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ICF, quality of life, and depression in breast cancer: perceived disability in disease-free women 6 months after mastectomy

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Abstract

Goal of work Aim of the present observational study is to focus on health-related quality of life (HRQL), mood and everyday life of breast cancer affected women disease-free 6 months after mastectomy, paying particular attention to the International Classification of Functioning, Disability and Health (ICF) framework contribution.

Materials and methods Sixty-five breast cancer-affected women disease-free 6 months after mastectomy hospitalized for reconstructive surgery (mean age 46.3 ± 7.3) were enrolled. Their depressive symptoms (Beck Depression Inventory—BDI-II), HRQL, and every day life functioning/barriers and facilitators (ICF) were assessed.

Results At the BDI-II, 6 patients (9.2 %) reported mild depression and 6 (9.2 %) severe depression; when the subscales were considered, 7 (10.8%) resulted depressed at the somatic–affective factor and 16 (24.6 %) at the cognitive factor. Compared to normative data no differences emerged at the HRQL Physical Component Summary (46.4 ± 9.3 vs 49.1 ± 10.1), whereas patients reported lower scores at the Mental HRQL Component Summary (45.9 ± 10.1 vs 51.5 ± 9.1; $p=0.00001$ $t=-4.3$). As for the activity and participation domain, 11 of the 42 categories investigated were compromised in at least 20% of the sample: lifting and carrying objects (d430), acquisition of goods and services (d620), doing housework (d640), remunerative employment (d850), and many categories relating to interpersonal relationships; moreover the caregiver seems to be perceived as an important and positive modulator of disability.

Conclusions The addition of the ICF evaluation to the usual psychological assessment gives a more complete picture, enabling a broader perspective of the psychological–clinical implications. Mainly, the women that we have evaluated continue to function in their everyday lives, thanks in part to their ability to accept help from their own families. However, they inevitably carry signs of their disease which some translating into problems with interpersonal relationships, depressive thoughts and negative ideation. Only the synergistic use of all these assessment instruments can one truly perceive all the nuances relating to the social and psychological conditions of the assessed patients' life, overcoming a binomial vision of well-being and ill-being.

Keywords ICF · Disability · Depression · Breast cancer

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Introduction

Breast cancer is the second most common cancer worldwide and, according to the World Health Organization (WHO), the most common cancer in women. Every year, more than one million women are diagnosed with the disease, corresponding to 23 % of all cancer cases in women and 10 % of new cancer cases [35]. In 2002,

there were 1.15 million new cases of breast cancer and approximately 4.4 million women, diagnosed with the disease in the previous 5 years, were still alive [21]. As a result of advances in treatment, including the combined use of surgery, radiation therapy, and chemotherapy, cancer survivor rates have increased by 50 % [6]. Nevertheless, breast cancer is associated with a wide range of functional and emotional impairments which has a profound psychosocial impact.

The spectrum of psychiatric disorders and psychological distress in cancer sufferers has been assessed over many years and in various studies. Anxiety, depression, energy loss, fatigue, and sleeping problems are common responses to stressors [10, 27]. The prevalence of depression among women with early diagnosed breast cancer is twice as high as that found in the general female population, especially during the first year after diagnosis [8]. However, major depression and depressive symptoms are underrated and undertreated in women with breast cancer [28]. Failure to diagnose mood disorders may cause problems as depression and its associated symptoms lower health-related quality of life (HRQL), affect compliance with medical therapies and could contribute to a reduced survival rate. The latter is due to the fact that depression may affect interpersonal relationships, occupational performance, stress, and perceptions of health and physical symptoms. Many studies have found that depression is correlated with a lower HRQL [25], but few studies have concentrated specifically on long-term HRQL in disease-free breast cancer survivors. These patients seem to have a good HRQL, less affected by the type of treatment than by their demographic characteristics, elapsed time since surgery, comorbidity, fatigue, and depression [1].

Bearing in mind the effect of breast cancer treatment on a patient's HRQL is a central clinical and research issue. HRQL assessment generally refers to a number of domains including physical functioning, psychological well-being (such as level of anxiety and depression), and social support. Based on a review by Peery and colleagues, HRQL instruments were identified as being the most widely used assessment tools within the breast cancer population. Because of the complexity of breast cancer and the heterogeneity of the patients affected, no single instrument is both comprehensive and sensitive enough to perceive clinically meaningful changes in all outcomes across all phases of care [22]. Knowing patients' subjective experience of physical and mental health, functioning in daily living, participation in social networks and general sense of well-being have become important factors in cancer patients' evaluation.

The International Classification of Functioning, Disability and Health (ICF) framework provided a new perspective for the assessment of a patient's disability, and the potential benefit of the synergism between the ICF evaluation and HRQL in terms of quality of care, evaluation of needs and optimisation of resource use has been underscored [9, 11, 18]. In fact, the ICF [2, 7, 9, 20, 34] has ratified the importance of a broad vision of a person's life, picking up, describing, and classifying a person's health condition with respect to the individual and society and not only with respect to the functional profile or the subjective perception of well-being [12]. In fact, the ICF describes disability as the result of interactions between the individual, society, and the environment in terms of both barriers and facilitators.

Some studies are now available on the implementation of the ICF in cancer [2, 29, 30] and in palliative care of patients with advanced stages of cancer [12] but only few have focused on women with breast cancer [7, 14, 31] and on women who have had breast cancer but are currently disease-free [35].

The aim of the present observational study was to focus on HRQL, mood, and everyday life of women with breast cancer who had been disease-free for at least 6 months after mastectomy, paying particular attention to the contribution made by the ICF.

Method

Procedure and study population

From May 2008 to November 2010 all women at the Breast Surgery Unit who had undergone primary curative surgery for breast cancer and hospitalized for reconstructive surgery were consecutively enrolled. Women were eligible to participate if they had had a past diagnosis of breast cancer, were on no current cancer therapy other than tamoxifen, were currently free of the disease, and had no other history of cancer. Exclusion criteria were: cognitive deficits interfering with language and reasoning, psychiatric or severe psychological disorders prior to the disease onset, and other relevant clinical conditions.

Overall, 65 consecutive in-patients were enrolled into the study. There were no refusals to participate, probably because psychological assessment is part of routine clinical work and psychologists are usually accepted well by both patients and relatives.

The study was approved by the institute's ethics committee and all patients signed an informed medical consent form.

Instruments

During the first week of admission, patients were administered the following:

- A socio-demographic and perceived health status schedule: assessing socio-demographic and clinical characteristics, and perceived health status (subjective evaluation of mental and physical health on a five-point Likert scale). The questionnaire consisted of 15 questions and had been appropriately developed by our study team.
- Beck Depression Inventory II (BDI II) [4]: a 21-item rating scale to assess the presence and prominence of depressive symptoms which reflects the diagnostic criteria of the Diagnostic and Statistical Manual for Mental Disorders—Fourth Edition. It identifies a total score and two factors (Somatic-Affective and Cognitive). Raw scores (range 0–63) can be transformed into percentile scores when compared to the Italian normative sample (<85th percentile, no depression; 85th–90th percentile, mild depression; 91st–95th percentile, moderate depression; >95th percentile, severe depression). BDI-II has already been used with cancer patients [23].
- Short-Form Health Survey-12 (SF-12) [33]: a HRQL instrument based on the reputable 36-item Short-Form Health survey (SF-36) [32]. Two synthetic scores are available: Physical Component Summary (PCS) and Mental Component Summary (MCS) (range 0–100; lower scores representing greater functional impairment).
- ICF Checklist [20, 34]: a user–friendly display of the most relevant ICF categories for clinical purposes in order to record information regarding an individual's functioning and disability. In this study only the "Activity and Participation" and the "Environmental Factors" domains were taken into consideration. Activity is the execution of a task or action by an individual whereas Participation is a person's involvement in a real-life situation; it represents the societal perspective of functioning. The Environmental Factors refer to all aspects globally—both barriers and facilitators—of the external or extrinsic world that form the context of an individual's life and, as such, have an impact on that person's functioning.

As to the *activity and participation* domain, activity limitations and participation restrictions were assessed by means of two qualificators: (1) "performance with equipment aids only"—considering only the help provided by equipment and instrumental aids; and (2) "performance with equipment aids and with other's assistance"—considering both the help provided by equipment and instrumental aids and the help provided by family members, friends, and other people. The qualificators range from 0 (no activity limitation nor participation restriction) to 4 (maximum activity limitation or participation restriction). In this study, the delta values originating from the difference between activity and participation categories together with equipment aids only and activity and participation categories with equipment aids along with a person's help were also considered. Delta values provided information about the caregiver's impact: a delta value=0 neutral caregiver role, a delta value ≥1 caregiver as a positive disability modulator (facilitator), while a delta value <0 caregiver as a negative disability modulator (barrier) [12].

With regard to the *environmental factors* domain, the qualifier, in a range of 0–4, can be used to denote the extent of positive effects (facilitator—positive values) or the negative effects (barrier—negative values) of the environment.

All questionnaires and tools were administered in their Italian-validated versions [3, 5, 20]. Women self compiled the socio-demographic and perceived health status schedule, BDI-II and SF-12; the ICF checklist was completed during an interview carried by trained psychologists.

Statistical analyses

Descriptive analyses were performed on the socio-demographic data and depression (BDI-II) and QoL (SF-12) scores. The SF-12 scores were compared to normative data by means of a *t* test for independent variables. *P* was set at 0.01.

As for the ICF classification, a descriptive analysis, mode, and median of the ICF Activity and Participation delta values and chapters e3 and e4 of the environmental factors was calculated. All qualifiers, 8 (not specified) and 9 (not applicable), were considered as missing data. Statistical analyses were performed using SPSS 11.0.

Results

Table 1 represents the socio-demographic and clinical characteristics, and data regarding perceived health status. The mean age of the women considered was 46.3±7.3 years. All patients did not change their marital status after the cancer diagnosis and each of them had at least one clearly identified caregiver (mainly partner and/or daughter/son).

The mean score of the BDI-II total score was 8.6±6.0 (somatic–affective factor 6.1±3.8 and cognitive factor 2.5±3.0). As for the percentile scores, 6 patients (9.2 %) reported mild depression and 6 (9.2 %) severe depression; when the subscales were considered, 7 patients resulted depressed as regards the somatic–affective factor (3.1 % mild, 3.1 % moderate, and 4.6 % severe) and 16 resulted depressed as regards the cognitive factor (4.6 % mild, 4.6 % moderate, and 15.4 % severe).

The SF-12 showed no differences between the study subjects and a normative sample with regards to PCS (46.4±9.3

Table 1 Patients' characteristics (*n*=65)

		n (%)
Age		46.3±7.3
School years	≤5	3 (4.6)
	6–9	15 (23.1)
	10–13	31 (47.7)
	≥14	16 (24.6)
Lives alone	No	60 (92.3)
	Yes	5 (7.7)
Marital status	Married/cohabitant	54 (83.0)
	Unmarried	4 (6.2)
	Separated/divorced	4 (6.2)
	Widower	3 (4.6)
Current occupation	Employed	48 (73.8)
	House keeper	10 (15.4)
	Retired	3 (4.6)
	Unemployed	4 (6.2)
Chemotherapy	No	20 (30.8)
	Yes, in the last 6 months	13 (20.0)
	Yes, more than 6 months ago	32 (49.2)
Radiotherapy	No	43 (66.1)
	Yes, in the last 6 months	4 (6.2)
	Yes, more than 6 months ago	18 (27.7)
Subjective assessment of physical health	Very good	12 (18.5)
	Good	42 (64.6)
	Moderate	9 (13.8)
	Bad	2 (3.1)
	Very bad	–
Subjective assessment of mental and emotional health	Very good	10 (15.4)
	Good	34 (52.3)
	Moderate	18 (27.7)
	Bad	2 (3.1)
	Very bad	1 (1.5)

vs 49.1±10.1) indicating that physical health-related quality of life among respondents was as the general population; whereas patients reported lower scores for the MCS (45.9± 10.1 vs 51.5±9.1; $p=0.00001$, $t=-4.3$) showing a slightly lower mental HRQL than that of the general population.

As far as the activity and participation domain is concerned, 11 out of the 42 categories investigated were compromised in at least 20 % of the samples: lifting and carrying objects (d430), acquisition of goods and services (d620), doing housework (d640), remunerative employment (d850) (Table 2). Moreover, women report a significant perceived disability in the area relating to interpersonal relationships, both formal and informal, mainly with family members. Finally, also the intimate relationship with their significant other resulted impaired.

The caregiver was perceived as holding a neutral role or as a facilitator; in none of the domains resulted to be a barrier. Table 3 shows ICF activity and participation categories with the median of delta values ≥1 (caregiver as a facilitator) and delta values distribution.

Table 4 shows frequencies and percentages of ICF environmental factors qualifiers. Many domains are perceived neither as a barrier nor as a facilitator. Products or substances for personal consumption are perceived as facilitators: patients mainly refer to cancer therapy availability in Italy. Also, health and social security services, systems, and policies are considered as reducing disability. All people with an informal connection with the women assessed (family, friends and acquaintances) and the healthcare team, and their attitudes, are often perceived as facilitators, positively modulating the patient's perceived disability.

Discussion

The data from the BDI-II show that our patients had a fairly substantial level of depressive symptoms: although this was a sample of mastectomized women who were currently free of disease, 18.4 % of the patients had depression scores above the norm. Subscale analysis enabled more precise and better definition of the nature of the symptoms: 24.6 % of the sample had compromised cognitive features of depression (pessimism, sense of guilt, low self-esteem), while the somatic-affective sphere was compromised in only 10.8 % of the case study (loss of interest, loss of energy, sleep disorders, changes in appetite, restlessness, crying). The depressive symptoms were, therefore, related mainly to a redefinition of self and the history of the disease, in the context of which the patient must find room both to rebuild her own female identity and to create a new view of the future and expectations.

In concordance with the data from the BDI-II, the data from the SF-12, compared with scores obtained from normal groups, showed a reduction in perceived mental health, while the perceived state of physical health did not seem to be compromised. Indeed, the patients reported a certain psychological distress and consequent social and personal disability due to problems relating to the emotional sphere.

Similarly, at a qualitative level, the responses concerning perception of one's own physical and mental health, mirrored those from the SF-12: 83.1 % of the women in our sample reported good/very good physical health, but only 67.7 % reported good/very good mental health.

The data derived from using the ICF Checklist could be used to describe the disability perceived by the women in the sample, taking into account the impact the disease had on the women's life in more detail.

Table 2 Frequencies and percentages of ICF activity and participation qualifiers with 20 % or more patients impaired (the qualifiers range from 0=no activity limitation or participation restriction to 4=maximum activity limitation or participation restriction)

ICF coding	ICF domains	ICF qualifiers under Performance with equipment aids and with other's assistance					ICF qualifiers under Performance with equipment aids only				
		0 n (%)	1 n (%)	2 n (%)	3 n (%)	4 n (%)	0 n (%)	1 n (%)	2 n (%)	3 n (%)	4 n (%)
d430	Lifting and carrying objects	**49 (75.4)**	6 (9.2)	7 (10.8)	2 (3.1)	1 (1.5)	**22 (33.8)**	**15 (23.1)**	**15 (23.1)**	11 (16.9)	1 (1.5)
d620	Acquisition of goods and services	**52 (80.0)**	5 (7.7)	6 (9.2)	1 (1.5)	1 (1.5)	**26 (40.0)**	**14 (21.5)**	12 (18.5)	11 (16.9)	2 (3.1)
d640	Doing housework	**50 (79.6)**	10 (15.4)	3 (4.6)	1 (1.5)	1 (1.5)	**22 (33.8)**	**19 (29.2)**	13 (20.0)	9 (13.8)	3 (3.1)
d710	Basic interpersonal interactions	**44 (67.7)**	11 (16.9)	8 (12.3)	2 (3.1)	0	**44 (67.7)**	11 (16.9)	8 (12.3)	2 (3.1)	0
d720	Complex interpersonal interactions	**40 (61.5)**	**13 (20.0)**	9 (13.8)	3 (4.6)	0	**38 (58.5)**	**15 (23.1)**	9 (13.8)	3 (4.6)	0
d730	Relating with strangers	**47 (72.3)**	10 (15.4)	6 (9.2)	2 (3.1)	0	**47 (72.3)**	10 (15.4)	6 (9.2)	2 (3.1)	0
d740	Formal relationships	**50 (79.6)**	6 (9.2)	6 (9.2)	3 (4.6)	0	**50 (79.6)**	6 (9.2)	6 (9.2)	3 (4.6)	0
d750	Informal social relationships	**52 (80.0)**	3 (4.6)	2 (13.8)	1 (1.5)	0	**50 (76.9)**	4 (6.2)	10 (15.4)	1 (1.5)	0
d760	Family relationships	**49 (75.4)**	6 (9.2)	9 (13.8)	1 (1.5)	0	**48 (73.8)**	7 (10.8)	9 (13.8)	1 (1.5)	0
d770[a]	Intimate relationships	**48 (73.8)**	1 (1.5)	10 (15.4)	2 (3.1)	0	**48 (73.8)**	1 (1.5)	10 (15.4)	2 (3.1)	0
d850[b]	Remunerative employment	**25 (38.5)**	8 (12.3)	8 (12.3)	7 (10.7)	0	**25 (38.5)**	8 (12.3)	8 (12.3)	7 (10.7)	0

Values in bold are above or equal to 20 %

[a] 4 (6.2 %) not assessable

[b] 17 (26.2 %) unemployed, retired, and housewives

As far as the activity and participation domain is concerned, 11 out of the 42 categories investigated were compromised and concerned activities such as lifting and carrying objects (d430), acquisition of goods and services (d620), doing housework (d640), remunerative employment (d850), and interpersonal relationships. In the first three categories, the differences between capacity and performance highlight the facilitating role of environmental factors: treatments, together with family and social support, are helpful at an everyday activities and participation level. In our sample, in particular, the caregiver seems to play an important modulator role of the disability: the presence of a caregiver enables the patient to function well in everyday life, even with regards to those activities which could otherwise be affected by the disease.

The data relating to environmental factors confirm the foregoing. The number of categories of this component reveals the extensive involvement of contextual factors in the effective management of our patients. Women regard support and relationships (e3) and attitudes (e4) of family, friends, and health professionals as well as social and healthcare services and policies (e5) to be of great importance and support.

Consistent with results from the psychosocial literature on breast cancer, the level of independence in performing activities, the importance of positive relations and the amount of social support is assumed to be major factors in psychosocial adjustment and to influence patients' health final outcomes [16, 17, 24].

Matching ICF-based information regarding impairments, activities, participation, and environmental factors with HRQL data, could provide useful information on service utilization. Healthcare services might use this information when planning support and care for the patients and their families.

Table 3 ICF activity and participation categories with median of delta values ≥1 (caregiver as a positive disability modulator–caregiver as a facilitator) and their delta values distributions

ICF coding	ICF domains	Delta values				
		0 n (%)	1 n (%)	2 n (%)	3 n (%)	4 n (%)
d430	Lifting and carrying objects	37 (56.9)	10 (15.4)	9 (13.8)	8 (12.3)	1 (1.5)
d620	Acquisition of goods and services	39 (60.0)	9 (13.8)	6 (9.2)	10 (15.4)	1 (1.5)
d640	Doing housework	35 (53.8)	11 (16.9)	12 (18.5)	6 (9.2)	1 (1.5)

Table 4 Frequencies and percentages of ICF Environmental Factors qualificators (barrier—negative scores; facilitator—positive scores; 0—neither barrier nor facilitator)

ICF coding	ICF domains	Barrier −4 n (%)	Barrier −3 n (%)	Barrier −2 n (%)	Barrier −1 n (%)	Neither barrier nor facilitator 0 n (%)	Facilitators 1 n (%)	Facilitators 2 n (%)	Facilitators 3 n (%)	Facilitators 4 n (%)	n.a. 8–9 n (%)
e110	Products or substances for personal consumption	—	—	1 (1.5)	2 (3.1)	—	59 (90.8)	3 (4.6)	—	—	—
e115	Products and technology for personal use in daily living	—	—	—	—	65 (100)	—	—	—	—	—
e120	Products and technology for personal indoor and outdoor mobility and transportation	—	—	—	—	65 (100)	—	—	—	—	—
e125	Products and technology for communication	—	—	—	—	65 (100)	—	—	—	—	—
e150	Design, construction and building products and technology of buildings for public use	—	—	—	—	65 (100)	—	—	—	—	—
e155	Design, construction and building products and technology of buildings for private use	—	—	—	—	65 (100)	—	—	—	—	—
e225	Climate	—	—	—	1 (1.5)	64 (98.5)	—	—	—	—	—
e240	Light	—	—	—	—	65 (100)	—	—	—	—	—
e250	Sound	—	—	—	1 (1.5)	64 (98.5)	—	—	—	—	—
e310	Immediate family	—	1 (1.5)	1 (1.5)	5 (7.7)	2 (3.0)	3 (4.6)	6 (9.2)	24 (36.9)	23 (35.4)	—
e320	Friends	—	1 (1.5)	—	4 (6.2)	5 (7.7)	6 (9.2)	10 (15.4)	20 (30.8)	19 (29.2)	—
e325	Acquaintances, peers, colleagues, neighbors and community members	—	1 (1.5)	1 (1.5)	4 (6.2)	18 (27.8)	8 (12.3)	9 (13.8)	11 (16.9)	13 (20.0)	—
e330	People in positions of authority	—	1 (1.5)	1 (1.5)	2 (3.0)	52 (80.2)	—	1 (1.5)	3 (4.6)	1 (1.5)	4 (6.2)
e340	Personal care providers and personal assistants	—	—	—	—	—	—	—	4 (6.2)	3 (4.6)	58 (89.2)
e355	Health professionals	—	1 (1.5)	—	—	1 (1.5)	5 (7.7)	19 (29.2)	30 (46.2)	7 (10.8)	—
e360	Health-related professionals	—	1 (1.5)	—	—	64 (98.5)	—	—	—	—	—
e410	Individual attitudes of immediate family members	—	1 (1.5)	1 (1.5)	5 (7.7)	1 (1.5)	4 (6.2)	5 (7.7)	25 (38.5)	23 (35.4)	—
e420	Individual attitudes of friends	—	1 (1.5)	—	4 (6.2)	4 (6.2)	6 (9.2)	10 (15.4)	21 (32.3)	19 (29.2)	—
e440	Individual attitudes of personal care providers and personal assistants	—	1 (1.5)	—	—	—	—	2 (3.0)	4 (6.2)	—	58 (89.2)
e450	Individual attitudes of health professionals	—	—	—	2 (3.0)	2 (3.0)	5 (7.7)	17 (26.2)	32 (49.2)	7 (10.8)	—
e455	Individual attitudes of health-related professionals	—	1 (1.5)	—	—	62 (95.5)	—	1 (1.5)	1 (1.5)	—	—
e460	Societal attitudes	—	1 (1.5)	—	1 (1.5)	61 (94.0)	1 (1.5)	—	—	—	—
e465	Social norms, practices and ideologies	—	—	—	—	64 (98.5)	—	—	1 (1.5)	—	—
e525	Housing services, systems, and policies	—	—	—	—	65 (100)	—	—	—	—	—
e535	Communication services, systems, and policies	—	—	—	—	65 (100)	—	—	—	—	—
e540	Transportation services, systems, and policies	—	—	—	1 (1.5)	64 (98.5)	—	—	—	—	—
e550	Legal services, systems, and policies	—	—	—	1 (1.5)	64 (98.5)	—	—	—	—	—
e570	Social security services, systems, and policies	1 (1.5)	3 (4.6)	4 (6.2)	2 (3.1)	26 (39.9)	5 (7.7)	17 (26.2)	4 (6.2)	—	3 (4.6)
e575	General social support services, systems, and policies	—	—	—	—	65 (100)	—	—	—	—	—
e580	Health services, systems, and policies	—	—	—	1 (1.5)	—	4 (6.2)	23 (35.4)	29 (44.6)	5 (7.7)	—
e585	Education and training services, systems, and policies	—	—	—	—	65 (100)	—	—	—	—	—
e590	Labor and employment services, systems, and policies	—	4 (6.2)	4 (6.2)	7 (10.8)	46 (70.8)	—	1 (1.5)	1 (1.5)	1 (1.5)	1 (1.5)

n.a. not assessable

Conclusions

The data regarding depressive symptoms and perceived disability, if evaluated independently, show an apparently contradictory picture: the patients evaluated, despite having symptoms of depression, do not report significant impairment in everyday life, thanks above all to the active and psychological help provided by caregivers. Cancer seems to be an occasion for reorganizing roles of the family unit [13]. This was found to be the case also in a study carried out on Arab women: the husbands of Arab breast cancer survivors were more involved in household chores than husbands of matched healthy women even several years after the oncology treatment [15].

The addition of the ICF evaluation to the usual psychological assessment gives a more complete picture, enabling a broader perspective of the psychological–clinical implications. The women that we have evaluated continue to function as normal in their everyday lives, thanks in part to their ability to accept help from their own families. However, they inevitably carry signs of their disease which some translate into problems with interpersonal relationships, depressive thoughts, and negative ideation, and are certainly a source of distress. It is, therefore, important not to underestimate the significance of depressive symptoms, even those occurring some time after the acute event. Only the synergistic use of all these assessment instruments can one truly detect all the nuances of the social and psychological conditions of the assessed patients' life, overcoming a binomial vision of well-being and ill-being [19, 26].

The psychological intervention should not, therefore, be focused only on depressive features, but also on the reorganization of a female identity, related to both physical appearance and everyday life, as well as considering the active role of the family caregiver. The aim is, therefore, to guide patients towards a narration of self which can integrate the inevitably present psychological distress during active participation in life.

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