ESTILOS Y ESTRATEGIAS DE ADAPTACIÓN EN PACIENTES CON TRASTORNO DISTÍMICO

Mara Rúbia de Camargo Alves Orsini¹, Guilherme Nogueira², Daniel Bartholomeu³, José Maria Montiel⁴, Juliana Francisca Cecato⁵ e José Eduardo Martinelli⁶

Pontificia Universidade Católica de Goiás
Universidade São Francisco
Brasil

¹ Possui graduação em Psicologia pela Pontifícia Universidade Católica de Goiás, mestrado e doutorado em Psicologia pela Universidade de Brasília. Coordenadora do Laboratório de Pesquisa e Avaliação em Saúde Mental e Personalidade. Atualmente, é Professora Adjunto I no curso de Psicologia da Universidade Federal de Goiás - UFG. Correo electrónico: mararubia.mr@gmail.com

² Discente da Faculdade de Educação da Universidade Federal de Goiás – UFG. Correo electrónico: guylhermegyn@hotmail.com

³ Psicólogo, Mestre e Doutor em Avaliação Psicológica em Contexto de Saúde Mental pela Universidade São Francisco. É colaborador do Laboratório de Pesquisa em Psicologia do Esporte (Lepespe) e coordenador do Laboratório de Psicodiagnóstico e Neurociências Cognitivas (LaPeNC). Atualmente é Professor do Centro Universitário FIEO – UNIFIEO/SP - Programa de Pós-Graduação Strictu Sensu em Psicologia Educacional - Fundação Instituto de Ensino para Osasco. Contacto: Correo electrónico: d_bartholomeu@yahoo.com.br

⁴ Psicólogo em Contexto de Saúde Mental pela Universidade São Francisco. Pesquisador colaborador do Laboratório de Psicodiagnóstico e Neurociências Cognitivas (LaPEN) - Unisal - Americana. Atualmente é Professor do Centro Universitário FIEO – UNIFIEO/SP - Programa de Pós-Graduação Strictu Sensu em Psicologia Educacional - Fundação Instituto de Ensino para Osasco. Correo electrónico: montieljm@hotmail.com

⁵ Psicóloga, Bióloga pela Universidade São Francisco. Mestrado em Ciências da Saúde pela Faculdade de Medicina de Jundiaí, e Pós Graduanda em Psicopedagogia pela Anhanguera Educacional. Correo electrónico: cecatojuliana@hotmail.com

⁶ Graduação em Medicina pela Faculdade de Medicina de Jundiaí, mestrado em Gerontologia pela Universidade Estadual de Campinas e doutorado em Educação pela Universidade Estadual de Campinas. Médico responsável pela disciplina de Geriatria e Gerontologia da Faculdade de Medicina de Jundiaí - FMJ e pelo Instituto de Geriatria e Gerontologia Comendador Hermenegildo Martinelli. Correo electrónico: julicecato@yahoo.com.br
RESUMEN
El objetivo de este estudio fue conocer las principales estrategias de afrontamiento en una muestra de pacientes con distimia y comprobar cómo se formaron estas estrategias en este grupo de diagnóstico. Se analizó una base de datos con 24 historias clínicas de pacientes con diagnóstico de trastorno distímico, estas entrevistas se analizaron para hacer una comparación de los mismos con el material de la literatura, para que pudieran observar cuales estrategias de afrontamiento utilizadas por el grupo de pacientes distímicos. Por medio de los resultados descritos se puede observar que los pacientes que estaban usando la estrategia de afrontamiento centrado en sólo excitación fuera de foco tuvieron un mayor estrés. Por lo tanto, es evidente que muchos pacientes recurren a la medicación, la actividad física, la religiosidad, es mejor no dejar tan vulnerables al estrés al ocuparse de otras cosas y, por decirlo así, no tener mucho tiempo para experimentar la razón por la que les ha causado estrés.

Palabras clave: afrontamiento, salud mental, transtorno distímico.

STYLES AND COPING STRATEGIES IN PATIENTS WITH DYSTHYMIC DISORDER

ABSTRACT
The aim of this study was to understand the main coping strategies in a sample of dysthmic patients and check how these strategies were shaped in this diagnostic group. We analyzed a database with 24 case histories of patients diagnosed with Dysthmic Disorder, these interviews were analyzed to make a comparison of these with the material of literature, so that we could observe what coping strategies used by the group of dysthmic patients. By means of the described results we observed that patients who were using the coping strategy focused on only excitement took out of focus the stressor. Thus, is evident that many patients resorted to medication, physical activity, religiosity, it’s best not to be vulnerable to stress, to occupy themselves with other things and, so to speak, not having much time to experience the reason that caused them stress.

Key words: Coping, mental health, dysthmic disorder.

The concept of coping has been described as the set of cognitive and behavioral efforts used by the individual to cope with stressful events. These efforts to be expended for the adaptation of the subject to adverse and stressful, chronic
or acute conditions have become the object of study of Social Psychology, Clinical and Personality being intrinsically linked to the study of individual differences (Antoniazzi, Dell’Aglio & Banner, 1998). Folkman and Lazarus (1985) stated that from the 60s several studies began to relate coping not only with personality traits but with the subject-environment relation. From this perspective, the authors conceptualize coping as the process of interaction between the individual and the environment aiming the proper administration of stressful situation. The control of adverse circumstance is not the main focus of the coping actions. These actions would be subject to the perception the individual has of the event, ie, how he assesses the situation. This evaluation raises cognitive and behavioral efforts to decrease or make tolerable their own or environment demands. The actions are aimed at cope with stress (Lazarus & Folkman, 1980).

This definition implies that coping strategies are deliberate actions that can be learned, used and discarded. Therefore, cannot be confused with defense mechanisms unconscious and unintentional, such as denial, displacement, and regression. The defense mechanisms are considered rigid and tend to be inadequate to external reality, particularly when its exacerbation promotes maladaptive processes for the individual. The defense mechanisms originate from past issues and derivatives of unconscious elements. Rather, coping actions are considered flexible and purposeful appropriate to the reality and future-oriented with conscious derivations (Folkman & Lazarus, 1980; Câmara & Carlotto, 2007; Dell´Aglio, 2003).

According to Santos (1995), the stressor can be the same for different subjects but the ways we react to these events can be completely different. The way chosen to meet given situation depends on individual resources and previous successful experiences. The moderating variables of coping strategies relate to personal, physical and / or psychological and the individual social resources such as physical health, gender, ideological beliefs, morals, intelligence, temperament, influences acquired in childhood, past experiences, marital relationship, social networking, economic circumstances and position of control over the stressor, as well as the interaction between these features (Antoniazzi, Dell'Aglio & Banner,

Folkman and Lazarus (1980) classify the problem focused coping and emotion-focused coping. The problem focused coping consists in an effort to act in the situation that gave rise to stress trying to change it. For example, negotiate or seek practical help from others. The problem focused coping is internally directed and usually includes cognitive restructuring, for example, redefining the stressor element. The emotion-focused coping is defined as an effort in physical or psychological level, to regulate the emotional state resulting from the stressful event. For example, drink, go dancing, take soothing, watch the favorite program on TV, going to the gym. The use of coping strategies focusing on the problem or emotion depends on the perception of the subject, ie, the assessment he makes to the stressful situation in which it is involved.

The development of emotional disorders such as depression, may be related to inadequate or ineffective coping strategies (Borges, Manso, Thomas & Matos, 2006; Lopes, 2009). According to the authors, several studies points out the relationship between coping strategies and psychopathologic expression of different kinds. Depression, for example, tends to be present in most emotional disorders, a symptom of any disease, comorbid with other emotional states or its cause. Depression as nosological category is closely linked to mood disorders. A type of depression that becomes very common nowadays is Dysthymic Disorder which has mild and chronic symptoms such as depressed mood for at least two years, although in a less severe degree (American Psychiatric Association, 2002, Campos, Campos & Sanches, 2010).

Spanemberg and Juruena (2004), define dysthymia as a form of depression with less severe symptoms than major depression characterized by being non-episodic and chronic. Once the symptoms are mild and there is chronic disorder the diagnosis becomes difficult, since the individual shall be defined as sad person and thus say that this is their "way-of-being" that sadness is practically a feature of his personality (Orsini and Ribeiro, 2012). Dysthymia is a permanent state of depression associated with negative expression of affection, persisting over time, which interferes with the satisfaction in different areas of functioning. Continued
dissatisfaction, reinforce the frustration, the guilt and self-esteem, that would help lead to chronicity of symptoms. The DSM-IV (APA, 2002) describes that patients with dysthymia are seen as disinterested and incapable and that these symptoms become part of the patients life history only reported when directly investigated (Kocsis, et al, 1997). Another important feature of Dysthymic Disorder is that its onset occurs at earlier stages of human development compared to the major depressions. Individuals have persistent symptoms over several life stages (Kimura, & Silva, 2009). It is common that this disorder arises around 21 years (Andreasen & Hoenk, 1992; APA, 2002; Arriaga, Cavaglia & Lara, 1998).

Cope with Dysthymia symptoms can happen for example, with the work since patients can deposit their energy reserves on this nothing left for social and family activities which affect their interpersonal relationships. Thus, Dysthymia implies in a departure from daily activities instead of facing them causing the patient to seek something beyond that to escape (Lima & Fleck, 2009; Spanemberg & Juruena, 2004). The possible relationship between coping strategies and the presence of depressive symptoms emphasizes the need for studies on the subject. The study on the coping in dysthymic patients may facilitate the understanding of this relationship widening the possibilities and alternatives to think more effective interventions in relation to the dimensions of coping characteristics of this group of patients.

METHOD

To carry out the work a literature review was done on coping themes and dysthymic disorder. The material consisted of books and journal articles. A database with 24 case histories of Dysthymic patients were analyzed. These interviews were analyzed by comparing with bibliographic material so that we could observe the coping strategies used by the group of dysthymic patients.

Objectives.
Understand the main coping strategies in a sample of dysthymic patients.
RESULTS AND DISCUSSION

We observed that the emotion-focused coping which aims to regulate the emotional state resulting from the stressful event, is the most widely used as a way of coping with the disorder. In two interviews (one man and one woman) we note that patients used the therapy to change the way they deal with the stressful event as illustrated in the following statement:

"Therapy has greatly improved my world view, my view that the world affects me was actually the opposite, it has changed a lot".  
(Male, 37 years).

Three women faced dysthymia symptomatic stress through physical activity, in which they left aside the problem for a few moments and a man tried to get rid of the isolation attending recreational events as an example we have the following excerpts from interviews:

"I also sought for physical activity and helped me a lot. Today I say that is my refuge when I start to get into crisis. Sometimes I'm not even wanting to go but I just go out there and get even better."  
(Female, 33 years)

"I am tired of this kind of contact with people and I'm even more isolated in bars and small parties trying to stay closer to friends and things like that."  
(Man, 41 years)

Religion has also been used as a powerful resource to change the way the patient dealt with the stressful situation. Six patients of both sexes reported having improved considerably seek this strategy and one patient even states:

"When I am depressed I do not like to talk to anyone. I have sought help in religion and felt good because since then the Catholic religion helps me to keep stronger."  
(Female, 39 years)
In this sample psychiatric treatment was an alternative used by patients. This has been observed since they sought medical help by their own or on the family and friends advice or by a religious leader to improve their state. It is very clear that the most used strategy for both men and women respondents was emotion-focused coping sometimes based on medication, since this mechanisms enables the individual to face the stressful situation in a least harmful way. We observed also that the doctor besides drug treatment indicated psychological treatment as well as any other relevant strategy. Approximately 67% of the interviewed patients reported using any medication what improved their mental state at all as shown in the following excerpts:

"The medicine helps me to go to work do the things I need to do, talk to people, pay the bills. Without medicine I am nothing."
(Man, 36 years)

"Suddenly you're cheerful, willing, begins to improve, it's amazing how the medicine takes effect."
(Female, 46 years)

"Guess what? Was bad, sought a psychiatrist and started taking medicine ... Take medication makes me feel good."
(Female, 31 years)

"I felt the possibility of a new crisis and to not let it happen I thought best to seek help. So I looked for a doctor and he identified [dysthymia], I am now without psychological counseling, psychiatric only."
(Male, 37 years).

Another strategy used by dysthymic patients was dealing directly with the stressor, seeking to modify it in its source which consists of coping focusing on the problem. We found that some patients have used this feature as a way of coping. Psychological treatment was a form used by them attempt to change the stressor. Five patients of both sexes reported that they might face the problem that distressed them after some psychological treatment, as in this example:
"The psychologist was very good for my life. I cannot live anymore without analysis. Do you know, what the analysis makes by a person? I really was very ill at that time but now, I went through all this."

(Female, 31 years)

Some patients showed examples of coping problem sources by acting out such as:

"Sometimes I was very upset very hurt by things and not now. I do not keep things inside me. I can handle her [sister] now. Recently she discuss with my other sister and I said so ' I cannot stand it. I have no more strength to stay with all these issues every day hour discussing."

(Female, 55).

In the example above, it is observed that the patient, after a certain time, faces the stressful situation directly expressing their displeasure and seeking thereby to change the source of the stressor event.

FINAL CONSIDERS

By means of the described results we can observe that patients who were using the coping strategy focused only on the emotion were able only to take the stressor out of focus. Therefore, it is evident that many patients resorted to medication, physical activity, and religiosity, to not be so vulnerable to stress, occupy with other things and, not have much time to experience sources of stress.

Patients that use problem-focused coping strategies needed somehow to cope with the stressor change the situation. Therapy and analysis were used by some patients as a strategy to face the affliction.

While coping strategies were classified by the patients, we realize that the two approaches suggested by Folkman and Lazarus (1980) mingled at various points. Patients who used a problem-focused coping strategy could act on the stressful situation often because before they had changed the way they deal with this emotionally or because they also used previously emotion-focused coping
strategies. Below the patient report about this:

"First aware that you need to do a treatment, to have medication and that without the medicine you has no way. It was difficult because I did not want to take medicine being only with therapy but had no improvement, sometimes it was not even possible to go to therapy because I cried a lot, cried all the time". (Female, 33 years).

The patient report illustrates well the need for both coping strategies being used. In this case, the patient began seeking therapy to address what was distressing him, i.e., problem-focused coping, but the results were not beneficial, because the event was too aversive for her, so much that she just cried in therapy when put forward the problem. It was also necessary to seek psychiatric treatment so that the medicine was inserted as an emotion-focused coping strategy, since the medicine tries to act to mitigate the stressful symptoms that stressor event causes the patient.

Thus, it is observed that the emotion-focused coping is apparently a strategy less assertive or effective as the stressor is still present. The analysis of the interviews makes it clear, this is the most commonly used strategy by patients in the sample. It can be inferred that among the aspects related to chronicity of dysthymia is the predominant use of this coping strategy, since this stress will continue in one form or another. It is for health professionals specially those related to mental health working with the patient so that it seeks to confront the problem that distresses him, and thus achieve better living conditions.

Finally, it was noted also that personal discontent and trouble in cope with the disorder seem to motivate the search for all types of treatment. Therefore not knowing the Dysthymic Disorder by professionals or by patients causes damage to the last to be seen as moody and pessimistic people. In this sense ignorance about Dysthymic disorder contributes to these guys refer to a pattern of functioning which is repeated throughout life with coping strategies based on emotion. Thus, it is assumed that this form of confrontation only seems to change when mental health professionals arise to help these patients cope with the disorder directly by providing increased resources to reach patients demand through problem-focused
coping.

REFERENCES


