Adaptation to Disability Among Middle-Aged and Older Adults: The Role of Assimilative and Accommodative Coping

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The purpose of this study was to investigate the links among coping, disability, and mental health among adults who are confronted with age-related vision loss. Drawing on the model of assimilative and accommodative coping (e.g., Brandtstaedter, 1999), hierarchical regressions were designed to examine the effects of coping and disability on mental health. Participants were 55 middle-aged and 52 older adults who had been recruited from a community-based rehabilitation agency. Findings demonstrate a critical role of accommodative coping for adaptation, with beneficial effects on mental health that were more pronounced in the case of high disability for younger participants. Finally, findings suggest that dealing with disability may pose more of a mental health risk in middle than in late adulthood.

Being confronted with the implications of functional impairment in middle or late adulthood constitutes a critical adaptational challenge that can put a person at risk for subsequent mental health problems. Age-related vision loss has been identified as the second most common disability among middle-aged and older adults (National Center for Health Statistics [NCHS], 1993). Its negative impact on functional ability and social activities has been shown to put individuals at risk for depression and poorer perceived life quality (Horowitz & Reinhardt, 2000). Although preliminary evidence based on the model of stress and coping (Lazarus & Folkman, 1984) shows that coping is a key factor in adaptation to vision loss, this research has contributed more to identifying maladaptive patterns of coping than to learning what may be adaptive (e.g., Brennan et al., 2001). However, optimal interventions depend as much on knowing about coping styles that are adaptive as on understanding what may increase the risk for poor mental health. Furthermore, because only a few studies have included a developmental perspective, this research has been mostly limited to the study of older adults.

The present study sought to fill this gap by including both middle-aged and older adults and by applying the model of assimilative and accommodative coping (Brandtstädter, 1999; Brandtstädter & Rothermund, 2002), a theoretical framework that incorporates a developmental component and specifies coping tendencies that mitigate depression, enabling a person to positively adjust to the experience of major decline. The insights gained from this study can guide subsequent research that serves to identify those who are at risk for mental health problems and to optimize interventions that help individuals adapt to vision impairment as well as to other disabilities.

Prevalence and Characteristics of Age-Related Vision Impairment

Age-related vision impairment affects 13.8 million Americans 45 years and older, and its prevalence increases with age (NCHS, 1993). Reported percentages range from 15% of Americans aged 45–64 years, to 17% aged 65–74, to 26% aged 75 and older (The Lighthouse Inc., 1995). The most common age-related eye diseases (i.e., macular degeneration and glaucoma) are characterized by a gradual and continual deterioration. Although complete blindness is relatively rare (Faye, 2000), this vision loss increasingly affects an individual’s functional ability and interaction with the physical and social environment (e.g., Wahl & Oswald, 2000). This negative impact on a person’s daily functioning can have critical mental health consequences. There is strong evidence from a number of studies demonstrating that the experience of chronic vision impairment is linked to depression and the perception of diminished life quality (e.g., Carabellese et al., 1993; Horowitz, Reinhardt, Boerner, & Travis, in press; Karlsson, 1998). In fact, several studies suggest that approximately one third of older adults who are visually impaired experience clinically significant depressive symptomatology (Horowitz & Reinhardt, 2000). Consistent relationships have been documented between age-related vision loss and lower morale, social isolation problems, affective disorders, and reduced feelings of self-worth (e.g., Bazargan & Hamm-Baugh, 1995; Wahl & Oswald, 2000). Furthermore, vision loss is often feared more than other age-related physical impairments because it tends to be associated with a state of complete dependency and helplessness (National Society for the Prevention of Blindness, 2000).

Coping With Vision Loss

Although research evidence demonstrates that vision impairment is often related to poor adaptation, there is still great variability among individuals in the extent to which vision impairment results in mental health problems. Prior work has documented differential adaptation to visual impairment depending on factors such as functional disability, social support, and spirituality (Brennan, 2002; Horowitz et al., in press; Reinhardt, 1996, 2001). However, most relevant to the focus of this study is prior work, which has documented that adaptation to visual impairment is critically affected by
personal coping resources (e.g., Brennan & Silverstone, 2000). Research on coping with age-related vision loss has mainly relied on the Stress and Coping Model of Lazarus and Folkman (e.g., Benn & Reinhart, 1999), which distinguishes a problem-focused (i.e., alter the problem) and an emotion-focused (i.e., regulate one’s emotional response to the problem) dimension of coping. However, this typology has been challenged with regard to two major points. First, the global definition of emotion-focused coping complicates the discussion about adaptiveness of coping because it encompasses coping strategies that are not only different in nature but also likely to have different implications (Brandstätter & Renner, 1990; Zeidner & Saklofske, 1996). For example, the emotion-focused mode includes intentional activities (e.g., using sedatives or relaxation techniques to regulate emotions) as well as more automatic responses that may be reflected upon retrospectively but are usually not deliberately chosen (e.g., positive reappraisal of negative events). Second, researchers have not sufficiently specified under which condition each mode will and should be used (e.g., Silver & Wortman, 1980). Both of these aspects may explain why empirical research using the two coping dimensions has shown weak to moderate relations to negative outcomes, and why there is a lack of consistent evidence supporting their relationship with positive outcomes (Carver & Scheier, 1994).

Several studies on coping with vision loss among older adults found that, although strategies from the emotion-focused dimension consistently predicted poor adaptive outcome, the role of problem-focused coping for positive outcome was less clear (Benn, 1997; Benn & Reinhart, 1999; Horowitz, Reinhart, McInerney, & Balisterri, 1994). For example, in a 2-year longitudinal study on adaptation to vision loss, Horowitz and colleagues (1994) found that the use of emotion-focused strategies at baseline increased the risk of poorer adjustment on all outcomes (i.e., adaptation to vision loss, life satisfaction, depression, and functional disability) available at the 2-year follow-up, whereas the use of problem-focused coping at baseline was only related to life satisfaction. Thus, research based on this model has contributed more understanding to coping patterns that are problematic than to those that enable a person to positively adjust to the challenge of major life stressors (Brennan et al., 2001; Carver & Scheier, 1994).

Understanding coping processes that are adaptive, however, is critical to the design and optimization of intervention programs. Finally, the Stress and Coping Model does not explicitly include a developmental perspective on coping. It would seem reasonable, however, that when a developmental phenomenon, such as age-related vision loss, is addressed, a theoretical framework of coping and adaptation that incorporates a developmental component would be important. Consequently, conceptual frameworks that attempt to explain how people adjust to the challenges, constraints, and losses at different points of the life span (e.g., Baltes & Baltes, 1990; Brandstätter & Renner, 1990; Heckhausen, 1997; Lang, Rieckman, & Baltes, 2002) are particularly germane to the study of the adaptation to vision loss in different age groups.

Empirical support for the appropriateness of a life-span theory framework for the study of coping with loss has been provided by Wahl and colleagues. For example, Wahl, Oswald, and Zimprich (1999) found that older adults with vision impairment, when compared with the nonvisually impaired control group, used more compensatory strategies, such as relying on other senses, simplifying daily tasks, or using optical and adaptive devices (e.g., magnifiers or large print material). With a more specific focus, Wahl, Schilling, Becker, and Burmedi (in press) recently applied the life-span theory of control, examining the use of control strategies among older adults suffering from age-related macular degeneration. Findings demonstrated that selective primary control (investing internal resources such as effort or time to reach a goal) was important for maintaining functional ability, and selective secondary control (cognitions that strengthen commitment toward the goal) was important for emotional adjustment. Whereas compensatory primary control (using external resources such adaptive devices) was also important for emotional adjustment, compensatory secondary control (reevaluation of or disengagement from goals) did not predict either of the two outcomes. The latter finding is not surprising if one keeps in mind that the participants in this study dealt with an early stage of the disease at a point when they are more likely to invest all coping efforts into maintaining their status quo.

Overall, this evidence underscores the benefit of using a life-span theoretical framework for the topic of adaptation to functional loss. Although the different life-span theories overlap with respect to the basic features that are thought to characterize adaptational processes, they converge only partially. For example, the measure derived from the life-span theory of control (Heckhausen, 1997) was specifically designed to assess control-related behavior and the frequency of its use. However, adaptational processes can also be conceptualized as general response tendencies rather than, on a behavioral level, as concrete day-to-day strategies. Control strategies may be considered as the behavioral manifestations of general coping tendencies, and, as such, mediators of the latter’s impact on adaptation. In furthering the line of research that applies the life-span framework to coping and adaptation in the context of chronic impairment, the present study seeks to add to the literature by focusing on the role of general coping tendencies in adaptation to vision impairment. Among the life-span theories, the model that most specifically formulates such general coping tendencies has been advanced by Brandstätter and associates (e.g., Brandstätter & Renner, 1990; Brandstätter & Rothermund, 2002).

Assimilative and Accommodative Modes of Coping

This model proposes two coping tendencies that are thought to mitigate or prevent depression and enable individuals to positively adjust to age-related losses and declines. Both modes have been found to predict high life satisfaction and low depression (Brandstätter & Renner, 1990). The assimilative mode (tenacious goal pursuit) reflects the persistent effort to actively adjust life circumstances to one’s preferences. In the accommodative mode (flexible goal adjustment), preferences and goals are adjusted to situational constraints. (It should be noted that, although the assimilative mode may be compared with problem-focused coping in that it includes concrete problem-solving efforts, the accommodative mode, unlike emotion-focused coping, is specifically conceptualized as a subintentional process of restructuring and reevaluating goal hierarchies. In fact, as Brandstätter and Renner [1990] pointed
out, some of the strategies in the emotion-focused category may even impede accommodative reorientation processes.)

In the context of dealing with a visual impairment, critical daily life tasks such as reading can constitute a major challenge. A person with a strong assimilative tendency may be inclined to invest a lot of effort into still being able to read by using all possible tools or devices to accomplish the goal of reading, no matter how much time and energy it takes. However, when vision further declines, this coping direction may become increasingly frustrating. At this point, a person with a more accommodative tendency may more easily switch gears, think about other aspects of life that are also important, remember that other people may be worse off, or come to the conclusion that this is a part of life.

Assimilative and accommodative modes of coping are not seen as mutually exclusive but as sometimes operating simultaneously. Personal coping tendencies could be reflected in a person’s reporting one mode more than the other, reporting high levels of both, or reporting little usage of both. Apart from the idea of personal coping tendencies, the model also predicts that assimilative processes tend to dominate as long as situations appear changeable, and that accommodative process should be activated when assimilative efforts become ineffective.

This assumption is supported by findings demonstrating an age-related increase in the accommodative mode of coping. For example, in a cross-sectional study of adults aged 34–63, Brandstädter and Renner (1990) showed evidence for a gradual shift from an assimilative to an accommodative mode of coping. Heckhausen (1997) found a similar age-related increase in flexible goal adjustment in a sample of adults aged 20 to 85. This increase is interpreted as an adaptive resource that helps maintain a positive developmental perspective despite the increasingly unfavorable gain–loss balance in later life. Specifically, in the face of increasing decline, accommodative processes are thought to help prevent or reduce severity and duration of depressive problems. Thus, older adults with functional impairments may show more flexibility in terms of readjusting their priorities and goals than middle-age adults because of greater life experience and the “on-time” character of limitations and losses in old age (Brandstädter & Rothermund, 1994; Krueger & Heckhausen, 1993).

Drawing on this theoretical framework, the present study extends prior research by linking vision impairment severity, functional disability, and assimilative and accommodative coping tendencies with two facets of mental health that capture both the impact on perceived daily functioning and depressive symptomatology. In addition, the consideration of middle-aged and older adults allows the determination of the extent to which the effect of coping tendencies varies depending on the stage in the life cycle at which adults deal with vision impairment. It was hypothesized that both vision impairment severity and functional disability would be positively related to mental health problems. Assimilative and accommodative modes of coping were expected to be negatively related to mental health problems, even after vision impairment severity and functional disability were controlled for. However, this effect was expected to be stronger for the accommodative mode because, ultimately, the ability to reevaluate one’s goals in the light of irreversible situational constraints (e.g., the task of reading becomes increasingly hard to accomplish) should be particularly beneficial with regard to a person’s mental health. On the basis of findings demonstrating an age-related shift toward accommodative coping in old age (Brandstädter & Greve, 1994), the effect of the accommodative mode of coping on mental health problems was expected to be stronger among older than among middle-aged visually impaired adults. Furthermore, because so little is known about the consequences of vision loss for middle-aged adults, the question whether or not the effect of functional disability on mental health would vary depending on age was also explored. Finally, the role of accommodative coping in the context of disability was addressed by exploring if its effect would differ depending on levels of disability and on age.

**METHODS**

**Sample and Procedures**

Participants were recruited from the pool of applicants at a vision rehabilitation agency in the Northeast. Eligibility criteria included being aged 40 or older, dwelling in the community, speaking English, being sufficiently free from hearing and cognitive deficits to participate in a telephone interview, being a first-time applicant for vision rehabilitation services, having completed services within the past 6 months, and having the onset of vision impairment within the past 5 years. The study sample (N = 107) was first stratified by age and then randomly selected from a pool of middle-aged adults (40–64 years) and older adults (65+ years). A response rate of 63% was obtained. Participants were interviewed over the telephone for approximately 45–60 min. All items and answering categories were read to the participant during the interview.

Participants in the middle-aged group (n = 55) were on average 55 years old (SD = 6.2), whereas the average age in the older group (n = 52) was 81 (SD = 7.6). There were no significant differences between the age groups with regard to gender. Nearly two thirds of the sample were women (65%). A lack of significant group differences was also found for race and education. Sixty-five percent of participants endorsed being non-Hispanic White, and 80% reported an educational level of at least high school graduate. However, as one would expect, participants in the older group were more likely to be widowed (48%) than those in the middle-aged group (9%), and they were less likely to be divorced or separated (8% vs. 33%). Also as expected, participants in the older group were more likely to be retired (83%) than those in the middle-aged group (11%). Interesting to note is that, although participants in the middle-aged group were more likely to be currently working (17% vs. 4%), they were also more likely to be unemployed (67% vs. 6%).

**Measures**

**Sociodemographic characteristics.**—Single items were used to assess participants’ age, gender, race, and education, as well as marital and employment status.

**Vision status.**—Vision impairment severity was measured with the 15-item self-report Functional Vision Screening Questionnaire (Horowitz, Teresi, & Cassels, 1991), which assesses the extent to which vision loss causes difficulty in specific.
functional areas (e.g., difficulty reading labels on medicine bottles). Each item was scored as $0 = \text{no difficulty}$ and $1 = \text{difficulty}$. Participants were also asked to self-report their eye disease diagnosis (e.g., macular degeneration, glaucoma, or cataract), and the extent to which their vision changed over the past 6 months.

Vision rehabilitation services.—Participants were asked whether or not they had received any vision rehabilitation (yes or no) following their application for services.

Functional disability.—This was assessed with a modified version of the Older Americans Resources and Services (OARS) Multidimensional Functional Assessment Questionnaire (Center for the Study of Aging and Human Development, 1975), which included both personal (7 items) and instrumental (6 items) activities of daily living ($\alpha = .89$). Items were assessed on a 4-point rating scale, ranging from 1 (no difficulty) to 4 (can’t do without help). The 13 items were summed to create a total score (range $0–52$).

Assimilative and accommodative coping tendencies.—These were measured with the English version of Brandtstädter and Renner’s (1990) Tenacious Goal Pursuit (TGP) and Flexible Goal Adjustment (FGA) Scale. This 30-item scale is a measure of assimilative and accommodative coping tendencies. (Assimilative is TGP; an item example is “When faced with difficulties I usually double my efforts.” Accommodative is FGA; an item example is “I adapt quite easily to changes in plans or circumstances.”) Each of these orthogonal dimensions contains 15 items. Respondents indicate to what extent items apply to them on a 5-point Likert scale, ranging from “strongly agree” to “strongly disagree” (0–4). Cronbach’s alphas for the two scales based on the current sample were .74 for TGP and .80 for FGA.

Mental health outcomes.—Two dimensions of mental health were assessed: The measure social dysfunction ($\alpha = .78$) is a 7-item subscale from the General Health Questionnaire-28 (GHQ-28), which is an abbreviated version of the original GHQ-60. The GHQ-28 has shown comparable reliability and validity, with higher sensitivity and equal specificity than the GHQ-60, and it is specifically recommended for the use of individual subscales (Goldberg & Williams, 1988). The social dysfunction subscale assesses perceived efficacy in psychosocial functioning. Items such as “Have you recently been satisfied with the way you have carried out your tasks?”; “Have you recently felt capable of making decisions?”; or “Have you recently felt that you are playing a useful part in things?” were assessed on a 4-point Likert scale (0–3), with the answering categories “better than usual,” “same as usual,” “worse than usual,” and “much worse than usual.”

Depressive symptoms.—These were measured with the 10-item Center for Epidemiological Studies Depression (CES-D) scale, a reduced version of the original 20-item CES-D (Radloff, 1977). Factor and reliability analyses indicate that scores from this short version have psychometric properties that are comparable with those of the original (Kohout, Berkman, Evans, & Cornoni-Huntley, 1993). Although the suggested answering format for the 10-item CES-D is “yes or no,” the answering format of the original CES-D scale was chosen for the present study in order to maintain consistency with the categories used in the GHQ subscales. Thus, respondents indicated on a 4-point Likert-type scale that ranges from 0 (less than 1 day) to 3 (5–7 times a week) how often they experienced the symptoms described by the item in the past week (higher score = higher depressive symptomatology). This scale showed a Cronbach’s alpha of .83.

Analysis Plan
A correlation matrix was computed prior to multivariate analysis in order to examine the interrelationships between all study variables (see Table 1; see it also for descriptives of all variables). Because the correlational links of study variables with the two mental health outcomes were so similar, and there had been no specific differential predictions with regard to these outcomes, the depressive symptoms and social dysfunction variables were combined into one measure of mental health problems ($\alpha = .86$).

The rationale of variable selection for the multiple regression analysis was largely conceptual in nature, addressing the hypothesized effects of impairment status and coping modes (see the aforementioned hypotheses) on mental health problems. Selected sociodemographic variables were included to control for basic characteristics that have been shown to have an effect on adaptational outcomes either in prior research on visually impaired adults (education; Reinhardt, 1996, 2001) or more generally in research on depression (gender, marital status; e.g., Earle, Smith, Harris, & Longino, 1998; Ernst & Angst, 1992). Employment status was included because the role of employment can be expected to be different for middle-aged adults than for older adults. Use of rehabilitation services was included to control for its potential influence on mental health outcome. Because of the hypothesized role of accommodative coping in response to major loss and constraints over the life course (Brandstätter & Greve, 1994), two-way interaction terms were added to examine if the effect of accommodative coping on mental health becomes more pronounced with older age, and to explore if this effect varies depending on levels of functional disability. (Interactive effects involving assimilative coping were not included in the final regression model because they were not expected on the basis of prior research. However, it is noted that a preliminary set of regressions confirmed that there were indeed no such effects.) Drawing on the concept of normative versus nonnormative developmental challenges (Neugarten, 1976), another two-way interaction term was included to see if the effect of functional disability on mental health varies depending on age. Finally, a three-way interaction of Accommodative Coping $\times$ Disability $\times$ Age was added to explore if there is an interactive effect of accommodative coping and disability on mental health problems that varies by age.

Findings from the blockwise hierarchical regression analysis are shown in Table 2. The four blocks were entered in the following order: first, sociodemographic characteristics (gender, marital status, employment status, and education); second, impairment status (vision loss severity, change in vision, functional disability, and use of rehabilitation services); third,
coping tendencies (assimilative and accommodative coping); and fourth, two-way interactions of Age × Accommodative Coping, Accommodative Coping × Functional Disability, Age × Functional Disability, and a three-way interaction of Accommodative Coping × Disability × Age. Finally, the 95% confidence intervals for beta coefficients were computed in order to compare the relative strength of the two coping variables.

RESULTS

As hypothesized, participants’ reported level of vision impairment severity and functional disability were positively linked on a bivariate level to both social dysfunction and depressive symptoms (see Table 1). Similarly, those who reported a decline in vision over the past 6 months were likely to show more mental health problems. The relationships between the two coping modes and mental health outcome were also as expected, significant and negative. Although the links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both outcomes, and of accommodative coping with social dysfunction, were similar to links of assimilative coping with both 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The key finding of the present study, which extended prior evidence based on the general aging population, was that the effect of accommodative coping on mental health problems varied depending on both functional disability and age. However, the beneficial effect of accommodative coping that existed in the older group independently of disability level emerged in the younger group only with high levels of disability, which underscored that disability rather than age became the critical variable among the middle-aged participants. Thus, the hypothesized difference in the impact of accommodative coping on mental health depending on age did exist but only when those with lower levels of disability in the younger group were compared with the older participants. These findings are not inconsistent with the conceptual framework if one considers the notion that the role of accommodative coping becomes increasingly important in old age as a result of the losses and constraints that typically accompany later life. If a younger age group is included that deals with the kind of functional loss and resulting limitations that often characterize old age, functional disability rather than age should become the critical variable. Thus, the notable implication of these findings for the theoretical framework of accommodative and assimilative coping seems to be that predictions about an age-related shift from assimilation toward accommodation have to be modified when the situation of a chronically impaired population is addressed. Evidence from the present study suggests that, in this population, the projected shift may occur much earlier than “normative” in younger age groups, and it may even emerge more strongly among younger than among older individuals. These insights may serve as guidance for the formulation of more specific hypotheses that take into consideration the unique situation of dealing with a chronic impairment in middle adulthood. Future work in this direction could help identify those who are at risk for mental health problems, and it could guide the design of interventions for middle-aged and older adults with chronic vision impairment as well as other age-related health impairments.

What is also of particular relevance for intervention planning is the evidence obtained in the present study, which suggests that dealing with a chronic impairment and related health and disability problems in middle adulthood carries particular implications different from those involved when chronic impairment occurs in later life. In fact, facing a chronic impairment seemed to pose more of a risk for mental health problems for middle-aged than for older adults. One explana-

**Table 2. Multiple Regression for Mental Health Problems**

<table>
<thead>
<tr>
<th>Block</th>
<th>B</th>
<th>SE B</th>
<th>Lower</th>
<th>Upper</th>
<th>β</th>
<th>ΔR²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>−1.63</td>
<td>0.60</td>
<td>−2.83</td>
<td>−0.44</td>
<td>−0.20**</td>
<td>.14***</td>
</tr>
<tr>
<td>Gender (female)</td>
<td>3.36</td>
<td>1.24</td>
<td>0.89</td>
<td>5.83</td>
<td>.19**</td>
<td></td>
</tr>
<tr>
<td>Marital status (married)</td>
<td>−0.10</td>
<td>1.22</td>
<td>−2.52</td>
<td>2.32</td>
<td>−0.01</td>
<td></td>
</tr>
<tr>
<td>Employment (yes)</td>
<td>−2.58</td>
<td>1.86</td>
<td>−6.28</td>
<td>1.12</td>
<td>−0.11</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>−0.07</td>
<td>0.40</td>
<td>−0.85</td>
<td>0.72</td>
<td>−0.01</td>
<td></td>
</tr>
<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision loss severity</td>
<td>0.39</td>
<td>0.19</td>
<td>0.02</td>
<td>0.76</td>
<td>.16*</td>
<td></td>
</tr>
<tr>
<td>Functional disability</td>
<td>1.80</td>
<td>0.68</td>
<td>0.05</td>
<td>3.15</td>
<td>.22*</td>
<td></td>
</tr>
<tr>
<td>Vision worse (yes)</td>
<td>0.80</td>
<td>1.22</td>
<td>−1.61</td>
<td>3.22</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>Rehab use (yes)</td>
<td>−0.71</td>
<td>1.39</td>
<td>−3.48</td>
<td>2.06</td>
<td>−0.04</td>
<td></td>
</tr>
<tr>
<td>Block 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assimilative coping</td>
<td>−1.59</td>
<td>0.62</td>
<td>−2.83</td>
<td>−0.35</td>
<td>−0.19*</td>
<td>.25***</td>
</tr>
<tr>
<td>Accommodative coping</td>
<td>−3.25</td>
<td>0.58</td>
<td>−4.41</td>
<td>−2.09</td>
<td>−0.39***</td>
<td></td>
</tr>
<tr>
<td>Block 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodative Coping × Age</td>
<td>−0.16</td>
<td>0.60</td>
<td>−1.35</td>
<td>1.04</td>
<td>−0.02</td>
<td>.10***</td>
</tr>
<tr>
<td>Accommodative Coping × Functional Disability</td>
<td>−2.26</td>
<td>0.70</td>
<td>−3.66</td>
<td>−0.87</td>
<td>−0.23**</td>
<td></td>
</tr>
<tr>
<td>Functional Disability × Age</td>
<td>−2.15</td>
<td>0.62</td>
<td>−3.39</td>
<td>−0.91</td>
<td>−0.24**</td>
<td></td>
</tr>
<tr>
<td>Accommodative Coping × Functional Disability × Age</td>
<td>1.48</td>
<td>0.71</td>
<td>0.07</td>
<td>2.89</td>
<td>.15*</td>
<td></td>
</tr>
<tr>
<td>Total R²</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.64***</td>
</tr>
</tbody>
</table>

Notes: Listwise N = 105; ΔR² = R² change. Centered values of age, accommodative coping, and functional disability were used for both individual effects and interaction terms.
tion may, again, lay in the off-time nature of having to deal with vision and disability problems at a point in life during which most people enjoy better health. In later adulthood, in contrast, physical constraints tend to be seen as rather normative, in other words, what many people would expect to occur as part of the aging process. Alternatively, cohort effects may have played a role in the sense that the older participants, as a result of life experiences that are characteristic for their generation (e.g., living through the Depression), were more prepared to deal with situational constraints or the experience of loss and limitation of any sort than the middle-aged cohort. Another matter of life experience may have been that, with an increasingly unfavorable gain–loss ratio in later life (Heckhausen, Dixon, & Baltes, 1989), the older participants may have had more exposure to loss in general and therefore may have been able to draw on this prior experience in order to cope with the new challenge of vision loss. To address the latter possibility, future research could directly assess the role of prior loss experience. The viability of the age-normative explanation could be addressed in further studies on coping with disability across the life span by assessing expectations for what is considered normative by middle-aged and older adults, and by accounting for these expectations in the analysis. Being able to ultimately exclude the cohort effect explanation, however, would require longitudinal data that allow a delineation of the transition from middle to late adulthood among adults in one cohort, and, within this cohort, a comparison of those who develop a chronic impairment in mid-life and those for whom this occurs in later life.

Longitudinal data would also be helpful to integrate and further refine the different attempts to apply life-span theories to the field of adaptation to chronic impairment. For example, there is evidence from the present study and prior research that the model of accommodative and assimilative coping and the life-span theory of control provide a useful framework for this topic. However, as already suggested, the question does not seem to be which of the two theories is more appropriate. Rather, it appears that they provide related yet distinct concepts and measures that can be used to assess adaptation on different levels, that is, general coping tendencies on the one hand and control-related behavior on the other. The usefulness of assessing these separately may be underscored by the fact that Wahl and colleagues found no relationship of compensatory secondary control with emotional adjustment, whereas the present study demonstrated an important role of the conceptually related accommodative mode for mental health outcome. Yet, it is also possible that these findings differed because the participants in the present study were at a more advanced point of the adaptation process. Thus, future research that would enable us to tease apart the similarities and differences of these concepts and to determine their exact role in adaptation to chronic impairment would have important theoretical as well as clinical implications for the field of adult development and aging.

As participants were drawn from a population who had contacted a vision rehabilitation agency for services, there may be limits to generalizing the presented findings to visually impaired adults who do not seek out services or to adults with other chronic impairments (e.g., hearing). However, this should not limit the relevance of determining the role of coping tendencies in the relationship among vision loss, functional disability, and mental health in middle and late adulthood. Finally, age-related vision loss constitutes a prototypical case in that it shares key features with other chronic age-related disabilities, such as gradual onset, progressive decline, and partial disability. Therefore, the present study can serve to inform and guide future research on adaptation to age-related disability in general.

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