Journal of Clinical Geropsychology, Vol. 7, No. 3, 2001

Personality Dysfunction, Coping Styles, and Clinical Symptoms in Younger and Older Adults

Daniel L. Segal,[1,2] **Julie N. Hook,**[1] **and Frederick L. Coolidge**[1]

*This study examined age-related differences in personality disorders, dispositional coping strategies, and clinical symptoms between younger (*n *= 79; age range = 18–29;* M *age = 21.2 years) and older (*n *= 79; age range = 55–89;* M *age = 65.5 years) persons (matched on gender and ethnicity). Participants completed the Coolidge Axis II Inventory (CATI), Coping Orientations to Problems Experienced Scale (COPE), and Brief Symptom Inventory (BSI). Personality results (*t *tests) based on the CATI revealed that older persons were significantly more obsessive–compulsive and schizoid than younger adults but significantly lower on 7 scales, including antisocial, borderline, histrionic, and sadistic. As assessed by the COPE, older adults reported lower levels of dysfunctional coping strategies than younger adults. Specifically, older persons were less likely to use mental disengagement, venting of emotions, and alcohol/drugs to cope with problems. BSI results for clinical symptoms revealed that younger adults were significantly higher on 5 of 9 scales, including anxiety, depression, and hostility. Results suggest that younger adults experience higher levels of personality and clinical symptoms and use more dysfunctional coping strategies than older adults, dispelling the myth that old age is associated with inevitable psychological impairment. Theoretical considerations, clinical implications, and future research ideas are discussed.*

KEY WORDS: personality disorders; coping; clinical symptoms; older adults; age differences.

One might conceptualize personality, coping, and mental state symptoms as strands of a Gordian knot, intricately intertwined and related. Indeed, much psychopathology research relates to one or more of these important domains. Each area, no doubt, contributes strongly to the psychological and social functioning of an individual. Whereas there is a substantial body of research examining diverse mental state symptoms or clinical disorders (e.g., anxiety, depression) in younger and older adult samples, studies pertaining to personality disorders and coping among older persons are less prevalent.

Personality disorders are described in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association [APA], 1994, p. 632) as "enduring patterns of thinking, feeling, and behaving" that are long-standing, long-lasting, inflexible, and maladaptive. Relatively little is known about these disorders in the elderly although

[1]Department of Psychology, University of Colorado at Colorado Springs, Colorado Springs, Colorado.
[2]Present address: Department of Psychology, University of Colorado at Colorado Springs, 1420 Austin Bluffs Parkway, P.O. Box 7150, Colorado Springs, Colorado 80933-7150; e-mail: dlsegal@mail.uccs.edu.

1079-9362/01/0700-0201$19.50/0

recently there has been an increase in investigative attention toward understanding personality disorders in older adults (see recent review by Segal and Coolidge, 1998). For example, researchers have recently studied prevalence of personality disorders in community-dwelling elderly (e.g., Ames and Molinari, 1994; Cohen *et al.*, 1994), geropsychiatric inpatients (Molinari *et al.*, 1994), and chronically mentally ill older adults (Coolidge *et al.*, 2000b). Other studies of the aged have investigated relationships between dysfunctional personality traits and clinical disorders, such as depression (Fogel and Westlake, 1990; Molinari and Marmion, 1995; Segal *et al.*, 1998), anxiety (Coolidge *et al.*, 2000a), and the comorbidity of anxiety and depression (Coolidge *et al.*, 1994). The comorbidity between major psychiatric disorders (Axis I) and personality disorders (Axis II) is now known to be an extensive problem that provides considerable challenge to clinicians who treat elderly clients with multiple and complex disorders (Coolidge *et al.*, 2000a).

There is some controversy in the geropsychological literature regarding whether or not personality disorders decline or "mellow" with advancing age (Coolidge *et al.*, 1992; Molinari *et al.*, 1999; Segal *et al.*, 1996; Segal and Coolidge, 1998). The *DSM-IV* provides some guidance in its statement that antisocial and borderline disorders tend to remit with age, whereas age-related decreases are less likely with obsessive–compulsive and schizotypal personality disorders. In contrast, several researchers have suggested that borderline personality disorder actually worsens with advanced age (Rose *et al.*, 1993; Rosowsky and Gurian, 1991, 1992; Siegel and Small, 1986). In one of the few cross-sectional studies, Coolidge *et al.* (1992) directly compared personality disorder rates in community-dwelling older adults ($n = 36$, M age $= 69.4$ years) and younger adults ($n = 573$, M age $= 24.0$ years). Results showed that the older adults were more schizoid and obsessive–compulsive than the younger adults. There were no age differences on the dependent and avoidant scales, and younger adults were higher on the remaining personality disorder scales.

Coping also plays an important role in psychological adaptation to stress and psychological functioning. Coping has been defined as "an individual's efforts to master demands (conditions of harm, threat, or challenge) that are appraised (or perceived) as exceeding or taxing his or her resources" (Monat and Lazarus, 1991, p. 5). Coping is a clinically relevant construct to investigate because the coping strategies one uses to handle stress are likely related to the severity of distress one experiences. For example, effective use of coping strategies may protect a person from cognitive, environmental, and biological factors that may bring about symptoms of distress. Unfortunately, few studies have examined specifically the coping strategies used by older persons. The coping strategies used by younger persons may differ from older persons because the current cohort of older persons were raised in a different era and have been influenced by different socialization trends. Older adults may also have the advantage of years of experience and wisdom.

In one of the first cross-sectional studies in this area, McCrae (1982) used the Ways of Coping questionnaire to evaluate coping. Results showed that independent of the type of stress faced by older adults, they were less likely to use hostile reactions and fantasy as coping styles compared with younger adults. Folkman *et al.* (1987) also used the Ways of Coping questionnaire to compare coping strategies used by younger adults and older adults, and they found that older adults used more positive reappraisal and distancing than the younger adult comparison group. Conversely, the younger group tended to seek social support more often and used more confrontive coping styles than the older group did. More recently, Diehl *et al.* (1996) assessed age differences related to coping, as assessed by the

California Personality Inventory. Results indicated that, compared to younger adults, older adults were more apt to have increased impulse control and tended to positively evaluate conflict situations. Although these studies lend some insight into differences in coping styles between younger and older persons, they are limited somewhat in that they failed to measure a wide variety of functional and dysfunctional coping strategies. Furthermore, these studies did not assess *typical* coping strategies because they measured coping strategies as situationally specific rather than as a stable disposition. The present study endeavored to expand on existing literature about potentially important effects of aging on three related areas of psychopathology: personality, coping, and clinical symptoms. The purpose, therefore, was to examine, between younger and older adults, age-related differences in personality disorders, dispositional coping strategies, and clinical disorders.

METHOD

Participants and Procedure

The present study was part of a comprehensive evaluation of social and emotional functioning in community-dwelling younger and older adults. Participants were community-dwelling adults who were divided into two groups: younger and older adults. The younger adults ($n = 79$) were students in psychology classes at a midwestern university. Their ages ranged from 18 to 29 ($M = 21.2$, $SD = 3.0$). The older adults ($n = 79$) were either family members or friends of students or recruits from local senior centers. Their ages ranged from 55 to 89 ($M = 65.5$, $SD = 7.8$). The two groups were group matched on gender and ethnicity. A full description of sample demographic characteristics is provided in Table I. Informed consent was obtained from participants who then anonymously completed the

Table I. Demographic Characteristics for Younger ($n = 79$) and Older Adult ($n = 79$) Groups

	Younger		Older		Total	
	n	%	*n*	%	*N*	%
Gender						
Female	48	60.8	48	60.8	96	60.8
Male	30	38.0	30	38.0	60	38.0
Missing	1	1.3	1	1.3	2	1.3
Ethnicity						
White	67	84.8	67	84.8	134	84.8
African American	2	2.5	2	2.5	4	2.5
Asian American	1	1.3	1	1.3	2	1.3
Native American	1	1.3	1	1.3	2	1.3
Missing	1	1.3	1	1.3	2	1.3
Does participant live alone?						
Yes	13	16.5	32	40.5	45	57.0
No	66	83.5	47	59.5	113	71.5
Marital status						
Never married	65	82.3	4	5.1	69	43.7
Married	11	13.9	33	41.8	44	27.8
Divorced	2	2.5	16	20.3	18	11.4
Widowed	1	1.3	21	26.6	22	13.9
Separated	0	0.0	5	6.3	5	3.2

questionnaires. Undergraduates received extra credit for their participation and older adults received a payment of $15.

Measures

Coolidge Axis II Inventory (CATI; Coolidge, 1993)

The CATI is a 225-item self-report measure in which respondents answer using a 4-point Likert scale that ranges from 1 (*strongly false*) to 4 (*strongly true*). It assesses all 10 personality disorders in accordance with *DSM-IV* criteria: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive–compulsive. The CATI includes both personality disorders in the *DSM-IV* appendix for further study: depressive and passive–aggressive personality disorders. Evaluation of two personality disorders from the *DSM-III-R*—self-defeating and sadistic—is also provided. The CATI has been normed on 682 normal adults and has strong psychometric properties (Coolidge, 1993). The CATI has test-retest reliability of .90 within a 1-week interval (Coolidge and Merwin, 1992). Internal consistency (Cronbach's alpha) of the 14 personality disorder scales ranged from .66 (self-defeating) to .87 (dependent), with a median reliability of .76. With regard to discriminant validity, the CATI had a 50% concordance rate with clinicians' diagnoses for 24 patients with personality disorders (Coolidge and Merwin, 1992).

Coping Orientations to Problems Experienced Scale (COPE; Carver *et al.*, 1989)

The COPE scale is a theoretically based 60-item self-report measure, developed with the belief that coping is a stable disposition rather than situationally specific. Participants are instructed to report what they *usually* do under stress. Answers are based on a 4-point scale that is anchored at 1 (*not at all*) to 4 (*a lot*). The COPE consists of three main groupings with five scales per group and four items per scale: (a) *problem-focused coping*: active coping, planning, restraint coping, seeking social support for instrumental reasons, and suppression of competing activities; (b) *emotion-focused coping*: positive reinterpretation and growth, religion, humor, acceptance, and seeking social support for emotional reasons; and (c) *dysfunctional coping*: focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and alcohol/drug use. Carver *et al*. reported alpha reliabilities all above .6 except for the mental disengagement scale (.45). The COPE is widely used in psychosocial research.

Brief Symptom Inventory (BSI; Derogatis, 1993)

The BSI is a 53-item self-report measure that yields scaled scores on nine mental state symptom patterns (anxiety, somatization, obsessive–compulsive, interpersonal sensitivity, depression, hostility, phobic anxiety, paranoid ideation, and psychoticism) as well as an overall index of distress, the global severity index (GSI). Individuals respond to items using a 5-point scale that has anchors at 1 (*not at all*) to 5 (*extremely*). According to Derogatis, internal consistency (coefficient alpha) for the nine symptom patterns ranges from

.71 (psychoticism) to .85 (depression). Test-retest reliability for the nine scales ranges from .68 (somatization) to .91 (phobic anxiety), with a mean of .82. The BSI is widely used in clinical practice and research.

RESULTS

Personality Disorders

Fourteen independent *t* tests were performed on the CATI personality disorder scales. The Bonferroni correction was used to control for the familywise error rate yielding a new significance level ($\alpha = .004$). Complete results are displayed in Table II. As can be seen in Table II, older adults reported significantly higher scores on two scales: obsessive–compulsive and schizoid, thus confirming our hypothesis (one-tailed *t* tests). There were no group differences (two-tailed tests) for five scales: avoidant, dependent, depressive, schizotypal, and self-defeating. Younger adults were significantly higher (two-tailed tests) on seven scales: antisocial, borderline, histrionic, narcissistic, paranoid, passive–aggressive, and sadistic. The highest mean elevations for the younger adults were passive–aggressive, self-defeating, borderline, and narcissistic, whereas the highest scales for the older adults were schizoid, obsessive–compulsive, self-defeating, and avoidant. Notably, only these four scales for the older adults were above the normative mean *T* score of 50. For the younger group, all scales with the exception of schizoid were above the normative mean *t* score of 50.

Coping Strategies

Eighteen independent *t* tests were performed upon COPE clusters and subscales. The Bonferroni procedure was used again ($\alpha = .003$). Results are presented in Table III. For the problem-focused coping cluster, only one group difference emerged: older adults were more likely to employ restraint coping. For the emotion-focused coping cluster, older persons were

Table II. Mean *T* Scores on CATI Personality Disorder Scales for Younger and Older Adults

	Younger		Older			
Personality disorder	*M*	*SD*	*M*	*SD*	*t* value	*p* value
Antisocial	52.1	10.9	44.0	6.9	5.56	.000*
Avoidant	51.1	8.9	51.3	9.4	−0.13	.900
Borderline	53.0	8.2	44.4	6.3	7.40	.000*
Dependent	52.3	8.5	49.4	7.6	2.25	.026
Depressive	52.4	9.3	48.4	9.4	2.72	.007
Histrionic	51.7	9.5	45.7	9.2	4.03	.000*
Narcissistic	52.9	8.2	45.1	7.9	6.02	.000*
Obsessive–compulsive	50.5	9.2	54.5	9.3	−2.73	.004**
Paranoid	52.5	10.5	46.6	8.1	3.97	.000*
Passive–aggressive	53.9	8.5	47.1	8.6	5.03	.000*
Sadistic	51.8	9.6	44.3	6.0	5.94	.000*
Schizoid	47.9	10.5	56.3	9.8	−5.19	.000**
Schizotypal	50.6	8.6	47.4	8.6	2.31	.022
Self-defeating	53.6	7.2	51.8	6.8	1.61	.110

Note. Younger and older adult groups, $n = 79$; Groups matched on gender and ethnicity.
*$p < .004$, two-tailed. **$p < .004$, one-tailed.

Table III. Mean Coping Style Scores for Younger and Older Adults

Coping strategy	Younger		Older			
	M	*SD*	*M*	*SD*	*t* value	*p* value
Problem-focused cluster	52.9	7.7	55.0	9.3	−1.50	.137
Active coping	11.1	2.1	11.6	2.4	−1.18	.242
Planning	11.5	2.4	12.5	2.4	−2.67	.016
Restraint coping	9.6	2.2	10.9	2.2	−3.82	.000*
Support for instrumental reasons	11.0	2.7	10.1	2.3	2.34	.018
Suppression of comp activities	9.7	1.8	10.0	2.7	−1.01	.312
Emotion-focused cluster	53.2	8.7	54.0	9.2	−0.60	.547
Acceptance	11.6	2.5	11.5	2.6	0.16	.876
Humor	9.7	3.0	8.3	3.1	3.01	.003*
Pos reinterpretation & growth	12.4	2.2	12.4	2.1	−0.04	.970
Religion	8.9	4.3	12.2	4.0	−5.06	.000*
Support for emotional reasons	10.7	3.4	9.7	3.0	1.96	.052
Dysfunctional cluster	38.8	6.3	33.3	4.8	6.14	.000*
Focusing on & venting of emotions	10.6	2.8	8.9	2.5	3.86	.000*
Denial	5.8	2.0	5.6	1.8	0.79	.430
Behavioral disengagement	6.2	1.8	6.4	1.9	−0.61	.546
Mental disengagement	10.3	2.5	8.4	2.0	5.16	.000*
Alcohol/Drug use	6.0	3.00	4.1	0.6	5.72	.000*

Note. Younger and older adult groups, $n = 79$; Groups matched on gender and ethnicity; These scales and clusters are from Carver *et al.* (1989); Suppression of Comp Activities = Suppression of Competing Activities; Pos Reinterpretation & Growth = Positive Reinterpretation and Growth.
*$p < .003$.

more likely to use religion, but less likely to use humor. Many differences emerged regarding dysfunctional coping, showing that older adults reported lower levels of dysfunctional coping strategies than younger adults. To cope with problems, elders, in particular, were less likely to use focusing on and venting of emotions, mental disengagement, and alcohol or drugs. Notably, older adults had lower absolute mean scores for each dysfunctional coping strategy, with three of the five subscales reaching statistical significance.

Clinical Symptoms

Ten independent *t* tests were performed upon BSI subscales and the GSI. The Bonferroni correction yielded a significance level of $\alpha = .005$. A complete listing of results for the BSI is provided in Table IV. Results revealed that younger adults were significantly higher on five of nine subscales (anxiety, depression, hostility, interpersonal sensitivity, paranoid ideation) and higher on overall distress (GSI). Interestingly, there were no group differences on somatization, contrary to anecdotal evidence suggesting excessive somatization in older adults. Overall, BSI results indicated that older adults showed significantly less psychopathology than younger adults on five out of nine symptom scales and the GSI.

DISCUSSION

Overall, the present study suggests that younger adults experience higher levels of personality disorder and clinical symptoms and cope with stress in more dysfunctional ways than older adults. Hence, these findings indicate that older adults may have comparatively

Table IV. Mean *T* Scores on BSI Clinical Disorder Scales for Younger and Older Adults

BSI scale	Younger *M (SD)*	Older *M (SD)*	*t* value	*p* value
Anxiety	61.1 (9.9)	54.3 (10.3)	4.23	.000*
Depression	62.1 (9.4)	56.0 (9.4)	4.08	.000*
Hostility	61.7 (9.9)	51.8 (9.1)	6.50	.000*
Interpersonal sensitivity	63.4 (9.1)	55.9 (9.4)	5.05	.000*
Obsessive–compulsive	62.3 (9.4)	59.2 (9.7)	2.04	.043
Paranoid ideation	61.6 (9.7)	57.1 (9.2)	2.98	.003*
Phobic anxiety	56.7 (10.2)	53.2 (9.5)	2.21	.029
Psychoticism	63.8 (11.3)	59.6 (9.3)	2.50	.013
Somatization	58.6 (9.9)	57.2 (10.5)	0.83	.406
Global severity index	64.1 (9.4)	58.2 (9.4)	3.92	.000*

Note. Younger and older adult groups, $n = 79$; Groups matched on gender and ethnicity.
*$p < .005$.

less psychological problems and better coping skills than younger adults, dispelling the myth that old age is associated with inevitable psychological impairment.

Regarding personality disorders, we found that older adults experienced more obsessive–compulsive and schizoid tendencies than younger adults did, replicating results from an earlier and smaller study using the *DSM-III-R* version of the CATI (Coolidge *et al.*, 1992). Our results are also congruent with Molinari *et al.* (1999) who reported higher rates of compulsive personality disorder (as assessed by the MCMI-I) in older versus younger inpatients. We did not confirm elevated rates of dependent personality as in the Molinari *et al.* study. Because the two elevated personality disorders in our study (obsessive–compulsive and schizoid) are characterized by a lack of emotional expressiveness, this finding might suggest that there is a general trend towards reduced emotionality in older adults, perhaps due to age-related biological changes in the brain (Coolidge *et al.*, 1992). No group differences were found on the avoidant, dependent, depressive, schizotypal, and self-defeating scales. Seven of the remaining personality disorders were found at lower rates in the older adults.

How do our findings relate to the claim in *DSM-IV* (APA, 1994) that some personality disorders remit with age, whereas remission is less likely for others? We found that seven of the personality disorders were lower in the elderly group. In contrast, seven personality disorders did not appear to decline with age. Specifically, older adults were higher on two scales (obsessive–compulsive and schizoid), and no differences were found on five scales, suggesting that remission is somewhat more likely than exacerbation, although only half the disorders showed such decline. We found support for the *DSM-IV* contention that antisocial and borderline disorders are likely to remit with age. We also supported the idea that obsessive–compulsive personality disorder might likely increase with aging, but could not find evidence for the increase in schizotypal personality disorder. Our data suggest that schizoid personality disorder (not schizotypal) is likely to become more prominent with age.

Our finding as to lower levels of borderline personality disorder in the older group are in contrast to some case reports of an exacerbation of this disorder (Rose *et al.*, 1993; Siegel and Small, 1986). Although it is possible (even likely) that individual cases of borderline personality may worsen, our results paint a picture of general decline in borderline symptoms as well as other immature and destructive types of personalities (e.g., antisocial, narcissistic, histrionic, and sadistic). One theory explaining development of personality disorders in later

life is that these disorders represent a deterioration of more adaptive personality traits in vulnerable older adults, likely due to an accumulation of stressors in old age. One possible implication of our study is that the adaptive coping strategies used by older persons may actually be a preventative process, reducing likelihood of the transformation of adaptive personality traits into maladaptive traits, despite significant environmental stressors. This theory could explain why older adults have less personality pathology compared to younger counterparts.

An alternative explanation of our results should also be considered, however. It is possible that the lowered rates of personality disorders in the elderly reflect *inadequate criteria* (and assessments based on such criteria) for some personality disorders in that population. As noted by several researchers (e.g., Rosowsky and Gurian, 1991, 1992; Segal and Coolidge, 1998), some criteria for personality disorders seem inappropriate for older persons and their unique biological, cognitive, psychological, and social contexts. Thus, personality disorders might exist at high rates but clinicians and researchers are not detecting them adequately. As noted by Sadavoy (1987), social, physical, and financial restrictions might affect expression of personality disorders among older adults because typical outlets for acting out may be blocked. For example, younger persons may act out through sexual promiscuity, running away, impulsive physical fights, and substance abuse, whereas some older persons may be prohibited from these behaviors by biological, financial, and social limitations. Also illustrative are data from Rosowsky and Gurian (1991) indicating that the *DSM-III-R* had only a 25% sensitivity in identifying clinically diagnosed borderline personality disorder in older patients. In response to this type of problem, several researchers have called for the formal adaptation or refinement of Axis II diagnostic criteria to better capture the expression of personality disorders in older persons (Rosowsky and Gurian, 1991, 1992; Sadavoy, 1996; Segal and Coolidge, 1998), and we concur with this suggestion.

Yet another possibility for our results is that persons with acting-out, impulsive, and destructive personality disorders (i.e., borderline, antisocial) may have excessive early mortality, which would decrease the prevalence figures for these disorders among olders persons. In any case, further study is recommended as to the relevance of criteria for personality disorders among older persons, and as to which specific symptoms of personality disorders are maintained and which decline or remain stable into old age. The best way to resolve these dilemmas would be to conduct longitudinal studies of personality disorders across the life span, which is the only way to specifically measure changes with age, not age-differences. Structured interviews might also be added to enhance reliability and validity of assessment procedures. Therefore, our study is limited in its cross-sectional design as well as the reliance on self-report measures that are inherently biased.

As expected, this research suggests that older adults cope with problems in significantly different ways than do younger adults. Most notably, older adults use dysfunctional coping strategies at lower levels and use some adaptive problem-focused and emotion-focused coping strategies at higher levels than do younger persons. The present findings regarding coping are also in some agreement with the prior literature on this topic. For example, Diehl *et al.* (1996) reported that older adults used more impulse control than younger adults did, both Diehl *et al.* and Folkman *et al.* (1987) found that positive reappraisal was used more by older adults, and Molinari *et al.* (1999) noted that there was more stability and better impulse control with age. In the present study, older adults did employ more restraint coping (e.g., waiting for the most advantageous time to act; showing impulse control), although there

were no group differences for the positive reinterpretation and growth scale as Diehl *et al.* and Folkman *et al.* would suggest. For the functional strategies, older adults were higher on two scales (restraint coping and religion) and younger adults were higher on one scale (humor). This finding may suggest that older adults have an overall tendency to use more functional and serious strategies, whereas younger adults are more able to laugh about and make light of a stressful situation. Older adults may show a tendency to be more religious as death becomes more salient.

An additional finding was that younger adults use comparatively more dysfunctional strategies. The younger adults were higher on the dysfunctional cluster as well as several specific scales (e.g., focusing on and venting of emotions, mental disengagement, and alcohol/drug use). Similarly, McCrae (1982) found that younger adults used more hostility and fantasy. It is also not surprising that the younger group was more likely to cope with problems by using alcohol or drugs because rates for substance abuse are higher in younger than in older adults (Segal *et al.*, 1996). Furthermore, this type of behavior may also be more condoned among younger individuals.

It is likely that a lifetime of problem solving and lessons learned from life experiences have resulted in more efficient and less destructive coping strategies in the aged. Interestingly, there were trends for older adults to be less likely to seek social support from others for either emotional or instrumental reasons. This trend toward independence may reflect the elders' increasing lack of a social network because of death of relatives or friends, but also may be a testament to their ability to adapt. An assessment of coping strategies is recommended for clinical work with older adults so that specific dysfunctional strategies can be reduced and specific functional strategies strengthened. Understanding of coping strategies could help clinicians better tailor their approach towards their specific needs and problems of the older person.

Regarding clinical symptoms, our study suggests that younger adults are more distressed than older adults. In a similar study using the BSI, Hale and Cochran (1992) assessed age-related differences in psychological distress. Their results suggested that older adults reported more physical distress and memory problems. Contrary to these results, our study did not confirm higher levels of somatization among older persons. Despite anecdotal evidence that older adults are excessively bodily focused, our findings may suggest that the current cohort of older adults do not internalize their emotions any more or less than younger adults. A limitation of the Hale and Cochran study is that they focused their analyses on the positive symptom total (an overall distress scale with limited validity; Derogatis, 1993) rather than specific BSI symptom scales. Our study examined cross-sectional rates for each specific BSI symptom scale, which should give a more thorough assessment of clinical disorders in younger and older adults. Our finding that younger adults experience higher levels of depression is in concordance with earlier reports (e.g., Blazer, 1993) suggesting that depression is less prevalent in older adults than in younger adults.

Past research investigating anxiety (Sheikh, 1992) and somatization (Lipowski, 1988) in older adults have reported mixed results as to their prevalence rates. Acierno *et al.* (1994) suggest that older adults are prone to higher levels of psychological, environmental, and physical stress, which would theoretically lead to higher levels of diverse psychiatric symptoms. In contrast, younger adults in this study were significantly more anxious, depressed, hostile, paranoid, and self-doubting (interpersonal sensitivity), and had an overall higher level of psychiatric distress (GSI) compared with older adults. Several reasons are offered

to explain these findings. First, it is possible that the current younger adult population may be facing more psychological and environmental stressors than older adults (uncertainties about their future, peer pressure, increased competition for jobs, increased peer violence), which may lead to symptoms of distress. Or, it is possible that some forms of psychological disturbances may lessen over time perhaps as a function of the accumulation of experience and wisdom.

We suggest that a more plausible explanation (based on our data) is tied to differences in coping abilities. Our results hint at an important association between younger adults experiencing more symptoms of Axis I (and Axis II) disorders and their higher usage of dysfunctional coping strategies. As noted by Rosenbaum (1980), the effective use of coping strategies may protect a person from cognitive and environmental factors that bring about emotional distress. It is possible that, despite being faced with diverse environmental stressors, older persons are able to more effectively cope with stressors and thus may experience lower levels of psychiatric symptoms. Conversely, coping resources of younger adults appear less developed which may lead to greater levels of psychiatric distress. Perhaps the maturity and experience of aging has better equipped older adults to handle the toils, trials, and tribulations of living.

Several limitations of the present study should be noted. Most notably, all assessments were self-report. Although self-report measures do have the advantage of being easier to collect, there are several disadvantages. Self-report measures depend on the respondent's ability to make accurate self-assessment; they depend on the respondent's understanding of the question; and they are subject to the respondent's willingness to disclose information accurately. Future research using structured diagnostic interviews (coupled with self-report measures) and a behavioral assessment of personality and coping would be warranted to advance research in this area. Another limitation was the sampling of younger adults who were all college students from a psychology class. Notably, the rigors of college may have placed additional strains on this younger adult sample, which could be associated with the higher levels of clinical and personality symptoms and more dysfunctional coping. As for the older adults, a more diverse sample was gathered (relatives of undergraduates and recruits from several senior centers). A replication of this study using a broader sample of younger adults should therefore be conducted. The samples for both groups were predominantly White, which limits potential generalization of these findings. Therefore, investigations that assess more diverse samples are needed. Lastly, the design was cross-sectional (not longitudinal), so findings could be attributed to cohort effects and not age changes per se. Nonetheless, this is one of the few cross-sectional studies looking at personality disorders, coping, and clinical symptoms among younger and older community samples.

One hitherto unexplored area of inquiry is that of the interrelationships among personality, coping, and clinical symptoms among older persons. For example, which personality disorders are associated with the most dysfunctional coping patterns? Which clinical symptoms are related to dysfunctional coping? Research could also address the question of which combination of personality traits and coping strategies best predicts various kinds of clinical disorders, such as depression and anxiety. An investigation into the relationship among these three areas would also lend insight into how coping styles may affect the evolution of disorders or play a part in sustaining disorders. Presently, it is not clear whether dysfunctional coping methods exist prior to the onset of symptoms or if they are artifacts or consequences of the disorder. Thus, research examining how specific coping strategies relate to specific

kinds of psychopathology in the aged could shed some light on the development and sustaining features of mental disorders, and these studies should be undertaken. In conclusion, there is no doubt that the association between personality, coping, and clinical disorders is strong and important among older persons. Now is the time to unravel the Gordian knot.

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