Osteoarthritis (OA) is by far the most common type of arthritis and is a leading cause of pain, physical disability and healthcare service use among older adults. However, despite its prevalence and impact, there has been relatively little interest in the ways in which older adults cope with the disease. By ‘coping’, researchers generally mean both conscious and unconscious efforts made by individuals to manage stress and negative feelings that are perceived as a drain on one’s resources. Defining coping as ‘effortful’ is critical and distinguishes it from automatic or routine thoughts and behaviours aimed at managing daily life.

Much of the existing coping research uses samples of predominantly older adults, but does not focus specifically on issues of ageing. Instead, checklists have been used to measure coping strategies with an emphasis on managing symptoms of pain. For example, research on OA knee pain by Keefe and colleagues uses the Coping Strategies Questionnaire (CSQ) and finds that adults who report using pain control and rational thinking to cope have lower pain scores, better health status and lower psychological distress. Other studies find that active coping efforts (e.g. problem-solving) predict less depressive effects, while passive coping strategies (e.g. wishful thinking) predict a worsening negative mood. Recent research has also utilised daily diary and within-day assessments of pain symptoms and coping. These studies typically reveal more complex inter-relationships of pain, coping and mood, and caution against pitting coping efforts against one another as many types of coping strategies co-occur.

In contrast, other OA studies with older adults above 60 years of age find that these individuals frequently endorse coping efforts reflecting resignation or doing nothing. This suggests that many older adults may believe they are unable to deal with OA in their lives. In fact, older adults often minimise or normalise their OA, perceiving symptoms such as pain, stiffness and fatigue as common and to be expected as one ages, rather than as indicative of a treatable health problem. This strategy is often further endorsed by health professionals, who either make no recommendations to manage OA symptoms, attributing them instead to ageing, or recommend pharmacological management of pain with little or no discussion of drug effects and self-management strategies.

As a result, older adults report becoming frustrated with health professionals, can lose trust in them and not follow advice and remain uncertain about where else they can seek help or what to do to cope with OA. Where does this leave us? One of the potential limitations of the coping literature is the almost exclusive reliance on coping checklists. While useful descriptively and as a means of comparing the strategies used across different stressors, checklists have been criticised by a number of researchers. They are limited in their ability to illuminate coping processes, often confound emotion-based coping with psychological outcomes and appraisals, may contain socially desirable items that inflate the frequency of particular strategies and tend to focus less on coping behaviours and more on a wide range of cognitive efforts.

As a result, some researchers have examined the coping and adaptation of older adults using other theoretical perspectives. For example, models of successful ageing suggest that older adults may improve in their ability to monitor their emotions and cope over time. Research by Baltes and colleagues posits that adaptation across the lifespan involves selective optimisation with compensation (SOC). That is, older adults learn to compensate for health problems and optimise capacities that they still retain. To date, there are few studies of SOC processes in arthritis. One exception is a study of older adults with OA that used an inductive approach with open-ended questions and content analysis to reveal a wide array of beneficial adaptations to manage activity limitations in different domains of life. These adaptations included:

- selection, where time spent on some activities was reduced either because of disease symptoms or in order to spend additional time on other tasks;
- compensation, where behaviours and activities were modified or assistive devices used to perform activities;
- optimisation, where older adults anticipated frequent problems related to their OA and expended efforts to avoid them occurring (e.g. planning, pacing and exercise); and
- help from family and friends, as well as from health professionals.

The findings revealed that older adults were far from passive in dealing with difficulties related to functioning with OA. Instead, they revealed the flexibility of the coping strategies employed by older adults and the sizeable reserves they possessed with which to accommodate activity limitations and to continue participation in valued roles.
More recent research looking at age differences in adapting to arthritis and employment among individuals with OA and inflammatory arthritis found that there were no age differences in the type of coping efforts used to manage arthritis at home or at work, although the older adults reported fewer efforts overall. In addition, older participants appraised their arthritis differently to younger adults, reporting less anger, pain catastrophising and changed capacity and goals, and greater coping efficacy.24–26 These findings highlight the importance of linking coping efforts to the meaning that people give to experiences such as OA and potential age differences in the regulation of distress. In the case of OA, coping may be closely tied to goals around maintaining participation in different activities and the normative expectations that different age groups have for participation.

Also important in coping with OA is greater specificity in the stressors, goals and domains of life that are examined. Coping research has focused mainly on managing pain. However, research asking older individuals about the challenges of living with OA finds a much wider range of stressors, most of which have not been examined from a coping perspective. These stressors include retaining or regaining independence, physical manifestations of OA in addition to pain such as fatigue and mobility, medication concerns, financial concerns, participation in relationships and social activities, employment and worries about the future, including the worsening of OA.15,16,23,27,28

Some research also finds that coping relates to the domain in which the activity is taking place. For example, difficulties with tasks such as walking, bending, reaching, sitting and standing may be managed differently at home and at work. In a study by Gignac,21 participants reported being more likely to modify behaviour and use assistive devices when activity limitations were at home. At work, they were less likely to use this strategy and were more likely to try to anticipate problems and find ways to prevent them from occurring. In part, this seemed to be related to a desire by individuals with arthritis not to let their employers know about their OA. This points to a complex interplay among stressors, coping and contextual variables that requires additional attention in research studies.

Finally, it is critical for research on older adults who are coping with OA to be better integrated with other efforts in arthritis self-management and education. To date, a variety of research on OA coping skills training exists, including innovative models of pain management that utilise support from spouses,29 group approaches focusing on the psychosocial needs of people with arthritis30 and research with house-bound older adults with arthritis aimed at helping to manage pain and depression.31 However, much of this work has yet to be integrated with existing work on self-management and education. The latter research has traditionally relied on models of cognitive theory and behaviour change.32,33 Greater integration of coping research and self-management research has the potential to benefit those living with OA in several ways. For example, coping research in self-management studies may be useful in identifying gaps related to issues of ageing, as well as the diverse stressors and contextual variables that may influence the coping and self-management strategies preferred by individuals with OA. Greater integration could also promote better understanding of the links between appraisals of the meaning of living with OA and subsequent use of self-management strategies. Finally, by bringing longitudinal research to bear on issues of coping and self-management, we may be better able to find ways of sustaining changes in behaviour for the long-term benefit of older adults living with OA.