Acceptance as a coping reaction to unchangeable negative events has been discussed controversially. While some studies suggest it is adaptive, others report negative effects on mental health. We propose a distinction between two forms of acceptance reactions: active acceptance, which is associated with positive psychological outcomes, and resigning acceptance, which is associated with negative psychological outcomes. In this study, 534 individuals were surveyed with respect to several hypothetical situations. We tested the proposed acceptance model by confirmatory factor analysis, and examined the convergent and discriminant validity using personality and coping measures (Trier Personality Questionnaire, Bernese Bitterness Questionnaire, COPE). The results support the distinction between the two forms of acceptance reactions, and, in particular, that active acceptance is an adaptive reaction to unchangeable situations.

Keywords: Acceptance, coping behavior, mental health, negative events

In research on coping with negative life events, a number of relevant factors have been identified in recent years. The following have been shown to influence adaptation: causal attributions (Mendola, Tennen, Affleck, McCann, & Fitzgerald, 1990; Tennen & Affleck, 1990), control beliefs (Flammer, 1990; Skinner, 1995; Taylor, 1983; Weiss, Schneewind, & Olson, 1995), search for meaning (Frankl, 1963; Taylor, 1983), and positive illusions (Fiske & Taylor, 1991; Taylor & Brown, 1988). All these factors play a role in the process of accommodative coping, i.e., coping with events that have proved to be unchangeable (Brandtstädter, Wentura, & Rothermund, 1999).

However, one possible way to deal with negative events that holds a prominent position in folk psychology has only recently begun to receive much attention. A common piece of everyday advice is that it is best to simply accept a negative event in order to get over it and continue with life. There seems to be a generally held belief that in order to cope with negative events, it is important to accept things as they are, and not to dwell on them too much. Up to now, psychological research has not devoted much attention to examining coping by accepting, although the interest in acceptance has grown in the last few years (Carver et al., 1993; Carver, Scheier, & Weintraub, 1989; Ma & Teasdale, 2004; Reed, Kemeny, Taylor, Wang, & Visscher, 1994; Roemer & Orsillo, 2003; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Especially in coping with situations where perceived control is low, people seem to prefer to rely on acceptance, amongst other things, rather than direct action (David & Suls, 1999).

Interestingly, the literature on acceptance not only disagrees about its definition, but also about its adaptivity. If acceptance of a negative event means acknowledging the reality of the event, this might imply that the individual is preoccupied with thinking about it, leading to impaired well-being. But acceptance could also mean achieving closure on a matter and moving on in life, thus supporting an individual’s adaptation and thereby enhancing psychological well-being. Much depends on the exact definition of acceptance. Moreover, the type of situation is of major importance; e.g., it might be crucial whether the event is over or still going on, and/or what its consequences are. However, the literature provides few findings with respect to situation effects. Therefore, the aim of the present study is to propose a conceptualization of acceptance and to test it.
Acceptance as an Adaptive Coping Reaction

Acceptance can be an adaptation to unchangeable negative events by helping to maintain the individual’s psychological well-being and capacity to act. Acceptance means to face the reality even if it does not fit one’s expectations or desires, and the willingness to deal with this reality nevertheless. As Carver et al. (1993) state, such individuals “make every effort to stay engaged with the important goals that give structure to their lives” (p. 387).

In their COPE-questionnaire, Carver et al. (1989) included a scale of acceptance. This scale was found to be an important predictor of psychological adaptation and well-being in a prospective study with breast cancer-patients (Carver et al., 1993), whereas active coping or seeking social support did not show significant effects. Furthermore, denial, which can be regarded as the opposite of acceptance, was clearly related to higher levels of stress and impaired psychological well-being.

In another study, Wright and Kirby (1999) examined how patients with renal failure adapted to this very debilitating disease. Acceptance was found to be one of the key variables in the adaptation process. According to Wright and Kirby, acceptance has emotional as well as behavioral and cognitive components. Moreover, acceptance of the disease can take two different forms according to how the disease is interpreted by patients and integrated into their identity. Patients who actively accepted their illness incorporated the disease into their daily life, but did not let it dominate affairs completely. These patients deemed it important that their lives should not be completely disrupted by the treatment, and thus they continued to work and to pursue their hobbies. In contrast, patients characterized by passive acceptance gave up many activities and roles, and allowed the disease to take central control of their lives. These individuals primarily organized their lives around the disease and treatment, were strongly influenced by it in their self-perceptions and identities, and had a significantly lower sense of well-being than the actively accepting patients.

One domain where lack of controllability is strongly experienced is that of chronic pain. McCracken (1998) circumscribes acceptance as “acknowledging that one has pain, giving up unproductive attempts to control pain, acting as if pain does not necessarily imply disability, and being able to commit one’s efforts toward living a satisfying life despite pain” (p. 22). In several studies, McCracken and colleagues found positive effects of acceptance in the context of chronic pain. Acceptance seems to support the ability to cope with pain (McCracken, Spertus, Janeck, Sinclair, & Wetzel, 1999); moreover, acceptance has been found to be associated with less pain, less disability, less depression, less pain-related anxiety, and a better work status (McCracken & Eccleston, 2003).

An explanation of these findings might be found in the model of experiential avoidance (Hayes, Strosahl, & Wilson, 1999), according to which attempts to alter the form or frequency of aversive internal experiences, e.g. pain, can have the paradoxical effect of increasing negative experiences. Indeed, in a study by Feldner, Zvolensky, Eifert, and Spira (2003), more emotional avoidance was associated with higher levels of anxiety and affective distress. Thus, it seems that, rather than seeking to control inner events, it might be more helpful to develop a stance of acceptance towards them, namely to become experientially open (Hayes, Strosahl, & Wilson, 1999). Such a stance enhances resilience in the face of stressors as shown in an experiment by Hayes, Bissett, et al. (1999). They compared the effectiveness of two different strategies for dealing with pain. One experimental group received an acceptance-based intervention, which taught them how to just observe bodily and emotional perceptions without reacting to them. The other group received a cognitive-behavioral intervention, which taught them how to breathe quietly and mentally induce positive images. The results showed that pain tolerance was higher in the acceptance-intervention group.

In the last few years several treatments have been developed that are based on an acceptance approach and that have brought about encouraging results for a range of disorders (see Roemer & Orsillo, 2002, 2003). Mindfulness-based treatments, with their strong emphasis on nonjudgmental awareness and acceptance of inner states, have been found to be efficient in the treatment and prevention of both medical and psychological disorders (Kabat-Zinn, 2003; Ma & Teasdale, 2004; Teasdale et al., 2000).

On the whole, these studies support the conclusion that there is a form of acceptance that is highly adaptive and that includes acknowledging the negative reality and staying in touch with the experience. It also encompasses a readiness to face the situation and to make the best of it. This characteristic distinguishes adaptive acceptance from cognitive reinterpretation strategies such as downwards-comparisons (Taylor, 1983) or accommodative goal devaluations (Brandtstädter, Wentura, & Rothermund, 1999).
Acceptance as a Maladaptive Coping Reaction

In contrast to the above, acceptance has also been described as a psychological reaction with negative consequences for physical and mental health. AIDS-patients who realistically accepted their disease were found to pass away sooner than patients who refused to accept their situation (Reed et al., 1994). In the study, realistic acceptance was the most significant predictor of survival time on all coping measures, even when other potential explanatory variables (risk factors, behavioral measures) were controlled for. As the authors conclude, “realistic acceptance appears to represent a fundamentally cognitive phenomenon and to be a function of negative disease-specific expectancies in the context of AIDS” (p. 305). However, the mechanism by which realistic acceptance leads to a decreased survival time is not clear.

The reason for these apparently contradictory findings might be found in the operationalization of realistic acceptance. Reed et al. (1994) used items based on Folkman and Lazarus (1980), such as: “Try to accept what might happen”, “Prepare myself for the worst” or “Go over in my mind what I would say or do about this problem”. These items seem to express a somewhat resigned, or, more accurately, resigning attitude. It is unclear whether they measure acceptance in the same sense as discussed in the preceding section.

Similar results, again with AIDS-patients, have been reported by Griffin and Rabkin (1998), who found correlations between acceptance of the disease and negative indicators. Self-reported acceptance of the fact that the disease might get worse and lead to death was significantly correlated with hopelessness and depression. The authors conclude that acceptance of this kind is maladaptive, at least at advanced stages of progressive diseases.

Negative effects of acceptance were also found in a study with HIV-positive prison inmates (Thompson, Collins, Newcomb, & Hunt, 1996). Secondary control, in the sense of acceptance, impaired the well-being of those men with low control beliefs.

While these studies seem to document negative effects of acceptance on physical and mental health, recent studies have put these findings into a new perspective. In one such study (Reed, Kemeny, Taylor, & Visscher, 1999), the acceptence items loaded on a factor named “negative HIV-specific expectations”, together with other clearly maladaptive items such as low control beliefs, indicating that this operationalization of acceptance measures a pessimistic rather than optimistic accepting attitude. It should be noted here, however, that the negative effect of this expectation scale was primarily found in patients who had lost a close friend (Taylor et al., 2000), thus calling into question the generalizability of this result.

Active Acceptance and Resigning Acceptance

On the whole, it seems that judgments on the adaptivity of acceptance are highly heterogeneous and controversial. How are these different opinions to be interpreted? One point on which several authors agree is that acceptance is especially relevant in the face of unchangeable and uncontrollable situations, such as chronic pain, life-threatening disease, or imprisonment. Acceptance is a form of accommodative coping (Brandstädter, Wentura, & Rothermund, 1999) when changing the situation is not possible, because acceptance aims at changing the emotional impact of an event. Therefore, acceptance can be defined as an emotion-focused coping reaction which is close to secondary control (Rothbaum, Weisz, & Snyder, 1982). However, it does not seem appropriate to view acceptance and secondary control as identical. While secondary control denotes an intentional act to regain control by reinterpreting a situation (such as identification with powerful others, devaluation of goals, etc.), acceptance is characterized as giving up the striving for control.

Thus, the contradictory findings might be the result of different definitions and operationalizations of the acceptance construct. Therefore, it might be necessary to distinguish two different forms of acceptance, one of which leads to better mental health, the other to negative effects. While both forms of acceptance are similar in that the individual abandons his or her efforts to influence the situation, they differ with respect to how the individual psychologically reacts. We propose to call these reactions active acceptance and resigning acceptance.

Active acceptance means acknowledging a negative, difficult situation and dealing with it in a constructive way. The individual dispenses with fruitless attempts to control what is neither controllable nor changeable. Nevertheless, where possible, the individual still finds meaningfulness in life and goals worth pursuing in spite of difficulties. The ability to actively accept an event is characterized by a well-balanced and peaceful emotional state. Therefore, active acceptance can be seen as emotionally competent behavior in the face of lack of controllability.

Resigning acceptance also means abandoning outward-directed actions; however, this behavior is combined with negative expectations about the future and a loss of hope. Also, unlike active acceptance, resigning acceptance does not mean only to stop controlling the actual situation, but
becoming passive in other areas of life as well. Feelings of resignation, disappointment, or sorrow are dominant.

The opposite reaction to acceptance is the attempt to regain control by reactance (Wortman & Brehm, 1975). Not accepting an event means not wanting to admit the definitive reality of it and fighting it. This will probably be accompanied by negative feelings such as anger or rage towards the situation or towards the person held responsible for the situation. Table 1 summarizes the hypothesized cognitive, emotional and behavioral reactions for active acceptance, resigning acceptance, and non-acceptance.

Effects of Person and Situation Characteristics

It is well established that coping success depends on person as well as situation factors (Aldwin, 1994; David & Suls, 1999; Lazarus & Folkman, 1984). Personal resources such as optimism (Carver et al., 1993) or good mental health (Becker, 1992) support the coping process. According to Becker (1992, 1999), mental health is one of two robust higher-order factors of personality, besides behavior control, which is related to more adequate coping behavior. Mentally healthy individuals are better at dealing with stress caused by internal or external demands, and at the same time they react less strongly with negative emotions to stress (Becker, 1992), a characteristic that might be relevant for the ability to actively accept a situation. Therefore, we assume that mental health substantially influences the ability to cope with an unchangeable situation by helping the individual to accept the situation.

In addition, situation is a crucial factor for coping success (Folkman & Lazarus, 1980; Mattlin, Wethington, & Kessler, 1990). As pointed out earlier, acceptance is relevant in situations where a negative event cannot be changed or controlled. However, a large portion of variance remains unexplained, if the importance of the situation and the situation-specific reactions are not taken into account. As a consequence, coping reactions have to be examined with respect to specific situations.

Goals of the Study and Hypotheses

The first goal of the study was to develop a measure of active acceptance, resigning acceptance and non-acceptance. We hypothesized that these reactions can be empirically distinguished as separate factors. Of particular interest was how well active acceptance and resigning acceptance can be distinguished. We also hypothesized that the situations would have a considerable influence on the reactions.

The second goal of the study was to determine the relations between acceptance reactions and personality and coping measures. Active acceptance was hypothesized to be positively related to measures of mental health and adaptive coping. In contrast, resigning acceptance and non-acceptance was hypothesized to be negatively related to measures of mental health and adaptive coping.

Method

Participants

The study was conducted in Switzerland and included four subsamples. Efforts were made to balance gender and to include different educational levels in all samples; however, this goal could not be fully reached in all samples.

Sample 1 consisted of 127 adolescents between 15 and 18 years of age ($M = 16.2$ years) living in the region of St.Gallen; 57% were female. Questionnaires were distributed through secondary schools (72%) and high schools (28%) and filled out by the adolescents during class. Compared to the normal population these students had a higher educational level.

Table 1
Cognitive, Emotional and Behavioral Aspects of Active Acceptance, Resigning Acceptance, and Non-Acceptance

<table>
<thead>
<tr>
<th>Cognitive aspect</th>
<th>Emotional aspect</th>
<th>Behavioral aspect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active acceptance</td>
<td>Acknowledging the reality of the event, dealing with the new situation, finding meaningfulness in the new situation</td>
<td>Calmness, confidence</td>
</tr>
<tr>
<td>Resigning acceptance</td>
<td>Resignative thoughts, negative future expectations</td>
<td>Resignation, hopelessness, avoidance</td>
</tr>
<tr>
<td>Non-acceptance</td>
<td>Denial, searching for strategies</td>
<td>Anger, rage</td>
</tr>
</tbody>
</table>

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Sample 2 consisted of 180 participants between 20 and 30 years of age ($M = 23.1$ years); 56% were female. The participants were contacted via different tertiary educational institutions in the area of Berne (professional technical school, professional art school, professional social work school: 35%; university: 22%; medical school: 12%) and via the compulsory military training for young men (16%). Questionnaires were handed out during classes or were filled out in special examination sessions.

Sample 3 consisted of 120 participants between 40 and 50 years of age ($M = 45.5$ years, $SD = 3$); 54% were female. They were employees of different departments of a large insurance company and received the questionnaire by mail. The educational level of this sample was higher than in the general population: 22% had a university degree, 27% had a degree from another tertiary institution, 34% had finished an apprenticeship, 14% had finished academic high school and only 3% had basic compulsory schooling.

Sample 4 consisted of 107 participants between 50 and 75 years of age ($M = 64.3$ years); 56% were female. General practitioners from the area of Zurich were asked to hand out the questionnaire to their elderly patients together with an addressed and prepaid envelope. One hundred and fifty questionnaires were distributed and 128 were returned, however, only 107 could be included in the analysis because 21 questionnaires had not been correctly filled out. 12% had a university degree, 19% a degree from a technical university or similar institution, 47% had finished an apprenticeship or professional training, 14% had a high school degree and 4% had absolved compulsory school.

Because of the different composition of the samples with respect to educational levels we checked for possible effects of this factor by means of MANOVA. No significant effect was found for educational level.

**Measures**

**Acceptance Questionnaire**

Because acceptance was conceptualized as a coping reaction related to specific situations, we decided to measure the reactions using situation vignettes. An advantage of this approach is that it is easier for an individual to report his or her reactions to specific situations than to report general behavioral patterns. Therefore, the validity should be higher for situation-specific answers compared to general answers. Also, it is of theoretical interest whether acceptance is specific to certain situations or whether there is a general disposition towards acceptance or non-acceptance.

The situations used were selected in several steps. It was decided that, as a general characteristic, the situations should have a negative affective quality and they should be unchangeable. In a pretest, we surveyed individuals of different ages with open questions about negative and unchangeable situations they had experienced. On the basis of these answers a list of possible situations was generated, which was reduced to those situations that were frequent and seemed appropriate for all age groups. Because we expected possible biases if using rare and unfamiliar situations, we decided to choose situations with rather small or medium consequences, which are more familiar to the participants. Even if coping reactions undoubtedly differ with respect to serious vs. less serious events, the relations of coping reactions with other psychological variables should remain approximately the same.

In addition, the situations had to cover a wide range of life-domains (social relationships, health, career, etc.). The final selection of situations included the following: your television breaks down and ruins your joyfully expected TV-evening (TV), you break a leg and have to stay in bed for 6 weeks (leg), you fail your driving test (failure), your partner ends the relationship against your wish (partner), you miss an important social event due to illness (illness), a hairdresser ruins your hair (hair), an important personal belonging is stolen (theft), you feel isolated in a new place of work (isolation), a friend reveals your secret among your peers (betrayal). As can be seen from the list, the situations differed greatly with respect to their implications: included were both trivial situations, which might be more familiar, and far-reaching events, which are more relevant but not necessarily familiar. But, all of them shared the characteristic of being unchangeable. There is nothing a person can do about a broken leg or a betrayal in the situation itself.

For each situation the participants were asked about cognitive ("What are your thoughts in such a situation?") and emotional reactions ("What are the feelings you have in such a situation?"). Three items measuring active acceptance, non-acceptance or resigning acceptance were asked for both cognitive and emotional reactions, resulting in six items per situation. Answers were measured on a 4-point scale ranging from 1 (very unlikely) to 4 (very likely). The acceptance items are simultaneously used as indicators of latent construct factors and latent situation factors within structural equation models (see below); therefore, Cronbach’s alpha is not an appropriate reliability statistic of the acceptance questionnaire, because high homogeneity is not assumed and, moreover, is not necessary. Nevertheless, Cronbach’s alpha is reported for reasons of documentation: .85 for active acceptance, .75 for resigning acceptance, .79 for non-acceptance.

Item examples of active acceptance are: ‘This can happen. It is not tragic.’, “This seems inevitable. I have to learn to live with it.”, “This is the way it is. I will stay at
home.” (cognitive reactions); “I am calm and peaceful.”, “I am composed and open for everything that might come.”, “I do not allow myself to get upset.” (emotional reactions).

Item examples of resignation acceptance are: “Typical. Such things always happen to me.”, “All my practice was for nothing. I did not need to do it at all.”, “This had to happen. The whole relationship was a mistake.” (cognitive reactions); “I am frustrated.”, “I feel empty.”, “I am disappointed.” (emotional reactions).

Item examples of non-acceptance are: “This assessment is unfair. This I cannot accept.”, “I am not going to give in so quickly. Let’s see.”, “This looks terrible! I am not going to tolerate that.” (cognitive reactions); “I am outraged and cannot believe it.”, “I am upset.”, “I am irritable and annoyed at those people.” (emotional reactions).

**Trier Personality Questionnaire**

The Trier Personality Questionnaire (TPF; Becker, 1989) measures the two higher-order factors mental health and behavior control, and a range of first-order factors. In this study, the scales measuring the higher-order factors were included. The scale measuring mental health consists of 19 items (Cronbach’s alpha = .95 in this study), the scale measuring behavior control consists of 17 items (Cronbach’s alpha = .75 in this study). Answers were measured on a 4-point scale ranging from 1 (always) to 4 (never).

**COPE**

In order to investigate the convergent validity, the COPE (Carver et al., 1993; Carver et al., 1989) was used in the German translation by Kälin (1995). The general format, not the event-specific format, was used. In this study, Cronbach’s alpha values were as follows: active coping (.69), planning (.77), suppression of competing activities (.62), restraint coping (.56), seeking social support for instrumental reasons (.80), seeking social support for emotional reasons (.81), positive reinterpretation and growth (.74), acceptance (.72), turning to religion (.95), focus on and venting of emotions (.69), denial (.72), behavioral disengagement (.72), mental disengagement (.45), alcohol-drug disengagement (.94). The acceptance scale of the COPE, which was expected to correlate positively with active acceptance, was particularly relevant. It includes four items such as “I learn to live with it” and “I accept that it has happened and that it cannot be changed”. Answers were measured on a 5-point scale ranging from 1 (exactly true) to 5 (exactly false).

**Bernese Bitterness Questionnaire**

This scale developed by Znoj (2002) is a trait measure of feelings of bitterness and consists of 9 items (Cronbach’s alpha = .85 in this study). Item examples are: “I am filled with bitterness when I think about my unfulfilled wishes” and “I am often dissatisfied with my destiny”. Answers were measured on a 5-point scale ranging from 1 (not true) to 5 (exactly true).

**Procedure for the Statistical Analysis**

In this study, application of structural equation modeling is required because the constructs under investigation, acceptance reactions, are assumed to vary systematically in the different situations included in the acceptance questionnaire. In contrast to exploratory factor analysis, confirmatory factor analysis allows for specifying construct factors and situation factors simultaneously.

As a first step in the preparation of the statistical analysis, 27 parcels of acceptance reactions were computed, averaging the values of the cognitive and emotional items for each combination of 3 acceptance factors and 9 situation factors. In the analysis, parcels were used as indicators, because parcels provide more reliable manifest variables than individual items by reducing random error as well as systematic error due to differences in emotional and cognitive reactions (Little, Cunningham, Shahar, & Widaman, 2002).

As a second preparatory step, a missing value analysis of the data set was conducted, including all variables that are used in the analyses reported in this study. In 521 of the total 538 cases, no values were missing. In the remaining cases, missing values were imputed by the expectation maximization procedure included in SPSS 11.0.1, following the recommendation by Wothke (2000).

Based on the 27 parcels of acceptance reactions, the hypothesized model included three latent acceptance factors (the construct factors) and nine latent situation factors (Figure 1). Each acceptance factor loaded on the corresponding indicator in each of 9 situations. Each situation factor loaded on the 3 indicators related to the situation. The acceptance factors were allowed to covary with each other for theoretical reasons. However, no covariances of situation factors were included in the model, as the situation factors should measure the unique variance in specific situations.

For model estimation, we used fixation of factor loadings as scaling method; for each factor, the unstandardized value of the first loading was set to 1. For the computations we used Amos 5 (Arbuckle, 2003; Arbuckle & Wothke, 1999). The computations were based on the covariance matrix. The maximum likelihood procedure was used as estimation method, following the recommendation by Hu and Bentler (1998).

In addition to the hypothesized model, alternative models were tested and the fit of the different models was compared. Relevant alternative models were those with a high-
er parsimony, and thus models with a lower number of acceptance factors (only two acceptance factors or one general acceptance factor), as well as the model as hypothesized but without specification of situation factors.

Model fit was assessed by four fit indices that are currently recommended as most useful (Hu & Bentler, 1998, 1999; MacCallum & Austin, 2000): the Tucker-Lewis-Index (TLI), the Comparative Fit Index (CFI), the Standardized Root Mean Square Residual (SRMR), and the Root Mean Square Error of Approximation (RMSEA). Hu and Bentler (1999) suggest that good fit is indicated by values greater than or equal to .95 for TLI and CFI, and values less than or equal to .08 for SRMR, and less than or equal to .06 for RMSEA. In addition to these indices, we report the confidence interval for RMSEA and $\chi^2$-statistics.

Results

The model estimation required four error variances to be set to zero. Initially, error variances of the indicators of active acceptance in four situations (leg, failure, hair, theft) showed negative values, even if the solution was convergent. Improper solutions with negative error variances are a common problem in structural equation modeling (Chen, Bollen, Paxton, Curran, & Kirby, 2001). If outliers can be ruled out as cause, and if negative error variances do not significantly deviate from zero, it is assumed that improper estimates are the result of sampling fluctuations rather than specification errors, and it is recommended that estimates be constrained to zero or to low positive values (Chen et al., 2001). In this study, the data were controlled for outliers, and the four negative error variances did not deviate significantly from zero; therefore, we set these error variances to zero. The fit values of the initial model and the model with constrained error variances were virtually identical.

Table 2 shows the fit values for the hypothesized model and alternative models (all models with the constrained error variances specified above). For models with only two acceptance factors or one general acceptance factor (Models 3 to 6), proper model estimation required replacing the situation factors by covariances of the error terms. This

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procedure bypasses the problems in model estimation and results in virtually identical fit values with slight differences in degrees of freedom. The results for all indices (TLI, CFI, SRMR, RMSEA) show that the hypothesized model with three acceptance factors (Model 1) fits the data substantially better than the model without situation factors (Model 2), the model with one general acceptance factor (Model 3), or the models with two acceptance factors (Models 4 to 6). Moreover, the fit values for the hypothesized model meet the criteria for good model fit as recommended by Hu and Bentler (1998, 1999). Given these results, there was no need for model modification. However, for exploratory purposes, fit values were computed for an additional model, in which the indicators of the situation with the lowest construct loadings (TV situation, see Table 2) were omitted. The results show that the fit values are slightly, but not substantially, better for this model (Model 7) compared with the hypothesized model (Model 1).

Table 3 shows the loadings of the acceptance factors for the hypothesized model. As already mentioned, indicators of the TV situation show the lowest values. However, the sizes of the loadings are generally acceptable. On average, the acceptance factors explain 25% of the indicator variance (mean squared loadings), the situation factors explain 30% of the indicator variance (mean squared loadings), and the residual variance of the indicators amounts to 45%. The acceptance factors intercorrelate with $r = -.49$ for active acceptance and resigning acceptance, $r = -.59$ for active acceptance and non-acceptance, and $r = .62$ for resigning acceptance and non-acceptance. Thus, the correlations between the construct factors are substantial, but low enough to justify the distinction of three different factors. For purposes of documentation, Table 4 shows the loadings of the situation factors for the hypothesized model.

The subsamples comprised in the total sample of this study can be used to investigate the validity of the hypothesized model. A frequently used strategy is to test for measurement invariance in subsamples (cf. Byrne, 2001). We tested for measurement invariance of loadings of the acceptance factors, using two subsamples (adolescents and young adults combined, $n = 307$, and adults and older adults combined, $n = 231$). We did not analyze the single four subsamples to ensure sufficiently large subsample sizes as required in structural equation modeling. The $\chi^2$-difference test shows that the model with equality constraints on the loadings (the measurement invariance model) does not fit significantly worse than the model without equality constraints (the measurement variance model), with $\Delta\chi^2 = 32.65$, $\Delta df = 24$, and $p = .112$. Thus, the results corroborate the validity of the hypothesized model.

Table 5 shows the results of the discriminant and convergent validation analysis with the COPE, the TPF, and the BBQ. As can be seen, active acceptance has more or less the opposite pattern from resigning acceptance and non-acceptance. The positive relationship between active acceptance and COPE-acceptance indicates the convergent validity of this scale. Active acceptance also seems to be related to a coping style where an individual seeks to interpret things in a positive way and refrains from venting emotions. Resigning acceptance, in contrast, was correlated with bitterness, again indicating convergent validity. However, in contradiction to the conceptualization of resigning acceptance, the scale was also positively correlated with denial. Non-acceptance had correlations similar to resigning acceptance but seems to go together with a somewhat stronger activity such as venting emotions or taking drugs. Active acceptance was positively correlated with mental health and behavior control, whereas resign-
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...ing acceptance and non-acceptance were negatively correlated with mental health and uncorrelated with behavior control.

### Discussion

In this study, two forms of acceptance were postulated: active acceptance was hypothesized to be adaptive, resigning acceptance was hypothesized to be maladaptive. In a confirmatory factor analysis, a model was tested that included three construct factors (active acceptance, resigning acceptance, non-acceptance) and nine situation factors. The results show that the hypothesized model is supported by the data and that this model has a better fit than more parsimonious models postulating only two or one construct factors. The measurement invariance of the model in two subsamples corroborates the model’s validity.

As expected, certain situations strongly influenced participants’ reactions, thus leading to marked differences between situations. In particular, the TV situation showed relatively low loadings in the model, maybe because it was trivial compared to the other situations. However, without knowing about how participants interpreted the situations, it is not possible to draw specific conclusions about the role of the situations.

Taking the situation effect into account, the model indicates that a substantial proportion of variance can be attributed to person-related factors of acceptance. People differ with respect to their tendency to actively accept frustrations in daily life or not. In future studies, it might be interesting to explore the reasons behind these interindividual differences.

The correlation pattern confirms most of the hypotheses and reveals that active acceptance and resigning acceptance are differentially related to coping styles. Active acceptance is associated with a generally positive outlook and with constructive efforts to shape one’s life; in resigning acceptance, on the other hand, an individual gives up and turns away from the situation. This supports the notion that active acceptance is in fact a helpful reaction to unchangeable situations, whereas resigning acceptance can indicate a problematic reaction. A possible explanation might be that active acceptance helps to withdraw an individual’s energy from a situation where further attempts would be fruitless and redirects the energy into other, more constructive actions. In resigning acceptance however, the individual is in danger of getting caught up in negative inner states and thus to be unable to move on freely.

As can be seen from the results, resigning acceptance was correlated with denial, which is an interesting but unexpected finding. Thus, those individuals who tend to maintain negative thoughts and expectations in stressful situations also tend to deny and ignore negative events.
future- and past-oriented cognitions about unchangeable events, it would be worthwhile to study the difference between a future event, namely death, for realistic acceptance. While resigning acceptance and so-called realistic acceptance (Reed et al., 1994, 1999) used items which referred to a future event, Reed et al. (1994, 1999) used items which referred to a past event, namely death, for realistic acceptance. It would be worthwhile to study the difference between future- and past-oriented cognitions about unchangeable negative events more closely.

What about the relationship between resigning acceptance and so-called realistic acceptance (Reed et al., 1994, 1999)? Although we tried to formulate resigning acceptance in the same way as realistic acceptance, there is cause for doubt. The main difference between these constructs is the time perspective of the items used. While resigning acceptance was assessed in this study with respect to a past event, Reed et al. (1994, 1999) used items which referred to a future event, namely death, for realistic acceptance. It would be worthwhile to study the difference between future- and past-oriented cognitions about unchangeable negative events more closely.

With respect to mental health, the results support the study hypotheses: active acceptance is positively related both to mental health and to behavior control, whereas resigning acceptance and non-acceptance are negatively correlated with mental health. Mentally healthy individuals are more apt to accept actively and show less resigning acceptance and less non-acceptance.

Although the results provide evidence for the postulated distinctions, there are important limitations that make further research necessary. First, due to the cross-sectional design of the study, causal effects and intraindividual changes over time could not be studied. It cannot be inferred from the existing data whether active or resigning acceptance causally influence mental health or not. Also, the question whether active acceptance, resigning acceptance and non-acceptance are consecutive reactions or alternative reactions remains unanswered. Longitudinal studies are necessary to examine the course of acceptance reactions over time.

Second, the use of situation vignettes to measure acceptance reactions is a limitation. Possibly, the reactions to hypothetical situations differ from reactions to real-life situations, which reduces the generalizability of the results. Moreover, the selection of situation has to be taken into account. For this study, we chose situations that were familiar and easily imaginable to most participants, which should increase the validity of the acceptance measures. However, at the same time, this procedure reduces the generalizability of the results with respect to serious events like coming to know that one has a life-threatening disease.

Third, it can be argued that the constructs under investigation, the acceptance reactions, are to some extent confounded with the criterion variables of mental health and coping styles. Indeed, there are similarities among some items of the acceptance questionnaire and the validity measures used in this study. However, as active acceptance, resigning acceptance and non-acceptance were defined and operationalized as reactions to specific situations, they differ from dispositional variables such as mental health or coping styles.

A final limitation is that we did not include variables such as self-concept and optimism which might explain differences in acceptance reactions. Future studies should include these variables to test whether the relation between acceptance reactions and mental health remains significant when, e.g., optimism is controlled for.

Overall, the results of the study suggest that two types of acceptance can be distinguished which are related to indicators of mental health in different ways and which therefore should be taken into account in studies investigating acceptance.

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