Distinctive Late-Life Challenges: Implications for Coping and Well-Being

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Two distinctive late-life challenges, community relocation and caring for an adult child with mental retardation, were studied to determine their influence on coping and well-being. These challenges differ in terms of their normativeness, duration, and whether they were expected. Data from 2 ongoing longitudinal studies (N = 449) were used to test the hypotheses that women experiencing residential relocation would report higher well-being and use problem-focused coping more frequently than women with long-term caregiving responsibilities. As predicted, more positive changes in well-being across time were reported by the relocation sample, which also showed more problem-focused coping. Women in the caregiving sample, however, showed stronger relationships between coping and well-being, underscoring possible gains in expertise that accompany challenges of lengthy duration.

The purpose of this study was to examine the association between coping and psychological well-being in two samples of older women who face very different life challenges. In one sample, all of the women were in the process of residential relocation (Smider, Essex, & Ryff, 1996); whereas in the other sample, all of the women were caregivers for a coresident adult son or daughter with mental retardation (Seltzer & Krauss, 1994). There is growing recognition that the nature of the problem facing an individual influences the selection of coping strategies that are used to respond to the challenge (Seltzer, Greenberg, & Krauss, 1995). Our analysis of coping in the context of two contrasting and distinct life challenges brings the problem with which the individual is coping into sharper relief and offers the opportunity to examine a variety of hypotheses that emanate from past research on coping. As in previous work (Seltzer et al., 1995), the nature of the specific challenge facing the respondents was used to predict different coping patterns. In addition, in the current study we used a longitudinal design to examine the dynamic relationship between coping and changes in well-being across time.

Our study provides an opportunity to understand how specific problems evoke specific coping responses. For several reasons we selected residential relocation and caregiving for an adult child with mental retardation as our two examples of problems with which older women cope. First, relocation and caregiving for an adult child with mental retardation are life challenges that differ in terms of their normativeness (Seltzer & Ryff, 1994). Whereas residential relocation is a typical life transition experienced by many aging people, caring for a child with retardation is a nonnormative and uncommon life challenge. Second, these two examples differ in duration, with residential relocation being a relatively discrete and time limited problem; whereas caring for a child with retardation is a continuing challenge that lasts for decades. Third, the two challenges differ in the extent to which they are expected before their occurrence, with residential relocation a more anticipated life challenge than caring for an adult child with retardation.

These differences can sharpen our understanding of coping processes and their influence on well-being. When a life challenge is normative, commonly experienced, short in duration, and expected—such as residential relocation—the context for coping is very different from a challenge that is nonnormative, unending in duration, and unanticipated—such as caring for a child with a disability. On the basis of these differences, we hypothesized that the experience of caregiving compromises well-being more than residential relocation. Because both our samples have been followed longitudinally, we were particularly interested in the dynamic properties of these hypothesized differences in well-being. That is, we expected that over time the relocation women would show positive gains in well-being; whereas the caregiving women would show no gains, and possibly losses.

Related to these hypothesized differences in well-being, we further postulated that the different challenges faced by these women would influence their use of problem-focused and emotion-focused coping. Problem-focused coping includes cognitive and behavioral problem-solving strategies aimed at altering or managing the stressor, whereas emotion-focused coping strategies are cognitive and behavioral efforts to reduce or manage emotional distress (Folkman & Lazarus, 1980; Pearlin & Schooler, 1978). Key to our expectations about emotion-focused and problem-focused coping is the alterability of the situation.
Folkman (1984) postulated that problem-focused coping strategies are more likely to be used to maintain psychological well-being in situations in which it is possible to alter the aspect of the environment that is producing the challenge. In contrast, emotion-focused coping strategies are more likely to be used when the problem is inalterable. This formulation led to a further hypothesis about the differential use of coping strategies by aging women experiencing residential relocation and aging mothers caring for an adult child with mental retardation. Because the challenges associated with relocation are more amenable to change, we hypothesized that problem-focused coping strategies would be used more frequently by relocation respondents; whereas emotion-focused coping would be used more frequently by women caring for an adult child with retardation.

Our remaining hypothesis pertains to the linkages between coping and well-being over time, or the effectiveness of coping strategies. In reviewing the literature on stress and coping, Thoits (1995) wrote that “coping effectiveness depends importantly on the type of stressful situation that the individual confronts” (p. 61). We focused our hypothesis of differential coping efficiency on a particular dimension along which the two challenges facing our respondents differed—the duration of the challenge. Specifically, we hypothesized that as one gains experience in coping with a particular challenge, the effectiveness of one’s coping skills may improve. That is, the strength of the relationship between coping and change in well-being will increase as one gains experience with a given problem. Given that the caregiving respondents have greater experience coping with their life challenge than the relocation respondents, we predicted that the relationship between coping and changes in well-being would be stronger in the caregiving sample than in the relocation sample.

In support of this hypothesis are indications in the literature that, over time, individuals gain experience in coping with certain types of problems. Carver, Scheier, and Weintraub (1989) argued that people “do not approach each coping context anew, but rather bring to bear a preferred set of coping strategies” (p. 270). Aldwin (1991) found that, among older people, coping with health problems resulted in an increase in feelings of mastery and self-efficacy. She accounted for this unanticipated finding by explaining that the familiarity and chronicity of health problems gave people the opportunity to develop effective coping strategies. Mattlin, Wethington, and Kessler (1990) also noted that experience with a stressful situation can build effective coping strategies and found that those coping successfully with short-term life events become significantly less anxious and less depressed over time.

The view that experience with a given stressful circumstance can build the coping repertoire is consistent with Thoits’s (1994) conceptualization of the individual as a psychological activist. She found that individuals deliberately shape their own lives rather than merely react passively to environmental stress. Thus, past experience with problematic circumstances may have a cumulative effect on attempts to cope with these problems. Thoits found that effective coping results not only in decreased negative symptoms but also in increased positive well-being, which in turn poises the individual for the next life challenge.

In summary, we advanced three sets of hypotheses regarding coping processes and well-being within the context of the later life challenges of residential relocation and caregiving. First, because residential relocation is seen as a more normative, commonly experienced, short-term, and expected transition than caring for an adult child with a disability, we hypothesized that aging women experiencing relocation would have better psychological well-being—both in terms of mean levels and with regards to positive changes over time—than aging women caring for an adult son or daughter with retardation. Second, on the basis of the differential alterability of the two challenges, we hypothesized that women experiencing residential relocation would report more frequent use of problem-focused coping strategies; whereas women caring for an adult son or daughter with mental retardation would report more frequent use of emotion-focused coping. Third, we predicted that aging mothers of adults with retardation would show a stronger association between coping and psychological well-being changes than women moving to a new residence, independent of their levels of coping and well-being, because the latter challenge is more of a “confrontation with the unknown” and because the caregiving group of women has had decades of experience with a particular challenging life circumstance to develop and refine their coping skills.

Method

Relocation Sample

The relocation sample consists of a subsample from the ongoing Wisconsin Study of Community Relocation (Ryff & Essex, 1992; Smider et al., 1996). Throughout the course of the study, approximately 500 women were assessed four times: once before they move and then three times after they move. Each assessment consisted of an in-home interview with trained female interviewers and the completion of a packet of self-administered questionnaires. The subsample used in the current analyses consisted of the 219 women for whom data were available for the assessment before the move and 8 months after the move.

To be recruited for the study, women had to be over the age of 55, had to have sufficient mental and physical health to complete interview materials, and had to be planning to move to an independent living setting, not to a private home, within the next year. Both the old and new homes needed to be within a 2-hr driving radius of either Milwaukee or Madison, thus, all of the moves are considered local moves. Of the 219 respondents, 120 reported that they owned the home in which they lived at Time 1. For all respondents, the average number of years spent in their premove homes was 18.2 (SD = 15.4). The respondents were interviewed within 1 to 2 months before their move and then approximately 8 to 10 months after the move. Because actual move dates were sometimes difficult for the respondents to predict accurately, and such prediction was linked to the scheduling of the interviews, the time between assessments, by necessity, varied by respondent. The average time between the premove and postmove assessments was 1 year and 18 days.

At the time of recruitment into the study, the women in the sample ranged in age from 55 to 91 (M = 69.6, SD = 8.2). Approximately 1/3 of the women were widowed (31%); the remainder were married (27%), divorced or separated (13%), and never married (9%). Almost half of the women had completed high school (47%), with 9% reporting

1 The relocation project includes an assessment of initial responses to the move, administered 1 month after the move, which is not used in the current analysis. The premove and 8 months postmove assessments were chosen for this article to approximate the time interval between assessments in the caregiving study.
less than a high school education, 17% having vocational—technical training or junior college, 16% having college degrees, and 12% having schooling beyond the college level.

Caregiving Sample

The caregiving sample used in the current study is a subsample from an ongoing longitudinal study of approximately 450 families with adult children with mental retardation, living in either Wisconsin or Massachusetts (Seltzer et al., 1995; Seltzer & Krauss, 1989, 1994; Seltzer & Ryff, 1994). To be included in the study, women had to be over the age of 55, and they had to be living with an adult son or daughter with mental retardation. The mothers were first interviewed in 1988 and have been reinterviewed every 18 months since that time. Because the well-being measures of interest were first administered in the third wave of assessments, the third and fourth waves offered the first opportunity to examine changes in well-being. Thus, for the purposes of this study, the third and fourth waves were the source of data (hereafter referred to as Time 1 and Time 2). Since enrollment in the study, approximately 16% of the mothers have placed their son or daughter with mental retardation in a supervised living situation outside of the home. Surviving mothers who were coresiding with their surviving son or daughter at Time 1 form the subsample used in the current analysis.

The mean age for the caregiving sample at the first of the two assessments was 70.7 (SD = 6.1, range = 61—90). More than half of the sample were married (61%), with 5% divorced or separated and 34% widowed. Almost half of the sample had completed high school (44%), with 14% reporting less than a high school education, 25% reporting trade school or some college, 12% reporting a college education, and 6% reporting schooling beyond the college level.

Comparison of the Samples

The two samples were similar in many respects. Both samples were approximately the same size and were similar in age (M_caregiver = 70.7, M_relocation = 69.6), t(447) = 1.70, ns. In addition, the two samples have similar proportions of women with high school education or less compared with those who have education beyond high school, x²(1, N = 449) = 0.07, ns. Despite these similarities, the samples did differ in marital status. Most notably, the proportions of married women differed between the groups such that a larger proportion of women in the caregiving sample was married (61%), compared with 27% in the relocation sample, x²(1, N = 449) = 52.2, p < .001.

Measures

Coping assessment. Carver et al.'s (1989) multidimensional coping inventory was used in both samples to assess the different ways in which people respond to stressful events. The inventory consists of 13 subscales, of four items each, and was administered at the initial assessment. For each item, the respondent indicated how often, 1 (not at all) to 4 (a lot), she used a specific strategy in coping with stress in general.

The Carver et al. scale (1989) was not designed to generate values for emotion-focused coping and problem-focused coping. To accomplish this, seven subscales were chosen, on an a priori basis, to represent problem-focused and emotion-focused coping. Four of the seven subscales were used to assess problem-focused coping: active coping, planning, positive reinterpretation and growth, and seeking social support for instrumental reasons. Carver et al. provided definitions for each of these coping strategies. Active coping involves taking direct action to remove the stressor or lessen its effects (e.g., "I take additional action to try to get rid of the stressor problem"). Planning involves the process of thinking about the actions that should be taken to deal with the stressor (e.g., "I made a plan of action"). Positive reinterpretation and growth involves construing a stressful event in a positive light (e.g., "I learn something from the experience"). Although Lazarus and Folkman (1984) suggested that positive reinterpretation and growth is a form of emotion-focused coping, Carver et al. suggested that it may be more appropriately classified as a problem-focused coping strategy because it moves an individual to change or alter the nature of the stressor. Seeking social support for instrumental reasons involves seeking assistance, information, or advice about what to do (e.g., "I talk to someone who could do something concrete about the problem"). The Cronbach's alpha reliabilities of the four problem-focused coping scales (active coping, planning, positive reinterpretation and growth, and seeking social support for instrumental reasons) were .62, .79, .66, and .75, respectively, in the relocation sample and .72, .80, .71, and .81, respectively, in the caregiving sample. When the four subscales were combined to create a problem-focused coping measure, the alpha reliability of the scale was .86 in the relocation sample and .91 in the caregiving sample.

Three other coping subscales were chosen to assess emotion-focused coping: focusing on and venting emotions, denial, and behavioral disengagement. Focusing on and venting emotions, as described by Carver et al. (1989), is the tendency to focus on the stress that one is experiencing and ventilating those feelings (e.g., "I get upset and let my emotions out"). Denial is a refusal to believe that the stressor exists or acting as if the stressor is not real (e.g., "I refuse to believe that it has happened"). Behavioral disengagement is reducing one's efforts to deal with the stressor (e.g., "I just give up trying to reach my goal"). The alpha reliabilities of venting emotions, denial, and behavioral disengagement were .69, .66, and .57, respectively, in the relocation sample and .78, .56, and .63, respectively, in the caregiving sample. When the venting of emotions, denial, and behavioral disengagement subscales were combined to create an emotion-focused coping measure, the alpha reliability was .72 in the relocation sample and .74 in the caregiving sample.

Confirmatory factor analyses (CFA) supported the creation of two copings factors from these seven subscales. Specifically, the hypothesized two-factor model was pitted against a one-factor model, in which the seven subscales were used as indicators of a latent Supercoping factor. The CFA revealed that the specified two-factor model, with emotion-focused coping and problem-focused coping as latent constructs, x²(13, N = 449) = 100.0, goodness of fit (GFI) = .95, provided a significantly better fit to the observed covariances among the subscales than the one-factor model, Δ in x²(1, N = 449) = 100.7, p < .001. As a replication, the same structural analysis was applied to the intercorrelations presented by Carver et al. (1989). In Carver et al.'s sample of 978 undergraduates, the two-factor model, x²(15, N = 978) = 223.2, GFI = .94, again provided a significantly better fit than the one-factor model, Δ in x²(1, N = 978) = 211.1, p < .001.

Psychological well-being. Respondents completed a self-report inventory that measures five different facets of psychological well-being (Ryff, 1989a), which included autonomy, environmental mastery, personal growth, purpose in life, and self-acceptance. These dimensions were derived from the literature on life span development, mental health, and personal growth (Ryff, 1989b) and have extensively been used with aging samples (Heidrich & Ryff, 1993; Ryff, 1991, 1995). Recent analyses with reduced measures, administered to a national probability sample, supported the hypothesized multidimensional structure of the

2 The CFA for the relocation and caregiving combined sample was conducted on covariances among the coping subscales. Because standard deviations were not provided by Carver et al. (1989) for the coping subscales in the sample for which the correlations were presented, the CFA on their sample was conducted by using correlations.

3 Because of a clerical error, a sixth dimension of psychological well-being, positive relations with others, was omitted from the caregiving study. Because change in this scale could not be assessed in one of the samples, it was excluded from all analyses in this article.
well-being domain (Ryff & Keyes, 1995). High scorers on self-accep-
tance have a positive attitude toward self and feel positively about their past life (e.g., "For the most part, I am proud of who I am and the life I lead"). Someone with a high score on purpose in life has a sense of directedness and aims and objectives for living (e.g., "Some people wander aimlessly through life, but I am not one of them"). A high scorer on personal growth has a feeling of continued development (e.g., "In my view, people of every age are able to continue growing and developing"). Those who are high on autonomy are self-determining and independent (e.g., "I am not the kind of person who gives in to social pressures to think or act in certain ways"). Someone who is high on environmental mastery has a sense of mastery and competence in managing the environment (e.g., "In general, I feel I am in charge of the situation in which I live"). Each dimension was assessed with a five-item scale, which asked the respondent to rate the extent to which they agreed or disagreed with the statement: 1 (strongly disagree) to 6 (strongly agree). In the relocation sample, the alpha reliabilities of the five well-being scales (self-acceptance, purpose in life, personal growth, autonomy, and environmental mastery) were .74, .73, .70, .59, and .66, respectively; in the caregiving sample, the comparable reliabilities were .73, .72, .60, .58, and .64, respectively. Self-esteem and depression were assessed by using the Rosenberg Self-Esteem Scale (Rosenberg, 1979) and the Center for Epidemiological Studies Depression Scale (Radloff, 1977).

Plan for Data Analysis
The first set of analyses examined sample differences in well-being at the two times of measurement. A repeated measures multivariate analysis of variance (MANOVA) was conducted on the well-being measures across time to test whether the two samples differed in well-being, whether well-being changed significantly over time, and whether the well-being changes differed by sample. Turning to the coping measures next, sample differences in emotion-focused and problem-focused coping were examined by using t tests. Finally, within-sample analyses (using partial correlations) examined the extent to which coping predicted well-being changes, and the strength of the relationships between coping and well-being change in the caregiving sample was compared with the relationships in the relocation sample (using a procedure outlined by Cohen and Cohen, 1983, to compare the magnitude of partial correlations from two independent samples).

Results
Zero-order correlations for the coping, background, and outcome measures are presented in Table 1, with caregiving correlations above the diagonal and relocation correlations below the diagonal. In both samples, when coping and well-being were assessed at the same point in time, problem-focused coping was significantly associated with higher levels of well-being, and emotion-focused coping was significantly associated with lower levels of well-being on all seven measures of well-being.

The use of a repeated measures MANOVA allowed for the simultaneous testing of sample differences with respect to all seven well-being measures. Significant multivariate effects were then followed up with univariate tests to examine the well-being measures individually. A repeated measures MANOVA, with time of assessment as the within-subject variable and sample membership as the between-subjects variable, tested three effects: (a) whether the samples differed simultaneously from each other on all of the well-being measures, collapsing across time; (b) whether the well-being measures, collapsing across the two samples, changed significantly over time; and (c) whether the changes in the well-being measures differed between the two samples. These three effects, and the appropriate univariate follow-ups, are presented in the Sample Differences in Well-Being section.

Sample Differences in Well-Being
Because the challenge of relocation is viewed as more normative, commonly experienced, and short term than the challenge of caring for a son or daughter with mental retardation, we predicted that the relocation sample would report higher levels of well-being than the caregiving sample at both times of measurement. Means and standard deviations at Time 1 and Time 2, reported separately by sample, are found in Table 2. The multivariate effect of sample membership indicated that, collapsed across time of measurement, the two samples differed significantly from one another on all well-being measures when examined simultaneously, Pillai–Bartlett F(7, 441) = 10.02, p < .001. Significant univariate follow-ups indicated that the groups differed in purpose in life and self-esteem (Fs of 5.03, p < .05 and 17.7, p < .001, respectively). An inspection of Table 2 indicates that the relocation sample reported higher levels of self-esteem at both Time 1 (Mrelocation = 35.1, M caregiving = 33.7) and Time 2 (Mrelocation = 35.6, M caregiving = 33.9). On the purpose-in-life measure, however, the caregiving sample reported higher levels at both Time 1 (M caregiving = 23.9, M relocation = 22.8) and Time 2 (M caregiving = 23.9, M relocation = 23.2). Thus, although our first hypothesis predicted higher levels of well-being in the relocation sample on the seven well-being scales, it was only with respect to one scale (i.e., self-esteem) that the hypothesis was supported. Indeed, the purpose-in-life scores revealed the opposite pattern such that the caregiving sample reported higher levels of well-being.

Changes in Well-Being
Next we examined mean level changes in well-being across time. The significant multivariate effect of the within-subject variable of time indicated that, regardless of sample membership, the outcome measures were considered simultaneously, they changed significantly over time, Pillai–Bartlett F(7, 441) = 4.8, p < .001. Univariate follow-ups indicated that, except for purpose in life, changes in six of the seven outcome measures were significant (all Fs > 4.9, all ps < .03).

Because relocation is a more discrete and short-term challenge than caring for a child with mental retardation, we predicted that the relocation sample would report more positive changes in well-being over time. This hypothesis is tested by examining the Sample Membership × Time interaction effects from the MANOVA. Overall, the Sample Membership × Time interaction was significant, indicating that, as a whole, the well-being changes differed by sample, Pillai–Bartlett F(7, 441) = 3.9, p < .001. Univariate follow-ups indicated that the changes differed by sample membership for environmental mastery, personal growth, and depression (all Fs > 7.7, all ps < .01). In all three cases, the caregiving sample reported more stable levels of well-being, whereas the relocation sample reported improvements in well-being; that is, the relocation women reported higher levels of environmental mastery and personal growth and
Table 1

Intercorrelations of Study Variables

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Note. Caregiving sample is above the diagonal, relocation sample is below the diagonal. N_relocation = 219, N_car = 230. Education, 0 (high school or less) to 1 (more than high school). Marital status, 0 (not married) or 1 (married). EFC = emotion-focused coping; PFC = problem-focused coping.

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

lower levels of depression at Time 2—all of which are supportive of our hypothesis that relocation would be accompanied by more positive changes in well-being.

Mean-Level Coping

Because the two life challenges differ in their alterability, we predicted that the relocation sample would report higher levels of problem-focused coping and that the caregiving sample would report higher levels of emotion-focused coping. A comparison of the coping scales revealed that the relocation respondents reported higher levels of both problem-focused coping (M_relocation = 50.6, SD_relocation = 6.4; M_car = 46.1, SD_car = 9.6), t(447) = 5.79, p < .001, and emotion-focused coping (M_relocation = 23.2, SD_relocation = 4.6; M_car = 20.3, SD_car = 5.6).

Table 2

Mean Level Well-Being at Time 1 and Time 2

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</tr>
<tr>
<td>SD</td>
<td>4.2</td>
<td>4.6</td>
</tr>
<tr>
<td>Self-acceptance</td>
<td>22.5</td>
<td>22.6</td>
</tr>
<tr>
<td>SD</td>
<td>4.7</td>
<td>5.2</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>35.1</td>
<td>33.7</td>
</tr>
<tr>
<td>SD</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Depression</td>
<td>11.0</td>
<td>9.3</td>
</tr>
<tr>
<td>SD</td>
<td>7.6</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Note. N_relocation = 219, N_car = 230.

* Indicates that, collapsed across both samples, the scale scores changed significantly over time (significant univariate F follow-up for within-subject variable of time). † Indicates that, collapsed across time of measurement, the scale scores differ significantly between samples (significant univariate F follow-up for sample membership). ‡ Indicates that the change in the well-being measure differed significantly between samples (significant univariate F follow-up for Sample Membership × Time interaction).
Association Between Coping and Well-Being Changes

Although the results in Table 1 demonstrate that coping and well-being are associated with another when assessed simultaneously, the final set of analyses tested whether coping could predict changes in well-being across time. These analyses were conducted separately for each well-being measure and for each of the two kinds of coping. The partial correlations between Time 2 well-being and coping, with Time 1 well-being score as a control variable, assess the extent to which coping was associated with well-being changes. In addition to controlling for Time 1 well-being, the following variables were controlled: age of respondent, marital status (married vs. not married), and education (high school and under vs. beyond high school). Because the two kinds of coping were correlated with one another, the effects of one were partialled out when examining the influence of the other. The partial correlations are presented in Table 3.

The results presented in Table 3 indicate that coping predicted changes in well-being over time. The results for problem-focused coping, presented in column 1 for the relocation sample and in column 3 for the caregiving sample, indicate that, in general, the use of problem-focused coping was associated with improvements in well-being. The emotion-focused coping results, presented in columns 2 and 4, indicate that the use of emotion-focused coping was associated with declining well-being.

Our hypothesis regarding the magnitude of the relationships between coping and well-being was based on the caregiving sample's greater experience with their life challenge and predicted that coping would be more closely associated with changes in well-being in the caregiving sample than in the relocation sample. To test this hypothesis, we used a procedure outlined by Cohen and Cohen (1983, pp. 54, 111) to compare the magnitude of partial correlations from two independent samples. Comparisons revealed that relationships between problem-focused coping and changes in well-being were stronger in the caregiving sample than in the relocation sample for environmental mastery ($pr_{caregiving} = .20$, $pr_{relocation} = .04$), $z = 1.70, p < .05$, one-tailed, and purpose in life ($pr_{caregiving} = .31$, $pr_{relocation} = .06$), $z = 2.72, p < .01$, one-tailed. Emotion-focused coping in the caregiving sample was more strongly associated with well-being changes than in the relocation sample for environmental mastery ($pe_{caregiving} = -.20$, $pe_{relocation} = -.04$), $z = 1.70, p < .05$, one-tailed, self-acceptance ($pe_{caregiving} = -.21$, $pe_{relocation} = -.03$), $z = 1.91, p < .05$, one-tailed, and depression ($pe_{caregiving} = .21$, $pe_{relocation} = .00$), $z = 2.22, p < .05$, one-tailed. In summary, our hypothesis that greater coping experience would strengthen the link between coping and changes in well-being, such that coping would be more strongly associated with well-being changes in the caregiving sample than in the relocation sample, received support on select measures of well-being.

**Table 3**

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Relocation</th>
<th>Caregiving</th>
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<tbody>
<tr>
<td></td>
<td>Problem-focused coping</td>
<td>Emotion-focused coping</td>
</tr>
<tr>
<td>Autonomy</td>
<td>.18**</td>
<td>-.12†</td>
</tr>
<tr>
<td>Environmental mastery</td>
<td>.04, -.04</td>
<td>.20**</td>
</tr>
<tr>
<td>Personal growth</td>
<td>.15*</td>
<td>-.10</td>
</tr>
<tr>
<td>Purpose in life</td>
<td>.06, .09</td>
<td>.31***</td>
</tr>
<tr>
<td>Self-acceptance</td>
<td>.17*, .03</td>
<td>.23***</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>.09, .03</td>
<td>.16*</td>
</tr>
<tr>
<td>Depression</td>
<td>-.11</td>
<td>.00</td>
</tr>
</tbody>
</table>

Note. $N_{relocation} = 219$, $N_{caregiving} = 230$. Subscript indicates a significant difference between the two samples, $p < .05$, one-tailed. For each correlation, the following controls were used: Time 1 score, age of respondent, education (high school vs. beyond high school), and marital status (married vs. unmarried). When problem-focused coping was assessed, the effects of emotion-focused coping were partialled out, and vice versa. †$p < .08$. *$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

The purpose of the present investigation was to direct the focus of research on coping to the nature of distinctive later-life challenges. Our guiding assumption was that aging brings confrontations with a wide variety of dramatically different stresses, each having possibly unique implications for the demand for coping responses and related levels of well-being. Although prior research has documented the differential effectiveness of various types of coping on well-being (Haley, Levine, Brown, & Bartolucci, 1987; Holahan & Moos, 1990, 1991), we posit a need for greater attention to the type of problem with which one is coping as a way of understanding coping effectiveness.

To implement this perspective, we contrasted two later-life challenges: residential relocation and caregiving for an adult child with mental retardation. These challenges differ in their normativeness, duration, and expectedness. The sociodemographic profiles of the women selected to study these contrasts were quite similar, as were the time intervals within which we investigated changes in well-being. Both ongoing longitudinal studies were designed for explicit focus on dynamic processes. Our objective was to examine coping and well-being changes in parallel as the older women dealt with distinctly different challenges.

Because of the more atypical and unexpected nature of having a child with mental retardation, caregiving mothers were hypothesized to have more compromised well-being, both in terms of lower mean levels of well-being and less positive well-being changes over time. The evidence for this hypothesis was mixed.

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4 Time between assessments was investigated as a potential covariate. The inclusion of the time lag as a covariate was deemed unnecessary for the following reasons: (a) the time lag was essentially a constant for the caregiving sample, and (b) in none of the 14 regressions used to generate the partial correlations for the relocation sample was the time lag a significant covariate.
Although the relocation sample did report higher levels of self-esteem than the caregiving sample, the caregiving sample reported higher levels of purpose in life. This finding suggests that the act of providing care for a child with mental retardation can have a positive impact on mental health, especially in terms of feeling as though one’s life has important direction and purpose. Notably, this difference emerged only when Ryff’s more differentiated measure of psychological well-being was used, as compared with the more traditional global measures of self-esteem and depression (Ryff, 1989a; Ryff & Keyes, 1995).

Our prediction that the relocation sample would experience more positive well-being changes was supported. Specifically, the significant multivariate effect for sample membership by well-being change and the univariate follow-up tests indicated that the relocation respondents experienced improvements in well-being, particularly gains in environmental mastery and personal growth and declines in depression; whereas well-being in the caregiving sample was stable over time. Presumably, this reflects the more discrete beginning and end points of the relocation challenge as well as its more typical and expected nature. Such an interpretation, however, points to the need for explicit empirical tests of respondents’ views of the typicality and expectedness of their respective experiences.

The nature of these differing challenges was further hypothesized to evoke different coping responses, with residential relocation viewed as a problem to be negotiated and solved; hence, an expectation of greater problem-focused coping. Alternatively, long-term caregiving was seen as a problem less amenable to final resolution; hence, the expectation of a greater likelihood of emotion-focused coping. As hypothesized, the relocation women reported higher profiles on problem-focused coping, but contrary to prediction, they were also higher on emotion-focused coping. Perhaps change of one’s residence, involving transformation in one’s social networks, lifestyle, and daily routines, mobilizes all aspects of coping. In addition, caregiving mothers, because of the more enduring, long-term nature of their task, may have “settled into” their challenge some time ago and thus engage in generally lower levels of activated coping of all types.

The preceding differences in well-being and coping profiles seem to convey a generally more dismal profile for the caregiving mothers compared with the relocation women. Such a portrait misses the possible advantage of the former group with regard to expertise and the process of adapting to a life challenge. In support of the hypothesized expertise model, we found that problem-focused coping strategies more successfully predicted improvements in psychological outcomes for caregiving respondents. That is, the relationship between the use of problem-focused coping and improving well-being was stronger in the caregiving sample for environmental mastery and purpose in life. Similarly, the use of emotion-focused coping was more strongly associated with declining well-being with respect to environmental mastery, self-acceptance, and depression in the caregiving sample. Thus, for those confronted with the caregiving challenge, gains in well-being were linked with using problem-focused coping and refraining from using emotion-focused coping. Such findings are particularly interesting, given that the caregiving respondents reported less coping overall (see above-mentioned discussion of mean-level differences). There appear to be gains in the “efficiency” of coping in the caregiving sample—they do less of it, but it is more effective (i.e., has stronger consequences for well-being). These findings of differential coping efficiency point out that merely using a given coping strategy more or less frequently can tell us little about its effects on psychological well-being. The greater coping efficiency of the caregiving mothers in our study mirrors the findings of another study, which found that the relationship between coping and psychological distress was stronger for mothers caring for physically disabled children compared with mothers caring for nondisabled children (Miller, Gordon, Daniele, & Diller, 1992).

For both samples, the findings regarding problem-focused coping converge with the conception of individuals as psychological activists (Thoits, 1994) who shape their own destinies. That is, in the life challenges we examined, gains in well-being followed from a problem-focused orientation. Although our data support the utility of an activist stance, we caution against an overemphasis on activist possibilities and suggest that future research may identify particular life challenges that are less amenable to an activist orientation.

Our investigation is limited by a largely global assessment of coping that cannot explicate specific coping responses to these individual challenges, as has been called for in prior studies (Folkman, 1984; Pearlin & Schooler, 1978). That we obtained significantly different effects (differences in coping styles and in links between coping and well-being) for the two samples with general measures underscores the likely prominence of the unique nature of the challenges confronted. Context-specific measures might thus be expected to strengthen the nature of differences obtained with more general measures. We also note the differences in our samples with regard to marital status. Although the analyses controlled for these differences, they may nonetheless point to possible differences in social support. However, the marital status variable was a nonsignificant covariate in all 28 analyses, indicating that within each sample, marital status did not influence the relationship between coping and changes in well-being.

Against the potential weaknesses, we juxtapose the strengths of the study, namely our focus on distinctive late-life challenges and their effects on not just the usual negative indicators (e.g., depression) but also on positive functioning. That the relocation sample showed improvements on all well-being outcomes, when considered simultaneously, underscores the dynamic nature of well-being, and of more importance, the potential for enhancing quality of later life through successfully negotiated transitions. Psychological well-being provides an explicit test of whether different coping changes and related coping strategies contribute, not just to less of the negative, but also to gains in multiple dimensions of well-being.

Our finding that coping efforts are associated with changes in well-being underlines an additional strength of the current study: its longitudinal design. Without such designs, it is impossible to test an assumption implicit in much research on coping—that coping efforts result in changes in well-being. Our findings suggest that coping efforts may not be equally predictive of well-being changes in the face of different life challenges. The differences, we believe, reflect variations in the nature of the challenges themselves and their duration. As time unfolds, and the relocation sample continually negotiates the
transition to their new living environment, it may be the case that coping will become as predictive of well-being changes for the relocation sample as it is in the caregiving sample. Alternatively, there may be something unique about caring for a child with a disability that increases the effectiveness of one’s coping. These speculations highlight a potentially fruitful area for future inquiry, in which researchers seek to identify the qualities of different coping challenges that influence the magnitude of the relationship between coping efforts and changes in well-being. Such information would expand our understanding of the coping process and would aid researchers in their efforts to design effective interventions for individuals undergoing significant life stressors.

To conclude, we reiterate the view that old age is not a time of isolated, single life challenges that appear on the horizon one at a time. The real scenario involves confrontation with multiple interacting challenges. Prior traditions in the stress and coping research (e.g., Holmes & Rahe, 1967; Sarason, Johnson, & Siegel, 1978) emphasized the cumulative impact of multiple life stresses over time to understand differences in psychological symptomatology. We contend that different events and transitions constitute notably distinct kinds of challenges, each of which may require different kinds of effective response. Our call is for greater attention to the nature of these challenges and what they pose for coping and well-being.

References


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