PROBLEM AND HYPOTHESES

Arthritis is a group of conditions where there is degeneration and/or inflammation of the joints, frequently resulting in pain and discomfort (Hughes, 2004). In a normal joint, where two bones meet, the ends are coated with cartilage, a smooth, slippery cushion that protects the bone and reduces friction during movement. A tough capsule lined with synovial membrane seals the joint and produces a lubricating fluid. Ligaments surround and support each joint, connecting the bones and preventing excessive movement. Muscles attach to bone by tendons on each side of a joint. Inflammation can affect any of these tissues.

Inflammation is a complex process that causes swelling, redness, warmth, and pain. It's the body's natural response to injury and plays an important role in healing and fighting infection. Joint injury can be caused by trauma or by the wear and tear of aging. But in many forms of arthritis, injury is caused by the uncontrolled inflammation of autoimmune disease, in which the immune system attacks the body's own tissues. In severe cases, all joint tissues, even bone, can be damaged. The major complaint by individuals who have arthritis is joint pain. Pain is often constant and may be localized to the joint affected. So to summarise, the pain from arthritis occurs due to inflammation that occurs around the joint, damage to the joint from disease, daily wear and tear of joint, muscle strains caused by forceful movements against stiff, painful joints and fatigue.

The term arthritis is used to refer to several different musculo-skeletal problems. These include osteoarthritis, rheumatoid arthritis, juvenile arthritis, systemic lupus, gout, and fibrositis. The term has also been extended to include symptoms that arise from injuries in tissues near the joints where no specific damage to the joint itself is evident. Arthritis and rheumatism include a wide variety of disorders affecting the peripheral joints (knees, ankles, finger joints) the spine the soft tissues surrounding joints (tendons, ligaments, capsules), and the connective tissues may be affected by congenital anomalies, metabolic or biochemical abnormalities, infections, inflammatory conditions or cancer (Kidd and Jawad, 2003). Certain rheumatic disorders occur more commonly in the young.
(inflammatory arthritis), in women (connective tissue diseases such as lupus erythematosis, and rheumatoid arthritis), in men (gout, ankylosis spondylities), or in the aged (osteoarthritis).

Arthritis is considered a stressful chronic illness (Melanson and Downe-Wamboldt, 2003). It is known that the persistent pain, joint stiffness, and joint damage of arthritis not only produce substantial physical disability, but also negatively influence numerous aspects of individuals' lives, including functional ability, work, family and social relationships, and psychological status (Escalante and del Rincon, 1999; Yelin and Callahan, 1995; Katz, 1998), as well as lost or reduced independence, uncertainty, and role changes (Melanson and Downe-Wamboldt, 2003). In other words, the arthritis is not only a biological problem but also affects one's daily routine life as well as psychological and social health. The interference in daily routine itself may lead to many routine maladjustment and emotional maladjustment.

In such situation of disturbance every individual has to and tries to adopt different ways of coping as an effort to resume maximum normality. Many studies show that diseases have negative effect on our health (Yelin and Callahan, 1995; Katz, 1998; Katz et al, 2006). Pain is perceived as uncontrollable which also create psychological and behavioral disabilities. These disabilities include depression, functional impairment, decreased self-esteem and negative changes in family functioning. People use different types of coping strategies in order to deal with disease related stress. Pain is perceived as stressor followed by limitations in mobility, difficulties in carrying out activities, interference in family relationships, difficulties performing at work, and discomfort of treatment (Mahat, 1997).

On the basis of the above discussion it is obvious that the disease negatively affect the QOL of the diseased person. Its impact however differs in different persons. People try to deal with disease related stressors, to maintain their well-being and good QOL using different resources. As already mentioned in introduction chapter Tak (2006) found that there are six important sources of stress in daily life of arthritis patients: (i) Health (ii) Routine Tasks (iii) Family Issues (iv) Financial Management (v) Social Relationships and (vi) Living Conditions. In this study three major strategies of coping with daily stress
emerged: (i) Cognitive Efforts (ii) Diversional Activities and (iii) Assertive Activities. So arthritis is a chronic disease that affects the activity levels of the patient and becomes a major chronic daily stressors. This single study has shown that the impact of arthritis is enormous on the patient and various efforts are made by the patients to cope up with it. The impact of arthritis could be understood in terms of the effect of arthritis on patient’s day to day activities e.g. walking, sitting etc., pain felt by them and limitations caused by it, limitations in social relationships and stress of the disease felt by the patients. So coping with arthritis is difficult and disruptive.

Individuals differ in the way they adjust to chronic illness. Although arthritis is not a life-threatening disease, but it more or less imposes disability on the individual. So self-management in terms of symptom control is especially important in the disabling but not life-threatening types of chronic diseases to reduce the impact of the disease on Quality of life (Miller, 1992). All this makes very evident that coping for the patients of arthritis has its own relevance and implications. Coping is increasingly implicated as an important mediator between stress and illness outcome. So impact, coping and QOL are relevant and important variables of study for the arthritis patients.

To summarise the review of related studies, it is clear that both problem focused and emotion focused coping are used by the arthritis patients in order to manage the disease related problems (Downe-Wamboldt, 1991). Religious coping are also used by the people in order to manage pain and also with the disease related complains (Dunn and Horgas, 2004). Falton and Revenson (1984) found that information seeking (PFC) have positive impact on adjustment whereas wishful thinking has negative effect. Fitzpactrick et al. (1988); Deoglas et al. (1994); Tak and Laffrey (2003); Trehare et al. (2005); Zyrianova et al. (2006) also found that social relationship (PFC) is helpful in improving health. Patients who have high score on social relationship also have high score on psychological well-being. Patients who coped by restructuring life goals were found to have better psychological adjustment and functional status than patients who hoped for unrealistic solutions or engaged in self-blame (Parker et al., 1988). In some studies PFC is found to be better strategy as compared to EFC. Also it is found that PFC is an important predictor of quality of life in arthritis. The respondent found PFC more useful (Downe-Wamboldt and Melanson, 1995; Fry and Wong, 2000; Rock et al., 1997; Thulin and
Nortvedt, 1999). Some gender differences have also been found in using different coping strategies (Affleck et al., 1999). Some studies found that spirituality is directly associated with positive affect and health perception (Abraado et al., 2004; Bartlett et al., 2003). Although, psychological aspects of arthritis e.g. QOL have been a focus in the past but have not been studied much in relation of coping strategies.

As is evident in chapter II data related to arthritis and QOL/SWB, or arthritis and coping is not less, but relationship of coping styles/strategies with its impact and consequent QOL are really missing. However, comparative studies of EFC, PFC and Religious Coping (RC) are very less in number and they do not give clear picture about the effectiveness of either of the strategy.

Indian psychological literature also does not reflect such relationship between arthritis and coping. For preparing the health management programmes to educate the patients, it is important to find out which strategy is most effective. Arthritis was chosen in this study because this is one of the most frequently occurring diseases, with which an individual lives for a long period, and it is a chronic stressor affecting the life seriously and permanently as already mentioned. So in order to find out the relative effective of all the three strategies following problem was formulated.

Problem:

To study the effect of various types of coping on quality of life of arthritis patients.

Objectives:

1. To compare the effectiveness of the three types of coping (i.e. religious coping, problem focused and emotion focused) on quality of life of arthritis patients.

This was the major objective of the study. However, with the available data, it was further thought worthwhile to explore some more information. These later formulated objectives have been given below:

2. To explore that which coping is being used more by the arthritis patients.
3. To explore the impact of adopting various copings on arthritis and its management i.e. AIMS.

4. To explore the impact of adopting various copings on QOL of arthritis patients.

5. To explore the impact of adopting various copings on AIMS in different levels of pain i.e. moderate, high and low pain patients.

6. To explore the impact of adopting various copings on QOL in moderate, high and low pain patients.

Hypotheses:

1. Religious coping would lead to a better quality of life (i.e. general and disease specific) in arthritis patients than problem focused and emotion focused coping, and problem focused coping would lead to better quality of life than emotion focused coping of arthritis patients.

The hypotheses pertaining the other objectives are as follows:

2. The patients of arthritis would use the problem focused and religious coping more than emotion focused coping.

3. The patients of arthritis adopting religious coping would be better in managing arthritis than those adopting problem focused coping and both these styles would lead to better management than emotion focused coping.

4. The patients of arthritis adopting religious coping would have better QOL than those adopting problem focused coping and both these copings would lead to better QOL than emotion focused coping.

5. The impact of various coping ways would not differ in arthritis management amongst moderate, high and low pain patients.

6. The impact of various coping ways would not differ in arthritis QOL amongst moderate, high and low pain patients.