

Experiences of Mothers Living With Inflammatory Arthritis

CATHERINE L. BACKMAN,¹ LINDA DEL FABRO SMITH,¹ SHARON SMITH,² PAMELA L. MONTIE,³ AND MELINDA SUTO²

Objective. To describe the impact of chronic, inflammatory arthritis on parenting and to develop a conceptual framework for subsequent study of mothering.

Methods. A qualitative, grounded theory design guided data collection and analysis. In-depth interviews were conducted with a purposive sample of 12 women with either rheumatoid arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, or systemic lupus erythematosus who were mothers of at least 1 child living at home. Transcripts were analyzed using a systematic approach of coding and forming concepts and key categories to construct an explanatory framework. Peer checking and member checking enhanced analytical rigor.

Results. Analysis of participants' experiences resulted in 4 interrelated categories describing the impact of arthritis on their role as mothers: participation in mothering tasks, best described as "sometimes I can, sometimes I can't"; different types and levels of support from others; the influence of the mother's arthritis on the family; and the challenge of balancing energy and fatigue. Individuals' arthritis story, life stage, their children's developmental stage, and daily routine described the context in which mothers experienced elements of each of the 4 main categories.

Conclusion. Inflammatory arthritis has a dramatic impact on the experience of motherhood, with both positive and negative influences. The perspectives shared by study participants may inform practice regarding problem identification and adaptive strategies, and the explanatory model generated from the data proposes hypotheses for further study.

KEY WORDS. Parenting; Occupational role; Participation; Grounded theory.

INTRODUCTION

Motherhood is a major life role for many women, one that is highly valued yet historically taken for granted because it is so common (1). Although the literature on motherhood in general is extensive (2), there is limited research on the impact of chronic illness on mothers (2,3). Yet participation in life roles, such as motherhood, makes an

important contribution to quality of life (1–3), and illness may restrict participation.

Qualitative studies have illustrated the complexity of the tasks associated with motherhood, and how demands change over the lifespan (1,2). The concept of motherhood as an enfolded activity describes how mothers of young children are immersed in multiple, concurrent tasks, for example, tying a child's shoes (physical care) while singing the ABCs together (playful teaching) and finishing with a hug (nurturing) (1). In a participant observation study of families, Primeau (4) found that mothers embedded caring for and playing with their child into household work activities, which was in contrast to fathers' tendency to separate household work and parenting tasks. As children grow, the mother's role shifts to one of an invested participant in her children's lives, such as providing financial support for school and emotional support by listening to problems (1). These types of studies describe the complexity of the mothering role, but do not describe what happens when mothers concurrently manage a chronic illness.

Physical limitations and fatigue are 2 difficulties shared by mothers with a range of disabilities (3,5). Inability to put a daughter's hair in a ponytail, skate with a son, or drive children to activities contributes to women feeling

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¹Catherine L. Backman, PhD, OT(C), Linda Del Fabro Smith, BSc(OT): the University of British Columbia and the Arthritis Research Centre of Canada, Vancouver, British Columbia, Canada; ²Sharon Smith, MCS, BSc(OT), Melinda Suto, PhD, OT(C): the University of British Columbia, Vancouver, British Columbia, Canada; ³Pamela L. Montie, Consumer Advisor: Arthritis Research Centre of Canada, Vancouver, British Columbia, Canada.

Address correspondence to Catherine L. Backman, PhD, OT(C), UBC School of Rehabilitation Sciences, T 325-2211 Wesbrook Mall, Vancouver, British Columbia, Canada V6T 2B5. E-mail: backman@interchange.ubc.ca.

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different from other mothers (those without disabilities) (3). Fatigue prevents performance of some mothering tasks, and engaging in mothering tasks increases fatigue (5). Mothers with disabilities experience interactions with health and social service professionals that tend to target either the illness or the parenting concerns, but rarely both: “They expect you to be servicing your illness all the time and not getting on with your life” (5).

The impact of arthritis on performance of mothering tasks has not been widely studied. In studies predating new biologic drugs for rheumatoid arthritis (RA), limitations in household work were associated with lower functional capacity and greater disease severity (6,7). A substantial proportion of women with RA reported disability in household work (8) and parenting, particularly in caring for young children (9). Parenting disability has been associated with lower functional status, more severe symptoms, and psychological distress (9), but the impact of individual experiences has not been fully described. Mothers with ankylosing spondylitis (AS) reported having the greatest difficulty with practical tasks for preschool children: feeding and lifting children, changing diapers, putting children to bed, bathing children, and playing physical games (10). These findings are consistent with those reported in a survey of Norwegian women with rheumatic conditions and children younger than 6 years of age (11). With older children, problems were related to an increased volume of laundry and shopping, but mothers also cited the psychological bonus of children who were caring and independent.

To summarize, women with chronic conditions including arthritis report difficulties managing the sometimes competing demands of their illness and motherhood. This suggests a need to develop more effective interventions. To do so requires a fuller understanding of being a mother living with the physical and psychosocial sequelae of arthritis. This report describes a qualitative study using grounded theory to answer the question, “What is the impact of inflammatory arthritis on the role of mother?” The purpose was 3-fold: to describe parenting experiences, to identify strategies used by women with arthritis to fulfill their role as mothers, and to develop a conceptual framework for subsequent study based on the perspective of mothers living with arthritis.

SUBJECTS AND METHODS

Sample. Purposive sampling was used to ensure a broad representation of mothers with differing family composition, socioeconomic status, and ethnicity. Participants were identified among the patients of 2 rheumatologists and an occupational therapist at a university-affiliated arthritis program. Potential participants were mothers of at least 1 child living at home and were diagnosed with RA, AS, systemic lupus erythematosus (SLE), or juvenile idiopathic arthritis (JIA) by a rheumatologist. Sampling ensured inclusion of women with children across 4 age groups (infants to 5 years, 6–12 years, 13–18 years, and 19–25 years). The Behavioral Research Ethics Board at the University of British Columbia approved the study.

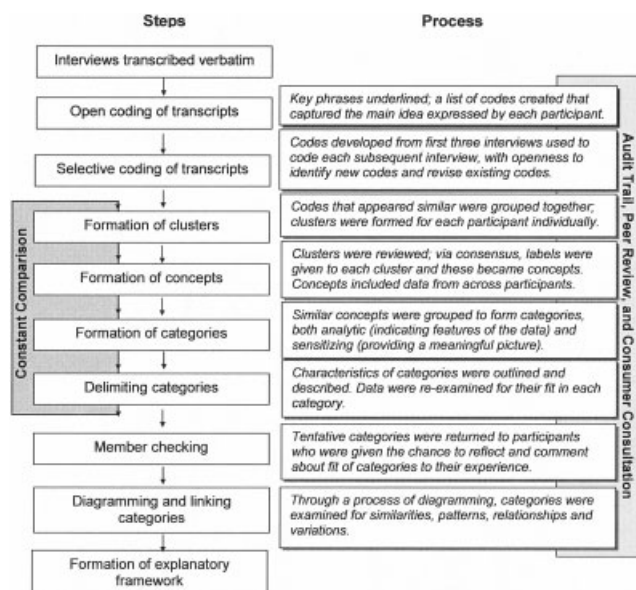


Figure 1. Outline of data analysis process.

Data collection and analysis. Semistructured, in-depth interviews were conducted by the principal investigator (CLB) and a research assistant (LDFS) at a location chosen by the participant (9 at home, 1 at the researcher’s office, 1 at work, and 1 at a community teahouse). Interviews lasted 1–2 hours and explored the impact of arthritis on performance of tasks perceived by the participant as part of her role as a mother and factors that enhanced or hindered role performance. Consistent with a grounded theory approach, the interview guide was revised as data from preceding interviews were analyzed, and recruitment continued to the point of theoretical saturation (no new ideas emerged). Interviews and field notes were audiotaped and transcribed verbatim.

Transcripts were analyzed using a synthesis of grounded theory approaches (12–15) outlined in Figure 1. Two researchers (CLB and LDFS) independently reviewed transcripts at the initial coding stage. Coding memos captured the decision-making process throughout analysis, forming an audit trail (16). An experienced qualitative researcher (MS) provided peer reviews on 3 occasions during the iterative process, and additional validation was provided by a consumer collaborator, a mother with arthritis (PLM). Preliminary concepts and categories were summarized in writing (CLB and SS) and mailed to participants. Participants were asked to reflect on the findings, state whether or not the categories fit with their experience, and comment on how the categories were distinct or linked. This process, known as member checking, further validated interpretive findings.

RESULTS

Participants. The 12 participants ranged in age from 24 to 53 years, with two-thirds in their 40s. They had 1–6 children living at home (median 2 children), and the range of the children’s ages was 3 months to 26 years. In 3

families, 1 child also had a significant health problem. Nine participants were married, 2 were remarried/partnered, and 1 was a single parent. One participant was an adoptive parent and 2 had stepchildren. Six women were currently employed (3 full time, 2 part time, 1 home based), 2 of whom were on maternity leave. Diagnoses included RA (n = 6), AS (n = 3), SLE (n = 2), and JIA (n = 1), with disease duration ranging from 3 to 40 years. Seven women were diagnosed before becoming mothers, 2 were diagnosed in conjunction with their pregnancy, and 3 were mothers before developing arthritis. Education ranged from high school graduate (n = 2) to master's degrees (n = 2). Based on neighborhood of residence, the sample included families with lower to upper-middle income in both rural and urban settings. Families were culturally diverse, including European and Asian immigrants to Canada, and 2 participants described their marriages as having mixed ethnicities and/or cultures.

Categories (key themes). Analysis of participants' experiences resulted in 5 interrelated categories describing the impact of arthritis on their role as mothers. Full descriptions of the data supporting each theme are not practical, but categories are summarized below.

Participation in mothering tasks: "sometimes I can, sometimes I can't." Women described an array of motherhood tasks that were dependent on the needs of their children and their perceptions of what mothers do. Their ability to participate fluctuated, both over time (related to disease progression, changing demands of the role, and shifting attitudes about what was most important) and from day to day (related to symptoms and abilities including pain, fatigue, strength, dexterity, and mood). Therefore, participation in mothering tasks is described along a continuum of ability anchored at one end by satisfactory task performance and at the other end by inability to perform or choosing to forfeit specific activities (Figure 2). Two midpoint concepts on the continuum explain adaptive strategies and emotional responses to fluctuations in participation. "Figuring things out" describes strategies that evolved as mothers identified difficulties in child care and household tasks or chose to leave things undone. "Frustrating times" describes situations that caused distress or sadness arising from the way mothers engaged in activities with their families. The continuum is not intended to represent a linear progression through the disease course, but reflects differing abilities that may occur at any time. More than 1 participant described this as "sometimes I can, sometimes I can't," and this sentiment was broadly endorsed in the member checking: "In the past, participation was a very big issue, as I expected (or assumed) my role as a mom demanded a level of commitment to physicality (biking, running, playing) as a positive role model. When I was in greatest pain my ideals as a mom were in the toilet. I've had to adjust my whole concept of an engaged, positive parent, based on a realistic picture of myself and my limitations."

Sometimes sacrificed tasks were mourned as the loss of highly valued activities, but often they were perceived as part of the ongoing negotiation of duties between parents.

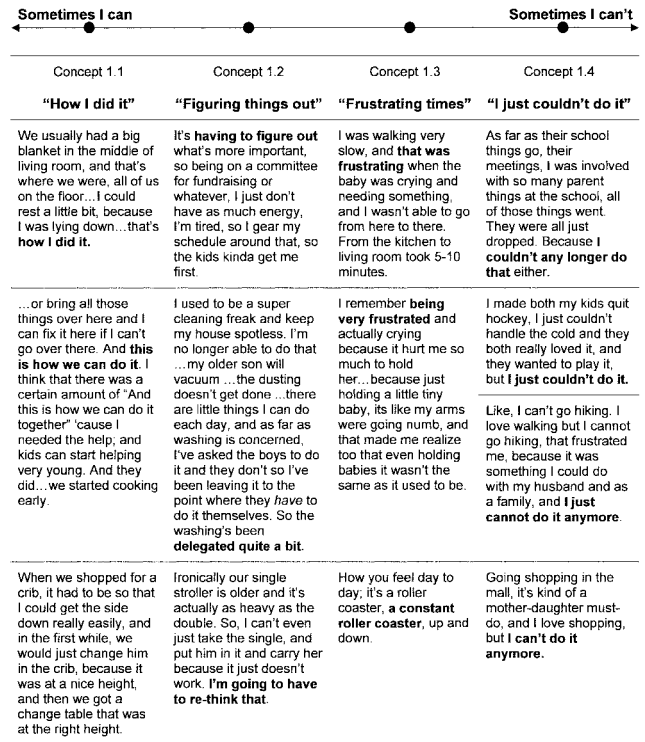


Figure 2. Participation in mothering tasks is comprised of 4 concepts on a continuum from "sometimes I can" to "sometimes I can't."

One mother stated, "I'm the one that gets the homework done" while her husband drives the children to sporting events. Whereas some mothers were saddened to forego sports or shopping with their children, other mothers were more philosophical about physical limitations. These women indicated that their children pursued strenuous activities with fathers or grandparents, viewed as important relationships to nurture, with the bonus of giving mothers much appreciated "my time." For example, "Wednesdays were grandpa days, and he did all kinds of things with my kids that gave me a day to rest."

However, not all participants endorsed the concept of "my time," with some stating that there was neither time nor opportunity to consider "indulging" themselves. In contrast, the women who agreed that this concept was part of their experience noted the evolution of "my time" as something they learned to become healthy and a better mother. In this way, "my time" was a concept that supported participation in mothering, and therefore linked with the next category: support.

Different types and levels of support. Women described situations where support was present and effective, ineffective, or absent. Some commented on the lack of resources for mothers with arthritis and desired a person or place to go to when facing specific challenges. Participants referred to 3 types of support: practical (help with child care or cleaning), emotional (help dealing with feelings), and moral (someone to listen and share). Sources of support included family and friends, health professionals, and hired help. Two women commented on not expecting support from their husbands for household tasks and par-

Table 1. Examples of different types of support experienced by mothers with arthritis*

Type of support	Sample quotes from interviews
Presence of effective, practical support	“One of the things that did work was to hire middle school-aged children in the neighborhood who would come in and read to the girls after school, just for an hour or 2.”
Absence of practical support	“The arthritis came on very severely and um, very quickly, and initially I had a little adjustment time but absolutely I was shunned by people. What moms tend to do is ‘I’ll take care of your kids and you take care of my kids’; nobody wanted to do that kind of sharing thing with me because when they needed me they didn’t want to ask me to do things . . . All those kind of resources dried up very quickly.”
Emotional support	“I was working at that time, and I was quite stressed out. I tried to do everything and I just couldn’t. . . . and my husband could see the resemblance between what she [women’s wellness group leader] was talking about and what was happening at home, so he sent me there and said ‘please do it for me, please do it for me’ (laughing). So basically this is how I went there . . . Yes, it changed me a lot, and other mothers as well.”
Need for support from other parents	“The AS and the fear of another attack, and what would I do with my kids . . . it gives a certain amount of anxiety, always on the edge, and it—you know, I found that I was getting really angry and really aggravated . . . and I knew that I really needed to have some outlook, whether it be through discussion or parenting support or whatever. [I was always telling my daughter] ‘No, you just can’t do that, I cannot catch you I cannot push you on the swing, I just can’t do that, and lift you in and out of those silly little [basket] swings . . . because you kick, and when I’m holding you at this level and you kick it hurts me.’ And it hurts me to say that right now, but in some ways that was a big issue, and I knew that they were going to go into care or I was going to go into the psych ward (laughing) so you know—that’s [when I found] a parenting course, and I found that summer, that’s what I really did need, that other parent connection.”
Seeking specific types of support from health professionals	<p>“I wasn’t diagnosed thoroughly until 3 years ago. I knew there was something wrong, you know, and finally I said to my doctor, ‘I want to go see this specialist [rheumatologist],’ and he said, ‘Oh, alright, you are chasing after a golden goose’ and made me feel really awful, but he said, ‘Ok, we’ll take an x-ray then,’ and that is what pinned it down, was the x-ray . . . look at this, you have rheumatoid arthritis!”</p> <p>“Now that I am seeing [rheumatologist] I feel that I’m in good hands, she knows what she’s doing and I trust her on that one.”</p> <p>“The thing is, is that a lot of them [community health nurses] don’t understand the disease anyway, so you get somebody coming in telling you things, and you’re like, no, that’s not going to work for me, I can’t do that. You know, like, some of them don’t have that understanding, so they’re explaining the way a typical mother [would do it] and then they talk about, ‘Oh, you should be breastfeeding,’ and ‘Oh, you didn’t have this baby on that medication,’ and you just don’t need to hear that, you know.”</p>

* AS = ankylosing spondylitis.

enting because of their “traditional upbringing” and expectation that, as stay-at-home mothers, they should manage on their own. Others generated a great deal of support within and outside the family, as in this example: “I have great friends, they have kids around the same age, we go hangout at their house. I mean, I think just being out, [my son] is also better behaved. They’ll help out with all kinds of things when I’m over there.” In contrast, one participant clearly stated, “I had no support at all. Like none.” Instead, she purchased practical support: “I hired a tutor to help the children with homework because I just wasn’t up to it.” Participants with lower household incomes could not purchase services and noted the lack of services available to the “working poor.” Some experienced changes in support: after living with her sister for months following her

daughter’s birth and concomitant RA diagnosis, one participant reported “absolutely no support from my family” in part because they did not expect RA to be chronic. Examples of types of support sought, but not always obtained, are in Table 1.

Participants had differing opinions on disclosing their diagnosis to obtain support. Some indicated that arthritis could not be hidden and had no impact on friendships, and that disclosure was necessary to request help, whereas others had learned to avoid disclosing their diagnosis based on prior perceptions of lack of understanding and being shunned.

Impact on the family. Mothers described the impact of their decisions and participation restrictions on the family’s activities and collective well-being. There were in-

Table 2. The perceived impact of a mother's arthritis on her family

Perceived impact	Sample quotes from interviews
Problematic	<p>“It’s just decisions I’ve made in my life have been based on not what’s good for me, not what’s good for my family, they’ve been based on what’s good for my health. I would say, in a nutshell, . . . call it chronic illness and parenting, it’s not what’s best for your family, it’s what’s best for your illness and that’s the driving force behind most decisions.”</p> <p>“I can’t walk to the corner store to get a popsicle or any, you know, any normal thing a parent would do. Bicycling—no, ice skating—no, soccer—no, rollerblading—no, skiing—no. There are no real games or playtime that I can do with them . . . so I think it’s sad for them, they’re missing out on a lot . . . it affects the family in a lot of areas.”</p> <p>“We eat a lot of pizza, because I can order in, to the point where when my kids were young, they said, ‘please Mom, I can’t eat any more pizza!’ (laughing) And so when they grow up and they get married, they might think that ordering in pizza 2 or 3 times a week is normal, and it’s not, it’s expensive—they shouldn’t be doing that kind of stuff. They think that a lot of the things we do in our household are normal. But it’s not normal, because we’re not a normal household.”</p>
Beneficial	<p>“In an odd way, it’s not so bad, because when I cannot move so much, or don’t go out, it’s kind of bringing the family together. ‘Cause then everybody . . . brings our stuff, our projects, our books, and we can talk. The TV isn’t on, so that’s actually time when I’m available to listen and nothing is rushing me . . . I’m there, mentally I’m there and physically I cannot, but actually, it’s not bad, we use that time wisely.”</p> <p>“In some ways I think that it’s good for them [her children] . . . And I don’t know if it made them more understanding or if that’s just in their nature, because it is hard to tell, it’s always been there . . . They’re always lifting, moving and carrying something . . . If I was having a bad day, they always knew that they could make themselves a peanut butter sandwich . . . I think that it [arthritis] did make my kids more independent . . . because they have to be.”</p> <p>“From day 1, I wasn’t trying to lift him, at all . . . I would ask him to climb up on me, and that’s how I’d hold him, I would not lift him, and because of that, I never had the problem that girlfriends had. [Their children] wanted to ‘go up’ and ‘pick me up’ and ‘carry me,’ so from day 1, he wasn’t exposed to that. And I asked everyone else around not to pick him up, and it was respected, and he didn’t feel that it’s like some kind of disadvantage. It’s actually good because still today, he’s 3 years old, he climbs into anybody’s lap, he likes it, he just stays there (laughing). He’s not asking ‘Oh, pick me up and carry me.’ If he wants to be close to somebody he climbs up on their laps and he makes himself comfortable.”</p>

stances of undesirable impact on families, including overuse of adaptive strategies and perceptions of not being normal, and stories about arthritis being beneficial in raising responsible and sensitive children (Table 2). Several women stated that their household routines were atypical, and they regretted what one called “the focus on illness” that influenced parenting decisions. This perception was not shared by all participants, despite similarities in participation restrictions. Although participants still worried about not doing a good job, they viewed these feelings as typical of mothers in general. They believed that all mothers struggle with societal and family expectations about what is best, and that arthritis was just part of the package they were given in life; it could just as easily be another challenge: “I never feel like I am doing a good enough job—I mean my friends will get down on the floor and play with their kids really easily, and often I can’t and if we are over there, and he says Mommy, let’s play, and I can’t do that . . . it’s funny how it’s day-by-day, so honestly the one nice thing about arthritis is that it seems to travel. It will stay for a few weeks in one joint and then move, so I’m never permanently not able to do something, I’m just permanently not able to do everything, so that’s kind of a bonus.”

Balancing energy and fatigue: “moms need energy to do a really nice job.” Without exception, participants described the huge impact of fatigue not only on mothering activities, but on all aspects of their lives: “I would say that I’m more tired than most mothers, be it the medication or

be it the arthritis, I am definitely more tired.” They guarded against expending “precious energy” on unimportant tasks. For some women, episodes of fatigue were incapacitating, as in the following example: “I’m so tired, but it’s the kind of tired that you would press stop in an elevator just so you could lay down on the floor. I remember . . . being in the store, and wanting to hide in the clothes rack so I could just lay down and no one would see me. These were actual thought processes: I can’t take another step.”

Rest, although considered necessary, was difficult to schedule. As one participant stated, “Kids get into mischief when their mother’s napping.” Another shared a strategy: when she wanted the family in bed early to accommodate her fatigue, she turned the clocks back an hour, similar to daylight savings time. Fatigue was often cited as the primary reason for giving up activities with children, such as attending school or sporting events, to reserve energy. For one mother who was busy with 2 small children, the demands of motherhood were such that balancing fatigue and energy was desirable but likely not achievable: “Fatigue for me is number one. Sometimes you feel like you just don’t have the energy to spend the quality time that you wanted to spend, because you really don’t have the time for yourself, so sometimes you just need to try to lie down or something. You need to be able to have a cup of tea and have your breakfast (laughing) . . . It gets [reheated] about 5 times before I leave it. So that’s challenging, and feeling guilty about things all the time . . . you

don't have the energy to be doing something you should be doing with them."

Contextual factors: *arthritis story, life stage, and daily routines.* Participants described how the demands of their daily routines, their experience with arthritis symptoms and treatment, and their current life stage and that of their children influenced their decisions about which activities they would do. Young children required more physical assistance, and bathing, dressing, and playing safely and effectively presented specific challenges. School-age children were involved in more activities, often requiring their parents to volunteer to raise funds for clubs or schools and to drive to various activities. These perceived demands influenced their perceptions about being effective mothers. Some participants cared for aging parents as well as their own children. One participant with SLE had experienced episodes of such severe illness that her children lived with their grandparents for prolonged periods. Now that her illness was controlled and the grandparents were elderly, she felt committed to care for them as much as she was able.

Central to understanding the context in which women fulfilled their role as mother were their personal experiences of diagnosis, treatment, episodic illness, and the resilience needed to live with arthritis. The diagnosis was sudden for some, "... it came on like a freight train as they say, it was literally overnight." For others, diagnosis provided confirmation of longstanding health issues not accurately diagnosed, as the following experience illustrates: "I wasn't imagining things, there was really something going on, and it had been going on for a while. And that was why my feet were so sore all of the time and why my hands were so sore... yeah, it was good to hear that [diagnosis] it was like, oh, thank you, I'm not making this up." Effective medical treatment was critical in enabling women to care for their children: "For me, right now if I wasn't on [a biologic medication] I just wouldn't be able to do what I'm doing, there's just no question. Without the right medications you're in trouble."

For some mothers who had arthritis before having children, a particularly poignant chapter in their arthritis story was their pregnancy. Two participants described doctors who would not support their decision to have children, leading them to seek new physicians. Some experienced a remission and better health during pregnancy: "The healthiest I have ever felt was when I was pregnant both times." In contrast, others had difficulties: "I was induced months earlier because I couldn't carry the weight. I was walking on crutches and I could not take my medications because it would affect the baby, so that was my hard time."

Explanatory framework. The goal of grounded theory is an explanatory framework illustrating how the key categories arising from the data are linked. The framework both summarizes results and guides future research. The impact of inflammatory arthritis on the role of mother is illustrated in Figure 3. Contextual factors form a backdrop against which 4 key categories are situated. The primary category is participation in the role of mother, character-

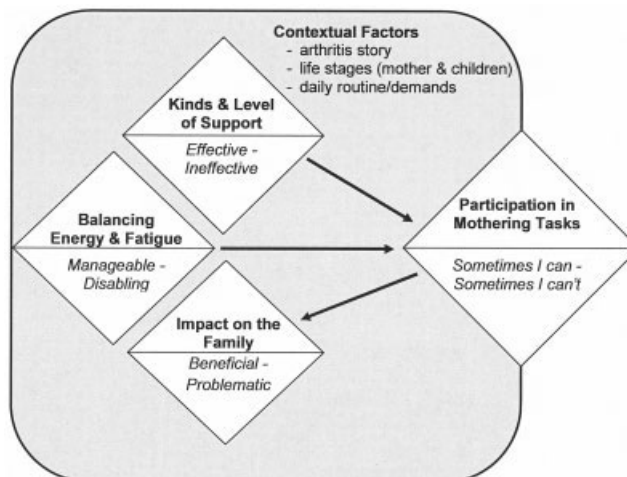


Figure 3. Explanatory framework.

ized by fluctuations in ability. The extent to which women can be mothers and do the activities they associate with motherhood is influenced by the type and level of support obtained and the unpredictable balance of fatigue and energy. The ups and downs of participation are a visible expression of how a mother is living with arthritis, which in turn affects members of the family. This ripple effect has both positive and negative consequences: sometimes it makes the family more cohesive, sometimes it results in regret that certain family activities are no longer possible.

DISCUSSION

Study participants provided explicit examples of daily struggles and successes, describing how performing specific tasks and being available to their children gave meaning to their lives. Their narratives were vivid, and although space precludes fully sharing their stories, the transcripts document an emotional intensity that has not been adequately portrayed in professional literature.

One of the strengths of this type of qualitative research is that it produces detailed descriptions of phenomena previously taken for granted or otherwise not recognized as contributing to (in this case) role fulfillment and health outcomes. The grounded theory proposed in Figure 3 is a new framework for future research regarding arthritis and parenting. It is compatible with the person-environment-occupation (PEO) theory proposed by other researchers (17), but is explicit to the occupation of mothering. PEO theory posits that optimal performance of an occupation results from effective interaction among environmental factors, personal characteristics, and the demands of the occupation. In the present study, the category "participation in mothering tasks" describes occupations that constitute a mother's role and, more specifically, the role of a mother with arthritis. These occupations are influenced not only at the person level in the form of fatigue and energy levels, but also by the social environment through the practical, emotional, and moral support received.

Therefore, what mothers living with arthritis can actually do is substantially shaped by the interaction between their health status (energy and fatigue), available environmental supports and constraints, and the tasks they feel obliged to do or choose to do. As contextual factors change over time, so does participation in mothering tasks.

Findings from this study begin to address issues that research participants identified in Thorne's report (5), specifically, health and social service providers separating the management of chronic illness from mothering responsibilities. The nascent grounded theory offered here depicts the interrelatedness and complexity of these phenomena, and therefore supports multifaceted approaches to the problems of chronic illness and role fulfillment. It is not sufficient to address arthritis symptoms alone and expect improvement in role performance.

Findings from small qualitative studies are not intended to be generalized, but the theoretical framework produced in our study may be used to design future research of mothers with arthritis in which different questions are posed. For example, one might ask what types of social support best contribute to the capacity of mothers with arthritis to engage in both paid and unpaid work, or what strategies mediate fatigue sufficiently to support performance of motherhood tasks. Based on the details provided by study participants, it could be hypothesized that satisfactory participation in a valued role (motherhood) positively influences well-being and quality of life. Desrosiers noted that satisfaction with participation is more strongly associated with quality of life than is the actual ability to participate (18), and the significant association between loss of valued activities and poor health outcomes such as depression has been observed as a consequence of RA (19). The proposed framework offers a basis for study of mothers with and without arthritis to distinguish between typical experience and the potential complicating impact of arthritis.

One of the purposes of this study was to document strategies to assist women with arthritis in fulfilling their mothering role. These strategies, such as adjusting expectations and adaptive approaches to completing tasks, may be applicable rehabilitation and public health interventions targeting individuals living with chronic illness. The credibility of advice grounded in the everyday experiences of mothers with chronic illness cannot be understated. Study participants stated that the resources they knew about or were eligible to receive were inadequate for their needs.

A previous study exploring the impact of arthritis on families found that greater family cohesion was an unanticipated benefit (20). The present study supports this finding in some families, but not all families. In part, this seemed to be explained by the mother's resilience and attitude regarding participation restrictions, as well as the response of family members to her way of doing mothering tasks. This presents a hypothesis for further research regarding what factors lead to beneficial rather than detrimental impacts on the family.

Although this study is limited to the experiences of its participants, it is a rigorous example of qualitative inquiry and the findings may be transferable to other mothers

living with arthritis. In-vivo coding ensured that the analysis relied on mothers' experiences in their own words and a consumer collaborator helped keep the analysis true to the mothers' experiences. The use of member checking at a later stage of analysis further validated the interpretation of the common themes emerging from the data.

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AUTHOR CONTRIBUTIONS

Dr. Backman had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study design. Backman.

Acquisition of data. Backman, Del Fabro Smith, Smith.

Analysis and interpretation of data. Backman, Del Fabro Smith, Smith, Montie, Suto.

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