# The Impact of Arthritis on Older Adults' Social and Leisure Participation

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Promoting Participation for All

## Introduction

**Prevalence:** 49.6% of people 65+ have arthritis (Barbour et al., 2017), resulting in:
- Participation restrictions in meaningful occupations
- ↓ quality of life and ↑ caregiver burden

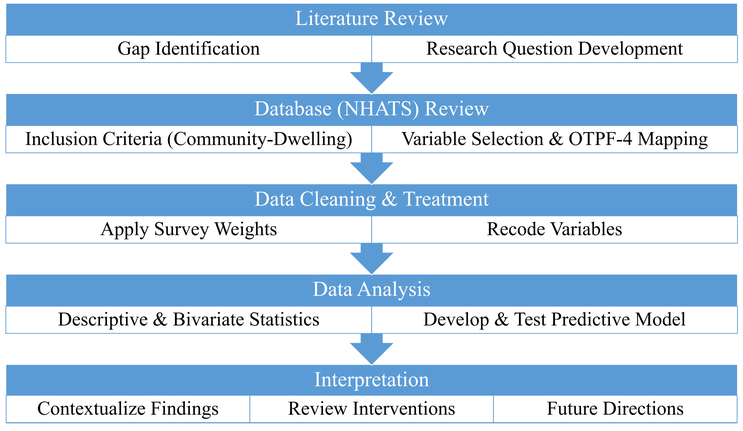
**Social participation:** activities involving social interaction with others (AOTA, 2020)
- ↑ participation = ↑ successful aging (Payne, Mowen, & Montoro-Rodriguez, 2006)
- Individuals with arthritis report ↑ restriction (Theis, Hootman, & Wilkie, 2013) and ↓ satisfaction (Gignac et al., 2008)

**Leisure engagement:** non-obligatory, intrinsically motivated, and engaged in during discretionary time (AOTA, 2020)
- ↑ leisure = ↑ arthritis-based health (Payne et al., 2006; Son & Janke et al. 2015)
- Individuals with arthritis report symptom-related impacts (Leino et al., 2015)

**Research gaps:**
- Comprehensive definitions of leisure and social participation
- Nationally representative sample and control group

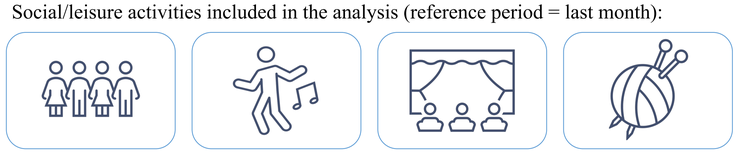
**Design**: Retrospective, cross-sectional analysis of community-dwelling elders (65+)
**Data:** National Health and Aging Trends Study (NHATS), Round 9 (2019)
- Aim 1: Compare the social/leisure participation of older adults by arthritis status
- Aim 2: Explore what factors predict the likelihood of social/leisure restriction
- Aim 3: Characterize how individuals with arthritis engage with and respond to rehab

## Method

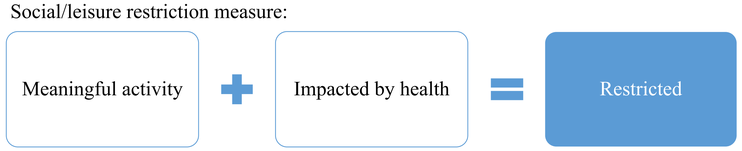



**Total Sample:** 4,043 → 70% (2,969) with arthritis, 30% (1,070) without
- Characteristics: 55% female, 86% 65-84 years, 80% white, 55% married/partnered

Social/leisure activities included in the analysis (reference period = last month):

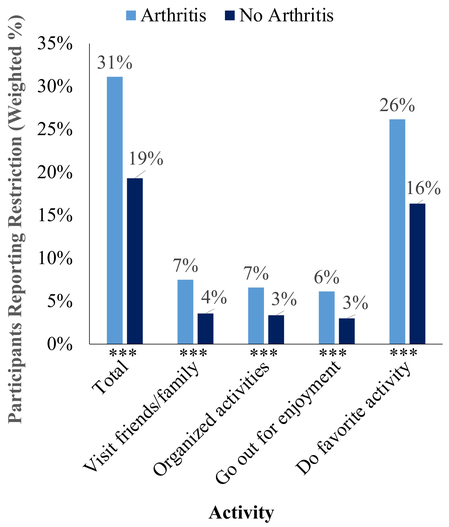



Social/leisure restriction measure:

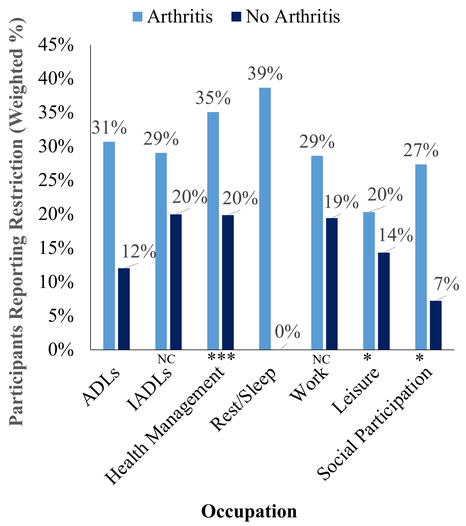



## Results

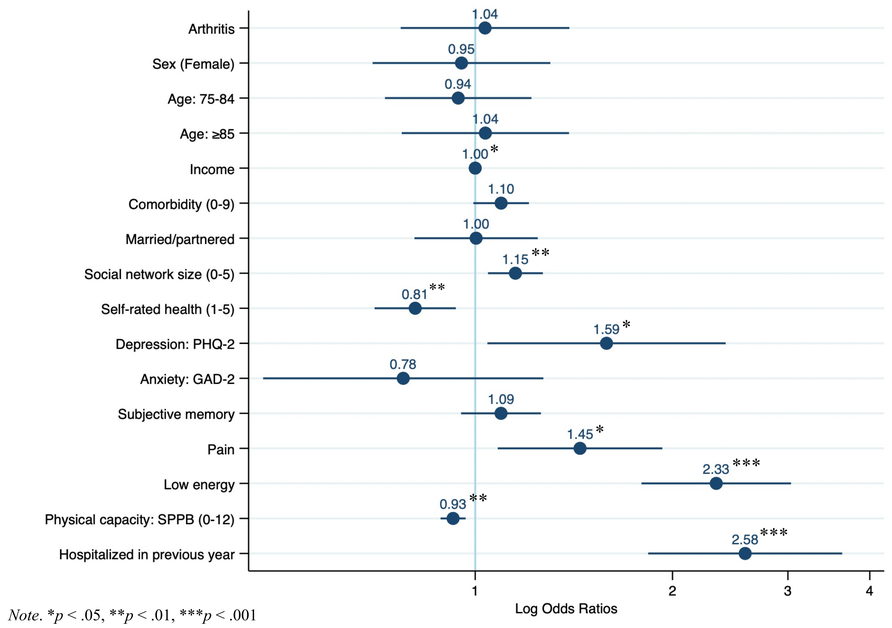
**Social/Leisure Restriction by Arthritis Status**




**Favorite Activity Restriction by Arthritis Status**




**Multivariate Regression of Social/Leisure Restriction**



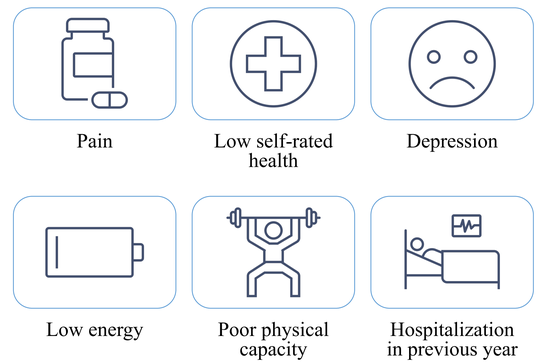

*Note.* $*p < .05$, $**p < .01$, $***p < .001$

**Rehabilitation Factors**
- 26% of participants with arthritis received rehab services in the last year

| Duration | Goals | Functioning |
|---|---|---|
| • <1 month (18%)<br>• 2-3 months (63%)<br>• 4-5 months (10%)<br>• >6 months (9%) | • Pain level (49%)<br>• Strength (60%)<br>• Range of motion (64%)<br>• Participation (18%) | • (During rehab, post-rehab)<br>  • Improved (72%, 44%)<br>  • No change (26%, 50%)<br>  • Declined (2%, 6%) |

## Discussion

Older adults with arthritis experience greater social/leisure restriction than those without the condition.
- However, arthritis is **not** an independent predictor of social/leisure restriction when specific sociodemographic variables and health markers are controlled.
- Specifically, the following constructs predict an increased likelihood of restriction:




- Higher income and a larger social network was also positively correlated with restriction. Why?
  - ✓ Possible **endogeneity**: resources may provide individuals with greater opportunity to participate in these activities, resulting an increased likelihood of finding them meaningful.

**Service gap**: only 26% of those with arthritis received rehab services in the past year; however, 31% reported social and leisure activity restriction within the last month.

**Occupational therapy interventions**:
- *Occupations & activities*: social participation & leisure
- *Interventions to support occupations*: orthotics, environmental modifications
- *Education & training*: joint protection, pain management, emotional regulation
- *Advocacy*: chronic illness self-management programs
- *Group*: community-based
- *Virtual*: electronic gaming

| Limitations | Future Directions |
|---|---|
| • Cross-sectional analysis<br>• Sample homogeneity<br>• Self-report recall bias<br>• Seasonality of activity participation<br>• Lack of activity intensity measures | • Longitudinal analysis<br>• Disease severity<br>• Participation frequency<br>• Explore activity adaptations |

## Implications

1. Regularly screen for social/leisure participation restriction when working with the community-dwelling older adult population.
2. Consider prioritizing arthritis symptomatology rather than the presence or absence of a clinical diagnosis of the condition in assessing restriction likelihood.
3. Employ evidence-based interventions to target mutable factors that can increase social/leisure restriction.

**References:**