

## CHAPTER SIXTEEN

### MANAGING DEPRESSION IN PERSONS WITH DISABILITY

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#### **Introduction**

Mental health is an important aspect in the daily life and person-environment interaction and experience of persons with disabilities across all society. This experience includes activities in home, school, peer group, workplace, and community participation. The environmental barriers associated with impairment seem to make it really difficult to separate disability from mental disorders for a number of reasons besides the impairment itself. Exclusive society may be contributing to the mental health concern experienced by them. Loss of specific body organ, whether temporal or permanent is swamped with psychological problems; some of these problems come and go with time and treatment, while others come and maintain a posture of posttraumatic stress disorders and other psychological troubles, suicide inclusive.

American Psychiatric Association (APA, 2019) designed mental health as the foundation for emotions, thinking, communication, learning, resilience and self-esteem. Mental health also plays a key role in relationships, personal and emotional wellbeing and does contribute to community and societal development; and the other way round can be succinctly described as mental illness or psychological disorders (Kinanee, 2020). Mental illness is the subjective condition involving undesirable change in the pattern of behaviour, relationship and learning and it is often associated with frustration, and problems functioning appropriately in home, school, family and community activities and participation. One of the commonest features of mental illness in disabilities is depression.

Depression was once classified as a disability as disability was once severe categorized as a disorder. This may be because it alters the adequate structural and functional life of a person with disability and often comes with associated physical and health issues that really make life uncomfortable to the person and the significant others around him or her. Special needs persons are susceptible to depression for a number of personal characteristics, environmental factors and barriers within the society.

In the revelation of Kovac (2019), under the Accessibility for Ontarians with Disabilities Act (AODA), a barrier is anything that prevents a person with a disability from fully participating in all aspects of society because of his or her disability. In other words, barriers happen when places and activities that all

people should have access to are designed in ways that limit this access. Barriers limit the things people with disabilities can do, the places they can go, or the attitudes of others toward them, hence they get dissatisfied with life and depressed.

There is an unfortunate relationship between depression and disability. Without disability, **depression negatively affects physical, psychosocial and educational functioning** hence its intensified more in those with limited abilities. Conversely, decreased physical activity is associated with increased risk for depression. Depression is a common experience in disability.

Literally, loss of any kind such as impairment of vision, hearing, limb or capacity to learn often lead to psychological problems; adjustment in disability can only be completed when the individual exceeds the stage of depression; rejection as a result of disability leads to depression; environmental barriers and societal attitude are most likely to lead a person in the path of depression. Attitude is the most potent barriers to persons with disabilities. Attitudinal barriers are the most basic and contribute to other barriers persons with disabilities often encounter in school, workplace and community.

Impairment is biological, disability is society based leading to handicap thereby making persons affected with the condition to experience disadvantages and frustrations in accomplishing task, daily activities and enjoying adjustment free from depression. A combination of disability and depression comes with huge constrains that add to the restrains already experienced by persons with disabilities. The development and maintenance of depression in disability most likely result in isolation or withdrawal, invisibility, reduced task and academic performance, increased chances of exhaustion, infrequent suicide thoughts, routine traumata, inability to experience life in its fullest and other health related problems.

Furthermore, professionals describe depression as a leading cause of disability globally and stand as a prominent contributor to the overall global burden of disease. Also, depression is considered a psychiatric disability under the Americans with Disabilities Act (ADA). As one of the significant mental health problems it restricts the daily activities, involvement and contribution of a person with disabilities which may include inability to learn, work and interact freely and fruitfully in society.

The fair news is that even with the numerous crises introduced by the experience and expression of depression, this psychological problem is treatable or there exist possible management strategies for persons with disabilities to adopt and adapt. Some people utilize both appropriate and inappropriate management strategies to cope with the symptoms of melancholia.

The thesis statement of this discussion is hinged on the fact that depression prevails in persons with disability. Majority of them don't get treated and lack the basic skills to manage their depression under the present regime of exclusivity and should be assisted to migrate to an inclusive institutions and programme that will enhanced their Quality of Life. Consequently, this discussion addressed managing depression in persons with disabilities considering dynamics of disabilities,

describe the nosology of depression; identify the sources of depression, highlight gender roles in depression, identify strategic ways to manage depression in disability and finally draw up implications for inclusive education. Conclusion and suggestions will end the discussion.

### **Dynamics of Disability**

A disability is any structural and functional condition of the body or mind that affects the functional activities and abilities of a person in specific area which limits conventional interaction or conversation with the systems of the society and full participation in the community. The specific area of participation restrictions could be related to sight, mobility, memory, learning processes, communicating, ability to receive signals and sounds and assign meaning to them, quality of life, and interpersonal relationship as well as thought processes such as imagination, creativity and an individual pursuit for a life of excellence. Some persons may have more than one disabilities and it is highly possible that a person with one area of disability may experience disability in relative areas.

In the three dimensions of disability, Ajobiewe (2014) succinctly describes impairment as the distortion in biological factors, e.g. genetic mutation, chromosomal errors and accidents leading to inappropriate state of the organ(s) of the body. Disability as the result of the inappropriate state of the organ(s) of the body such as eye that cannot see well or can't see at all. Handicap is described as environmental or societal when the appropriate facilities one needs to function well as not available and in most cases creates huge amount of disadvantage to deal with. The absence of assistive technologies and other barriers can really make life more difficulty for those with disability (Bright-George & Owopetu, 2021).

### **Nosology of Depression in Disability**

Depression has been described as the most common disease in mental health across globe community for centuries. Everyone experiences sadness at times, but depression is something more that alters individuals' daily activities, it attacks personal enjoyments, social participation and all round Quality of Life (QoL) irrespective of the environment. A lot of scholars have identified this psychological and social disease as darkness invisible and the devil in the mind, perhaps as a result of its capacity to inhibit happiness, cause anhedonia, tendency to stop pleasure in life and anticipate end of life at the other extreme (Briggs, 2022; Nolen-Hoeksema, 2004). Depression is indeed a toxic emotion that saps the individual experiencing hopelessness and meaninglessness due to either huge loss or disappointment (Iwundu, 2020; Ozoji, 2005).

Depression is a common serious illness that causes people with disabilities to experience depressed outlook, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration, and tendency toward suicide. Living with depression is more difficult for those with disabilities, their families, friends, and colleagues than the general population in a

post COVID-19 Era. It can be more challenging to know if you are depressed and you can't do anything about it.

As with any significant loss, entering the world of disability requires mental adjustment. When the magnitude of the personal and environmental demands surpasses the social, emotional, and cognitive resources available to the individual, the prevalence of depression often prevails, and further complicating the experience in disability.

The features of depression are not fundamentally different between physically able and physically disabled individuals; however, there is reason to believe that a positive correlation exists between depressions associated with disabilities (Bright-George, 2022). The National Institute of Mental Health reports if any of the following symptoms are experienced for most of the day, almost every day, for at least two weeks, a person could be suffering from clinical depression; persistent sad, anxious, or "empty" mood; pessimism; irritability; feelings of guilt, worthlessness, or helplessness; loss of pleasure; decreased energy; moving or talking more slowly; having trouble sitting still; difficulty concentrating, and making decisions; early-morning awakening, or oversleeping; appetite and/or weight changes; thoughts of death or suicide; aches, or digestive problems without a clear physical cause and/or that do not ease even with treatment.

### **Types of Depression**

There are 5 major types of depression that can affect persons with disabilities. They include;

**Depressive Reaction or Stress Response Syndrome;** this is a normal feeling people with disability experience when they are predisposed to simple conflict stimulating condition or environment and negative attitude. This experience surfaces as a reaction to life's situations, environmental limitations and barriers, and it is often characterized as a temporary type. The question is, at what point did this depression becomes a problem. When experiences such as sadness, despair, sleep problems, loss of appetite, and loss of interest in activities a person once loved and wishes to end one's life last more than two weeks, then it calls for clinical attention.

**Major Depression or Clinical Depression;** this can occur as a result of life's condition, and social exclusion and severe environmental barriers. Clinical depression often interferes with people's ability to enjoy their life, maintain consecutive state of happiness over life, and inability to enjoy work, play, learning and essential daily activities. Major depressive disorder surfaces with a warning sign which was overlooked and degenerate to severe disturbances until it become a problem that requires the attention of a therapist. Warning symptoms include; persistent sadness; complex unhappiness; loss of interest in hobbies/ activities once enjoyed, internal expression of hopelessness, outward manifestation of helplessness; depreciating in energy most of the times in functional activities; non-participatory behaviour and considering suicide, etc.

**Dysthymia or Persistent Depressive Disorders (PDD);** some symptoms of reactive depression often surface at the onset of dysthymia. One core characteristic of this type is the persistent nature of reoccurring symptoms over a period of two months. In the view of Kinanee (2018), dysthymia could be diagnosed if a person with disabilities experiences a depressed mood in addition to two (2) other symptoms for at least two (2) years.

**Double Depression;** exceptional persons may experience the interaction of both clinical depression and dysthymia. They move from one extreme to the other; as if they feel they are getting better over one side of the coin, suddenly they switch to the other extreme with ease. Special persons diagnosed show behaviour of other emotional problems such as anxiety, eating disorder or sleep disorder that alter their chances of being receptive to treatment or management.

**Bipolar;** persons with disabilities who experience this type of depression often show extreme, rapid and dramatic or gradual mood swing that includes emotional highs and low. Kinanee (2020) identified seven signs to watch out for in bipolar; an excessive amount of energy; inability to relax; severe mood swing; inability to sleep; noticeable poor judgement; talk too much and too fast; overestimating one's abilities.

### **Sources of Depression in Persons with Disabilities**

Sources of depression in persons with disabilities are discussed under sub-headings; they include biological, health related, personal, social, home, school, workplace and community sources.

**Biological Sources of Depression;** this includes impairment, hereditary/genetic, prenatal / perinatal damage, biological deprivation and pains.

**Health Related-Sources of Depression;** this includes poor health services, affiliate health problems, stress, infection, brain defect or injury, etc.

**Personal Sources of Depression;** this includes personality type, belief, gender, impairment, adjustment seasons, learned helplessness and therapeutic nihilism (nothing works), etc.

**Sources of Depression in School;** this includes exclusion and restriction in classroom activities and participation, attitude of students, bully, abuse, tolerance, rigid teaching strategies, poor performance as a result of impairment, absence of Individualized Educational Programme (IEP), and unavailability of assistive device/technologies to aid learning and learning outcomes, etc.

**Sources of Depression in Home;** this includes parental attitude, pity, tolerance, invisibility, poor medical attention, poverty, dysfunctional family, single parenting, and abandonment, etc.

**Sources of Depression at Workplace;** this includes lack of accessibility to office building, work space, toilet and transportation to work, workplace constrains limiting work effectiveness, office tolerance and attitude of colleagues, employment conditions and demand of the job, organizational restrictions, and poor interpersonal work relationship, etc.

**Sources of Depression in Community;** this includes handicap inaccessibility, exclusive society, issues with mobility, no ramps or walkway support, attitude; negative thinking, speaking, feeling, and behaviour often isolate persons with disabilities from the mainstream, resulting in abnormality, and existence of barriers (self-limiting attitude and doubt in one's ability), etc.

Inferentially, community barriers include; physical environment that is not accessible, including absence of ramps; services and policies that are either nonexistent or that hinder participation and contribution in some areas of life; transportation barriers that limits movement; employment barriers that reduce incomes; Informational/communicational barriers; social barriers to disability are related to where someone grows up, learns and works – their employment, education, income and safety in the home; Absence of need assessment based assistive technology for adjustment and rehabilitative living; and attitudes such as stereotyping, stigma, and discrimination as well as social/self-prejudice are fatal ground to incubate the development and maintenance of depression (Bright-George, 2022).

### **Gender and Depression in Disability**

Reimagine Gender (2022) indicated that gender and depression connect in many ways, and the consequences can be literally life or death. Girls are almost twice as likely as boys to be diagnosed with depression and attempt suicide 1.5 times as often as boys, yet boys die by suicide 3.63 times more often than girls. Some reasons why girls may be more likely to seek care and thus receive a diagnosis for depression;

1. Girls experience particular gender-based stressors and double discriminations with disability.
2. Girls face greater stress on their time: Women do two more hours of housework than boys.
3. Girls are more likely to be sexualized from an early age, which harms mental health (and can contribute to illnesses like depression and eating disorders).
4. Girls also live with a threat of violence - This takes a toll on them. Of course, this is compounded by other factors of identity.
5. Girls who are of a marginalized race, special population, ethnicity, sexuality, or religion. They face even more threats and stressors in their lives.
6. Most girls treat rejection with withdrawal and invisibility which are likely to lead to heightened development and maintenance of depressive symptoms
7. Reactions to problems or distress from the angle of girls are more emotional which makes them to be perceived as easily depressed and sad

Studiesshow that boys' depression is also impacted by gendered experiences;

1. If girls are more likely to be diagnosed with depression, and more likely to attempt suicide, men are nearly four times more likely to die by suicide.
2. Boys exhibit courageous means to end their lives and make sure it is effective to cause them enough harm.

3. Boys also face extreme gender-based pressures and dire pressure of ownership mentality.
4. The heightened need to support a family in masculine based roles as assigned to them by the society and the increased expectation.
5. Traditional notions of masculinity dictate that boys should be strong and stoic; that can keep boys from feeling like they can share their emotions or communicate their suffering.
6. Boys are likely than girl to express emotional tantrum when depressed. When they find it difficult to communicate their frustrations, it leads to violent behaviour later in life as well.
7. Boys also experience trauma such as physical and sexual abuse, and are often left unable to talk about it.
8. Boys' friendships may be more likely to rely on shared activities, rather than talking about emotions, family, and relationships.
9. Boys treat rejections with isolation and unhappiness which increase the depressive behaviour.
10. Boys who cannot talk to girls about their feelings are vulnerable to depression.
11. Reactions to distress from the angle of boys are more mental which triggers prolonged emotional or impulsive approach to life.
12. Boys are likely to experience posttraumatic stress disorders because of their cognitive involvement in recycling depressive issues.

Women put others' interests first more often, which promotes internalizing problems, while men tend to privilege the self, more strongly, hence facilitating externalizing problems.

### **Managing Depression in Persons with Disability**

Management of depression are personal and professional coping or self-employed coping patterns to ward off the effects or pains associated with the experience of depression or at least to reduce its negative impacts irrespective of the absence or presence of the stressors. Often, people with disability who are rehabilitated, don't have their emotional or spiritual needs addressed. Application of personal and psychotherapeutic management strategies of depression in persons with disability are effective in the Post COVID-19 Era. The study has discussed management of depression in subgroups:

### **Social Management of Depression in Disability**

This includes building a network of happy friends, family social-emotional support, home safe haven, social participation, inclusive network and learning; inclusive classroom, inclusive work space, involve in physical activities, socializing practices encourage self-regard along with high regard for others to benefit mental health and individualized programmes such as Individualized Education Programme, individualized instruction and Individualized Counselling Services.

## **Psychological Management of Depression in Disability**

**Counselling intervention;** individual and group relationship between a professional personnel who is experienced in resolving specific crisis that has to do with self-understanding, decision making, relationship and other adjustment in school, home and community, can help a person with disabilities suffering from depression to adjust effectively and lead a successful life.

**Psychotherapies;** psychologists utilized various psychological tools and approaches to help a person with disabilities in a state of depression to adjust to crises and loss, cope with frustration and disadvantages, deal with negative attitude and poor self-concept, transform thought patterns, participate in useful and fruitful relationships that enhance mood, equipped to handle distress and other stressors, set SMART goals (Specific, Measurable, Achievable, Reachable and Time conscious goals). Some psychotherapies include:

**Logotherapy;** Viktor Frankl recommended that interpreting negative events such as impairment and difficulty in disability in meaningful structures can help people enjoy Quality of Life (QoL); identifying a worthy meaning in suffering reduces the severe effects in disabilities; hope is the most needed commodity in seasons of loss; making room for positive expectation to experience the good life; love for work and volunteering in seasons of distress curb the spread of noogenic pains; the true freedom of a person with disability is the one within which is the will to freely choose the path of love, work, art, peace, joy, kindness and frequent search for good meaning in a damaging environment; and live happily for those whom a person with disability loves.

**Cognitive psychotherapy;** Aaron Becks and Albert Ellis suggest that depression is a deep seated emotional wound/scar--Often leaves traces of its presence behind even after treatment of impairment or depression. With professional help individuals suffering from psychological pains can identify and alter undesirable patterns of thinking and endeavour to intentionally substitute and restructure those harmful thought, feelings and imaginations with positive beliefs, feelings, reasoning, ideas, opinion, and act according to good thinking (Jonah & Briggs, 2022).

**Learning new patterns of behaviour;** behaviour analyses and other learning principles are adequate in managing depression in persons with disability. A person can increase the value of physical activities such as sports, participations, social networks, and can learn new attitudes such as prosocial behaviour, positive outlook, stress free life and consciously adjust to barriers through learning. By maintaining a well-adjusted interaction with the environment people are predisposed to fulfil their life and satisfy needs. Gradually confronting fears of inability and exclusion can enhance ability and wellbeing--Systematic Desensitization heals.

**Psychotherapoetic;** the introduction of healing art such as therapoetic, proverbs, poems, music, dance, creative works, etc have being useful in managing psychological problems for the reason that most of them travel into the soul and

transform the heart in some positive ways consistent with the needs of a person (Adeosun&Bolaji, 2013; Trinya, 2019).

**Spiritual therapy** such as pastoral care and visitation, meditating on religious tenets, prayers, confessions, fellowshiping with others persons of similar faith often provide social and emotional supports system to mollify and heal emotional pains. Spiritual activities build resilience and faith to face the future (Jonah & Briggs, 2022).

**Network therapy**; in seasons of loss this treatment proves really effective for the empathic exchange and social roles it plays in restructuring emotional state and mental positions. It gives a person a sense of solidarity as friendly visitation is made by familiar persons who pray, sings, make material contributions and spend time with the affected persons (Adeola, 2022).

**Interpersonal psychotherapy**; this equips people with social relations and problems solving skills to deal with isolation and invisibility and promote involvement in seasons of distress.

**Medical /Psychiatric Management of Depression.**Health professionals with the prerequisite trainings often prescribe antidepressants for the management of all types of depression, though some scholars believe they seldom treat the mind.

### **Personal Management**

- Meditation in terms of imagination, muttering and speaking to one self in some positive ways often gives closure, creates satisfactions and stimulates emotional enjoyment.
- Planning one's life and being passionate about great expectations uplifts a downcast heart.
- Relaxation techniques such as solitary meditation and other relaxation techniques such as swimming, appropriate amount of sleep, seeing and listening to a nerve calming movie and music feed the heart with peace, happiness, and pleasure.
- Mental/Physical Exercise; the Holy Bible reveals that "bodily exercise profits one's life," "mental exercise improves wellbeing" (1Timothy 4:8). They nurture the nerves that build positive moods.
- Mobility; isolation is a sickness and results in more psychological disorders; going out to participate in social activities helps a lot in managing distress.
- Spiritual awareness
- Work; job related activities help in coping with depression.
- Volunteerism; one can enjoy social-emotional support from volunteering.
- Responsibility; taking the time out to pursue ones passion can help in managing depression.
- Identify your signature strengths by focusing on signature strengths such as creativity, happiness, to control the effects of psychological disorders and manage it successfully.

**Prove of Effective Management of Depression in persons with Disability** include happiness, participation in community life, having better way of thinking, feeling satisfied with life, wake new and productive plans, understanding your depression and reaction pattern, controllable anger and aggression, visibility and socializing, building positive components of self-concept; self-image, self-ideal and self-esteem, swift resilience in tough times, better adjustment in the environment and participating in creative and innovative works

### **Conclusion**

Depression in disability is a disease that causes depressed mood, reduced participation in pleasurable activities, changes in weight, changes in sleep patterns, irritability, fatigue, problems with concentration, and a tendency toward suicide. Boys and girls expression of depression. Differs. Depression may not be a consequence of disability, however, both personal and social sources can exacerbate depression. Application of personal and psychotherapeutic management strategies of depression in persons with disability are effective in the Post COVID-19 Era.

### **Implications for Inclusive Education**

1. Building sense of community and social acceptance as psychological medicines have been proven to manage depression in disability to help them learn effectively and satisfactorily.
2. Adapting the curriculum to suit the educational needs of special students vastly and positively influence their interaction and Quality of Life (QoL).
3. Counselling practitioners' supports and collaborations with parents and schools have promoted psycho-educational/psychosocial development and adjustment in inclusive society.
4. Appreciation of students' diversity is a unique model to adopt and adapt in promoting inclusive mental health service in the post COVID-19 Era in Nigeria.

### **Suggestions**

1. Creating sufficient accessibility to inclusive mental health services and utilizing social media, apps, and increased media representation to enhance adjustment in disability.
2. Build a structure of mental health first aiders where people spend the most part of their time, such as in school, home, religious centre and community to enjoy Quality of Life.
3. It is suggested that rehabilitative services should be designed to match the unique personality, potentialities and needs of all to yield fruitful result in aiding mental health.
4. Reducing/removing the sources of depression in disability requires knowledge, counselling practitioners, and problem solving/self-care skills in schools/homes to live happy.

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