Accommodative Coping and Well-Being of Midlife Parents of Children With Mental Health Problems or Developmental Disabilities

Marsha Mailick Seltzer, PhD, and Jan S. Greenberg, PhD
University of Wisconsin—Madison

Jinkuk Hong, PhD
University of Wisconsin—Madison

This study examined how accommodative coping via flexible goal adjustment affects the well-being of midlife parents. Using data from the Wisconsin Longitudinal Study, a population-based study of midlife adults, the authors compared parents who have a child with a severe mental health problem, a child with a developmental disability, or a child with no chronic illness or disability. Overall, parents had better well-being (i.e., lower levels of depressive and physical symptoms, higher levels of environmental mastery and self-acceptance) if they used accommodative coping. This effect was stronger for parents of individuals with a severe mental health problem than for the comparison group.

Parents who have an adult child with a lifelong or chronic disability face atypical caregiving challenges that may cause stress and threaten their physical and mental health (Seltzer, Greenberg, Floyd, Pettee, & Hong, 2001). Yet, similar to other types of family caregivers, there is great heterogeneity in parents’ responses to the demands of the long-term caregiving role. Coping and social support are protective factors that can maintain the resiliency of individuals exposed to adversity (Johnson, 2000; Solomon & Draine, 1995), whereas the stresses of the caregiving situation are risk factors that may increase the likelihood of physical and mental health consequences (Schulz et al., 2001; Smith, Oliver, & Innocenti, 2001).

This study examines how accommodative coping affects the well-being of midlife parents who have a child with a disability, either a severe mental health problem or a developmental disability. As described by Brandstadter and Renner (1990), accommodative coping involves flexibly adjusting one’s goals in response to a persistent problem. When people are faced with uncontrollable events, coping by flexibly relinquishing unachievable goals is associated with positive well-being. Furthermore, there is a life course gradient to accommodative coping. Among adults between the ages of 34 and 63, accommodative coping is lowest among the cohort of individuals in their 30s, peaks between ages 52 and 57, and levels off and declines thereafter (Brandstadter & Renner, 1990). Thus, accommodative coping appears to be a strategy preferred in midlife, the stage of life of the individuals we studied for this analysis.

We applied Brandstadter and Renner’s (1990) conceptual framework to our ongoing research on parents of adult children with disabilities (Seltzer et al., 2001). In a previous study (Seltzer, Greenberg, & Krauss, 1995), we found that although mothers of adults with developmental disabilities had a lower risk of depression if they used problem-focused coping strategies, mothers of adults with mental illness did not benefit from using problem-focused coping. In addition, emotion-focused coping was not a productive way of coping for either group, as such strategies actually increased the risk of depression. We are
left with the unanswered question of how parents of adults with mental illness can cope effectively with the high levels of stress that they experience on a daily basis.

For several reasons, we expect that accommodative coping will be a particularly important coping strategy in midlife for parents of individuals with mental illness, and this factor will set them apart from other parents, including those whose adult child has developmental disabilities. First, whereas developmental disabilities are generally diagnosed in the first few years of the child’s life, often at birth, severe mental health problems are typically diagnosed during late adolescence or early adulthood. Thus, these two groups of parents must cope with their child’s diagnosis at different times in their own life course—early adulthood for parents of children with developmental disabilities, and midlife for parents of persons with severe mental health problems. As this study focuses on parents who are in their early 50s, those who have a son or daughter with severe mental health problems have had much less time to adjust to the diagnosis of mental illness in their child than those who have a son or daughter with developmental disabilities, whose diagnosis came more than 2 decades earlier. It is possible that accommodative coping has more powerful effects during the early years after diagnosis, when the need for accommodations is great, than later in the caregiving career.

Second, in contrast with developmental disabilities, the symptoms of severe mental health problems are generally less predictable, and parents of adults with mental illness experience more uncertainty regarding how their son or daughter will react in everyday situations. In contrast, persons with developmental disabilities show considerably more stability in their behaviors (Eyman & Widaman, 1987), and, hence, their parents may have greater feelings of control or mastery over the caregiving situation. Given the intermittent and unpredictable nature of mental health symptoms (American Psychiatric Association, 2000), accommodative coping might be particularly beneficial in maintaining parental psychological and physical well-being because it places greater emphasis on cognitive strategies that involve the reappraisal of the stressor or a change in personal values or goals, in response to persistent and uncontrollable stress.

Research Questions

We posed three research questions. First, we asked whether midlife parents of children with disabilities differ from parents whose children do not have any chronic health problems or disabilities with respect to their use of accommodative coping strategies. We hypothesized greater use of accommodative coping by midlife parents of individuals with disabilities than their age peers whose children have no health problems or disabilities. We based this hypothesis on Brandstader and Renner’s (1990) formulation that persistent sources of stress may require different coping strategies than more discrete problems, such as “adjustments of aspiration level, revision of value priorities and evaluative standards, . . . and cognitive reappraisals that aim at the construction of meaning” (p. 59). Given the persistence of caregiving stress for midlife parents of individuals with disabilities, we expect that these parents would be more likely to use accommodative coping than their age peers whose children are healthy.

Our second research question asked whether midlife parents of children with disabilities differ from those whose children do not have any chronic health problems or disabilities with respect to level of well-being. We hypothesized that midlife parents of individuals with severe mental health problems would have poorer well-being than their counterparts with either a child with developmental disabilities or a child who is healthy. Our prior research (Seltzer et al., 2001) showed elevated levels of depressive symptoms and physical health problems among midlife parents of individuals with severe mental health problems, and the present analysis extends this hypothesis to positive indicators of well-being, which have been examined in other studies of the well-being of mothers of children with disabilities (Florian & Findler, 2001).

Our third research question was whether accommodative coping has a different effect on well-being for parents of children with disabilities than for parents of healthy children. We hypothesized that the use of accommodative coping would have positive effects on well-being for all three groups, on the basis of Brandstader and Renner’s (1990) findings of significant correlations between accommodative coping and well-being in their study of the general population. However, we expected stronger effects for parents of individuals with disabilities than for the comparison group because accommodative coping is particularly important in the context of chronic stress (Brandstader & Renner, 1990). Furthermore, we expected these effects to be particularly strong for parents of individuals with severe mental health problems because of the greater recency of the diagnosis and the unpredictability of the caregiving context (Greenberg, Seltzer, & Greenley, 1993; Seltzer et al., 2001).
ACCOMMODATIVE COPING AND WELL-BEING OF MIDLIFE PARENTS

Method

The Wisconsin Longitudinal Study

To address these questions, we used data from the Wisconsin Longitudinal Study (WLS; Hauser et al., 1992). The WLS began in 1957 with a random sample of one third of all young men and women who graduated from Wisconsin high schools that year (N = 10,317). In 1975, when respondents were 36 years old, 9,138 of the surviving original sample (90.1%) completed a telephone interview that, in addition to research measures, included a roster of their siblings. In 1992, when the respondents were in their early 50s, 8,493 of the surviving participants (87.2%) responded to a telephone survey and provided a roster of their children, with more detailed information about one randomly selected target child. In addition, they completed a mail-back self-administered questionnaire.

In addition to the original respondents, the WLS contains parallel data about a random sample of 5,363 of their siblings, who ranged in age at the time of the most recent data collection from 35 to 67, with an average of 52 years (i.e., roughly the age of the original respondents). The present analysis uses data from both the original respondents and their siblings.

Sample

Through a series of screening procedures described elsewhere (Seltzer et al., 2001), we identified 218 parents of children with disabilities among all of the WLS participants, of whom 165 had a child with a developmental disability and 53 had a child with a severe mental health problem. The sample for the present analysis consisted of a subset of these 218 parents: 127 who had a child with a developmental disability, and 45 who had a child with a severe mental health problem. The cases not included in the present analysis had missing data on the measure of accommodative coping. There were no significant differences in background characteristics between those with missing data and those included in the analysis.

We randomly selected a comparison group of 218 WLS respondents whose children did not have disabilities or chronic illness, stratified by gender of the respondent to reflect the proportions in the disability samples. The present analysis included 215 of the 218 members of the comparison group, all those who completed the measure of accommodative coping.

In each family, a target child was designated. For families who had a child with a disability, the target child was the son or daughter with the developmental disability or severe mental health problem. In the comparison group, the target child was the randomly selected child on whom in-depth data were collected.

As shown in Table 1, more than half of the parents included in our sample were mothers. Parents were in their mid 50s at the time of the interview, and over 80% were married. The median income of the respondent and spouse was between $55,000 and $60,000. Well over three fourths of the respondents were employed, either full or part time. Respondents had between three and four children, including the target child. About 40% of the target children were sons, with an average age in their mid 20s at the time of the interview.

There were only two significant differences among the three study groups with respect to these background variables. Parents of adults with developmental disabilities had larger families than parents in the comparison group, but there was no significant difference in number of children between parents of adults with mental health problems and those in the comparison group. In addition, adults with either of the two types of disability were more likely to be employed. About 90% of the respondents were employed either full or part time.

In each family, a target child was designated. For families who had a child with a disability, the target child was the son or daughter with the developmental disability or severe mental health problem. In the comparison group, the target child was the randomly selected child on whom in-depth data were collected.

As shown in Table 1, more than half of the parents included in our sample were mothers. Parents were in their mid 50s at the time of the interview, and over 80% were married. The median income of the respondent and spouse was between $55,000 and $60,000. Well over three fourths of the respondents were employed, either full or part time. Respondents had between three and four children, including the target child. About 40% of the target children were sons, with an average age in their mid 20s at the time of the interview.

There were only two significant differences among the three study groups with respect to these background variables. Parents of adults with developmental disabilities had larger families than parents in the comparison group, but there was no significant difference in number of children between parents of adults with mental health problems and those in the comparison group. In addition, adults with either of the two types

Table 1

Characteristics of the Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>MH group (n = 45)</th>
<th>DD group (n = 127)</th>
<th>Comparison group (n = 215)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (% female)</td>
<td>62</td>
<td>60</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td>54.6</td>
<td>54.1</td>
<td>53.9</td>
<td></td>
</tr>
<tr>
<td>Marital status (% married)</td>
<td>82</td>
<td>90</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>Income (median)</td>
<td>$55,014</td>
<td>$59,500</td>
<td>$59,500</td>
<td></td>
</tr>
<tr>
<td>Employment status (% employed)</td>
<td>92.3</td>
<td>74.8</td>
<td>79.8</td>
<td></td>
</tr>
<tr>
<td>No. children</td>
<td>3.6</td>
<td>3.9</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Characteristics of target child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (% female)</td>
<td>42</td>
<td>39</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td>26.9</td>
<td>25.6</td>
<td>26.4</td>
<td></td>
</tr>
<tr>
<td>Coresides with parent</td>
<td>36.0</td>
<td>59.0</td>
<td>15.0</td>
<td></td>
</tr>
</tbody>
</table>

Note. The median incomes are reported in the table, although the F ratio is based on the natural log of income. MH group = parents of children with severe mental health problems; DD group = parents of children with developmental disabilities. ***p < .001.
of disabilities were more likely to be living in the parental home than their counterparts in the comparison group. Apart
from these two differences, the three groups were very similar. In addition, we have reported in past research that the
three groups were similar in 1957 as 18-year-old high
school seniors in family socioeconomic status, population
town of origin, and IQ score (Seltzer et al., 2001).

Measures

In addition to group membership (parent of a child with
severe mental health problems, developmental disabilities,
or healthy children), the key independent variable in this
analysis was Brandstadter and Renner’s (1990) measure of
accommodative coping, which they termed flexible goal ad-
justment (FGA). The WLS version of the FGA measure,
shortened from the original measure, consists of five items,
rated from 1 (strongly disagree) to 5 (strongly agree): “In
general, I am not upset very long about an opportunity
passed up,” “If I don’t get something I want, I take it with
patience.” “It is very difficult for me to accept a setback or
defeat” (reverse coded), “I find it easy to see something pos-
tive even in a serious mishap,” and “When everything
seems to be going wrong, I can usually find a bright side to a
situation.” The first three items focus on the ability or will-
ingness to relinquish goals, whereas the latter two items re-
fect the ability to reappraise situations positively. In our
sample, the alpha reliability was .67. The dependent vari-
bles were two measures of negative well-being (depressive
symptoms and physical symptoms) and two measures of
positive well-being (self-acceptance and environmental
mastery). The measure of depressive symptoms was the
Center for Epidemiological Studies–Depression Scale
(CES-D; Radloff, 1977; Gatz & Hurwicz, 1990). For each of
20 depressive symptoms, the respondent is asked to indicate
how many days in the past week the symptom was experi-
enced. The measure of physical symptoms was a count of
the number of symptoms reported by the respondent (from a
list of 22 symptoms, e.g., chest pain, headaches, dizziness,
trouble sleeping, nausea, joint pain). The measures of self-
acceptance and environmental mastery are from Ryff’s
(1989; Ryff & Keyes, 1995) measures of psychological
well-being. Each of these measures consist of seven items
(1 = strongly disagree to 6 = strongly agree). People who
have high scores on self-acceptance have a positive attitude
toward self and feel positively about their life. People who
have high scores on environmental mastery have a sense of
competence in managing the demands of the environment.

Control variables included the parental gender (1 =
mother, 0 = father), income (in dollars), age, employment
status (1 = employed full or part-time, 0 = otherwise),
number of children, and whether the target child lived with
the parent (1 = living with parent, 0 = otherwise).

Data Analysis

The first two research questions concern the extent to
which midlife parents of persons with severe mental health
problems, persons with developmental disabilities, or
healthy children differ, first, in their use of accommodative
coping strategies and, second, in their psychological well-
being. To address these questions we used analysis of vari-
ance (ANOVA) to compare the scores of the three groups
first on FGA and next on the four indicators of psychological
well-being. Post hoc follow-up contrasts were conducted
when the overall F ratio was significant.

The third research question, which concerns the effects of
FGA on psychological well-being, was addressed via ordi-
nary least squares (OLS) regression models. Separate mod-
els were estimated for each of the four dependent variables.
Each regression model included control variables (gender of
respondent, income, age, employment status, number of
children, and whether the target child coresided with the re-
spondent), two dummy variables for type of group (develop-
mental disabilities vs. comparison, severe mental health
problems vs. comparison), and the measure of FGA, all en-
tered on Step 1. Interaction terms for Type of Group × FGA
were entered on Step 2. This use of contrast coding and ap-
propriate follow-up analyses (Aiken & West, 1991) makes it
possible to assess the significance of the main effect of FGA
on the dependent measure and whether the groups differed in
the effect of FGA on the dependent variable. In follow-up
analyses, we tested the simple effects of FGA for each of the
groups and plotted the regressions for the separate groups to
contrast their slopes and intercepts. In addition, we included
in the regressions variables that controlled for missing data
on income, employment status, and whether the adult child
lived with the respondent.

Results

The first research question concerned the extent to
which the three groups differed in their use of accom-
dorative coping, as measured by the FGA scale. As
shown in Table 2, the mean scores for the groups were
virtually identical, and the ANOVA produced a non-
significant effect for group. Thus, contrary to our hy-
pothesis, the three groups did not differ in their use of
accommodative coping.

The second research question asked whether
midlife parents of children with mental health prob-
lems or developmental disabilities differed from other
midlife parents with respect to their level of depres-
sive symptoms, physical symptoms, environmental
mastery, and self-acceptance. These analyses are also
presented in Table 2. Consistent with our hypothesis,
there were significant group differences on the two
negative well-being measures. Post hoc contrasts
indicated that parents of individuals with severe men-
tal health problems had significantly more depressive
symptoms and physical symptoms than parents in the
comparison group, but parents of persons with devel-
mental disabilities did not differ significantly from the
comparison group. However, for the positive
well-being measures, the three groups of midlife
ACCOMODATIVE COPING AND WELL-BEING OF MIDLIFE PARENTS 191

parents did not differ in their level of either environmental mastery or self-acceptance.

For the third research question, we examined whether accommodative coping had significant effects on parental well-being for parents overall and also whether these effects were strongest for midlife parents of individuals with serious mental health problems, as we had hypothesized. The results are presented in Table 3.

Regarding depressive symptoms, Step 1 shows that the main effect of FGA was significantly and negatively associated with depressive symptoms, as expected. For the sample overall, parents who have lower scores on FGA have elevated levels of depressive symptoms, whereas parents who are more likely to use accommodative coping have lower CES-D scores. In addition, the coefficient for the group of parents of children with mental health problems (MH group) is significant, consistent with the results of the ANOVA, signifying that parents of individuals with severe mental health problems differed from the comparison group in level of depressive symptoms.

Next, at Step 2, the addition of the interaction between the MH group and FGA made a significant contribution to the prediction of depression, which indicates that the effect of FGA on depressive symptoms is greater for parents of individuals with severe mental health problems than for parents of comparison group children. However, the Developmental Disabilities (DD) Group × FGA interaction was not significant, which indicates that parents of individuals with developmental disabilities did not differ from the comparison group in the effect of FGA on depression.

In follow-up analyses, we tested the slope of the effect of FGA on depressive symptoms for each group separately (see Figure 1) and found that all three effects were significant (MH: $B = -.93, p < .001$; DD: $B = -.04, p < .001$; comparison: $B = -.91, p < .001$), with the slope steepest for parents who had a child with severe mental health problems. Thus, these regression analyses show that accommodative coping is useful for the sample as a whole in avoiding the symptoms of depression, and, as expected, it is a particularly effective way of reducing the risk of depression for parents whose son or daughter has a severe mental health problem.

Regarding physical health symptoms, similar to the findings for depression, FGA was a significant predictor of physical symptoms for the sample overall (Step 1). In addition, the MH group coefficient was significant, consistent with the results of the ANOVA, signifying that parents of individuals with severe mental health problems had a greater number of physical symptoms than the comparison group. There were no significant interactions of Group × FGA, indicating that parents of individuals with mental health problems and parents of individuals with developmental disabilities did not differ from the comparison group in the effect of FGA on physical symptoms.

### Table 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>MH group (n = 45)</th>
<th>DD group (n = 127)</th>
<th>Comparison group (n = 215)</th>
<th>F(2,384)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGA</td>
<td>17.22</td>
<td>17.80</td>
<td>17.47</td>
<td>0.707, ns</td>
</tr>
<tr>
<td>SD</td>
<td>3.76</td>
<td>3.08</td>
<td>2.98</td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>11.55</td>
<td>9.01</td>
<td>8.14</td>
<td>3.466**</td>
</tr>
<tr>
<td>SD</td>
<td>12.07</td>
<td>8.03</td>
<td>6.77</td>
<td></td>
</tr>
<tr>
<td>Physical symptoms</td>
<td>6.89</td>
<td>5.58</td>
<td>5.13</td>
<td>3.971**</td>
</tr>
<tr>
<td>SD</td>
<td>5.00</td>
<td>3.85</td>
<td>3.52</td>
<td></td>
</tr>
<tr>
<td>Environmental mastery</td>
<td>31.84</td>
<td>32.99</td>
<td>33.71</td>
<td>2.478</td>
</tr>
<tr>
<td>SD</td>
<td>5.98</td>
<td>5.36</td>
<td>5.22</td>
<td></td>
</tr>
<tr>
<td>Self-acceptance</td>
<td>28.69</td>
<td>28.98</td>
<td>28.83</td>
<td>0.130</td>
</tr>
<tr>
<td>SD</td>
<td>4.21</td>
<td>3.65</td>
<td>3.57</td>
<td></td>
</tr>
</tbody>
</table>

Note. MH group = parents of children with severe mental health problems; DD group = parents of children with developmental disabilities; FGA = flexible goal adjustment. *Post hoc contrasts show that the MH and comparison groups are significantly different.

$p < .05$.

![Figure 1](image)

Figure 1. Effect of flexible goal adjustment (FGA) on Center for Epidemiological Studies–Depression Scale (CES-D) results. MH = parents of children with severe mental health problems; DD = parents of children with developmental disabilities.
Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>Depressive symptoms</th>
<th>Physical symptoms</th>
<th>Environmental mastery</th>
<th>Self-acceptance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1</td>
<td>Step 2</td>
<td>Step 1</td>
<td>Step 2</td>
</tr>
<tr>
<td>Control variables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>3.12***</td>
<td>2.96***</td>
<td>0.94*</td>
<td>0.94*</td>
</tr>
<tr>
<td>SE</td>
<td>0.80</td>
<td>0.79</td>
<td>0.42</td>
<td>0.41</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-0.74</td>
<td>-0.75</td>
<td>-0.25</td>
<td>-0.24</td>
</tr>
<tr>
<td>SE</td>
<td>0.40</td>
<td>0.39</td>
<td>0.21</td>
<td>0.21</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>0.03</td>
<td>0.03</td>
<td>-0.04</td>
<td>-0.04</td>
</tr>
<tr>
<td>SE</td>
<td>0.10</td>
<td>0.09</td>
<td>0.05</td>
<td>0.07</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>0.84</td>
<td>0.80</td>
<td>-1.07*</td>
<td>-1.07*</td>
</tr>
<tr>
<td>SE</td>
<td>0.98</td>
<td>0.97</td>
<td>0.51</td>
<td>0.50</td>
</tr>
<tr>
<td>No. children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-0.05</td>
<td>-0.10</td>
<td>-0.12</td>
<td>-0.13</td>
</tr>
<tr>
<td>SE</td>
<td>0.21</td>
<td>0.21</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Coreside</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-1.15</td>
<td>-0.95</td>
<td>-0.23</td>
<td>-0.17</td>
</tr>
<tr>
<td>SE</td>
<td>0.91</td>
<td>0.90</td>
<td>0.47</td>
<td>0.47</td>
</tr>
<tr>
<td>Main effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-1.13***</td>
<td>-0.91***</td>
<td>-0.22**</td>
<td>-0.11</td>
</tr>
<tr>
<td>SE</td>
<td>0.12</td>
<td>0.16</td>
<td>0.06</td>
<td>0.09</td>
</tr>
<tr>
<td>MH group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>3.52**</td>
<td>3.57**</td>
<td>1.85**</td>
<td>1.85**</td>
</tr>
<tr>
<td>SE</td>
<td>1.20</td>
<td>1.19</td>
<td>0.62</td>
<td>0.62</td>
</tr>
<tr>
<td>DD group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>1.43</td>
<td>1.38</td>
<td>0.54</td>
<td>0.52</td>
</tr>
<tr>
<td>SE</td>
<td>0.91</td>
<td>0.90</td>
<td>0.48</td>
<td>0.47</td>
</tr>
<tr>
<td>Interaction effects</td>
<td>MH Group × FGA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-1.02**</td>
<td>-0.30</td>
<td>0.45*</td>
<td>0.41*</td>
</tr>
<tr>
<td>SE</td>
<td>0.33</td>
<td>0.17</td>
<td>0.23</td>
<td>0.16</td>
</tr>
<tr>
<td>DD Group × FGA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-0.13</td>
<td>-0.20</td>
<td>0.30</td>
<td>0.19*</td>
</tr>
<tr>
<td>SE</td>
<td>0.26</td>
<td>0.14</td>
<td>0.18</td>
<td>0.13</td>
</tr>
</tbody>
</table>

Note. FGA = flexible goal adjustment; MH = parents of children with severe mental health problems; DD = parents of children with developmental disabilities.

*p < .05. **p < .01. ***p < .001.

However, in follow-up analyses (see Figure 2), we found that lower FGA scores were significantly predictive of a greater number of physical symptoms for parents of individuals with severe mental health problems ($B = -0.41$, $p < .01$) and developmental disabilities ($B = -0.31$, $p < .01$) but not for parents of individuals in the comparison group ($B = -0.11$, ns).

In terms of positive well-being outcomes, for environmental mastery, again there was a significant effect of FGA for the sample overall, with higher levels associated with higher levels of mastery, as expected (see Step 1). It is interesting that the main effect for MH group was a significant negative predictor of environmental mastery. Although the ANOVA failed to detect differences among the groups, with the additional control variables and FGA included in the regression, parents of children with severe mental health problems were found to have significantly lower levels of environmental mastery than the comparison parents.

Also, there was a significant interaction between MH group and FGA (Step 2), which indicates that the effect of FGA on mastery is greater for parents of individuals with severe mental health problems than for...
ACCOMMODATIVE COPING AND WELL-BEING OF MIDLIFE PARENTS 193

Figure 3. Effect of flexible goal adjustment (FGA) on environmental mastery. MH = parents of children with severe mental health problems; DD = parents of children with developmental disabilities.

Parents in the comparison group. Again, there was no significant DD Group × FGA interaction, so the parents of individuals with developmental disabilities did not differ from the comparison group in the effect of FGA on environmental mastery. In follow-up analyses, we tested the slope of this effect for each group (see Figure 3) and found that all three were significant (MH: $B = 0.93, p < .001$; DD: $B = 0.78, p < .001$; comparison: $B = 0.48, p < .001$), with the steepest slope for parents of individuals with severe mental health problems.

Finally, similar to the other outcomes, FGA was significantly predictive of self-acceptance for the sample overall (see Step 1). Also, at Step 2, there was a significant interaction between MH group and FGA, which indicates that the effect of FGA on self-acceptance is again greater for parents of individuals with severe mental health problems than for parents of comparison group children. The lack of significance of the interaction of DD Group × FGA indicates that parents of individuals with developmental disabilities did not significantly differ from the comparison group in the effect of FGA on self-acceptance. However, the follow-up analyses (see Figure 4) indicated that lower FGA scores were significantly predictive of a greater level of self-acceptance for both parents of individuals with severe mental health problems ($B = 0.55, p < .001$) and parents of individuals with developmental disabilities ($B = 0.33, p < .01$), but this effect was not significant for parents of individuals in the comparison group ($B = 0.14, ns$).

Discussion

These findings provide partial support for our hypotheses, and in so doing, they have interesting implications for the relative impacts of normative life course factors versus nonnormative life events on midlife coping and well-being. First, in terms of nonnormative life events, we expected that midlife parents of individuals with disabilities would have higher scores on accommodative coping than the comparison group. If accommodative coping is affected by cumulative experiences, as suggested by Brandstädter and Renner (1990), we would have expected to see elevations in FGA for these groups. In fact, the three groups were virtually identical in their FGA scores. This general consistency across the groups, irrespective of nonnormative parenting experiences, is consistent with a normative life course perspective. As Brandstädter and Renner showed, there is a steep life course gradient of FGA, with this coping style peaking in the early 50s, the age of the WLS parents. Life course theory might thus be a better
explanation for the level of accommodative coping than life events theory.

However, the fact that hypothesized differences were found with respect to the effects of accommodative coping on parents’ physical and mental health points to the importance of nonnormative parenting experiences on well-being in midlife. As we hypothesized, the protective effects of FGA were weakest for the comparison group and strongest for parents of individuals with severe mental health problems. It is important to note that, as compared to the other groups, these parents also reported more depression and physical symptoms and less self-acceptance after other factors were controlled for. These differences are likely indicative of relatively greater stress for the MH parents. Thus, even if the use of FGA as a coping strategy may be a normative feature of midlife, the impact of this strategy is affected by nonnormative life experiences.

Why do parents of adults with developmental disabilities profit less from accommodative coping than parents of adults with mental illness? Our thesis is that the relatively greater impact of FGA for parents of those with mental illness as opposed to developmental disabilities relates to both the timing in the parents’ life course and the types of problems that these parents face. Our prior analysis of the life course impacts (Seltzer et al., 2001) demonstrated that, because of the childhood diagnosis of developmental disabilities, parents undergo major accommodations earlier in the adult life course, when they adapt family routines, work roles, and child care responsibilities to meet the child’s special needs. Other studies of families of young children with developmental delays have documented the many accommodations that these families make to cope with the extra needs and demands that such children pose (Gallimore, Coots, Weisner, Garnier, & Guthrie, 1996). By the time parents of individuals with developmental disabilities reach midlife, they have had many years to adjust to these circumstances, and there is less need for new accommodations. Under these circumstances, although FGA is consistently associated with positive well-being, the association is not significantly different than that for comparison group parents.

In contrast, because the onset of mental illness generally occurs in late adolescence or young adulthood, the parents of these children undergo major life stressors during midlife and generally show poorer emotional and physical well-being as compared to other parents in midlife (Seltzer et al., 2001). Thus, the need for new accommodations is stronger for these parents. Indeed, our findings show that although these parents are not more likely than others to adopt accommodative strategies, when they do so, they are more likely to profit from their use. These analyses point to new avenues for research on distinct ways of coping in different caregiving contexts and suggest an agenda for future research by specifying conditions under which accommodative coping might be a particularly important psychological resource for caregivers—when the diagnosis is recent and when control over the source of stress is low.

A particular strength of this research is that it uses a population-based sample, selected prior to and independently of the diagnosis of the child as having a disability. It thus circumvents selection biases that are nearly universal in research on parents of individuals with disabilities. An additional strength is the inclusion of the comparison group, which is representative of the population with respect to the use of accommodative coping in midlife and the effects of accommodative coping on well-being. Thus, we are able to gauge the extent to which parents who have nonnormative parenting responsibilities are similar to other parents (as in the case of parents who have a child with developmental disabilities) or evidence altered patterns (as in the case of parents who have a child with severe mental health problems).

The findings of the present analysis suggest that accommodative coping may be a strategy with clinical importance for parents of adults with severe mental health problems. A confluence of factors—life course timing of the child’s diagnosis, lack of control over the caregiving context, and the need to make major life accommodations—puts these parents at risk. Our research findings are consistent with the goals of psychoeducational programs that aim to help families learn new strategies to cope with their relative’s illness. Also, by educating families about mental illness, these programs tend to encourage family members to reframe their relative’s behavior as due to an illness and thus view the mental illness in a more positive light (Anderson, Hogarty, & Reiss, 1980; Goldstein & Hahlweg, 1986). In addition, because use of accommodative coping by the general population peaks in midlife, it is a type of coping that may be more easily introduced through psychoeducational interventions to midlife parents. Finally, the present findings underscore that the context of caregiving varies according to the diagnosis of the child, so there is a need to tailor interventions accordingly.

References


Received August 28, 2002
Revision received January 19, 2003
Accepted February 21, 2003