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Influence Of Age, Gender And Marital Status On Depression Among The Physically Disabled

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Abstract: *The study was designed to investigate the influenceof age, gender and marital status on the manifestation of depression among the physically disabled. 165 participants simple randomly drawn from Rehabilitation centre for the disabled, Old and Tramps (RECDOT), Ozubulu Anambra Sate (45),Obosi, disabled home, Anambra State (40), Oji River Rehabilitation Centre Enugu State (40) and Imo State, disabled Community, Owerri Imo State (40) participated in the study. Their age ranged between 12–26 years with mean age of 19. A 21 item Beck Depression Inventory (BDI) was used to assess the cognitive, emotional vegetative symptoms associated with depression, developed by Beck (1976). A 2 x 2 x 2 factorial design was used in the data analysis. The result showed no significant influence of age on the manifestation of depression among the physically disabled (F(1, 161) = 1.090; P>0.05). The result of the study further revealed a significant influenceof gender on depression among the physical disabled (F(1,161) = 87.830; P<0.001). In addition, marital status significantly has an influence on the manifestation of depression among the physically disabled (F(1, 161) = 29.076; P<0.001). The result revealed no significant interaction effects. Discussion of the results together with recommendations were made.*

Key words: *Age, Gender, marital Status, Depression and physically Disabled.*

I. Introduction

We all experience periodic fluctuations in our emotions, such as becoming briefly depressed after personal losses or failures. But people with mood disorders experienced prolonged periods of extreme depression or elation, often unrelated to their current circumstances, that disrupt their everyday functioning. The frequency and intensity of depressive episodes varies from person to person. Winston Churchill was so hounded by depression that he called it the "black dog" that followed him around. People with depression experience extreme distress that disrupts their lives for weeks or months at a time. They may express despondency, helplessness, and loss of self-esteem. Their depression is usually worse in the morning(Graw et al, (2009). They may also suffer from an inability to fall asleep or to stay asleep, lose their appetite or overeat, feel constantly fatigued, abandon good grooming habits, withdraw from social relations, lose interest in sex, find it difficult to concentrate, and fail to perform up to their normal academic and vocational standards. About 2 to 3 percent of men and about 5 to 9percent of women suffer from major depression (American Psychiatric Association, 1994).
Ustian (2014) conceptualize depression as a drastic alteration in a person's mood resulting in the individual experiencing a number of very unpleasant symptoms. This state is accompanied by at least some of unpleasant symptoms such as increased or decrease in sleep (insomnia) dissatisfaction with one's life, and sometimes suicidal thinking or actual attempt. In psychotic cases, there may be delusions of persecution centering on sin guilt and punishment, somatic delusion in which the person or the individual believes that part of his/her body is missing or unfunctional and auditory hallucination of a persecutory nature.

The most common emotion in depression found in those that are physically disabled is sadness. This sadness is not the general form of sadness we all feel sometimes, but a deep unrelenting pain, as Travedi (2014) wrote, she was "unbearably miserable and seemingly incapable of any land of joy or enthusiasm". However, many disabled people diagnosed with depression report that they have lost interest in life. In depression found among physically disabled the crippled, to be precise, many bodily functions are disrupted. Changes in appetite, sleep and activity level can take many forms. Some physically disabled lose their appetite while others find themselves eating more, perhaps some want to sleep all day while some find it difficult to sleep and many may experience a particular form of insomnia (Travedi, 2014) behavourally, the physically disabled persons that are depressed are slowed down – a condition known as psychomotor retardation. They work more slowly, gesture more slowly and talk more slowly and quietly. They have more accidents because they have poor reaction time (Travedi, 2014).A few depressed people experience extreme behavioural disturbances referred to as catatonia. This is a collection of unusual behavioural act that can range from complete lack of movement to excited agitation. One form of catatonia is catalepsy. People with this condition seen to be in a trance like state and their muscles assume a waxy rigidity, so they tend to remain in any position in which they are placed. Catatonia can also involve recessive motor activity such as; fidgeting hands, foot tapping, jacking back and forth, and pacing,

all without any apparent purpose. The thought of physically disabled people may be filled with themes of worthlessness, guilt, hopelessness and even suicide. They often have trouble concentrating and making decision. In some severe cases, cognition of physically disabled depressed individual lose complete touch with reality and may experience delusion and hallucination. For example, people have delusions that they have committed a terrible sin, that they are being punished. They may have auditory hallucinations in which voices accuse them of having committed an atrocity or instructing them to commit suicide (Graw et. al, 2009).

Many individuals experiencing depression are unhappy and finds little pleasure in life. It has been proved that there is no single cause of depression; in fact many factors can contribute to this. Scholars of behavioural perspective believes that depression is a mood disorder characterized by pervasive dysphonia. Depending on the severity of this negative mood and the manner in which it has developed, dysfunctional thoughts and overt behaviour as well as physiological complaints may be present (Rechard, 2015). This approach construes depressive behaviours as being learnt largely by means of operant conditioning. While expanding this theory, Peter Lewinston contended that the life stress leads to depression because it creates a reduction in positive reinforcement in a person's life (Lewiston, 2011). The person begins to with draw and a self- perpetuating chain is created. According to Seligman (1975), depression comes about when one is faced with uncontrollable aversion stimulation or situation; unavoidable problems. He pointed out that though anxiety is often a reaction to a problems situation, depression could result when a person sees that there is no way out of the problem situation. He becomes helpless, confused and then depressed, that is the person's ego discovers shockingly, his helplessness becomes depress. This theory attempts to say that it is not the loss of reinforcement; but the loss of control over reinforcers that causes depression.

Research on learned helplessness inspired another line of work on the ways people cope when they are depressed (Rechard, 2015). Some people, when depressed, focus intently on how they feel their symptoms of fatigue and poor concentration, their sadness and helplessness can identify many possible causes of these symptoms. They do not attempt to do anything about these causes, however, and instead, just continue to engage in rumination about their depression. People with more ruminative coping style remain depressed longer than those people with a more action – oriented coping style, (Rechard, 2015). Disabled depressed people differ on the extent to which they ruminate and those who ruminate more become more severely depressed overtime and remain depressed longer than those who do not.

One of the first cognitive themes of depression was developed by a psychiatrist Aaron T. Beck in (1967). This theorist viewed depression as caused by a distortion of the patient's evaluation of himself, his world and his future. Beck (1986) argued that physically disabled depressed people look at the world through a negative cognitive triad; they have negative view of themselves, of the world, and the future. They feels that they committed characteristic illogical errors in thinking, illogical conclusions about self, excessive self–blames, and an excessive perception of hopelessness of life.They are victims of their own illogical self–judgment. They see themselves as losers. Beck (1976) also asserts that certain individuals are predisposed to depression by certain painful life situation such as the loss of some vital part of the body as in the case of the physically handicapped. Due to this and other early experiences, they are apt to overreact to similar situations later in life. Beck cognitive theory of depression (1967) has gained wide spread attention. One of it's major assertion is that it provides an etiological perspective of the disorder that is consistent with plan for the treatment. It has led to one of the most widely used and successful, therapies for depression, cognitive behavioural therapy.

The bio psychological view point on the etiology of depression has it that depression have a biological basis, apparently influenced by heredity.Identical twins have higher concordancerates for major depression (Ozil 2016) than do fraternal twins. Because identical twins have the same genetic inheritance, while fraternal twins are not more genetically alike than ordinary siblings, this provides evidence of a heredity predisposition to develop depression and other mood disorders. The heredity predisposition to develop depression may also manifest itself by it's effect on neurotransmitters. Major depressions are related to abnormally low levels of serotonin or nor epinephrine in the brain (Neal, 2014). One study measured levels of a chemical by product of serotonin in the cerebrospinal fluid of depressed people who had tried suicide. Of those with above – average levels, non subsequently committed suicide. Of these with below - average levels, 20 percent subsequently did (Branskman 2010). Antidepressant drugs, often prescribed for suicidal people, act by increasing the levels of serotonin (Pillner, 2014). Depression is associated with a combination of low levels of both serotonin and nor epinephrine.

Those who favour the humanistic viewpoint attribute depression to the frustration of self–actualization. More specifically depressed people suffer from incongruence between their actual self and their ideal self (Strauman & Higgins, 2004). The actual self is the person's subjective appraisal of his or her own qualities. The ideal self is the person's subjective judgment of the person he or she would like to become. If the actual self has qualities that are too distinct from those of the ideal, the person becomes depressed.

The manifestation of depression varies according to the particular symptom pattern displayed. The disabled person must also experience early morning awakening, marked psychomotor retardation or agitation, significant

loss of appetite and weight, inappropriate or exclusive guilt, reduced sex drive, irritability, demands for attention and love, rigidity, suicidal ideas and thought, loss of interest in people and usual/social activities and self castigation. All depressed persons also indulge in all the above during their periodic depression, but with differences in duration, severity, casual effects and extent to which it interferes with other general functioning.

The manifestation of depression varies in age and gender. Boer (2004), in his investigation of the link between age related physical incapacitation and depression submits that there is an existence of a positive correlation between both variables (age – related incapacitation and depression). Lake (2007); writing on psychological intervention for depressed elderly with chronic physical illness maintains that depression is common in elderly people. The study proposed,after a comprehensive literature review, that depression in elderly people with physical illness results from disability and reduction in psychosocial resources. Jackson (2010) studied the family histories of physical disabled people and concluded thatthe children of the depressed parents often experience poor parenting and many stressful experience, they may fail to develop good coping skills and a positive self concept. They are therefore vulnerable later in life (at old age) to stressful events that may trigger depressive reactions. As adults these people are constantly searching for approval and security in their relationship with others. They are anxious about separation and abandonment many may allow others to take advantage and even abuse them rather risking losing the relationship by complaining. They are constantly striving to be "perfect" so that they will be loved. Evenwhen accomplished great things, they do not feel secured or positive about themselves. Eventually, some problems in a close relationship or some failure to achieve perfection occur and they become depressed (Jackson, 2010).

It has long been observed that women are about twice as likely to become clinically depressed as are men and also women have difference responses to being in a depressed mood than do men, and it may be these different responses that lead to differences in the severity and duration of depression for women and men. In particular, some women are likely to ruminate when they become depressed. Ruminating includes responses such as trying to figure out why they are depressed, crying to relieve tension, or talking about the depression provoking situation. This is likely to maintain orexacerbate depression, in part inferring with instrumental behaviour (i.e taking action) and engaging in effectiveinterpersonal problem solving (Rechard, 2015). Men in contrast, are more likely to engage in a distraction activity when they get in a depressed mood, and distraction seems to reduce depression. Distraction might include going to movies, playing a game, going to club or avoiding thinking about the depression provoking situation. This suggest that prevention strategy for women would be to teach them distraction mechanism rather than rumination as a response to depression. Several psychological explanations have also been advanced. One viewed that depression on women arises from the social discrimination that prevents them from achieving mastery by self assertion. Inequality leads to dependency, low self esteem and depression (Leiman, 2010). Another psychosocial form focus on learned helplessness model. According to this model, stereotypical images of men and women producein women, cognitive sets of classic faminine values, reinforced by social expectations of which helplessness is one dimension (Leiman, 2010).

Depression is a complicated phenomenon as showed to manifest in different ways in different individuals and in different systems at different time. Thus the various Theoretical and empirical position cited, no doubt have broadened over horizon on the subject matter of depression, but this study focuses on the manifestation of depression among the physically disabled.

II. Method

Participants

Onehundred and sixty five (165) participants simple randomly drawn from Rehabilitation Centre for the disables, Old and Tramps (RECDOT), Ozubulu Anambra State (45),Obosi, disabled home, Anambra State (40), Oji River Rehabilitation centre Enugu State (40) and Imo state disabled community, Owerri Imo State (40) participated in the study. They included 84 males and 81 females in general.Their age ranged between 12–26 with mean age 19.

Instrument

The instrument used for the study was 21 item Beck Depression Inventory (BDI) to assess the cognitive, emotional vegetative systems associated with depression. The BDI was designed to detect and analyze the intensity of depression among the physical disabled developed by Beck (1967). The BDI scores ranges between 0 -60. Scoring is based on a five point graduates scale format ranging from 0-9 normal range, 10–15 mild depression, 16–19 mild – moderate depression, 20–29 moderate severe depression to 30–60 severe depression. The internal consistency was demonstrated by significant relation between each items and BDI total score. The instrument has odd–even item correlation of 0.86 and wasobtained along with spearmanBrown correlation of 0.93, deported spilt-half reliability ranging from .78 to .93. The mean co-efficient alpha reported

was .87. The construct validity was review with a correlation of .72. It was observed between the BDI scores and clinicians ratings of depression and also found useful as a research instrument (Osinowo, 1988).

Procedure

The researcher with the help of a research assistant, administered the instrument to the participants when permission from their management was granted. 200 copies of the instrument were distributed in general, 198 copies were retrieved, 33 were discarded based on mutilation and skipping of vital questions even when instructed and guided on what to do. As a result, 165 duly completed copies of the instruments remained and were eventually scored and used for the data analysis.

III. Design/Statistics

The Study adopted a 2x2x2 factorial design. A 3 way analysis of Variance (3 way ANOVA) with unequal sample size was used for data analysis. The F – test was also employed because of the unequal size.

IV. Result

The scores obtained from the depression questionnaire served as the dependent measures for the study.

Table 1: Table of means, standard deviations of the number/various groups on the dependent variables, Depression.

Variables	Level	Mean	SD	Number
Gender	Males	17.67	4.26	82
	Females	35.77	5.78	54
Age	Young	29.38	6.16	111
	Old	39.83	5.78	55
Marital Status	Married	20.06	5.54	110
	Single	40.12	5.37	54

The result as shown in Table 1 above, showed that there were a noticeable mean difference across the gender of the participants; 17.67 (mild moderate depression) for males and 35.77 (severe depression) for female. This tends to suggest that females were more depression than males. However, the mean differences across the ages of the disabled were not much 29.38 and 39.83 for the young and old respectively. But for their marital status, there were a great lean difference 20.06 for married and 40.12 for the single. Thus, age do not seem to be a great variable in depression for the disabled but marital status is. The singles appeared to experience more depression than the married.

Table 2: ANOVA Summary, Table for Age, Gender, Marital Status effect on depression scores of unequal sample size.

ANOVA	Sum of square	Df	Mean squares	Fraction	Significance
`Gender (A)	1689.924	1	1689.924	87.830	0.0001
Age (B)	20.975	1	20.975	1.090	0.298
Marital status (C)	559.450	1	559.450	29.074	0.0001
AXB	1.000	1	1.000	0.000	0.311
AXC	1.000	1	1.000	0.030	0.311
BXC	0.032	1	0.032	0.002	0.968
AXBXC	1.000	1	1.000	0.322	
Error	3067.767	161	3097.767		
Total	139406.000	166	139406.00		

The three way analysis of variance with two levels for Age, two levels, for gender two and two levels for marital status were used to analyze the data. From the above table, two out the three main influence were significant. We can see that gender is a significant factor depression among the disable ($F(1,161) = 87.830$; $P<O.001$). Age is not a significant variable in depression among the physically disabled ($F(1,161) = 1.090$, $P>O.05$). Finally, marital status is a significant variable on depression among the physically disabled, ($F(1,161)= 29.076$; $P<O.001$). There were no interaction effects.

V. Discussion

The result of the study the influence of age, gender, and marital status on depression among the physically disabled presented in Table 1 and 2 respectively showed that Age did not play a significant role in

influencingdepression among the physically disabled. The mean scores young (29.38) and old (39.83) disabled is insignificant. Judging from the table, the first hypothesis which stated that depression among physically disable will differ according their ages was rejected.

This study portends that physically disabled who are young suffered moderate severe depression. This work contradicts the work of Lake, (2007) who found out that young disabled could be so seriously depressed that they lose all sense of existence. Boer (2004) in his investigation of the link between age related incapacitation and depression also submits that there exists a positive correlation between both variables. This also does not provide support for the present finding.

However, the second hypothesis which stated that "there would be a significant influence of gender on depression among the physically disabled was accepted. This study shows that the physically disabled who are males suffered moderate depression to compared with their female counterparts who suffered severe depression. This result is in consonant with the work of American psychiatric Association (1994) that inequalities between men and women leads to dependency and depression and that about 2 to 3 percent of men and about 5 to 9 percent of women suffer from major depression. Thus while it is confirmed that age does not play a role in depression among the physically disabled or challenged, this study refutes the role active of gender. The result of this study support the influence of marital status on depression among physically disabled. However the third hypothesis was accept which implied that there is a significant influenceacross their marital status. This shows that the married disabled were moderately depressed compared with single who were severely depressed according to the result on table 1. Paradoxically, the singles always feel that the hope might be lost because of their physical disability in terms of marriage. This increases their tendency of being severely depressed. The married disabled feel little depressed because a times they are cared for by their spouse and their immediate environment is more responsive and more open.

The result however, showed no interaction effect.Age, genderand marital status had no more influence on depression among the physically disabled it is evident from the result presented in the proceeding pages that gender and marital status are implicated in depression thus, care givers as well as administration of the disabled centers and communities should direct programmed that would enhance the adaptive coping strategies of the female and the singles in their centre and community. The results will also help the family, educators, social/ clinical psychologist to treat and deal with the physically disabled with care and love in order to enhance and promote their self worth and self esteem. Government in conjunction with administrators or president of the disabled communities, counselors and clinical psychologists should organize workshops on periodic bases for the families of thee disabled, and the disabled themselves on how to foster effective coping strategies both for the young and the elderly who are physically challenged in the society. Government should also assist the physically disabled centers, communities and school to meet the challenges of daily needs of the disabled in order to boost their self esteem and sense of self worth. Formal and informal training should be encouraged among the physically challenged so asto enhance their independent life style, while reducing their dependent rate. The families, friends and other care givers should be tutored on how to reduce the physical burden of depression among the physically disabled in their houses and homes.

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