore the potential contribution of psychological care to strengthening patients' adaptive capacities, in line with contemporary psycho-oncological recommendations (Holland & Weiss, 2015).

4.2. Case B

4.2.1. Clinical presentation

Mrs. B, a 43-year-old married woman and mother of one child, unemployed at the time of the study, received psychological follow-up at a public hospital in the Wilaya of Bouira, Algeria, during the remission phase following treatment for breast cancer. Despite a favorable medical outcome, she described remission as a period characterized by uncertainty, persistent fear of recurrence, and difficulties in re-establishing a satisfactory life balance—experiences that are widely documented in the psycho-oncology literature (Ganz, 2009; Stanton et al., 2015).

From the initial interviews, Mrs. B presented as emotionally reserved and strongly inclined to maintain control over her emotional reactions. Her discourse was primarily focused on her therapeutic journey, leaving little room for the expression of subjective emotional experience. She reported persistent fatigue, recurrent headaches, and gastrointestinal complaints, all of which intensified during periods of emotional stress. Deeply committed to protecting her husband and child from

additional distress, she consistently minimized her own suffering and relied heavily on emotional inhibition, suggesting a pronounced repression of affective experience.

4.2.2. Personal history and illness context

Mrs. B described a personal history characterized by a strong sense of responsibility and a longstanding tendency to prioritize the needs of family members over her own. Accustomed to regulating her emotions through restraint and conflict avoidance, she perceived the expression of anger as potentially disruptive to family cohesion (Helgeson & Tomich, 2005).

Although the demands of medical treatment initially occupied the forefront of her experience, it was during remission that enduring psychological distress became most apparent. Her clinical narrative was dominated by fear of cancer recurrence, a pervasive sense of vulnerability, and the challenge of reconstructing her identity following the illness (Ganz, 2009; Stanton et al., 2015). Furthermore, treatment-related bodily changes adversely affected her body image, contributing to diminished confidence in her physical self and complicating the process of psychological recovery (Fobair et al., 2006; Paterson et al., 2016).

4.2.3. Analysis of psychosomatic functioning

Mrs. B's psychological vulnerabilities became particularly evident following the completion of medical treatment. Her psychosomatic functioning remained characterized by marked emotional overcontrol and persistent repression of aggressive affects. Emotional experiences were seldom expressed directly and were instead replaced by factual accounts focused on follow-up examinations, surveillance procedures, and family responsibilities, a discourse consistent with the pattern of *operative thinking* (*pensée opératoire*) described by Marty (1990).

This psychological organization was accompanied by chronic fatigue, recurrent headaches, and fluctuating gastrointestinal symptoms, whose intensity varied according to emotional stress. Within the present psychosomatic framework, these manifestations are understood not as evidence of a psychogenic origin but as reflecting limitations in emotional elaboration and symbolic processing. Throughout psychological follow-up, progressive improvements in emotional verbalization and mentalization capacities (Fonagy et al., 2002) were associated with a reduction in the subjective emotional burden accompanying these somatic complaints.

4.2.4. Clinical course during follow-up

Psychological follow-up progressively facilitated a deeper recognition and elaboration of the emotional experiences associated with breast cancer. Whereas Mrs. B initially concentrated almost exclusively on the medical aspects of her illness, she gradually became able to articulate her fear of recurrence, her enduring sense of vulnerability, and the challenges involved in reclaiming a positive relationship with her body. This clinical evolution reflects enhanced mentalization capacities and the development of more flexible emotional regulation processes (Fonagy et al., 2002).

At the same time, she became increasingly aware of her habitual tendency to protect those around her at the expense of her own emotional needs, leading to more authentic and reciprocal family interactions. At the somatic level, she reported fewer headaches and gastrointestinal symptoms, improved sleep quality, and a greater capacity to understand and tolerate persistent fatigue. These changes are indicative of improved psychological adjustment rather than alterations in medical prognosis (Faller et al., 2013; Stanton et al., 2015).

Overall, the follow-up process demonstrated a progressive integration of the illness experience, characterized by more authentic emotional expression, reduced affective overcontrol, and the gradual reconstruction of personal identity in the aftermath of breast cancer.

4.2.5. Interpretative synthesis from Marty's psychosomatic perspective

The clinical analysis of Mrs. B highlights a psychosomatic organization in which affective control serves as the principal mode of adaptation to the experience of breast cancer. Unlike Mrs. A, whose psychological distress emerged immediately following diagnosis, Mrs. B's emotional difficulties became more apparent during the remission phase. As noted by Ganz (2009), remission introduces specific psychological challenges related to recovery and reconstruction, while Stanton et al. (2015) emphasize that patients' concerns progressively shift toward fear of recurrence, altered body image, and the redefinition of personal identity. In Mrs. B's case, the reduction of treatment-related demands appeared to create psychological space for emotional experiences that had previously remained largely inaccessible.

This clinical trajectory illustrates the dynamic nature of psychosomatic functioning described by Marty (1990). The psychological resources mobilized to cope with intensive medical treatment supported adaptive functioning during the active phase of illness but simultaneously postponed the elaboration of certain affects. As medical pressure diminished, these emotional experiences gradually became available for psychic processing, provided that a sufficiently containing therapeutic environment facilitated their symbolic integration. The observed evolution therefore suggests not a stable pattern of *operative thinking* (*pensée opératoire*), but rather a temporary restriction in representational functioning that progressively gave way to renewed reflective capacity. From the perspective of Fonagy et al. (2002), this development reflects the strengthening of mentalization capacities and an enhanced ability to understand and integrate internal emotional states.

Nevertheless, the repression of aggressive affects remained a central organizing feature of Mrs. B's psychological functioning. Her commitment to maintaining an image of herself as resilient, emotionally available, and protective toward her family encouraged persistent emotional overcontrol, sustaining a level of psychological tension that may have found expression through functional somatic complaints. Within this psychosomatic framework, these symptoms are understood not as direct consequences of intrapsychic conflict but as indicators of the distinctive ways in which psychosomatic regulation attempts to preserve psychological equilibrium.

Overall, this case illustrates that remission represents not merely a period of medical recovery but also a critical phase of subjective reconstruction requiring the mobilization of new adaptive processes. It underscores the value of incorporating a psychosomatic perspective into psycho-oncological follow-up to facilitate emotional elaboration, promote the reintegration of bodily experience, and support identity reconstruction after cancer treatment. As with the preceding cases, these interpretations are grounded in qualitative clinical inquiry and should not be construed as evidence of a causal relationship between psychological functioning and the development of breast cancer. Rather, they aim to deepen understanding of the individualized psychological processes through which patients experience, interpret, and transform the illness trajectory.

4.3. Case C

4.3.1. Clinical presentation

Mrs. C, a 47-year-old married woman and mother of three children, unemployed at the time of the study, received psychological support at a public hospital in the Wilaya of Bouira, Algeria, following a recurrence of breast cancer. This recurrence represented a profound psychological disruption, reactivating fears related to the illness, dependency, and the future of her family, as consistently reported in the psycho-oncology literature (Holland & Weiss, 2015; Stanton et al., 2015).

During the initial clinical interviews, Mrs. C appeared deeply distressed while making considerable efforts to maintain emotional composure. Her narrative alternated between detailed accounts of medical events and prolonged periods of silence, reflecting difficulties in elaborating certain emotional experiences. She reported severe fatigue, thoracic and back pain, sleep disturbances, and persistent bodily tension. Strongly committed to her family role, she continued to shield her loved ones from her emotional suffering by suppressing her own fears and affective experiences.

4.3.2. Personal history and illness context

Mrs. C described a life history characterized by a strong sense of responsibility and a longstanding tendency to place the needs of her family above her own. Accustomed to avoiding interpersonal conflict and regulating her emotions through inhibition, she perceived the expression of anger as a potential threat to family stability and cohesion (Helgeson & Tomich, 2005).

Following an initial period of remission, the recurrence of breast cancer was experienced as a profound rupture that disrupted the psychological equilibrium she had gradually re-established. It reactivated fears concerning the future, intensified feelings of vulnerability, and amplified the challenges associated with treatment-related bodily changes (Holland & Weiss, 2015; Paterson et al., 2016). Mrs. C also described profound psychological exhaustion, compounded by her persistent determination to continue supporting her family despite her own physical and emotional limitations.

4.3.3. Analysis of psychosomatic functioning

The clinical analysis revealed a psychosomatic organization characterized by pronounced repression of aggressive affects and pervasive emotional overcontrol. Although Mrs. C was able to provide detailed accounts of her medical history, she experienced considerable difficulty verbalizing feelings of anger, discouragement, and injustice associated with cancer recurrence. The predominance of factual discourse over emotional elaboration is consistent with the pattern of *operative thinking* (*pensée opératoire*) described by Marty (1990).

Periods of emotional distress were accompanied by thoracic and back pain, sleep disturbances, and persistent exhaustion, with symptom intensity fluctuating according to her psychological state. Within Pierre Marty's psychosomatic framework, these manifestations are understood as reflecting an increased burden on psychosomatic regulation rather than a psychogenic origin of the disease itself. Throughout the therapeutic process, Mrs. C progressively developed a greater capacity to connect her emotional experiences with her personal history and bodily symptoms, indicating a gradual strengthening of mentalization capacities (Fonagy et al., 2002).

4.3.4. Clinical course during follow-up

Psychological follow-up progressively facilitated a more open expression of the fear, anger, and feelings of injustice associated with cancer recurrence. Mrs. C increasingly accepted the possibility of sharing her concerns with her husband and children, gradually relinquishing the need to maintain

an image of unwavering strength. This evolution was accompanied by greater acceptance of her personal limitations and by increased flexibility in her interpersonal functioning (Helgeson & Tomich, 2005).

At the same time, she progressively established meaningful connections between her personal history, the emotions reactivated by the recurrence of cancer, and her bodily experiences. This psychological integration was associated with reduced muscular tension, improved sleep quality, and a less overwhelming experience of pain, although these changes cannot be attributed exclusively to psychological intervention and must be understood within the broader context of comprehensive oncological care (Holland & Weiss, 2015).

Overall, the clinical follow-up demonstrated strengthened mentalization capacities, more adaptive emotional regulation, and greater psychological flexibility in coping with cancer recurrence, further illustrating the value of integrating psychological support into multidisciplinary breast cancer care.

4.3.5. Interpretativesynthesisfrom pierre Marty'spsychosomatic perspective

Mrs. C's case illustrates how cancer recurrence can profoundly disrupt psychosomatic equilibrium without necessarily leading to enduring psychological disorganization. From Pierre Marty's psychosomatic perspective (1990), renewed confrontation with a life-threatening illness places considerable demands on the individual's capacity for psychic elaboration, highlighting the inherently dynamic nature of psychosomatic functioning, whose regulatory processes fluctuate according to both internal and external sources of stress. In Mrs. C's case, recurrence temporarily compromised representational capacities while preserving sufficient psychological resources to support a gradual process of reorganization.

The repression of aggressive affects remained a central organizing feature of this adaptive process. Feelings of anger, discouragement, and injustice were consistently inhibited in order to preserve an image of strength and emotional protection toward family members. Although this defensive strategy initially facilitated adaptation, it also sustained a level of psychological tension that was expressed, in part, through the bodily manifestations observed during clinical follow-up. As emphasized by Fonagy et al. (2002), mentalization should be understood not as a fixed personality characteristic but as a dynamic psychological capacity that may be weakened or strengthened according to relational and emotional circumstances. Mrs. C's clinical evolution reflects this developmental plasticity rather than a structural deficit in symbolic functioning.

Throughout psychological follow-up, she gradually achieved greater integration of her emotional experiences, increased flexibility in affect regulation, and a more coherent articulation between the psychological and bodily dimensions of her illness experience. From Marty's perspective, this evolution reflects not the disappearance of psychological vulnerability but a more effective mobilization of the regulatory resources available to the individual. These observations are consistent with findings reported by Faller et al. (2013), demonstrating that psycho-oncological interventions can enhance emotional adjustment and improve quality of life among individuals living with cancer.

Overall, this third clinical case underscores that cancer recurrence represents a period of particular psychological vulnerability requiring sustained therapeutic support to facilitate emotional elaboration throughout the continuum of oncological care. The observations conducted within a public hospital in the Wilaya of Bouira, Algeria, further demonstrate the clinical relevance of integrating a psychosomatic perspective into psycho-oncology in order to better understand patients' adaptive

processes. At the same time, these findings should not be interpreted as implying any causal relationship between psychological functioning and either the onset or recurrence of breast cancer. Rather, consistent with the perspective advanced by Holland and Weiss (2015), the primary objective of psychological care is to support patients' ongoing psychological reorganization in response to illness, rather than to explain the disease itself through psychological determinants.

5. Cross-case analysis: Convergences, divergences, and contributions of pierremarty's psychosomatic framework

5.1. Repression of aggressive affects as a common organizing principle of psychosomatic functioning

The comparative analysis of the three clinical cases reveals a striking convergence despite differences in personal histories and stages of the oncological trajectory: the repression of aggressive affects emerged as the principal organizing feature of the psychosomatic functioning observed across participants. This finding should not be interpreted as supporting the obsolete notion of a "cancer-prone personality," a hypothesis that has been largely abandoned in contemporary psycho-oncology. Rather, consistent with the work of Helgeson and Tomich (2005) and Stanton et al. (2015), it suggests that some women rely persistently on emotional inhibition as an adaptive strategy to preserve interpersonal relationships and maintain family roles while coping with breast cancer.

Across all three cases, aggressive affects were neither openly expressed nor externalized through interpersonal conflict. Instead, they remained inhibited, only partially recognized, and rarely verbalized. Each participant described a profound commitment to her roles as wife and mother, accompanied by a persistent concern for safeguarding family stability. This relational orientation encouraged the de-prioritization of personal emotional needs and the suppression of anger, disagreement, and frustration, experiences perceived as incompatible with the values of caregiving, patience, and emotional protection with which they strongly identified.

Within Pierre Marty's psychosomatic model (1990), it is not aggression itself that is considered pathogenic, but rather the diminished capacity to integrate aggressive affects into ongoing processes of psychic elaboration. When emotional experiences cannot be adequately recognized, represented, or symbolized, psychosomatic regulatory mechanisms become increasingly mobilized. This perspective converges with mentalization theory, according to which reduced mentalization capacities constrain the integration of emotional experience without implying any causal relationship between psychological functioning and the development of somatic disease (Fonagy et al., 2002).

Although the repression of aggressive affects constituted a common clinical feature, its expression varied according to the stage of the illness trajectory. In Mrs. A, emotional inhibition predominated during the diagnostic phase, when protecting her family took precedence over expressing personal distress. In Mrs. B, it became more apparent after the completion of medical treatment, as previously deferred emotional conflicts gradually emerged during remission. In Mrs. C, cancer recurrence intensified emotional overcontrol as a means of protecting family members while confronting a renewed existential threat. These differences illustrate that emotional inhibition represents a dynamic adaptive process, continuously shaped by the psychological demands associated with successive stages of the disease.

The clinical interviews also underscored the influence of relational and sociocultural norms on these adaptive patterns. All three participants emphasized self-sacrifice, emotional restraint, and the

protection of loved ones, while frequently perceiving the expression of anger as a potential threat to family cohesion. Gross (2015) and Aldao et al. (2010) have similarly demonstrated that although emotional suppression may be adaptive in the short term, its chronic use is associated with increased psychological burden and reduced flexibility in affect regulation.

Within the Algerian context, these findings acquire additional clinical significance. Without implying broader generalization, the observations conducted at the public hospital in the Wilaya of Bouira suggest that culturally embedded expectations regarding women's familial roles may reinforce emotional self-silencing and encourage patterns of relational overadaptation. These sociocultural influences should not be viewed as explanatory factors in the etiology of breast cancer; rather, they provide an important framework for understanding how participants regulated their emotional experiences throughout the course of illness.

Finally, the longitudinal follow-up across all three cases demonstrated that a secure therapeutic environment progressively facilitated the recognition and verbalization of previously inhibited affects. Feelings of anger, frustration, and injustice gradually became more accessible to reflection and interpersonal communication, while participants reported greater psychological flexibility and a subjective reduction in certain psychosomatic complaints. These observations are consistent with evidence demonstrating that psycho-oncological interventions enhance emotional adjustment and quality of life, although they have not been shown to influence the biological course of cancer (Faller et al., 2013).

Taken together, the convergences identified across the three clinical cases underscore the heuristic value of Pierre Marty's psychosomatic framework for understanding the emotional regulatory processes mobilized throughout the cancer trajectory. Within this perspective, the chronic repression of aggressive affects is best understood as a clinical indicator of reduced capacity for psychic elaboration rather than as a causal determinant of breast cancer. These findings further emphasize the importance of integrating psychological interventions aimed at strengthening mentalization and symbolic functioning within comprehensive psycho-oncological care.

5.2. Heterogeneity of mentalization capacities and modes of symbolization

While the repression of aggressive affects emerged as the principal point of convergence across the three clinical cases, their comparison also revealed substantial heterogeneity in mentalization capacities and modes of symbolization. This finding is consistent with one of the central principles of Pierre Marty's psychosomatic theory (1990), namely that psychosomatic manifestations can only be understood in relation to each individual's unique psychological organization. Thus, although confronted with the same disease, the participants mobilized different psychological resources to process and elaborate their emotional experiences. The observations conducted within the oncology department of a public hospital in the Wilaya of Bouira, Algeria, illustrate the diversity of psychological trajectories that may unfold within a common clinical context.

From Marty's perspective, mentalization refers to the capacity to transform emotional tensions into representations that can be thought about, symbolized, and integrated into psychic functioning. When this representational capacity is temporarily compromised, internal conflicts become more difficult to elaborate, and psychosomatic modes of regulation may assume greater prominence in the adaptive process (Marty, 1990, 1998). Mentalization theory converges with this conception by viewing

mentalization as a dynamic psychological capacity that is continuously shaped by developmental history, interpersonal relationships, and exposure to stressful life events (Fonagy et al., 2002).

The three cases illustrate distinct patterns of psychological functioning. In Mrs. A, representational capacities initially appeared restricted, as reflected in a discourse largely confined to the concrete realities of illness and treatment. Psychological follow-up progressively facilitated stronger links between emotional experience, personal history, and bodily manifestations. In Mrs. B, reflective capacities remained largely intact but were temporarily constrained by the adaptive demands of cancer treatment and sustained emotional overcontrol. As these demands diminished during remission, she became increasingly able to elaborate her subjective experience, consistent with the developmental perspective described by Bateman and Fonagy (2016). In Mrs. C, cancer recurrence generated a level of emotional overload that transiently weakened symbolic functioning without producing enduring impairment. Clinical intervention progressively supported the restoration of representational activity and the integration of emotional experiences reactivated by recurrence.

These differences demonstrate that similar psychosomatic manifestations may arise from markedly different patterns of psychological organization. Consequently, symptom severity alone provides limited insight into psychosomatic functioning, which can only be understood through an individualized analysis of mentalization capacities and the processes through which emotional experiences are symbolically elaborated.

The cross-case analysis also highlights the pivotal role of the therapeutic setting in facilitating the development of these psychological capacities. Across all three participants, a secure and emotionally containing clinical environment progressively promoted emotional verbalization, enriched associative processes, and fostered deeper integration of affective experience. Bateman and Fonagy (2016), together with Luyten et al. (2020), have likewise emphasized that reflective functioning develops within sufficiently containing relational contexts, underscoring the essential role of psychological care throughout the oncological trajectory.

The present findings further demonstrate the conceptual complementarity between Pierre Marty's psychosomatic model and contemporary mentalization theory. Although these perspectives originate from distinct theoretical traditions, both assign a central role to the individual's capacity to represent, symbolize, and elaborate internal emotional states in the regulation of psychological functioning. Whereas Marty (1990) primarily emphasizes the importance of these processes for psychosomatic equilibrium, Fonagy et al. (2002) focus on their contribution to psychological flexibility, resilience, and interpersonal functioning. Their integration provides a particularly informative clinical framework for understanding the adaptive processes observed in the present study.

Finally, the findings indicate that mentalization capacities do not constitute an absolute safeguard against psychological suffering. Despite the significant progress observed during follow-up, all three participants continued to experience periods of emotional vulnerability. Accordingly, the primary therapeutic objective is not the elimination of distress but the promotion of greater psychological flexibility, enabling emotional experiences to be recognized, symbolized, and integrated more effectively. The diversity of the trajectories documented in this study reinforces the individualized perspective that characterizes Marty's psychosomatic approach and highlights its particular relevance for understanding and supporting women living with breast cancer within the Algerian clinical context.

5.3. Somatic manifestations as expressions of a psychosomatic economy under strain

The cross-case analysis indicates that the somatic manifestations reported by the participants cannot be attributed solely to the biological consequences of breast cancer or its treatment. Although these medical factors remain the primary determinants of physical symptoms, the clinical observations conducted within the oncology department of a public hospital in the Wilaya of Bouira, Algeria, suggest that the intensity, persistence, and fluctuation of these symptoms are also embedded within each patient's distinctive mode of psychosomatic regulation. This interpretation is consistent with the biopsychosocial model, which conceptualizes the experience of illness as the product of continuous interactions among biological, psychological, interpersonal, and environmental factors.

Across all three participants, persistent fatigue, sleep disturbances, diffuse pain, muscular tension, headaches, and gastrointestinal complaints tended to intensify during periods of heightened emotional demand, including the initial diagnosis, active treatment, surveillance examinations, remission, and cancer recurrence. The clinical interviews further revealed that these manifestations evolved alongside the participants' capacity for psychological elaboration. As previously inhibited emotions gradually became accessible to reflection and verbal expression, several functional symptoms were experienced as less intrusive and more manageable. These observations do not establish a causal relationship between psychological processes and somatic manifestations; rather, they highlight their reciprocal interaction within the subjective experience of living with breast cancer.

This interpretation is closely aligned with Pierre Marty's psychosomatic theory (1990), according to which somatic manifestations should not be understood as direct symbolic expressions of unconscious conflict. Instead, they reflect a psychosomatic economy temporarily challenged by limitations in the processing and regulation of internal emotional excitation. When mentalization and symbolization capacities become overwhelmed, the body participates in adaptive regulatory processes without functioning as a symbolic language of psychic conflict. Functional somatic symptoms may therefore be understood as clinical indicators of the degree of strain placed upon the psychosomatic organization.

The three clinical cases illustrate this dynamic across different phases of the oncological trajectory. In Mrs. A, symptom exacerbation coincided with the diagnostic period, a phase characterized by profound disruption and intense emotional mobilization. In Mrs. B, physical complaints persisted during remission despite favorable medical outcomes, reflecting the enduring psychological burden of fear of recurrence and identity reconstruction. In Mrs. C, cancer recurrence produced substantial emotional overload accompanied by increased pain, sleep disturbances, and profound exhaustion, followed by gradual improvement as therapeutic work facilitated emotional integration.

These findings demonstrate that similar physical symptoms may reflect markedly different psychosomatic organizations. Chronic fatigue or sleep disturbances do not carry identical clinical significance across individuals; their meaning depends upon the person's mentalization capacities, symbolic functioning, and the existential context in which they arise. This individualized understanding of symptom expression represents one of the major contributions of Marty's psychosomatic model, which emphasizes that somatic symptoms can only be interpreted within the broader context of the individual's overall psychological organization.

The longitudinal evolution observed across the three cases further supports this interpretation. Progressive strengthening of mentalization capacities was accompanied by a subjective reduction in

several functional somatic manifestations, particularly sleep disturbances, muscular tension, psychological fatigue, and diffuse pain. These improvements should be understood as multifactorial, occurring alongside ongoing medical treatment, social support, and the participants' own psychological resources. Accordingly, psychological intervention should not be regarded as the sole explanation for these changes but rather as one component of a broader adaptive process that facilitates greater emotional flexibility and psychosomatic regulation.

Recent developments in psycho-oncology and psychoneuroimmunology further support this integrative perspective. Antoni et al. (2023) and Lutgendorf and Andersen (2024) have shown that chronic stress and difficulties in emotional regulation may influence physiological systems involved in adaptation to illness, including neuroendocrine, autonomic, inflammatory, and immune pathways. However, these complex biopsychological interactions provide no evidence that psychological factors cause breast cancer or directly determine its biological progression. Instead, they contribute primarily to understanding variations in quality of life, symptom burden, and psychological adaptation throughout the cancer trajectory.

Taken together, the findings suggest that the somatic manifestations observed in this study are best understood not as evidence of psychogenic causation but as indicators of a psychosomatic economy operating under considerable adaptive strain. Although based on a limited number of clinical cases, these observations underscore the value of integrating psychosomatic assessment into psycho-oncological care. They further demonstrate that Marty's psychosomatic framework remains highly relevant when considered alongside contemporary theories of mentalization, emotion regulation, psychoneuroimmunology, and the biopsychosocial model, offering a nuanced and scientifically coherent framework for understanding psychological adaptation in women living with breast cancer.

5.4. The effects of integrative psychosomatic care on processes of psychological reorganization

The cross-case analysis indicates that integrative psychosomatic care does not influence the biological course of breast cancer but rather facilitates the progressive reorganization of psychological functioning in response to the experience of illness. Consistent with contemporary psycho-oncology, its primary objective is to strengthen patients' adaptive capacities by promoting emotional elaboration, restoring symbolic functioning, and supporting the integration of identity transformations associated with cancer. The clinical observations conducted within the oncology department of a public hospital in the Wilaya of Bouira, Algeria, suggest that this approach provides a valuable complement to medical treatment by addressing the subjective dimensions of the cancer experience.

A first process common to all three cases concerns the gradual strengthening of mentalization capacities. At the beginning of psychological follow-up, the participants' narratives were largely confined to medical treatments, diagnostic procedures, and practical aspects of the disease, whereas more distressing emotional experiences—such as fear, anger, feelings of injustice, and vulnerability—remained only partially accessible to reflection and verbalization. The establishment of a secure therapeutic environment progressively facilitated the recognition, representation, and integration of these emotional states. From Marty's psychosomatic perspective (1990), this evolution reflects a restoration of mental functioning in which emotional tensions become increasingly available for psychic elaboration rather than being managed primarily through inhibitory regulation.

A parallel process involved changes in emotional regulation. Initially characterized by emotional overcontrol, affective inhibition, and relational overadaptation, these defensive strategies gradually

became more flexible throughout the course of therapy. Conflict-related emotions became easier to identify, differentiate, and communicate without threatening family relationships. This evolution is particularly noteworthy given the sociocultural context of the participants, in which values such as self-sacrifice, emotional restraint, and the protection of family members occupy a prominent place.

Psychological intervention also facilitated a transformation in the participants' relationship with their bodies. Bodily changes resulting from cancer and its treatment progressively ceased to be experienced exclusively as signs of irreversible loss or persistent threat. Although physical suffering remained present, the therapeutic process promoted a more integrated subjective experience of the body by fostering meaningful connections between bodily sensations, emotional experiences, and interpersonal relationships. This development contributed to a more coherent integration of the biological, psychological, and social dimensions of illness.

This broader process of psychological reorganization was accompanied by a subjective improvement in several functional somatic manifestations, including fatigue, sleep disturbances, muscular tension, headaches, and gastrointestinal complaints. These changes should be understood as inherently multifactorial, occurring alongside medical treatment, social support, and the participants' own psychological resources. Nevertheless, the progressive strengthening of mentalization capacities appears to have contributed to greater emotional flexibility and to changes in the subjective experience of physical symptoms, in accordance with the biopsychosocial model.

The analysis further highlights the central role of the therapeutic relationship. The continuity of psychological follow-up, the quality of the therapeutic alliance, and the recognition of each participant's unique subjective experience created conditions conducive to the development of reflective functioning. According to Fonagy et al. (2002), mentalization develops within sufficiently secure interpersonal relationships; accordingly, the therapist supports the processes through which patients progressively construct a more coherent understanding of their illness experience. In this respect, Marty's psychosomatic framework converges with contemporary mentalization theory by emphasizing the fundamentally intersubjective nature of symbolization and psychological change.

Beyond these specific developments, psychological follow-up also promoted the gradual reconstruction of identity continuity. The experience of breast cancer, initially lived as a profound biographical disruption, became progressively integrated into a more coherent personal narrative. Over time, participants moved beyond defining themselves primarily through the illness and gradually reinvested other dimensions of their familial, social, and personal identities.

These findings should nevertheless be interpreted with appropriate caution. Derived from a qualitative study involving only three clinical cases, they do not permit causal inferences regarding the effects of psychological intervention. The observed changes most likely reflect the interaction of multiple factors, including medical treatment, individual psychological resources, social support, and the therapeutic process itself. Their principal contribution lies in identifying the psychological reorganization processes that may accompany adaptation to breast cancer rather than demonstrating treatment efficacy.

Taken together, these observations suggest that the concepts developed within Pierre Marty's psychosomatic theory remain highly compatible with contemporary perspectives in psycho-oncology, mentalization theory, and the biopsychosocial model. Rather than representing competing explanatory frameworks, these approaches complement one another by illuminating how individuals

mobilize psychological resources to preserve identity continuity while adapting to the profound challenges imposed by cancer.

Finally, this study underscores the importance of integrating structured psychological care into oncological services in Algeria. Although based on a limited number of clinical cases, the findings indicate that an integrative approach attentive to the biological, psychological, relational, and sociocultural dimensions of illness addresses needs that extend well beyond the management of emotional distress alone. They also provide a foundation for future research examining these adaptive processes in larger samples across diverse hospital settings.

6. General discussion

6.1. Repression of aggressive affects: A psychosomatic vulnerability rather than an etiological factor in breast cancer

The findings of the present study indicate that, despite differences in personal histories and oncological trajectories, all three participants displayed convergent patterns of emotional regulation characterized by persistent repression of aggressive affects, pronounced relational overadaptation, and limited capacity to verbalize intrapsychic conflict. These observations, however, must be interpreted with caution. They provide no evidence that the repression of aggressive affects constitutes an etiological factor in the development of breast cancer. Rather, they suggest that this pattern of psychological functioning may influence the subjective experience of illness, adaptive capacities, and psychosomatic equilibrium throughout the cancer trajectory.

This interpretation is fully consistent with the evolution of contemporary psycho-oncology. Earlier hypotheses proposing the existence of a *cancer-prone personality*—the notion that a specific psychological profile predisposes individuals to cancer—have not been supported by empirical research. Longitudinal studies have failed to demonstrate that any particular psychological characteristic acts as a causal determinant of cancer. Current theoretical models instead endorse a multidimensional perspective in which biological, psychological, environmental, and social factors interact dynamically in shaping the experience of cancer and adaptation to illness (Lutgendorf & Andersen, 2024; Stanton et al., 2020).

The clinical observations reported here are closely aligned with this contemporary perspective. Across all three participants, the repression of aggressive affects emerged less as a pathological personality trait than as an adaptive strategy gradually developed over the course of their personal histories. Each participant described a strong commitment to family responsibilities, a consistent prioritization of others' needs over her own, and limited permission to express anger, disagreement, or frustration. Nevertheless, the expression of this defensive pattern differed according to the clinical context. In Mrs. A, emotional inhibition was most evident immediately following diagnosis; in Mrs. B, it became particularly salient during remission; and in Mrs. C, it intensified following cancer recurrence. These differences underscore the dynamic nature of psychosomatic regulation, which evolves in response to individual psychological resources, life history, and changing medical circumstances.

This interpretation is also consistent with Pierre Marty's psychosomatic theory. Marty did not propose that specific psychological conflicts directly produce particular organic diseases. Rather, his work focuses on the functioning of the psychosomatic economy and on the conditions under which mentalization capacities become insufficient to process internal emotional tensions. When

representational resources are persistently challenged, regulatory processes may become less effective, yet this should not be interpreted as establishing a causal relationship between psychological vulnerability and the onset of cancer (Marty, 1990, 1998).

The present findings may also be considered in light of contemporary research on emotion regulation. Gross (2015) has demonstrated that chronic emotional suppression may serve adaptive social functions in the short term but is frequently associated with significant psychological and physiological costs over time. Persistent emotional inhibition has been linked to increased stress burden, reduced emotional flexibility, and impaired interpersonal functioning. The clinical cases examined in this study reflect this pattern: difficulties in recognizing and expressing anger appeared to contribute to sustained psychological tension, thereby complicating adaptation to breast cancer without providing any explanation for its development.

The analysis further highlights the influence of sociocultural context on these regulatory processes. All three participants strongly endorsed values emphasizing caregiving, family self-sacrifice, emotional restraint, and responsibility toward others. Within this framework, the expression of anger was often experienced as incompatible with their identities as mothers and wives, encouraging emotional self-silencing and limiting the use of interpersonal support. These observations are consistent with psycho-oncological research indicating that many women living with breast cancer adopt emotionally protective roles toward family members while minimizing or concealing their own distress (Cordova et al., 2017; Stanton et al., 2020).

Taken together, these findings suggest that the repression of aggressive affects should be regarded as a clinically meaningful indicator of vulnerability in emotional regulation and mentalization processes rather than as a risk factor for breast cancer itself. Its principal value lies in enhancing understanding of how patients process the experience of illness and mobilize psychological resources in response to the demands imposed by cancer. This distinction carries important scientific, clinical, and ethical implications, as it avoids stigmatizing or guilt-inducing interpretations while emphasizing the relevance of psychological interventions aimed at strengthening symbolic functioning and mentalization capacities.

From this perspective, the present findings encourage moving beyond the traditional dichotomy between biomedical and psychodynamic approaches. Instead, they support an integrative framework in which biological, psychological, relational, and social dimensions are understood as complementary components of the illness experience. Interpreted in light of contemporary developments in psycho-oncology, mentalization theory, and psychoneuroimmunology, Pierre Marty's psychosomatic model retains substantial heuristic and clinical value for understanding the psychological adaptation of women living with breast cancer, while unequivocally rejecting any notion that psychological functioning is responsible for the genesis of the disease.

6.2. Contributions and limitations of Marty's psychosomatic theory in light of contemporary knowledge

One of the principal contributions of the present study lies in revisiting Pierre Marty's psychosomatic framework through the lens of recent advances in clinical psychology, psycho-oncology, and affective neuroscience. Although the concepts developed by the Paris School continue to occupy a prominent position in psychosomatic theory, their scientific status remains a matter of debate because of the methodological challenges involved in subjecting them to rigorous empirical validation. This

limitation, however, does not diminish their clinical relevance; rather, it underscores the need to clarify their heuristic value and define the scope within which they can most appropriately be applied. The clinical observations reported in this study suggest that several of Marty's core concepts retain considerable explanatory value for understanding the psychological experience of women living with breast cancer. Concepts such as mentalization**,** psychosomatic economy**,** operative thinking, andpsychosomatic disorganization provide a coherent conceptual framework for interpreting the participants' difficulties in recognizing, differentiating, and elaborating emotional experiences. The findings therefore support Marty's central proposition that psychosomatic vulnerability depends less on the specific content of psychological conflicts than on the quality and effectiveness of the individual's mental processing capacities.

At the same time, the present data invite a more nuanced interpretation of certain aspects of Marty's model. None of the participants displayed operative thinking as a stable or enduring personality organization. Rather, it emerged as a transient mode of psychological functioning, particularly evident during periods of intense emotional mobilization, such as the disclosure of the cancer diagnosis or the experience of recurrence. As psychological intervention progressed, participants demonstrated increasingly rich associative processes and greater reflective capacity, suggesting that these characteristics represent adaptive psychological states rather than fixed personality traits. This observation is consistent with contemporary perspectives that conceptualize reflective functioning as a dynamic process influenced by stress, interpersonal context, and the availability of psychological resources.

One of the major limitations of classical psychosomatic theory lies in the potential risk of psychogenetic interpretations of organic disease. Current knowledge in oncology provides no evidence that impaired mentalization or chronic emotional inhibition can account for the onset or recurrence of breast cancer. Rather, breast cancer results from complex interactions among biological, genetic, hormonal, environmental, and behavioral determinants. Psychological factors primarily influence patients' adaptation to illness, quality of life, treatment adherence, and subjective experience rather than the biological mechanisms responsible for carcinogenesis.

The findings of the present study are fully consistent with this contemporary perspective. No causal relationship was identified between the repression of aggressive affects and the development of breast cancer. Instead, the study demonstrates that the manner in which emotional experiences are psychologically processed significantly shapes how patients cope with illness, mobilize internal resources, and progressively reconstruct psychological equilibrium throughout the cancer trajectory. From this standpoint, the principal contribution of psychosomatic theory lies in enhancing understanding of adaptive processes rather than explaining the etiology of cancer.

The present observations also create an opportunity for productive dialogue between Marty's psychosomatic model and contemporary mentalization theory. Although these frameworks originate from distinct theoretical traditions, they converge in emphasizing the fundamental importance of the capacity to represent, differentiate, and elaborate internal mental states in emotional regulation and psychological adaptation. Participants who progressively developed a more coherent understanding of their emotional experiences also reported more satisfactory psychological adjustment, thereby reinforcing the clinical value of integrating these complementary perspectives.

This theoretical complementarity makes it possible to move beyond the often-assumed opposition between psychoanalytic psychosomatic theory and evidence-based clinical approaches. Pierre Marty's concepts retain substantial clinical utility when interpreted within an integrative framework that recognizes the dynamic interactions among biological, psychological, relational, and social dimensions of health and illness.

Consequently, rather than representing an outdated theoretical model, Marty's psychosomatic framework continues to offer a particularly fruitful interpretive perspective for understanding the unique psychological experiences of women living with breast cancer. When integrated with contemporary developments in psycho-oncology, mentalization theory, and psychoneuroimmunology, it contributes to a multidimensional understanding of the illness experience while avoiding any reduction of cancer to psychological determinants or any contradiction of the well-established scientific knowledge underpinning modern oncology.

6.3. From mentalization to integrative psycho-oncology: Toward a multidimensional clinical model

The findings of this study invite a reconsideration of the traditional distinctions between psychodynamic approaches, emotion regulation models, and biomedical perspectives on cancer. The analysis of the three clinical cases demonstrates that these theoretical frameworks can be integrated into a comprehensive clinical model capable of capturing the complexity of the psychological experience of women living with breast cancer. Such an integrative perspective is particularly relevant given that breast cancer simultaneously engages biological, psychological, relational, and sociocultural dimensions of human functioning.

Pierre Marty's psychosomatic theory provides a first level of analysis by emphasizing the quality of the individual's psychosomatic economy and the mentalization capacities mobilized in response to situations of intense emotional stress. Across the three clinical cases, the primary difficulty did not lie in the intensity of emotional experience itself, but rather in its psychological elaboration. Feelings of anger, frustration, fear, and helplessness were frequently inhibited in favor of relational overadaptation and emotional self-control, supporting Marty's central proposition that psychosomatic vulnerability depends more on the quality of representational processing than on the specific content of psychological conflicts (Marty, 1990, 1998).

This conceptualization is further enriched by contemporary mentalization theory. According to Fonagy and colleagues, mentalization refers to the capacity to understand one's own and others' behaviors in terms of the underlying mental states that motivate them (Fonagy et al., 2018). The present findings demonstrate that this capacity is profoundly challenged by cancer diagnosis, medical treatment, bodily transformations, and uncertainty regarding prognosis. Consequently, breast cancer threatens not only physical integrity but also the reflective capacities through which individuals preserve a coherent sense of personal identity and psychological continuity.

The data also underscore the inherently dynamic nature of mentalization. Across all three participants, reflective functioning fluctuated according to the psychological resources available, the quality of interpersonal support, the stage of the oncological trajectory, and the characteristics of the therapeutic environment. Mentalization capacities appeared temporarily compromised during periods of greatest vulnerability before progressively strengthening through the therapeutic process. This developmental trajectory is consistent with contemporary conceptualizations that regard mentalization as a dynamic

psychological capacity capable of being restored within sufficiently secure relational contexts (Luyten et al., 2020).

The present findings also converge with recent developments in psycho-oncology, which emphasize that successful adaptation to cancer depends largely on the manner in which patients integrate the illness into their broader life narrative. Emotional processing capacities, psychological flexibility, social support, perceived self-efficacy, and adaptive coping strategies are now widely recognized as major determinants of quality of life and psychological adjustment among individuals living with cancer (Stanton et al., 2020; Watson & Kissane, 2023). In the three clinical situations examined, the most significant therapeutic changes involved precisely these domains: the gradual reconstruction of personal meaning, the restoration of identity continuity, and the renewed investment in interpersonal relationships.

Based on these findings, a multidimensional clinical model may be proposed in which the repression of aggressive affects is understood neither as a causal determinant of cancer nor merely as a psychological symptom, but rather as a clinically meaningful indicator of difficulties in emotional regulation that may shape the subjective experience of illness. Within this framework, cancer constitutes a potentially disorganizing life event that places substantial demands on mentalization capacities. When these capacities remain sufficiently intact, emotional experiences can gradually be recognized, symbolized, and integrated into psychological functioning. Conversely, when they become temporarily overwhelmed, emotional tensions may contribute to heightened psychological distress, increased functional somatic symptoms, and diminished quality of life. This perspective therefore represents a model of adaptive vulnerability, in which biological, psychological, relational, and social factors continuously interact without implying any unidirectional causal relationship.

This integrative framework offers several important theoretical contributions. First, it establishes a productive dialogue between Marty's psychosomatic theory and contemporary developments in clinical psychology and psycho-oncology. Second, it highlights mentalization processes as a conceptual bridge linking psychoanalytic theory, affective neuroscience, and health psychology. Finally, it encourages understanding psychosomatic suffering as an emergent property of complex biopsychosocial interactions rather than as the direct consequence of an isolated intrapsychic conflict.

From a clinical perspective, this model supports interventions aimed primarily at strengthening symbolization, mentalization, and emotional regulation capacities. The objective is neither to uncover a hidden psychological meaning of cancer nor to encourage indiscriminate emotional expression, but rather to assist patients in progressively recognizing, elaborating, and integrating the affective experiences elicited by the illness. The clinical evolution observed across the three participants suggests that this therapeutic approach promotes greater psychological flexibility, stronger identity continuity, and reduced subjective distress, without making any claim regarding modification of the biological mechanisms underlying tumor progression.

The principal contribution of the present study, therefore, lies in proposing an integrative conceptualization of the psychosomatic dimensions of breast cancer that brings Pierre Marty's theoretical framework into dialogue with contemporary developments in mentalization theory and psycho-oncology. This integration moves beyond the historical divide between psychodynamic perspectives and evidence-based clinical approaches while offering a robust conceptual framework capable of enriching both future clinical research and psychological care practices in oncology.

6.4. Clinical implications for the psychological care of women with breast cancer

The findings of the present study have several important implications for the psychological care of women living with breast cancer. Beyond the differences observed across the three clinical cases, they demonstrate that breast cancer represents a profound disruptive life event affecting not only the body but also identity, interpersonal relationships, and emotional regulation. This complexity supports the implementation of comprehensive care models that integrate biomedical, psychological, familial, and social dimensions, in accordance with current international recommendations in psycho-oncology (NCCN, 2024; IPOS, 2023).

A first clinical implication concerns the early identification of difficulties in emotional regulation. The present findings indicate that the persistent inhibition of affects—particularly aggressive affects—should not be regarded as a causal factor in breast cancer but rather as a clinically meaningful marker of psychological vulnerability that may complicate adaptation throughout the oncological trajectory. Importantly, this vulnerability does not necessarily manifest through overt symptoms of anxiety or depression. Across all three participants, emotional overcontrol, relational overadaptation, and a tendency to minimize personal distress often concealed significant psychological suffering. These observations highlight the importance of comprehensive psychological assessment extending beyond symptom screening to include the evaluation of mentalization capacities, coping strategies, relational resources, and symbolic functioning.

The study also supports the clinical relevance of an integrative psychosomatic approach centered on strengthening reflective functioning. Within this framework, psychotherapy is not intended to uncover a hidden psychological meaning of cancer nor to encourage indiscriminate emotional expression. Rather, it seeks to provide a secure therapeutic space in which patients can progressively elaborate the bodily and emotional experiences associated with illness. Across the three clinical situations, the quality of the therapeutic setting ,including a stable therapeutic alliance, empathic listening, and validation of subjective experience, facilitated richer emotional expression, greater affect differentiation, and more flexible emotional regulation.

The findings further emphasize the importance of individualized psychological care. Differences observed among the participants demonstrate that mentalization capacities, psychological resources, and adaptive strategies vary considerably from one patient to another. Consequently, psychological interventions should not rely on standardized protocols alone but should instead be tailored to each patient's psychological functioning, family context, stage of disease, and evolving clinical needs.

These observations also reinforce the value of interdisciplinary models of cancer care. Psychological intervention should be integrated with medical treatment and supportive care services through close collaboration among oncologists, nurses, psychologists, psychiatrists, and other healthcare professionals. Within this multidisciplinary framework, psychologists play a central role in facilitating psychological adaptation, strengthening emotional regulation, supporting identity reconstruction, and promoting patients' overall quality of life throughout the cancer journey.

The present findings also carry important ethical implications. Under no circumstances should they be interpreted as suggesting that emotional repression contributes to the development of breast cancer. Such an interpretation would be scientifically unfounded and could inadvertently increase patients' feelings of guilt or self-blame. Instead, the proposed framework is firmly grounded in the biopsychosocial model, which conceptualizes psychological processes as determinants of patients'

subjective experience, adjustment, and well-being while fully acknowledging the multifactorial biological etiology of breast cancer.

Beyond their clinical implications, these findings highlight several methodological strengths. The multiple-case design enabled an in-depth exploration of psychological processes across distinct phases of the oncological trajectory—diagnosis, remission, and recurrence—thereby providing a nuanced understanding of psychosomatic adaptation over time. Furthermore, integrating Marty's psychosomatic theory with contemporary mentalization theory and psycho-oncology offers a theoretically coherent framework capable of bridging psychodynamic concepts with current evidence-based perspectives.

Nevertheless, the study also identifies important directions for future research. Larger multicenter investigations involving more diverse patient populations are needed to examine the transferability of these findings across different sociocultural and clinical settings. Longitudinal designs combining qualitative and quantitative methodologies would further clarify how mentalization capacities, emotional regulation, and psychosomatic functioning evolve throughout the cancer trajectory. Future studies could also evaluate the effectiveness of mentalization-informed psychological interventions and explore their impact on psychological adjustment, quality of life, treatment adherence, and supportive care outcomes.

Overall, psychological care should be regarded as an essential component of comprehensive oncology services. By fostering mentalization, promoting more flexible emotional regulation, and facilitating the integration of bodily and emotional experiences, it contributes to improved psychological adjustment and quality of life among women living with breast cancer. Within this perspective, an integrative psychosomatic approach provides a clinically meaningful framework for addressing the biological, psychological, relational, and sociocultural dimensions of cancer through genuinely person-centered care.

6.5. Study limitations, methodological strengths, and future research directions

The present study provides a clinically grounded understanding of the relationships among the repression of aggressive affects, psychosomatic functioning, and mentalization processes in women living with breast cancer. As with any qualitative clinical investigation, however, its findings should be interpreted in light of several methodological limitations.

The first limitation concerns the sample size. The analysis was based on three clinical cases selected to represent different stages of the oncological trajectory rather than to achieve statistical representativeness. This sampling strategy is fully consistent with the objectives of qualitative clinical research, which prioritizes an in-depth exploration of psychological processes over statistical generalization. Consequently, the findings should be understood as context-specific clinical interpretations rather than universally applicable conclusions.

A second limitation relates to the nature of the data. The analyses were derived primarily from semi-structured clinical interviews, longitudinal psychological observations, and clinical notes collected throughout the therapeutic process. Although this methodology provides rich access to participants' subjective experiences, it also entails an unavoidable interpretive dimension inherent to the therapeutic relationship and the clinician-researcher's perspective. Consistent with qualitative research principles, the findings therefore reflect a process of co-construction among participants, the therapeutic setting, and the clinical interpretation.

Furthermore, the present study does not permit causal inferences regarding the relationships among the repression of aggressive affects, mentalization capacities, and psychosomatic manifestations. The psychological changes observed occurred within a complex clinical context shaped simultaneously by oncological treatments, disease progression, social support, individual psychological resources, and psychotherapy. Accordingly, the findings should be interpreted within a biopsychosocial framework that recognizes the dynamic interactions among these multiple determinants rather than privileging any single explanatory factor.

Despite these limitations, the study possesses several important methodological strengths. The longitudinal analysis of three clinical cases made it possible to examine processes of psychological change over time rather than relying on cross-sectional observations alone. In addition, the integration of Pierre Marty's psychosomatic theory with contemporary developments in mentalization theory and psycho-oncology represents an original theoretical contribution, offering an integrative conceptual framework that is fully compatible with current scientific knowledge regarding breast cancer.

The study also opens several promising avenues for future research. Larger multicenter studies involving more diverse populations would help determine the extent to which the present findings are transferable across different clinical and sociocultural contexts. Longitudinal mixed-methods research combining qualitative analyses with validated quantitative measures of emotional regulation, mentalization, psychological distress, resilience, and quality of life would provide a more comprehensive understanding of psychosomatic adaptation throughout the cancer trajectory. Future investigations could also evaluate the effectiveness of psychological interventions informed by this integrative framework, particularly their impact on psychological adjustment, emotional well-being, quality of life, treatment adherence, and supportive care outcomes, while carefully distinguishing these benefits from any influence on the biological progression of cancer.

In conclusion, despite the limitations inherent in qualitative clinical research, this study contributes to a deeper understanding of the psychological processes mobilized throughout the experience of breast cancer. By integrating psychosomatic theory, mentalization, and contemporary psycho-oncology within a coherent biopsychosocial perspective, it offers a clinically meaningful framework for exploring the complex interactions among body, mind, and interpersonal relationships, while supporting the development of more comprehensive and person-centered psychological care for women living with breast cancer.

Conclusion

Breast cancer is an experience that extends far beyond its biomedical dimension. It simultaneously challenges the body, personal identity, interpersonal relationships, and the psychological processes mobilized to cope with a life-altering and enduring illness. Drawing upon an in-depth analysis of three clinical cases, the present study explored the relationships among the repression of aggressive affects, mentalization capacities, and psychosomatic functioning within Pierre Marty's theoretical framework, while situating these concepts within the context of contemporary developments in psycho-oncology.

The findings demonstrate that all three participants shared a persistent tendency to inhibit aggressive affects in favor of maintaining harmonious interpersonal relationships and fulfilling family responsibilities. This pattern of emotional regulation emerged not as a stable personality characteristic but rather as an adaptive strategy developed in response to the psychological demands imposed by

cancer and the sociorelational expectations associated with their caregiving roles. Its clinical significance lies in what it reveals about the quality of psychological elaboration and mentalization capacities rather than in any implication regarding the etiology of breast cancer. Consistent with current scientific evidence, the present study provides no support for a causal relationship between psychological functioning and the development or recurrence of cancer.

The analysis also highlights the marked heterogeneity of psychosomatic functioning among the participants. Although similar defensive patterns were observed across cases, the women differed substantially in their symbolic capacities, the ways they integrated the cancer experience into their personal narratives, and the evolution of their mentalization capacities throughout psychological follow-up. These findings reinforce Pierre Marty's proposition that psychosomatic manifestations cannot be understood independently of each individual's developmental history, relational environment, and psychological resources.

One of the principal contributions of this study is the contemporary reinterpretation of Marty's psychosomatic theory. The concepts of mentalization**,** psychosomatic economy**,** and operative thinking retain considerable clinical relevance when integrated with recent advances in mentalization theory, psycho-oncology, affective neuroscience, and the biopsychosocial model. This theoretical integration moves beyond the historical divide between psychodynamic approaches and evidence-based models by proposing a multidimensional clinical framework focused on adaptive psychological processes rather than psychogenic explanations of disease.

From a clinical perspective, the findings underscore the value of incorporating assessments of mentalization capacities, emotional regulation, and symbolic functioning into supportive oncology care. Psychological intervention emerges as a therapeutic space that facilitates the elaboration of emotional experiences, promotes the reconstruction of identity continuity, and supports more flexible adaptation to the profound changes imposed by cancer. Its purpose is not to influence the biological course of the disease but rather to enhance psychological adjustment, emotional well-being, and overall quality of life throughout the cancer trajectory.

The study nevertheless presents several limitations, including the restricted number of clinical cases, the qualitative nature of the data, and the impossibility of isolating the specific contribution of psychological intervention from the multiple medical, social, and personal factors influencing patients' adjustment. These limitations point toward the need for future multicenter, longitudinal, and mixed-methods investigations combining qualitative clinical analyses with validated psychometric assessments, biological indicators, and psychosocial outcome measures in order to further clarify the interactions among mentalization, emotional regulation, psychosomatic functioning, and adaptation to breast cancer.

Ultimately, this study argues that understanding breast cancer requires a genuinely integrative perspective in which biological, psychological, relational, and social dimensions are viewed as complementary and mutually interacting components of the illness experience. Reinterpreted in light of contemporary scientific knowledge, Pierre Marty's psychosomatic theory continues to provide a valuable heuristic framework for understanding the psychological processes mobilized in response to cancer while enriching person-centered psychological care and advancing the theoretical foundations of integrative psycho-oncology.

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