Clinical note

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Psychological study of the dysthymic disorder in the woman

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In this article, we study two dysthymic women who we are treating with psychotherapy in order to reveal the inner components that maintain depressive symptoms. The same findings have been confirmed in other dysthymic patients.

The result of the study consisted in discovering a sentimental separation from their love object, while the woman still lives with her partner and while the depressive symptoms are appearing insidiously. This development leads them to the deterioration in the "ideal of love" they sought, that supported their lives and served as an "anchor of their personality. This point of view places classic notion about mourning into doubt.

Key words:
Dysthymia, Neurotic depression, Mourning, Ideals, Love object

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Estudio psicológico del trastorno distímico en la mujer

En este artículo estudiamos a dos mujeres distímicas a quiénes tratamos mediante psicoterapia y, a partir de ahí, se pusieron de manifiesto aquellos componentes "internos" que sustentan los síntomas depresivos. Estos mismos hallazgos se confirmaron en otras pacientes con idéntico diagnóstico.

El resultado consistió en descubrir una desinserción sentimental respecto a sus parejas, permaneciendo con ellos sin separarse, al tiempo que van apareciendo insidiosamente las manifestaciones depresivas. Este desarrollo las lleva a la caída del "ideal de amor" al que aspiraban, que sostenía sus vidas y funcionaba como una "agarradera de la personalidad". Tales apreciaciones ponen en cuestión las nociones clásicas acerca del "duelo".

Palabras clave:
Distimia, Depresión neurótica, Duelo, Ideales, Objeto de amor

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INTRODUCTION

Dysthymia consists in a mild chronic depression with almost constant altered mood,[1] although with **anarchic** variations due to environmental circumstances, without any major symptoms being registered but with the neurotic spectrum.[2-4] We currently know that gender is a significant differentiating factor in depressive disorders, affecting women more and causing greater discapacity in them.[5, 6] Some authors have dedicated themselves to the study of the psychological differences regarding gender.[7]

In the following, we present two cases of dysthymic women diagnosed according to the ICD-10,[8] attempting to approach those components of subjectivity in play in the appearance, maintenance and/or stabilization of the symptoms (depressive). This opportunity was offered through the psychotherapy treatment (psychoanalytic orientation) the subjects underwent. That found in them has also been confirmed in others treated in the same way (a total of 24).

CLINICAL CASES

- **Patient no. 1 (P-1).** A 52-year old woman, secretary, married with one child. She is sad, downhearted, exhausted and nervous but continues to work. She has been suffering this picture for several years, with improvement only in specific times, in spite of the treatment prescribed. She considers herself to be a person who "who takes things very seriously" and remembers herself to be very happy, amusing, sociable and somewhat coquettish when young.
- **Patient no. 2 (P-2).** A 43-year old woman, married with two children. She studied law and currently manages

her own business. She is downhearted, cries easily and anxious. There is no improvement at any time of the day. She has no desire to go out, but if someone calls her and she goes out she feels a little better. She has followed drug treatment with very poor results. She does her work with much effort and considered that she is very bond to her origin family.

RESULTS

At the beginning of treatment, lack of knowledge of what was happening to her prevailed, and as this goes on, the following elements are becoming manifest:

a) **Discovery of a very serious conflict with partner**, that leads her to express great rage and resentment against her significant other, who she considers to be responsible for the problem while she considers herself in the role of victim **(P-2.** "I will tell my husband he is guilty of everything that is happening to me." "I have done everything that he has wanted me to since I married him, but all of this is over now. Does he deserve everything I've done for him?").

b) **Recognition of a disappointment.** After a variable period of time, the consultant is capable of accepting that the problem is within herself, then admitting the existence of disillusionment regarding the "object of love" (**P-1.** " There was a time when it seemed to me that I no longer loved him, but I don't know exactly how to define when. Has my partner disillusioned me? I don't know, but I would say so").

The companion of the dysthymic person is not going to cover her (high) expectations, reaching the poll of denigration when he does not behave as expected. It is not rare to find some paranoid matrices in the contact (**P-2**. "He doesn't leave me alone, he is a nuisance and he's always watching me"). The clinical-symptomatic affect of this phenomenon (disillusionment) is dysphoric mood, recognized by the authors as characteristic of these depressions and almost nonexistent in the "recurrent" forms.[3, 9]

c) **The separation (sentimental) from the "object."** It is identified, during the process, that there has been a sentimental detachment from the partner. This is not a specific moment, but a more or less prolonged period that explains the insidious onset of the depressive symptoms (**P-2.** "I believe that we are currently not a couple, we have pretended we are. This is very sad, because I got married with very much illusion and "all for nothing.")

In spite of the "sentimental divorce" they are heading towards, these women do not generally separate from their husband. This puts the question in doubt of the generally admitted idea of "mourning"[8, 10] To understand the dysthymic situation, it is necessary to differentiate between "physical" and "sentimental" separation, since both do not necessary have to go together. When we speak of "mourning" we are referring to the former without considering the "sentimental separation" with the "physical separation," which is the point we have reached. This affective discord is generally overlooked in the conventional clinical interviews because the evident aspect of the definition of "mourning" ("physical separation") is not produced.

The malaise comes from the "cadaver" of the relationship they are experiencing: two persons sentimentally separated who continue together ("loneliness of two in company"). There are many signs observed in this sense: lack of effective communication, lack of agreement and independent functioning, avoiding of closeness, distancing of the sexual relationships, etc.

d) The patients studied **idealize the sentimental relationship,** up to the point of this being "the salvation table" of their lives (leaving home, being independent, changing psychologically, leaving behind a past full of frustrations, etc.). It is not strange that when the patient finds her partner, she becomes filled with a captivating illusion that is later transformed into disappointment proportional to the grade of previous idealization **(P-2.** "I thought that all my problems were going to be solved by getting married, that I would never feel unfortunate." "I am a very passionate woman, my strong points are passions, and I think I looked for a fairy tail love").

Before the idea that the woman has about her spouse deteriorates, who she does not know well when they start to live together, it is not uncommon to find desperate attempts to change his personality in order to make it fit into her fantasies. This chronic lack of knowledge, together with the disdain arriving from the frustration of the high expectations, inhibits the establishment of new pacts and alliances. Akiskal,[3] correctly stated: "if they are married, they are trapped in unhappy marriages that do not lead to either reconciliation or separation."

e) **What does the dysthymic person really lose?** This is not a problem of "loss of love" that can be resolved by separation or changing *partner*. It goes much beyond that, since the loss is found in the "romantic ideal" and is therefore goes towards one of the "anchors" or "basic supports" of the personality, that they call in different ways the "fairy tale love," " the Prince who was going to save me," "someone who treatment me like a queen," "the love of my life" or "the eternally in-love man." It coincides with this that many of the patients want to be adored by their husbands unconditionally and almost continually, without given back anything in exchange **(P-2.** "This guy does what he likes and he does not take me into account or pay attention to me. He should have paid attention to me." "I want someone by my side who is very affectionate and loving and I have not had this").

Finally, we can say that more than "loving the man" we can say that "they love love" and if that was not enough, those things that they do have (work, children, friendships, etc.) and that could help them in the difficult time they are going through, do not help them much, although they can provide some transitory relief.

CONCLUSIONS

We have studied a combination of dysthymic persons treated with psychotherapy and we have discovered in them a significant loss, which refers to the "ideal of love" without which they end up disappointed.

From this sad result, there is the continuous confrontations with the reality of the peers, who cannot help more, in relationship to the excessive demands. Deep down, we recognize a true "incapacity to love," which in other places are called "anagapia." [11] It is something obvious, since it could be asked: How is it possible to love someone who you don't really know? This shows that it is not the same to "be interested in love" as being "capacity of loving" or "having interest in a specific person."

Although it seems strange, the patient per se seems to settle into the psychic pain before admitting the "disappointment-separation-disconfiguration" that sequestrates them and that ends the illusions formed for years. Thus, many dsythymic persons indicate that the depression is for them a "shelter," preferring the vital stagnation before admitting their own limitations. This question, that seems impossible, but is clinically demonstrable, did not escape the enormous intuition of Victor Hugo, when he spoke of "the happiness of being sad."

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