SUMMARY

An inflammation of a joint or any damage to a joint that produces pain, is generally named as arthritis. The major complaint by individuals who have arthritis is joint pain. So arthritis is a group of conditions where there is degeneration and/or inflammation of the joints, frequently resulting in pain and discomfort (Hughes, 2004).

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). Furthermore, it has been shown that living with arthritis is associated with decreased Quality of life (Nadal, 2001).

It is also a troubling condition which require people to cope with pain, stiffness, fatigue, and physical limitations. The way they manage these aspects of their illness influences their ability to engage in meaningful, obligatory and discretionary activities, including the domains of work, family life, leisure, and social relationships. As social beings, with specific roles and responsibilities, humans engage in a range of life activities. Pain, along with other symptoms from arthritis, threatens the ability to participate in these activities, and may compromise psychological and social well-being. So coping is one important aspect in order to deal with disease and to maintain good Quality of Life. 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. Following section deals with the meanings and description of these variables.
Coping:
An examination of coping strategies that people with arthritis use to deal with stress has significant implications. Lazarus and Folkman (1984) defined coping as "Constantly changing cognitive and behavioural efforts to manage, reduce or tolerate external and/or internal demands that are appraised as taxing or exceeding the resources of the person". **Problem Focused Coping:** This strategy involves direct dealing with internal or environmental demands that create threats either by reducing its demands or by increasing their capacity to deal with the stressor. People tend to rely on problem – focused coping strategies when they believe their resources and situations are changeable (Lazarus and Folkman, 1984).

**Emotion Focused Coping:** In this strategy people use behavioral and cognitive strategies to manage their emotional reaction to stress. Behavioral strategies include seeking out others who offer social support, using alcohol or other psychoactive drugs, or keeping themselves busy to distract attention from problem.

**Religious Coping:** Religious coping refers to the uses of religious belief or practices to cope with stressful life circumstances. It includes activities such as prayer, seeking comfort from one’s faith and obtaining support from Church members. Religious coping is both positive and negative. In the positive religious coping religion is appraised as benevolent. And in negative religious coping religion is not appraised as benevolent e.g. anger at God. Religion interlocks with individual’s life and allows them to deal with stresses in life. There also appear to be general benefits of religious beliefs regarding health that may result from better health practices.

**Quality of Life:** Quality of life (QOL) is a descriptive term that refers to the person’s emotional, social and physical well-being and their ability to function in the ordinary tasks of living. QOL is often measured in its relation to health and disease. Bowling (1991) has also defined the QOL as individual’s responses to physical, mental and social effects of illness on daily living that influence the extent to which the personal satisfaction with life circumstances can be achieved. As health is generally cited as one of the most important determinant of overall quality of life, it has been suggested that QOL may be uniquely affected by specific disease processes such as Arthritis. According to Coons and Kaplan, (1992) the basic dimensions of health related quality of life are physical status and functioning, psychological status, social functioning, and disease or treatment- related symptomatology.
Along with the psychologists, now there is a growing awareness among health-care specialists that quality of life is an important health outcome in assessing the functioning of chronically ill. Regarding arthritis the prevalence all over the world including India is quite high. Since the disease is almost life long, patients need to learn the effective ways of dealing with the pain and to manage the disease. With an advent of positive psychology, there is a growing emphasis on psycho-educative programmes. However, such skill training programmes can be run only after knowing fully well that which coping affects the QOL in which way. The data on this is still lacking. Major studies are the correlational works. Beside this, the context is also important. Indian studies carry more relevance for Indian population. So the present 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.

Method

Design: A multi-group design having three groups of arthritis patients adopting religious coping, problem focused coping and emotion focused coping was employed.

Sample: A mixed gender group of total 707 diagnosed patients having arthritis of any type in an age range of 15-65 years was taken from PGIMS, Rohtak; Civil Hospital, Rohtak; and from many other places of Haryana. They were given a pain scale, two coping scales related to three types of copings, arthritis impact scale and QOL scale. Now the Ss having moderate intensity of pain who have adopted any one coping i.e. either religious, problem focused or emotion focused coping than the other coping strategies, were selected to form three groups for further research. There were total 374 Ss having moderate pain. Out of these 82, 107 and 78 Ss were high only on EFC, PFC, and RC respectively. Patients having high and low pain were also considered. There were total 169 Ss who were having high pain. Of these 64, 33, and
36 were high only on EFC, PFC, and RC respectively. There were total 164 Ss who were having low pain. Of these 35, 40, and 24 were high only on EFC, PFC, and RC respectively.

**Tools:**
1. Rheumatoid Arthritis Pain Scale (RAPS)
2. Ways of Coping (Revised) Questionnaire
3. Ways of Religious Coping Scale
4. Arthritis Impact Measurement Scale-2SF
5. World Health Organization Quality of Life (WHOQOL)

**Procedure**
After selecting the appropriate tools for the study, all the tools were translated to Hindi for better understanding of the subjects. Then the permission of the PGIMS, Rohtak; Civil Hospital, Rohtak; and from many other places of Haryana was taken in order to collect the data on the diagnosed patients of arthritis. The other social resources were also used for collecting data by distributing the scales. The patients were given arthritis pain scale, arthritis impact scale, ways of coping questionnaire, ways of religious coping scale and WHOQOL-BREF. Proper instructions were given for all the scales and scales were got filled. Scoring was done according to manual. After this, on the basis of Quartiles RAPS scores were differentiated for different pain intensities. The main purpose of the study was to consider only moderate pain patients. The Ss having high and low pain were also analyzed later on. The T-scores were calculated for WORCS and WAYS-R in order to make the coping scales comparable. T scores of each subject were categorized by mean ± SD. After that subject having moderate pain intensity and high score on any one of the coping strategy and low on other two types of coping strategies were taken as final sample. In this way three coping groups i.e. RC, EFC and PFC were formed. The AIMS and QOL score of the finalized subjects of each three coping groups were analyzed by one-way ANOVA followed by DRT. Similarly the scores of high pain and low pain Ss were also taken and analyzed.

**Results and Discussion**
Regarding the first objective no significant difference was observed in the patients having moderate pain in terms of impact of arthritis. Whereas for QOL scores, PFC and RC were found to be better than EFC in order to maintain better QOL when the
pain was moderate. Overall results indicate that PFC leads to better QOL in total as well as for all the dimensions of QOL.

For the findings related to second objective it seems that the number of subjects following the RC was less but the degree of faith or the following of religion as coping strategy was still higher than the amount of other two copings used by the subjects. The second hypothesis predicting that the patients of arthritis would use the problem focused and religious coping more than emotion focused coping, has thus not proved.

In the third objective regarding the arthritis impact, the AIMS-2SF score for total sample who are high on one coping and low on other two copings no significant difference was found in all the three groups i.e. the groups coping with arthritis by using RC, EFC and PFC. The third hypothesis predicted that those adopting religious coping would be better in managing arthritis than those adopting problem focused coping and both of these copings would lead to better management than adopting emotion focused coping. This has not proved.

The fourth hypothesis predicting that 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, has partially proved. This indicated that both RC and PFC led to better QOL than EFC, with an insignificant difference in the impact of the two. In simple words, in this study RC and PFC were equally effective in maintaining good QOL and significantly better than EFC.

Regarding the results of the AIMS-2SF for varying degrees of pain, in moderate and low pain the impact of arthritis in different coping strategies group did not differ significantly. For high pain RC was found to be most effective and EFC was the worst. So the fifth hypothesis predicting that the impact of various copings would not differ in arthritis management amongst moderate, high and low pain patients, has not proved.

The last hypothesis predicting that the impact of various copings would not differ in arthritis QOL amongst moderate, high and low pain patients, has not proved for the total QOL. However, the effect has varied for different dimensions. For moderate and low pain patients exactly same trend was observed on three dimensions, i.e. physical, psychological and social relationship, showing that EFC is the worst coping and there found no significant difference in PFC and RC. However, the impact of various copings on QOL has varied for high pain patients for all the dimensions. But EFC was found to be poor coping for high pain also.