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ORIGINAL ARTICLE

Exploring Occupational Disruption Among Women After Onset of Rheumatoid Arthritis

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Objective. **To portray experiences of women engaging in everyday tasks, activities, and occupations, from symptom onset to 12 months after diagnosis with rheumatoid arthritis (RA), and to explore the meanings attributed to their activities and occupations.**

Methods. **A secondary analysis of qualitative data, guided by phenomenography, explored the stories of 37 women with early RA. The original study used in-depth interviews to explore the help-seeking process from first symptom to diagnosis, and results indicated unexplored impacts on activity, stimulating the present analysis. Transcripts were read and coded by 3 investigators and then debated by the full team with this new research objective in mind. Descriptive categories were formed through a systematic, iterative approach with a focus on how early RA impacted daily routines and participation in occupation.**

Results. **Participants recounted a range of experiences characterized by changes in the way they engaged in occupations as a result of RA symptoms. Four interrelated categories were identified: uncertainties associated with good days, bad days, and worse days; experiencing activity disruption; doing things differently, which was perceived both positively and negatively; and changing views of self, as participants developed identities as individuals living with RA.**

Conclusion. **Daily activities and occupational identity can be profoundly impacted in the first 12 months after diagnosis with RA, resulting in significant life changes. Health professionals are encouraged to identify disrupted activities, facilitate participation in valued occupations, and create environments that enable patients to explore changes in identity to prevent negative life consequences.**

INTRODUCTION

As Bury (1) and Charmaz (2,3) indicated nearly 30 years ago, chronic illnesses such as rheumatoid arthritis (RA) can be experienced as a form of biographic disruption and can entail a corresponding loss of sense of self, or threatened identity. Individuals with established RA have reported disruptions in leisure occupations (4–7) and social life (6,7), paid (4,8,9) and unpaid work (5), activities of daily living (6,7), sense of identity (10), and occupational balance (11). Occupation, as defined in the occupational therapy literature, is broadly viewed as including all of the things that people do, from self-care to caregiving, participating in employment, unpaid work, and hobbies (12). Clusters of tasks and activities make up an occupation. Disruption in occupations and occupational balance therefore can have a profound impact. Alternatively, in other chronic illness literature, individuals have been found to develop a new, more positive sense of self in the face of chronic disease (13).

People with RA cope with life disruptions by finding new and alternative ways of performing activities, asking

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Significance & Innovations

- Significant activity disruption and loss may occur even in the earliest stages of rheumatoid arthritis (RA).
- Women with early RA may experience good days, bad days, and worse days. Worse days were associated with abrupt changes in function and are more challenging than bad days, and activity had stopped.
- Sense of self may change as people begin a transition from an identity as a healthy individual to that of an RA patient.
- Doing routine activities and activities previously taken for granted in different ways to accommodate arthritis symptoms may be perceived either positively or negatively depending on the meaning ascribed to the altered activity.

for assistance, limiting or taking more time to complete activities, using assistive devices (14), altering their environment, and setting priorities (15). An exploration of meaning within everyday activities showed that women wanted to be seen as ordinary, but also wanted their limitations to be accepted (16).

While extensive literature paints a clear picture of the longer-term impact of RA, in studies with mean disease duration of 6 years (17) to over 24 years (18), it is less clear how individuals with RA experience daily activities during the early stages of the disease. Further, the meanings of these experiences during the period around diagnosis have not been explored in depth. While research on the impact of early RA on activity participation is limited, studies have shown similar outcomes to longstanding RA, including loss of leisure (19), negative impact on valued activities, social participation, and mood (20), and reduced satisfaction with self-care activities, work, and life as a whole (21).

The Early Rheumatoid Arthritis Help Seeking Experience (ERAHSE) study explored the help-seeking process from symptom onset to 1 year after diagnosis to understand what prompted people to seek treatment (22,23). A theme of activity disruption emerged early in the analysis because participants described the impact of symptoms on activity participation, stimulating the secondary analysis presented here. Using an occupation-focused lens, a new core team of investigators, including two new members (HNM, TD) and one from the original ERAHSE study (CLB), reanalyzed the data. After the initial reading of 16 transcripts through this new lens, it was agreed that the transcripts were rich in information on the impact of early RA on daily activities and the topic worthy of focused analysis. Other analyses of the data have also been completed (24–26).

The impact of a disability varies depending on the meaning or value attributed by an individual to particular activities or occupations (27). In this study, we described the experience of everyday activity for women from symptom onset to 1 year after RA diagnosis and explored the meanings they derive from occupational engagement.

MATERIALS AND METHODS

Participants. Individuals were eligible for the original ERAHSE study if they were adults, diagnosed with RA in the past 12 months, living in British Columbia, Canada, and able to converse in English. Recruitment occurred through letters to patients from general practitioners and rheumatologists, and advertisements in arthritis centers and on consumer web sites. Thirty-eight individuals (37 women, 1 man) from urban and rural communities throughout British Columbia participated. The current analysis focused on the 37 women. Time since diagnosis ranged from <1 month to 12 months, with relatively even distribution across the 12 months. Participants were purposively sampled, ranged in age from the third to the seventh decade of life, came from a variety of household compositions, and included individuals who were in paid employment, on disability, homemakers, and retirees. Participants chose their own pseudonyms.

Interviews. In-depth interviews followed a guide that included the following key questions: can you tell me about your arthritis, starting from when you first noticed anything? How did it affect your daily life? Can you tell me what happened leading up to, and around the time of diagnosis? What about since the diagnosis? Interviews were audio-recorded and transcribed verbatim. Grounded theory and a narrative approach guided the original gathering of data and analysis. Informed consent was obtained and the study was approved by The University of British Columbia Behavioral Research Ethics Board.

Data analysis. Phenomenographic analytical methods were used to explore the impact of early RA on activity participation. The aim of this approach was to describe the different ways people relate to particular phenomena (28–30), and the meanings they attribute to phenomena in their world (30,31). Phenomenographic analysis began with a complete set of transcripts and categories are based on analysis of the data set as a whole (28,32). Therefore, a single transcript or quote may not exactly match any one category (33), but the analysis reflected the phenomenon across the entire data set. Because the ERAHSE study provided a full data set in which activity was a prominent issue, and because the goal of the present study was to portray collective experiences women had of daily activities after onset of early RA and the meanings derived from these activities, both of which aligned with phenomenography, it was an appropriate approach for analysis.

The new core team of investigators analyzed the data through an occupational lens following Heaton's (34) definition of a type 1a secondary analysis, which is an additional in-depth analysis of a single data set in order to explore a particular finding in more detail than was done in the original study. Using Dahlgren and Fallsberg's steps

Table 1. Data analysis process (31)

Step	Actions
Familiarization	Transcripts were read by a core team (HNM, TD, CLB), and the 16 most robust transcripts (pertaining to the research purpose) were chosen for more detailed reading. Memos and journaling began and formed an audit trail throughout the analysis
Condensation	Important passages related to the experience of everyday activity were identified and highlighted in these 16 transcripts
Comparison	Passages were extracted, similarities and differences were identified
Grouping	Similar passages were categorized into groups in a table with supporting statements from transcripts
Articulating	All 6 team members met to discuss and debate content of categories to clarify areas of disagreement and come to a consensus
Labeling	The full team agreed on category names to accurately reflect the meaning and content of the data
Contrasting	The core team analyzed and identified structural relationships among categories and made revisions to categories. Condensation, comparison, grouping, articulating, labeling, and contrasting were carried out for the remaining 21 transcripts
Refining	Categories were refined and structural relationships were made explicit based on the full set of transcripts and iterative analysis to accurately reflect participants' collective experience

(31) (Table 1), data were reviewed carefully for both positive and negative experiences. To enhance rigor, regular meetings were held with both the core team and full team (core members and 3 original ERAHSE investigators [AT, LCL, SC]) to bring different perspectives to the analysis.

RESULTS

Phenomenographic analysis provided a rich description of how early RA affected daily activities, resulting in 4 categories: uncertainties (hour-to-hour, day-to-day, and about the future), experiencing activity disruption, doing things differently, and changing views of self.

Uncertainties (hour-to-hour, day-to-day, and about the future). Participants described uncertainty associated with daily fluctuations in symptoms and activity participation, as well as a great sense of the unknown as they thought about the future. For some, participation varied throughout the day. One woman would "take the dog for a walk and then come back and rest for an hour."

This category was illustrated by good days, bad days, and worse days, which emerged as an undercurrent across the transcripts (Table 2). The days that would be experienced as good and the days that would be experienced as difficult were unknown, making it challenging for the participants to plan ahead. Within a continuum of activity participation to activity disruption, some participants described moderate fluctuations over time, while others described dramatic changes in function that often occurred abruptly, amplifying the sense of uncertainty. Participants questioned whether they would be able to continue doing the things they loved, and feared inability to care for themselves as they grew older. On good days, function was at near-preillness levels, and on bad days, participants struggled to complete simple activities like going for a walk (Table 2). Participants experiencing dramatic fluctuation in function also described worse days that were associated with significant emotional distress where the fatigue and pain were so severe that activities were impossible (Table 2).

Participants expressed frustration and anxiety over unpredictability of symptoms and their impact on function. Many were concerned about the ability to continue living

Table 2. Examples of uncertainties (hour-to-hour, day-to-day, and about the future)

Supporting evidence
"Am I going to be looked after all my life? Am I not going to be able to do for myself? Am I going to be under somebody else's control because I can no longer do for myself?" (Alicia)
"Maybe I just need to take each day as it comes . . . okay today's a good day, be grateful and leave it at that. Having said that, we are certainly planning for things in the future. . . . Will we continue to live where we are . . . we'll just have to see about that." (Cynthia)
"I couldn't walk one day. I could hardly get into my chair and two months later I am cutting almost a half acre of grass." (Debbie)
"It just goes up and down and up and down. You have a good week in a month. I will have a really good week and I will wrap myself all up and actually go for a walk. . . . It goes in little patterns. And on my best days . . . my cousin will take me out shopping." (Maple)
"I was absolutely, emotionally just a basket case because my life had changed in a blink of an eye. From being a very active person to being someone who couldn't get off the chair. And I thought is this what the rest of my life is going to be? And I just didn't know what to expect . . . I was so distraught." (Sally)
"It was so bad I was in bed for 10 days with severe pain. I thought I was going to die." (Debbie)

in their current homes, since performing yard work, housework, and using stairs became increasingly challenging. In light of this uncertain future, some participants expressed a sense of urgency to do things before it became too late. As one woman noted, "we may not always be able to do it."

Table 3. Examples of experiencing activity disruption

Supporting evidence
"The total loss of activities was just horrid. My husband had to help me dress, bathe, do up hooks." (Sally)
"I am sometimes searching for things to do. I am spending far more time than suits me at my computer playing FreeCell and it fills the time. It sort of vaguely occupies me but I really don't like it. This is something that I . . . I'm not satisfied with it. So the truth is I am now searching for other things that will occupy my time and satisfy me." (Cynthia)
"I have to find other things because I like to do what they're [friends] doing and I'm very often excluded by the mere fact that I physically can't go bowling with a bunch of people from work or because I can no more lift a bowling ball than fly to the moon." (Charlize)
"I am unable to go walking on a regular basis. I was into marathons. . . . Now lots of times I have to use a cane just to get from the car to the office that sort of thing. That's a major change in my life." (June)
"I was always able and capable to push through. You know you're tired and you just put the blinders on you can just plough through something. And you recover later. . . . You do what you have to . . . I kept pushing, and pushing, and pushing, right through. Just trying to complete the end of my program." (Danielle)

Experiencing activity disruption. Participation losses were described. This process often began with a reduced ability to engage in activities that became either too difficult or too time consuming to undertake and had to be stopped entirely (Table 3). Participants expressed frustration over lost abilities in the most basic daily routines of dressing, eating, and sleeping. Some participants were discouraged that, in spite of their healthy living choices, profound losses occurred.

Traveling, studying, hobbies, socializing, and work became increasingly difficult. Being "on the sidelines" was hard when participants would rather be productive members of society. The loss of work and leisure were relayed as life altering, leaving participants feeling "diminished," "excluded," and "bored." At times, pushing through pain and fatigue in order to continue participation in valued activities resulted in paying consequences later, in the form of more severe symptoms. Other times, "there's just no way around it," so they carried on, determined not to give up.

Doing things differently. This category explains the diverse ways participants found to maintain participation in meaningful activities and altered social relationships, and the emotional reactions that accompanied these changes (Table 4). Some solutions were driven by working around physical symptoms, such as doing things more carefully, using 2 hands instead of 1, and taking breaks for rest and recovery. Some participants solved problems through trial and error or observing role models, and others learned from health professionals. Sometimes, new activities were substituted for old, such as snowshoeing in place of skiing. Furthermore, participants acknowledged the importance of assistance and support from friends and family. While requesting and accepting help was often difficult, many participants also expressed the positive side of this experience, noting a deep appreciation for the practical and moral support received and a more acute awareness of the value of relationships.

Complex activities often required more creative and larger-scale modifications to facilitate continued participation. These modifications were often met with distress. Equipment resolved some problems; 1 participant replaced tenting with a pop-up trailer for family camping trips. Working from home, part-time work, or retirement replaced full-time employment, and participants described these larger changes as harder to accept.

Changing views of self. This category encompasses 2 subthemes: occupational identity and the job of patient (Table 5). The sense of self derived from participation in valued activities has been called occupational identity (12). Participants characterized actual and anticipated losses of work, leisure, or homemaking roles or tasks as a threat to their occupational identity. The emotional impact

Table 4. Examples of doing things differently

Supporting evidence
"The office I worked at had a long flight of stairs up and . . . what I would do is come home and work at home because I couldn't bear the thought of going up and down those stairs . . . my world was starting to get really, really small." (Flossie)
"I have to ask people for help now which is kind of hard. Help with things that are painful for me or I don't have the strength for any more." (Nora)
"I've just experienced so much thoughtfulness and kindness. [F]rom the guy who I bought my $300 shoes from, [laughs] the people in the health food store, everywhere . . . so I have become far more in tune with human relationships. And I value people so much more and I think ah, it's one of the fabulous bonuses of these god awful experiences and it's amazing." (Teresa)
"[My husband] and I have talked . . . we could get a double kayak, that would be a solution, probably not as satisfying, but okay that's where things are at . . . I have to decide is that better than not doing it at all or do I accept the fact that I can't do it anymore or do I accept the fact that we just go out for very little, short paddles?" (Cynthia)
"No more skiing. And that was really hard for me because our whole family skis . . . I'm OK with it now because I have snowshoeing. . . . [I]t was very difficult . . . because skiing was so big in our family . . . I didn't pick up snowshoeing until we moved here three years ago and I love it because I just do as much as I can that day and then that's it you know." (Barbara Anne)

Table 5. Examples of changing views of self

Subcategory	Supporting evidence
Occupational identity	"I was really struggling because I thought I was really a bad mom. I couldn't get down on the floor and play with my little baby. . . . So that was very difficult." (Kerry) "I do a lot of pottery . . . I will never be a great potter anymore." (Sherry) "It's very hard: who I was and who I am are two different people. It's very hard to reconcile the two." (Dorothy) "He just said to me, you have to face that you're not going back to that job period. . . . And so even all this time later, a year and a half later I am still kind of going . . . how do I define myself and that's been really hard. . . . And I know there is one part of me that says you're a lot more than your job description or your whatever but there is also a huge part of you that is." (Flossie)
The job of patient	"I had the methotrexate injection. . . . This week is my third week using it by myself. I've got a little diagram on the fridge of my belly button so I'm going around the belly button in the way, in the dates so that I'm not using the same injection site more than once." (Jane) "Because I mean this is your world. This is my health and RA has been my absolute world, all-consuming world, the last number of months." (Danielle)

of these losses was evidenced by statements of "I used to be . . ." as participants began the transition to a different occupational identity that included a new job, being an RA patient, and doing illness work to manage symptoms (35–37).

Occupational identity. Roles changed as participants relinquished activities to family members or friends when symptoms were severe. Occupation and identity, i.e., "doing" and "being," were intimately intertwined. As the ability to participate in daily occupations changed due to unpredictable symptoms, participants began to redefine life in terms of these new experiences. One participant described the impact of foot pain as she was faced with having to give up her high heels, "[F]eet became a big issue and shoes became a big issue 'cause I am a Nine West shoe person. Well not anymore [laughs]."

Work loss had a particularly important and detrimental impact on occupational identity. Giving up all or parts of their job negatively impacted participants' views of themselves as productive members of society. Transitioning or expanding one's identity to that of being a person with arthritis was a struggle.

The job of patient. The job of patient is hard work (35–37). For our participants, it involved medical appointments, managing medications and diet, attending education classes, and reading about RA. As the job of being an RA patient became more prominent, participants began redefining their lives to include this new occupational identity. Patient work became a dominant activity for participants.

While each of the 4 categories was distinct, the data also showed that they were closely connected and influenced one another. Structural relationships were identified during analysis (Figure 1). Three categories (uncertainties, disruption, and doing things differently) reflected aspects of occupational experiences, and each influenced the changing view of self. Doing things differently also moderated activity disruption. Changing views of self may influence factors associated with living well with arthritis, but the current data set was insufficient to report further.

DISCUSSION

Thirty-five years ago, Wiener (38) described the uncertainty associated with RA as a race between pain and activity participation, where the leader is unpredictable and the winner each day is unknown. Similar uncertainty was reflected by our participants with early RA, as their symptoms fluctuated. Participants reiterated the good days and bad days associated with chronic illness reported in previous research (3). However, worse days were highlighted as more profoundly challenging than bad days. On worse days, symptoms were extreme and activity virtually stopped. Worse days were the days where participants described emotionally taxing changes in function that varied dramatically from one day to the next. This finding suggests it is important for health professionals to be aware of, and distinguish between, the moderate fluctuations of good to bad days and the dramatic, unpredictable dysfunction associated with worse days so that appropriate supports can be provided. The often-shifting experiences of good, bad, and worse days have different meanings for participants because they present differing degrees of physical, functional, and emotional challenges. However, a few participants expressed hope for a more predictable future when describing the effect of new medications: "life had changed radically" for the better, allowing return to previous activities and feeling "alive again."

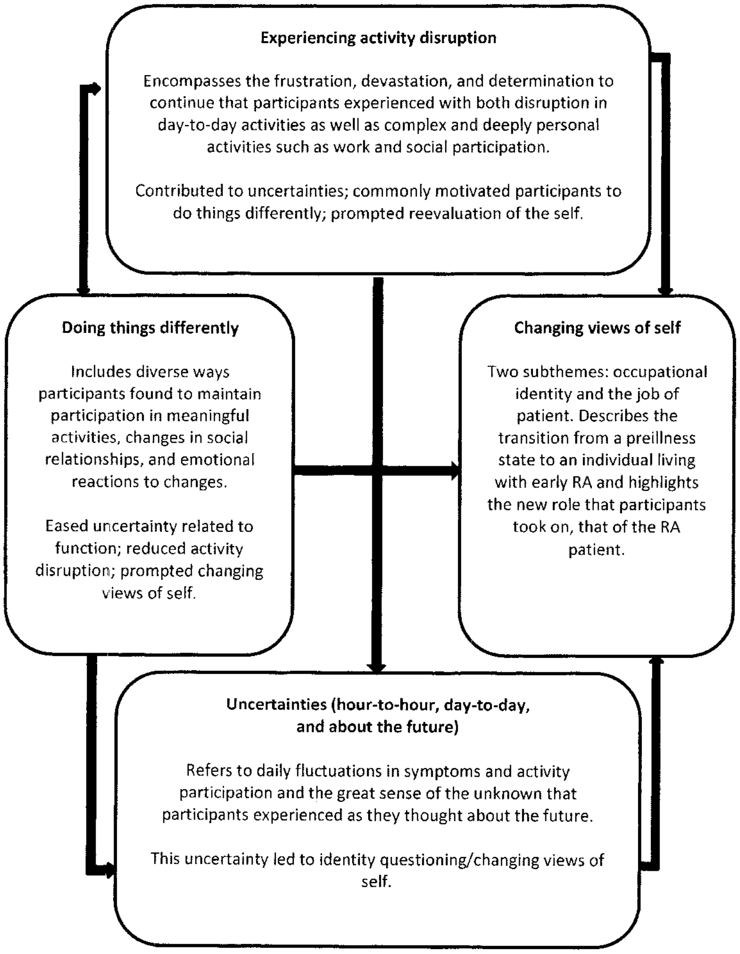

Figure 1. Key categories, definitions, and structural relationships arising from the analysis of experiences of everyday activities in early rheumatoid arthritis (RA).

As Bury (39) summarized, the meaning of chronic illness is tied to both consequences of symptoms and the significance of those consequences. In the present study, the frustration and anxiety expressed from fluctuating symptoms and their implication for function illustrates the deeper emotional meaning and impact of change brought on by early RA. The physical, social, and emotional context in which illness work is carried out mediates the experience of chronic illness (35). In the present study, large homes with multiple stairs and expansive property exacerbated participants' concerns about future living situations, particularly for those living in small towns. Some expressed relief at having someone to rely on when they were unable to do things or wanted to talk about fears, describing a fine balance between valuing social support and independence.

Activity disruption began even before diagnosis; it seemed to prompt some participants to seek medical attention (22,23). Participants tended to symptoms when they disrupted eating, sleeping, or engaging in hobbies or work. This corroborates other studies (1,20–21) describing activity disruption in chronic illness as an all-encompassing burden where even simple activities become an overwhelming challenge. However, it was somewhat surprising to hear about significant losses so early in the disease course. For many, it was interpreted as losing a fundamental part of themselves and their independence, and was met with profound distress.

Disruption to activities that were highly valued and central to participants' sense of self was difficult to accept. Several participants aligned with North American social norms that value the ability to work as a major contributor to the perception of a meaningful life (2). This has tremendous implications for the working-age early RA population, highlighting the need for early intervention to support clients in their work (40), allay fears about earning a living, and sustain identity. Similarly, pain and fatigue caused many participants to engage in fewer social roles, and others felt excluded due to the inability to participate in group activities. Charmaz (2,3) suggests that exclusion leads to isolation and loss of self. Social role participation is an increasingly important outcome measure for people with RA (41).

Participants also experienced positive social interactions after diagnosis. Daughters took care of mothers, and husbands took care of wives. This support allowed participants to maintain daily routines and strengthen valued relationships. However, it also implied roles in transition, from being independent or caretakers themselves to being taken care of at times, in line with research showing adjustment to new roles after diagnosis (42). As roles shifted with changing abilities, participants questioned their self-perception as independent, healthy individuals.

In the present study, activity disruption was a strong motivator for doing things differently. A range of factors, including frustration, fear of being a burden, pain, fatigue, support from others, and observing role models further propelled participants to modify how they engaged in activities. Altered methods and assistive devices enabled participants to maintain valued activities, eased uncertainty, and facilitated positive changing views of self (37). However, it was not always clear exactly when in the illness progression and how (self-discovery or learning from health professionals) participants modified their activities, which is likely a reflection of the original interview guide focused on help seeking in the context of lived experience rather than activity engagement specifically.

Mishel (43) described “mobilizing” or taking action as a strategy for coping with uncertainty in chronic illness. In the present study, techniques such as using 2 hands instead of 1 and substituting new activities for old helped participants cope with lost activities and maintain participation in other activities. However, many participants questioned whether making changes to valued activities was worth it. Would doing the activity differently change it so much that it no longer represented the valued occupation they enjoyed? Some activities were forfeited rather than pursued with adaptive strategies.

Christiansen (44) suggested that identity is developed and expressed mainly through occupation. In our study, when valued occupations were lost, identities were often lost with them. The inability to continue to work, the lost ability to run, and the impossibility of wearing favored shoes or clothes fundamentally challenged participants’ sense of self. For the previously mentioned participant who had to stop wearing high heels, shoes represented a symbol of femininity, her image as an independent working woman. When she was no longer able to wear high heels, it shook her core sense of who she was. The loss of the ability to perform parental duties, work, socialize, pursue hobbies, or maintain the home consistently changed how participants identified themselves and their life roles. This is similar to the literature on longstanding RA (45) and chronic illness (37), which shows that engagement in occupations supports role fulfillment (37,45).

The process of accepting an illness can take varying periods of time (13). Identity questioning occurs in chronic illness, yet many people ultimately experience self-acceptance as they reflect on their life and illness (3). Asbring (13) explained the transition as a life-changing disruption that results in degrees of identity transformation as portions of the old identity are lost and the new identity is integrated. For many, reflection upon this transition leads to illness gains that ultimately result in a new identity that is more positive than the preillness identity (13). The beginning of a similar transition was evident among our participants, suggesting identity is queried and life changes are pondered in the very earliest stages of living with RA. When faced with challenges to their preillness occupational identity of “worker” and “doer,” participants moved toward new occupational identities such as RA patient and struggled with whether or not this entailed letting go of past identities.

Participants conducted personal research, tried alternative therapies and diets, and modified activities in order to self-manage their illness. Similar searching and experimentation have been relayed as detective stories where people with multiple sclerosis described how they uncovered ways to live satisfying lives (46). This complex process of learning to navigate the health care system (23,42) and the concept of illness work (35,36) is not new; despite advances in medical management, the need for illness work persists and is likely to increase alongside efforts to support self-management. Narrative studies of longstanding RA have shown that mastery is possible (47), and health professionals might convey this as a positive message to (and from) patients.

While loss was experienced by all participants in the present study, the meaning of loss varied. Expressions of turmoil were common since occupational disruption evoked strong emotions. Words such as “useless,” “angry,” “isolated,” “devastated,” and “depressed” were used to describe the experience of daily activity after the onset of RA, consistent with existing reports of the relationship between psychological distress and activity loss (20,48). On the other hand, some participants found positive meanings in their experiences of activity disruption. Some were touched by the kindness and support they received from others, becoming “far more in tune with human relationships” and “valuing people so much more.” The meanings of these experiences may change as time and identity transition progress.

There were limitations to the present study. As a secondary analysis, the data were collected using a different theoretical approach to respond to a different research question. Not all of the transcripts contained rich descriptions of everyday activities, and therefore potentially important perspectives were not fully elicited in all interviews. A prospectively designed study on activity disruption would likely enhance understanding of the concepts presented here. Questions designed to explore positive impacts may generate affirmative experiences that did not emerge in the current data set. Participants were diagnosed with RA in the past 12 months; however, symptom duration prior to diagnosis varied from several months to several years, and this may not reflect others’ experiences of early RA. Furthermore, analysis related to identity transition and personal narratives in early RA would be more trustworthy had the interview been designed to probe these topics.

Strengths of this study include its focus on an important period of time in the illness trajectory, wherein activity disruption spontaneously emerged as an important experience. Yet it also showed that people manage symptoms on their own, sometimes for years, before seeking medical attention, thus illuminating experiences of everyday life in the period leading up to and including RA diagnosis. Additionally, the phenomenographic approach allowed the researchers to identify overarching meanings that crossed transcripts and were implicitly presented by the group as a whole.

Future research could tease out the detailed experience of identity transition and meanings associated with this transition in early RA to provide a clearer picture of this process as it unfolds. For instance, does acceptance of activity change happen in early RA? And if so, how does this transition occur and progress across time? Additionally, research delving deeper into the experience of moderate, gradual fluctuations between good days and bad days versus the abrupt changes associated with worse days could identify specific supports needed for those who may be vulnerable to more dramatic changes in function and uncertainty. For example, how do these different experiences relate to disease progression? Future research could further explore structural relationships among the categories identified in this study.

Early RA has a profound impact on daily activities. The experience is multifaceted, involving uncertainty, disruptions to daily activities, necessity to do things differently, and changes to occupational identity. As activities are disrupted, occupational identity is threatened or altered. This begins at the onset of RA and has significant consequences for the patients' function. The current research highlights the need for a holistic approach to caring for people from the very earliest stages of RA.

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AUTHOR CONTRIBUTIONS

All authors were involved in drafting the article or revising it critically for important intellectual content, and all authors approved the final version to be published. Ms McDonald 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 conception and design. McDonald, Dietrich, Townsend, Li, Backman.

Acquisition of data. Townsend, Li.

Analysis and interpretation of data. McDonald, Dietrich, Townsend, Li, Cox, Backman.

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