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Psychometric Properties of the COPE Scale in Older Adults

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Introduction

Researchers have encountered a number of difficulties with the measurement of coping in general (Coyne & Gottlieb, 2006; Parker & Endler, 1992) and most coping scales lack sufficient validation among older adults.

Building upon the Lazarus and Folkman (1984) theory of coping, Carver, Scheier, and Weintraub (1989) posited three types of coping strategies: problem-focused, emotion-focused, and dysfunctional.

Strategies included in both the problem- and emotion-focused clusters are oriented toward engagement and action in the direction of finding a resolution to a problem, whereas strategies included in the dysfunctional coping cluster are oriented toward disengagement and maladaptive avoidance of a problem.

Carver et al. (1989) created the Coping Orientation to Problems Experienced (COPE) scale to assess the different ways in which people respond to stress. However, it has not been widely used with older adults.

This study explored the reliability and validity of the COPE among community-dwelling older adults.

Problem- and emotion-focused coping were expected to be positively correlated with extraversion, openness, agreeableness, and conscientiousness. In addition, these two coping styles were expected to be negatively related to neuroticism, dysfunctional attitudes, and hopelessness. Expected relationships for dysfunctional coping were in the opposite directions.

Method

Participants and Procedure

Community-dwelling older adults ($N = 109$; M age = 71.4, $SD = 8.2$, range: 60–95 years; 61% female) anonymously completed questionnaire packets.

Measures

Coping Orientations to Problems Experienced Scale (COPE; Carver, et al. 1989) is a theoretically based 60-item self-report coping measure that assesses the different ways in which people respond to stress. Respondents use a 4-point scale ranging from 1 (*not at all*) to 4 (*a lot*) to report what they *usually* do under stress. High scores on each scale indicate the respondent engages in that type of coping frequently. The COPE consists of three main clusters: (a) Problem-focused Coping: Active Coping, Planning, Suppression of Competing Activities, Restraint Coping, and Seeking of Instrumental Support; (b) Emotion-focused Coping: Seeking of Emotional Support, Positive Reinterpretation and Growth, Acceptance, Humor, and Turning to Religion; and (c) Dysfunctional Coping: Focus On and Venting of Emotions, Denial, Behavioral Disengagement, Mental Disengagement, and Drug/Alcohol Abuse.

NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992) is a 60-item self-report questionnaire that assesses five lexically-derived broad domains of personality in normal adults: Neuroticism, Extraversion, Openness to experience, Agreeableness, and Conscientiousness. Items are rated on a five-point Likert scale and raw scores are converted into T-scores, where scores below 45 are considered low, 45 to 55 are average, and above 56 are high. Internal consistency measures for the NEO-FFI ranged from .68 to .86 (Costa & McCrae, 1992) and the validity of the NEO-FFI has been demonstrated through its relationship to both Axis I and Axis II disorders (Trull, Useda, Costa & McCrae, 1995). The NEO-FFI has been successfully utilized in research with older adults (e.g., Duberstein et al., 2000; Useda et al., 2004). Cronbach's alpha coefficients are provided in Table 1.

Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978) is a 40-item self-report measure that assesses attitudes that can predispose a person to depression. Respondents answer using a 7-point scale ranging from 1 (*totally agree*) to 7 (*totally disagree*), with higher scores indicating more dysfunctional thinking. Total possible scores range from 40 to 280. Among older adults, one-, two-, and three-factor structures are of equal validity (Floyd, Scogin, & Chaplin, 2004). The three-factor structure includes perfectionism, social approval, and self-acceptance in older adults. Cronbach's alpha coefficients are provided in Table 1.

Table 1

	<i>Pearson Correlations Between the COPE, NEO-FFI, DAS, and GHS</i>			
	α	Problem-focused	Emotion-focused	Dysfunctional
		NEO-FFI		
Neuroticism	.85	-.31*	-.23	.60**
Extraversion	.78	.33*	.39**	-.12
Openness	.59	-.06	-.21	-.13
Agreeableness	.78	.27*	.34**	-.22
Conscientiousness	.81	.39**	.33*	-.18
		DAS		
DAS Total	.88	-.13	-.16	.35**
DAS Perfectionism	.85	-.15	-.29*	.25*
DAS Social Approval	.77	-.03	-.02	.35**
DAS Self-acceptance	.26	-.21	-.11	.08
		GHS		
GHS Total	.88	-.26	-.54**	.11

$p < .01^*$, $p < .001^{**}$

Geriatric Hopelessness Scale (GHS; Fry, 1986) is a 30-item self-report measure that assesses pessimism and hopelessness in older adults. Respondents answer *true* or *false* to indicate if each statement applies to them. Scores range between 0 and 30, with higher scores indicating greater hopelessness or frequency of negative expectancies for the self or for the future. The scale had excellent internal reliability in the current sample (see Table 1).

Results

Internal consistency (Cronbach's alpha) values were .88 for the problem-focused coping cluster, .85 for the emotion-focused coping cluster, and .77 for the dysfunctional coping cluster.

Correlational analysis revealed small-to-medium positive relationships between problem-focused coping and extraversion, agreeableness, and conscientiousness, and a medium negative relationship with neuroticism.

Emotion-focused coping had medium positive relationships with extraversion, agreeableness, and conscientiousness, a small negative relationship with DAS perfectionism, and a large negative relationship with hopelessness.

Dysfunctional coping had medium-to-large positive relationships with neuroticism, DAS perfectionism, DAS social approval, and overall dysfunctional attitudes.

Discussion

Results indicate the COPE has strong internal consistency in the current sample and correlations were in the expected directions, providing modest evidence of convergent validity. Results also provide support for the notion that problem-focused, emotion-focused, and dysfunctional dispositional coping strategies should be measured separately.

Unexpectedly, problem- and emotion-focused coping were mostly unrelated to dysfunctional attitudes. Also unexpectedly, dysfunctional coping was unrelated to all of the personality traits besides neuroticism, as well as unrelated to hopelessness.

Limitations of the study include the use of a relatively homogeneous convenience sample, exclusive use of self-report data, and correlational analysis, which prevents the determination of causation.

Further validation of the COPE among older adults should include more demographically diverse samples, longitudinal methodology, and a factor analysis of the three underlying coping clusters.

In summary, the results provide strong evidence for reliability and modest evidence for validity of the COPE.