Social Science & Medicine 81 (2013) 87–93

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Social role participation and the life course in healthy adults and individuals with osteoarthritis: Are we overlooking the impact on the middle-aged?

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ARTICLE INFO

Article history:
Available online 20 December 2012

Keywords:
Canada
Participation
Roles
Age
Life course
Arthritis
Chronic disease
Depression

ABSTRACT

Little is known about life course differences in social role participation among those with chronic diseases. This study examined role salience (i.e., importance), role limitations, and role satisfaction among middle- and older-aged adults with and without osteoarthritis (OA) and its relationship to depression, stress, role conflict, health care utilization and coping behaviours. Participants were middle- and older-aged adults with OA ($n = 177$) or no chronic disabling conditions ($n = 193$), aged ≥40 years. Respondents were recruited through community advertising and clinics in Ontario, Canada (2009–2010). They completed a 45–50 min telephone interview and 20 min self-administered questionnaire assessing demographics (e.g., age, gender); health (e.g., pain, functional limitations, health care utilization); the Social Role Participation Questionnaire (SRPQ) (role salience, limitations, satisfaction in 12 domains), and psychological variables (e.g., depression, stress, role conflict, behavioural coping). Analyses included two-way ANOVAs, correlations, and linear regression. Results indicated that middle-aged adults (40–59 years) reported greater role salience than older-aged adults (60 + years). Middle-aged adults with OA reported significantly greater role limitations and more health care utilization than all other groups. Middle-aged adults and those with OA also reported greater depression, stress, role conflict, and behavioural coping efforts than older adults or healthy controls. Controlling for age and OA, those with higher role salience and greater role limitations reported more health care utilization. Those with greater role limitations and lower role satisfaction reported greater depression, stress, role conflict, and behavioural coping. This study has implications for research and interventions, highlighting the need to characterize role participation as multidimensional. It points to the importance of taking into account the meaning of roles at different ages among those with chronic diseases like OA when developing interventions to help understand the impact of roles on psychological well-being.

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Introduction

Living with a chronic disease can pose a significant threat to an individual's participation in social roles such as employment, parenting, intimate relationships, leisure, and community involvement. Conceptual reviews of life course research highlight the importance of roles, events, and transitions over time (Elder, Johnson, & Crosnoe, 2003) and emphasize that role activities are influenced by biological forces like disease, as well as by psychological, social, historical and geographical factors (Alwin, 2012; Dannefer, 2012; Hendricks, 2012). Critical to a life course perspective is that individuals proactively manage and shape their roles (Alwin, 2012; Carstensen, 1992; Christiansen & Matuska, 2006; Elder et al., 2003; Featherman, 2012; Hendricks, 2012; Marks, 2009; Neugarten, 1979). The element of time is also essential.

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http://dx.doi.org/10.1016/j.socscimed.2012.12.013

It illuminates age-graded sequences of events and can be used as a social benchmark (Hendricks, 2012). That is, individuals of different ages have social timetables related to their roles that shape a role's occupancy and their perceived meaning (Carstensen, 1992; Christiansen & Matuska, 2006; Hendricks, 2012; Marks, 2009; Neugarten, 1979). For example, when time is perceived as relatively long, many roles can be pursued. When time is perceived as limited, as in older age, roles may be given up or re-prioritized (Carstensen, 1992). Moreover, if expected or anticipated roles do not occur or they occur at a time that is not perceived as normative (i.e., a role is "off-time" – too early or too late), individuals may report distress or change their behaviour to better manage a role (Carstensen, 1992; Marks, 2009; Neugarten, 1979).

Research on health and disablement has increasingly focused on role participation and social functioning as a critical, under-emphasized domain of study (Badley, 2008; Baum et al., 2000; Brown et al., 2004; Cardol et al., 2002; Carr, 1999; Dijkers, Whiteneck, & El Jaroudi, 2000; Jette, Haley, & Kooyoomjian, 2003; Noreau et al., 2004; Perenboom & Chorus, 2003; Pollard, Johnston, & Dieppe, 2006; Wilkie, Peat, Thomas, & Croft, 2004; World Health Organization, 2001). In general, most of these studies have not applied conceptual perspectives from life course research. That is, although age is often included in research as an important personal factor, it is typically a proxy for the likelihood that health and functioning will decline over time. For example, numerous studies show that older adults are more likely to report ongoing health problems that may result in activity limitations and role participation restrictions than younger adults (Ferraro, 2005; Paillard-Borg, Wang, Winblad, & Fratiglioni, 2009; Rowe & Kahn, 1997; Verbrugge & Yang, 2002).

Lacking is an examination of perceived role participation at different ages within the context of health and chronic disease. Drawing on research from the health and disability literature, as well as integrating perspectives from life course research, role participation can be conceived of as multi-faceted. It includes not only involvement in a role (e.g., being a parent), but also perceptions of the importance of a role (i.e., its salience), appraisals of limitations or difficulties with role performance, and satisfaction with the ability to perform a role in the way an individual would prefer. These different perceptions of the meaning of role participation may vary by age and health. Role perceptions also could be important in explaining psychological appraisals of distress (e.g., depression, stress) and behaviours like health care utilization and coping efforts.

To examine this further, we took the example of a highly prevalent chronic illness, osteoarthritis (OA). OA ranks among the top ten causes of disability worldwide (Centers for Disease Control and Prevention (CDC), 2009; Murray & Lopez, 1996). It results in pain, fatigue, functional limitations, increased health care utilization and substantial costs to society (Badley, Rasooly, & Webster, 1994; Badley & Wang, 1998; LaPlante, 1991; Li, Gignac, & Anis, 2006a; Perruccio, Power, & Badley, 2006). Research on specific roles, especially employment, finds that OA is associated with role loss, role conflict (i.e., managing OA leaves too little time for other role demands or interferes with role performance), stress and depression (Gignac et al., 2012; Gignac, Sutton, & Badley, 2006, 2007; Li, Gignac, & Anis, 2006b). Moreover, OA disease symptoms are often minimized and normalized as part of "growing old" (Hudak et al., 2002; Kee, 1998; Sanders, Donovan, & Dieppe, 2002). As a result, OA is useful as a disease within which perceptions of role participation can be examined.

More specifically, in this study, we compared the role perceptions of middle- (40–59 years) and older-aged adults (60 + years). Although imperfect, we followed the lead of other researchers and used broad age groups as a proxy to assess potential differences in perceived role participation that may approximate life course changes. We also contrasted individuals who have no chronic disabilities with individuals living with OA. We expected that a higher proportion of middle-aged adults, regardless of OA, would be involved in more roles like employment and caregiving for children than older-aged adults. However, despite age-related differences in role occupation, participation across a wide range of roles (e.g., interpersonal relationships, leisure, socializing) would be perceived as important across age groups and regardless of OA. Role limitations might present a different scenario. Middle- and older-aged adults with OA were expected to report greater pain, fatigue, and disability than healthy adults and report more role difficulties or limitations.

Limitations in role participation were expected to relate to lower role satisfaction, particularly for those with OA. However, older adults with OA may perceive the onset of the disease as normative, while middle-aged adults may perceive it as premature or "off-time" (i.e., too early) (Gignac, Davis, et al., 2006; Hendricks, 2012; Hudak et al., 2002; Kee, 1998; Neugarten, 1979; Sanders et al., 2002). If so, both age and OA would be associated with role satisfaction, such that middle-aged adults with OA would report lower role satisfaction than older adults with OA and healthy adults (middle- or older-aged).

Previous studies have found that those with OA are more likely to report greater distress and health care utilization than healthy adults (Gignac, Davis, et al., 2006; Kee, 1998; LaPlante, 1991; Li et al., 2006a; Sanders et al., 2002). We expected similar findings. However, we also expected an age by OA interaction such that middle-aged adults with OA will report the greatest depression, stress, role conflict, health care utilization and behavioural coping efforts compared to other groups. Moreover, role perceptions are also expected to be important. In particular, greater role limitations and decreased role satisfaction are expected to relate to increased depression, stress, role conflict, health care utilization and self-management behaviours.

In sum, we hypothesized that a variety of roles would be salient to individuals regardless of their age or the presence of OA. Role limitations were likely to be shaped by OA and be less influenced by age. However, satisfaction with roles was likely to be shaped both by age and OA. Role limitations and satisfaction were also expected to mediate the relationship between age, OA and psychological well-being like depression, stress, and role conflict, as well as health care utilization and self-management behaviours.

Methods

Participants

Purposive samples of adults with OA and no chronic disabling health conditions (i.e., "healthy controls") were recruited to compare their participation. Participants were 40 years or older and were recruited in southern Ontario, Canada (2009–2010) using community advertising in several newspapers with a broad spectrum of socio-economic readership characteristics and through advertising in community centres. Additional participants with OA were recruited using The Arthritis Society (TAS) website, from our previous research, and hospital clinics at the Toronto Western Hospital and Toronto General Hospital, Toronto, Canada. Study eligibility was established with a telephone-screening questionnaire. Eligibility for the OA group included: 1) being diagnosed with OA by a health professional; 2) having knee, hip, and/or groin pain or other joints affected by OA; 3) being at least 40 years old; and 4) fluency in English. Exclusion criteria were: 1) being diagnosed with other musculoskeletal conditions; 2) an acute musculoskeletal injury in the previous 6 months; 3) hip or knee surgery within the

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