

# **The cohesion between living situation, loneliness, depressive symptoms, the preference for solitude and emotional dampening in a Dutch sample of older adults**

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This research aimed to give some insight into the unique and combined effects of living situation, loneliness, depressive symptoms, the preference for solitude and emotional dampening on the wellbeing of older adults. An interviewed sample of 164 Dutch adults aged 70 and over was used for regression analyses. Indicating that loneliness predicts lower life-satisfaction and more depressive symptoms. Furthermore, living in a care facility was associated with more loneliness and more depressive symptoms in older adults. These findings correspond with earlier research. However, although expected, the preference for solitude and emotional dampening of negative emotions did not predict life satisfaction or depressive symptoms. It is therefore important to investigate whether emotional dampening is actually an existing process in the aging group and maybe it manifests differently than we expected it to. The preference for solitude should be examined cross cultures, because this seems to have different effects in different countries. A last implication for future research is to use a larger group of care facility residents.

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## *Preface*

When I think of older adults, I think of the wisest people among society with the most life experience. My interest for this group of people has grown as I developed an interest in neuropsychology and as I volunteered in a nursing home. Thus, deciding on a subject for my thesis was a simple task. The past few months I have not only learned about all the aspects that come with growing older, but I really enjoyed myself during the interviews and made some friends as well. I met all sorts of people, from a former internationally famous ballroom dancer, to housewives who never really left their childhood environment. Some of the elderly were so lovely that I wished they were my grandparents (as I don't have my grandparents anymore) and some of these people I actually visited after the interview for a cup of coffee. Even though I always carried sympathy for elderly, through this experience my respect and appreciation for them has only grown. Not in the least, because most young people do not think of the struggles that the elderly face. Some of the older adults are so lonely and so socially isolated, I cannot imagine what that would be like. I wish I could help them all and I can only hope that I will not have to suffer from loneliness in my older days. However, I met some very inspiring people who were still so full of life and energy that I felt like they were more active and were more socially involved than me.

I want to thank all the people who helped me with my interviews and I am very grateful for the hospitality of the older adults who allowed me a view into their personal lives. Furthermore, I would like to thank Aafke Heude, Ashley van Geel and Eline van Basten for their pleasant collaboration in this study. They were a big help in times of frustration and were very inspiring to me. Finally, I would like to thank our thesis supervisor Anneke Vedder and Henk Schut, for their patience, their inspiration and their comments.

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## **Introduction**

In the Netherlands many care facilities have been closing their doors since January 2014 due to government cuts. This means that more older adults have to age in place and that they cannot always receive the proper care they need. These changes have several implications for the well-being of the elderly. However, literature concerning this subject is very contradictory. As some found higher levels of mental well-being in the community dwelling (Dobrzyn-Matusiak, Marcisz, Bak, Kulik & Marcisz, 2014; Noro and Aro, 1997), others found higher levels of mental well-being among those who live in care facilities (Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo-Perez & Martinez-Martin, 2011; Choi, Ransom & Wyllie, 2008; Jongenelis, Pot, Eisses, Beekman, Kluiters & Ribbe, 2004). Given the unique characteristics of late life, such as losing friends and family through death, the loss of social roles, a decline in mobility, illness and a decline in the size of their social network (Pinquart & Sörensen, 2001; Wrzus, Hänel, Wagner & Neyer, 2013) it is important to understand the changes that older adults experience and how living situation can influence these changes.

In 2012, almost 50% of the 75+ group in the Netherlands felt lonely and this percentage even increased with age, thereby almost 10% of the elderly who lived in a care facility in the Netherlands were alone on the holidays (GGD, CBS and RIVM, 2012). Loneliness is strongly associated with depression and both are associated with a decline in well-being (Cacioppo et al., 2006; Golden et al., 2009; Prieto-Flores et al., 2011; Theeke, 2010; Tiikkainen and Heikkinen, 2005). However, the prevalence of depression seems to decline with age, while the prevalence of subsyndromal depression increases with age (Trimbos, 2008; Oxman & Hull, 2001). All in all, life satisfaction does not seem to decline with age (McAdams, Lucas & Donnellan, 2012). This might be due to positive experiences of aloneness or the preference for solitude (Toyoshima & Sato, 2015) and a dampened frequency and intensity of emotional experience (i.e. emotional dampening; Shiota & Neufeld, 2014; Gross, Carstensen & Pasupathi, 1997). This study aims to give insight in the influence of all the above factors. More specifically the current research question was: ‘What is the relationship between living situation, loneliness, the preference for solitude, emotional dampening, depressive symptoms and life satisfaction in older adults?’

## Loneliness

Loneliness is a subjective and negative experience, which can be felt when a person is not satisfied with the quantity or quality of his or her relationships (Perlman and Peplau 1981). Loneliness is not necessarily characterized by a small number of relationships. Whether a person feels lonely depends on his or her relationship requirements. Feeling lonely is more strongly associated with qualitative than with quantitative characteristics of relationships (de Jong Gierveld 1998). Two components of loneliness can be distinguished; emotional and social loneliness. In which emotional loneliness is characterized by the absence of an intimate relationship and social loneliness is characterized by the absence of a broader, engaging social network (Weiss, 1973).

As moving to a residential care facility is accompanied by a shift from one's mundane environment to a new and unknown one (Grenade & Boldy, 2008), aging in place is usually believed to present the best opportunities for socializing with family and friends (Rojo-Perez, Fernández-Mayoralas, Rodríguez-Rodríguez & Rojo-Abuin, 2007). Older adults living in a residential care facility seem to experience more feelings of loneliness, possibly by the separation from their social networks and activities, which are often located close to their former homes (Reed, Roskell Payton & Bond, 1998; Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo Perez & Martinez-Martin, 2001). Additionally, residents of residential care facilities might have difficulties engaging in new relationships with other residents as a result of a cognitive and physical decline in both themselves as well as their peers (Pleschberger, 2007).

### Depression

Loneliness is often been recognized as a unique risk factor for depressive symptoms (Cacioppo et al., 2006; Golden et al., 2009; Prieto-Flores et al., 2011; Theeke, 2010, Tiikkainen and Heikkinen, 2005). Although older adults often feel lonely, depression in older adults is easily missed and consequently undertreated (Cole & Denduruki, 2003). This might be due to the fact that a lot of elderly do not meet the DSM-criteria for depression, even though they have several depressive symptoms.

Older adults who live in a care facility seem to be at greater risk of developing depressive symptoms than are the community dwelling (Gurland et al., 1979). This might be due to health-related factors like pain, stroke, and functional limitations as they are associated with both sub-clinical and major depression. Research by Choi, Ransom and Wyllie (2008) found

several causes for depression of elderly living in a nursing home by interviewing them. “The dominant themes were loss of freedom and continuity with their former life; feelings of isolation and loneliness; not enough privacy, loss of autonomy, ambivalence toward cognitively impaired residents; death and grief; and lack of meaningful residential activities”.

### Paradox

On the contrary of what might be expected to be the result of an increase of loneliness with age, the amount of diagnosed depression declines with age (Trimbos, 2008). An explanation for this paradox might be found in the preference for solitude. Although aloneness is frequently associated with feelings of loneliness, spending occasional time away from others has been said to predict psychological well-being (Luanaigh & Lawlor, 2008). Feelings of loneliness can give someone the opportunity to gain better self-insight and to become a more attentive and reflective person. The attitude towards being alone may determine increases or decreases in loneliness. Being able to enjoy solitary activities is associated with positive mental health (Leary, Herbst and McCrary, 2003). Research of Toyoshima and Sato (2015) revealed that the preference for solitude decreased negative affect after controlling for the influence of loneliness. These finding may indicate that the preference for solitude promotes emotional well-being and can protect (lonely) people against depression.

Another possible explanation for this paradox might be postulated by Carstensen and colleagues (1999), they hypothesize a change in social motivation in older age that explains the decline in social contact in later life in their socioemotional selectivity theory. Older adults become more selective and put effort in a smaller group of people who are important to them (Carstensen et al., 1999). This selectiveness may strengthen the quality of social and emotional experiences. Moreover, older adults might try to appreciate the positive things in life better as they spend less attention to the negative aspects in life, considering they feel like they only have limited time (Carstensen et al., 1999).

This emotional dampening of negative emotions might be associated with a decrease in depressive symptoms. Several studies found an association between increased age and improved emotion regulation and emotional stability (Carstensen et al., 2000; Charles et al., 2001). More specifically, age-related declines in negative emotional experience and increases in positive emotional experience were brought to light across age cohorts (Carstensen et al. 2000; Gross et al. 1997 Charles et al., 2001). Analysis of neural responses to emotional

stimuli, using fMRI, reveals age related changes in brain activation. Older adults show greater amygdala activation in response to positive stimuli in comparison to younger adults and relatively less activation in response to negative stimuli (Mather et al., 2004). Other research by Labouvie-Vief, Lumley, Jain & Heinze (2003) observed a reduction across adulthood in intensity of cardiac reactivity during relived anger, fear, sadness and happiness. These changes may reflect age-related shifts in emotion regulation (Scheibe & Carstensen, 2010), which promote emotional well-being in later life and may prevent older adults from depression.

### ***Confounders***

As stated above, age has a positive relationship with loneliness (Trimbos, 2008) and a negative relationship with major depressive disorder (Oxman & Hull, 2001). Some other variables were found to influence the relationship between living arrangement, the preference for solitude, emotional dampening, loneliness and depressive symptoms, and should be taken into account when analyzing the data. First of all, older women report more often that they are lonely than do older men (Pinquart & Sörensen, 2000). Secondly, the prevalence of depression appears to be higher in the lower socio-economic status population (SES)(Lorant et al., 2003). Furthermore, a higher educational level was associated with a lower prevalence of loneliness (Sundström, Fransson & Malmberg, 2009) and with less depressive symptoms (Bjelland et al., 2008). Additionally, marital status can have a big influence on feelings of loneliness, especially widowhood is correlated with (emotional) loneliness. Finally, a low self-reported health (SRH) is often associated with depressive symptomatology (Heikkinen & Kauppinen, 2004). Consequently, age, gender, SES, educational level, marital status and SRH will be considered as possible confounding variables.

The hypotheses are:

H1: Loneliness is associated with (a) lower life satisfaction and (b) more depressive symptoms.

H2: The preference for solitude is associated with (a) higher life satisfaction and (b) less depressive symptoms.

H3: Emotional dampening (of negative emotions) is associated with less depressive symptoms.

H4: Living in care facilities is associated with (a) more loneliness, (b) more depressive symptoms and (c) decreases in life satisfaction.

These hypotheses will be tested by interviewing a sample of older adults aged 70 and over from both the community dwelling and those who live in care facilities. It is expected that higher scores of loneliness will result in a lower grade of life satisfaction and higher scores of depressive symptoms. Furthermore, it is expected that older adults who live in their own homes will obtain lower scores on loneliness & depressive symptoms and higher scores on life satisfaction than the older adults who live in care facilities. Lastly, it is expected that older adults who have higher scores on emotional dampening and the preference for solitude will have less depressive symptoms, since these factors are thought to have a protective influence against depression.



## Method

### *Participants*

The sample consisted of one-hundred-seventy participants aged 70 years and over, living in four different regions of the Netherlands (Den Bosch, Utrecht, IJsselstein & Roosendaal). Participants were enlisted in the study between October and December via flyers, through approaching care facilities and acquaintances of the researchers and by convenience sampling. Exclusion criteria were cognitive impairment and insufficient Dutch language skills. The mean age of the sample was 79 (SD= 5.91), further sociodemographic characteristics of the sample are displayed in table 1.

Table 1. *Sociodemographic characteristics of the sample*

Characteristics	<i>n</i> (%)
Gender	
Women	111 (65.3%)
Men	59 (34.7%)
Living situation	
Independent (at home)	126 (74.1%)
Dependent (in a care facility)	40 (23.5%)
Other (living group)	4 (2.4%)
Marital status	
Never married	10 (5.9%)
Married or cohabiting	81 (47.6%)
Widowed	70 (41.2%)
Divorced	9 (5.3%)
Educational level	
Primary education	27 (15.8%)
Lower vocational education	86 (50.5%)
Medium vocational education	29 (17.0%)
Higher vocational education/university	28 (16.4%)
Socioeconomic status (SES)	
Low	44 (25.9%)
Medium	103 (60.6%)
High	23 (13.5%)

### *Design*

This study employed a cross-sectional, between subjects design, where scores on the independent variables gender, age, living situation, education level, marital status, SES, the preference for solitude and emotional dampening (of negative emotions) were assessed on the dependent variables; life-satisfaction, depressive symptoms and loneliness.

### *Procedure*

Participants were approached via flyers, connections and by approaching care facilities. Only older adults of 70 years and older were allowed to participate in this study. Participants were asked if they were interested in an interview of approximately 60 minutes concerning their well-being. If they were interested, the interviewer made an appointment to conduct the interview at the participant's home or at another place of the participants choice. All participants provided informed consent before beginning any study procedures. The interview would start with some basic demographic questions, about age, marriage, children, etcetera. Thereafter, the question concerning emotional dampening was asked, followed by the newly constructed Emotional Dampening Scale (EDS). After that, three other questionnaires were presented, starting with the 'The Loneliness Scale' (De Jong Gierveld & Van Tilburg, 1999), followed by the Geriatric Depression Scale 15 (GDS 15; Yesavage & Sheikh, 1986) and lastly a Dutch translation of the Preference for Solitude Scale (Burger, 1995). Participants were given the option to read and write the answers themselves, but if they preferred, the researcher would continue to ask these questions and write the answers for them. Finally, participants were asked to rate their health and their life-satisfaction. The full structured interview, with all used scales, can be found in the appendices.

### *Measuring instruments*

#### Emotional dampening: single item and EDS

Measuring emotional dampening started with the question: 'Do you feel like you have less emotional highs and lows in your life at this moment compared to when you were younger, or do you have just as much or more emotional highs and lows?' Then the self-constructed Emotional Dampening Scale (EDS) was presented. This scale consisted of 12 items, 6 pleasant (1-6) and 6 unpleasant (7-12) items. Participants had to rate the emotional impact of nice, sad or annoying day-to-day situations on a Visual Analogue Scale (VAS; Albersnagel, 1988) of 0-100, in which 0 made them feel very unpleasant and 100 was very pleasant. They

had to rate these situations twice by placing a vertical mark on a 15cm line. The first rating would concern their emotional state in current situations and the second would concern their emotional state in these situations around 40 years of age. Nice situations included: 'I get a pleasant visitor' or 'Someone tells a nice joke'. Unpleasant situations included: 'I see unpleasant or terrible things on the news' or 'Someone interrupts me while I am talking'. The difference between the 'now' scores and the 'past' scores would indicate emotional dampening. The higher the score, the more emotional dampening. However, negative scores could indicate that participants got more sensitive and emotional over time. Unfortunately, the EDS for negative emotions had a poor internal consistency ( $\alpha = .50$ ) and the EDS for positive emotions had a questionable internal consistency ( $\alpha = .63$ ). The single question for emotional dampening did not correlate with the EDS, but as the current existing literature seems to mark the importance of emotional dampening of negative emotions as a protective factor against depressive symptoms, we will only use the negative scale of the EDS for further analysis. Also, the dampening of positive emotions seems to be a feature and part of the definition of depression rather than a predictor of depression (Beblo, Fernando, Klocke, Griepenstroh, Aschenbrenner & Driessen, 2012).

Loneliness: The loneliness scale (De Jong Gierveld & Kamphuis, 1999)

The Loneliness Scale contains 11 items, of which 5 are positively formulated (1, 4, 7, 8, 11) and 6 are negatively formulated (2, 3, 5, 6, 9, 10). These items can either be answered with a 'yes', a 'no' or 'more or less'. If a negatively formulated item is answered with a yes, this will result in 1-point. If a positively formulated item is answered with a no, this will result in 1-point. Every point is an indication of loneliness and the higher the score, the lonelier someone appears to be. Scores are obtained by adding up scores on all items, resulting in a minimal score of 0 ranging to a maximum score of 11. An example of a positively formulated item is 'I know enough people that I can fully rely on', an example of a negatively formulated item is 'I often feel let down'. The Loneliness scale is a reliable measuring instrument, with a Cronbach's alpha of  $\alpha = .87$  (Penninx et al., 1996). The Cronbach's alpha in this study was  $\alpha = .82$ .

Depressive symptoms: Geriatric Depression Scale 15 (GDS-15; Yesavage & Sheikh, 1983).

The GDS-15 consisted of 15 questions that could be answered with 'yes' or 'no'. 10 of the 15 questions were negatively formulated (2, 3, 4, 6, 8, 9, 10, 12, 14, 15) and 'yes' for an answer on these questions resulted in a point. The positively formulated questions (1, 5, 7, 11, 13)

would result in one point if answered with ‘no’. An example of a negatively formulated item is ‘Do you feel like your life is empty?’ and an example of a positively formulated question is ‘Are u satisfied with your life?’. Scores on the total list are obtained by adding up scores on all items, resulting in a minimal score of 0 ranging to a maximum score of 15. A total score of 6 or more on this questionnaire might indicate a depression. The Geriatric depression Scale is a reliable measuring instrument with a Chronbach’s alpha of  $\alpha=.94$  (Fountoulakis et al., 1999) and an adequate construct validity (Friedman et al., 2005). The GDS-15 had an acceptable internal consistency in the current study ( $\alpha=.70$ ).

#### The preference for solitude: a translated version of the Preference for Solitude Scale (Burger, 1995).

The Preference for Solitude Scale consisted of 12 items in which the participant gets a forced choice option between two statements. They have to choose the statement that best describes themselves. Every item consists of A. a statement that is typical for people who have a preference for solitude and B. a statement that is not typical for people who have a preference for solitude. The questionnaire has a maximum score of 12 with higher scores indicating greater preference for solitude. An example of a forced choice option is: A. ‘When I have to spend several hours alone, I find the time productive and pleasant’ or B. ‘When I have to spend several hours alone, I find the time boring and unpleasant’. Several studies support the psychometric adequacy of the PSS (Cramer & Lake, 1998). The current study found an alpha coefficient of  $\alpha=.70$ .

#### Self-rated Health and Life satisfaction: single questions

Finally, participants were asked to rate their health and their life-satisfaction on a scale from 1 to 10.

#### *Statistical analysis*

The data was entered into Statistical Package for the Social Sciences (SPSS), the 20th edition. Firstly, based on effect sizes in the literature, a power analyses was executed and revealed that a sample size of 107 would be sufficient for the detection of associations between variables ( $\alpha=.05$ ; power: 95%). Secondly, normality tests were performed to analyze if a normal distribution was present for all scores. Spearman correlations were used for the preliminary analysis of all variables. To investigate the main analyses: the relative cohesion of living situation, loneliness, depressive symptoms, life satisfaction, the preference for solitude

and emotional dampening, a multiple logistic regression was carried out. In addition, SRH, age, gender, SES, educational level and marital status were used as covariates into the analyses.

## Results

### Descriptives

The descriptives of the outcomes of the different used scales and questions are displayed in table 2. Interestingly, the current sample has relatively low scores on loneliness and depressive symptoms and relatively high scores on SRH and life-satisfaction.

Table 2. *Descriptives of the scores from the used scales and questions*

	<b>N</b>	<b>Min.</b>	<b>Max.</b>	<b>M</b>	<b>SD</b>
Positive ED	170	-235	350	-.16	49.71
Negative ED	170	-180	225	.50	50.21
Loneliness Scale	170	0	10	1.55	2.28
GDS	170	0	12	2.68	2.32
Preference for solitude	167	0	11	5.53	2.70
SRH	170	2	10	7.15	1.41
Life-satisfaction	170	5	10	8.03	1.03

### Preliminary analysis

Spearman correlations were used to explore relationships between the variables of interest. Table 3 (page 16) shows the intercorrelations of the assessed variables.

### Assumptions

Before conducting the main analysis, the distributional shapes were checked for the assumption of normality. The histograms of the PSS, life satisfaction and the EDS showed sufficient evidence of normality. However, the GDS-15 and the Loneliness Scale were positively skewed, but giving the large sample that was used, a regression analysis should be robust against this skewed data. Furthermore, the scatterplots showed sufficient linearity and Mahalanobis distance, standardized residuals and Cook's distance did not suggest the

presence of any influential outliers in the regression analyses. Lastly, the assumptions of homoscedasticity and multicollinearity were both not violated.

### Regression analyses

A hierarchical regression analysis was conducted for every dependent variable: loneliness, life satisfaction and depressive symptoms. In every first step of the regression, six confounders were entered: age, gender, marital status, SES, educational level and SRH. In every second step of the regression analyses, living situation was entered. Finally, in the last step, the preference for solitude and emotional dampening (of negative emotions) were entered and depending on the outcome variable, loneliness or depressive symptoms was also entered in the last step. Four participants were excluded from analysis, because they did not fit in either the category 'living in a care facility' or 'lived at home', they lived in a community in which they would care for each other.

Overall, the models for the dependent variables life satisfaction, depressive symptoms and loneliness explained respectively 30%, 41% and 38% of the variance. It was expected that loneliness is associated with (a) lower life satisfaction and (b) more depressive symptoms. Both relationships were found to be significant: loneliness is associated with lower life satisfaction ( $\beta = -.20$ ,  $t(162) = -2.36$ ,  $p < .02$ ) and with more depressive symptoms ( $\beta = .44$ ,  $t(162) = 6.29$ ,  $p < .00$ ).

It was expected that emotional dampening would predict a decrease in depressive symptoms, however this relationship was not found to be significant ( $\beta = .04$ ,  $t(162) = .65$ ,  $p = .52$ ).

Furthermore, it was expected that the preference for solitude would predict a decrease in depressive symptoms and life satisfaction. These relationships were also not significant, the preference for solitude did not predict decreases in depressive symptoms ( $\beta = .02$ ,  $t(162) = .32$ ,  $p = .75$ ) or increases in life satisfaction ( $\beta = .04$ ,  $t(162) = .52$ ,  $p = .60$ ).

Living in care facilities was associated with more loneliness ( $\beta = .72$ ,  $t(162) = 3.41$ ,  $p < .00$ ) and more depressive symptoms ( $\beta = .16$ ,  $t(162) = 2.02$ ,  $p < .05$ ). However the relationship between living in care facilities and life satisfaction was not apparent ( $\beta = -.15$ ,  $t(162) = -1.89$ ,  $p = .06$ ).

### *Confounders*

Interestingly, some other variables appeared to influence the dependent variables as well. Age ( $\beta = -.23$ ,  $t(162) = -3.08$ ,  $p < .00$ ) and SRH ( $\beta = .31$ ,  $t(162) = 3.96$ ,  $p > .00$ ) were significant predictors for life satisfaction. SRH was also a significant predictor for depressive symptoms ( $\beta = -.40$ ,  $t(162) = -5.35$ ,  $p < .00$ ) and age was a significant predictor for loneliness ( $\beta = .26$ ,  $t(162) = 3.44$ ,  $p < .00$ ). Gender, marital status, educational level and SES were no significant predictors in any of the models.

### *Explorative research: mediation*

To explore whether the relationship between depressive symptoms and living situation was mediated by loneliness, a mediation analysis was performed. This analysis showed a significant indirect effect of loneliness on depressive symptoms through living situation ( $b = .76$ , BCa CI [0.3306, 1.4008 ], representing a medium effect,  $k^2 = .1697\%$  BCa CI [.078, .270] (Preacher & Kelley, 2001).

Table 3. *Intercorrelations for all assessed variables*

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
1. Gender	-											
2. Living situation	.09	-										
3. Marital status	.19*	.22**	-									
4. SES	-.13	-.18*	-.02	-								
5. Level of education	-.29**	-.18*	-.09	.27**	-							
6. Loneliness scale	.08	.31**	.21**	-.16*	-.20*	-						
7. GDS	.07	.24**	.10	-.22**	-.13	.39**	-					
8. Preference for solitude	.02	-.02	.03	-.04	.05	.00	.04	-				
9. SRH	.01	-.09	-.04	.27**	.19*	-.22**	-.43**	-.05	-			
10. Life-satisfaction	.00	-.24**	.10	.14	.02	-.30**	-.35**	.06	.33**	-		
11. Age	.12	.37**	.24**	-.11	-.16*	.29**	.22**	.01	-.11	-.30**	-	
12. Positive emotional dampening	-.024	.00	-.12	-.15*	.00	.06	.30**	.07	-.26**	-.06	.00	-
13. Negative emotional dampening	-.21**	-.09	.06	-.05	.16*	.00	.01	.00	.01	-.08	-.06	-.05

\* $p < .05$ ; \*\* $p < .01$



## **Discussion**

### *Findings*

This study aimed to give some insight into the combined relationship between living situation, loneliness, the preference for solitude, emotional dampening of negative emotions, depressive symptoms and life satisfaction in older adults. The results of this study suggest that older adults who are lonely have a lower life satisfaction and show more depressive symptoms, which means that hypothesis 1 (a & b) can be accepted. Explorative research revealed that living situation mediated in the relationship between loneliness and depressive symptoms. These findings correspond with previous research of Prieto-Flores and colleagues (2011) and Cacioppo and colleagues (2006). Just as loneliness, SRH appeared to predict life satisfaction and depressive symptomatology. Age predicted loneliness and life-satisfaction. Furthermore, the results of this study suggest that living in a care facility is associated with more loneliness and more depressive symptoms among older adults, meaning hypothesis 4 (a&b) can be accepted. These findings are in line with previous research (Reed et al. 1998; Prieto-Flores, et al. 2001). However, in spite of a visible trend, hypothesis 4c must be rejected, because the relationship between living in a care facility and life satisfaction was not apparent. This finding falls in line with earlier research of McAdams, Lucas & Donnellan (2012). Possibly, some negative effects of living in a care facility are counteracted by change in a positive direction in other aspects of life, such as receiving better care.

Although hypothesized, the preference for solitude did not predict life satisfaction or a decrease in depressive symptoms. This might be explained by cultural differences. The only research that directly revealed an association between the preference for solitude and a decrease of negative affect consisted of a Japanese sample (Toyoshima & Sato, 2015). However, in a Chinese sample the preference for solitude showed a positive relationship with negative affect (Wang, 2015). These contradictory results may indicate that the preference for solitude might be more desirable in individualistic cultures rather than in collectivistic cultures, but as both samples are Asian and no results were found in this study that pointed toward either direction, the preference for solitude is an interesting subject for future research. Emotional dampening of negative emotions did not predict a decrease in depressive symptoms either, even though this was hypothesized. An explanation for this might be found in the fact that the EDS had a questionable Chronbach's alpha. Another explanation could possibly come from research of Scheibe, Schepes and Staudinger (2015). They revealed that

older adults have a preference to choose for distraction over reappraisal and that this preference for distraction is much higher in older adults compared to younger adults. This could mean older adults avoid negative emotions and situations by distracting themselves and thus experience less negative emotions. If so, this means that their negative emotions are not generally less intense when actually confronted with negative situations in late-life. Madden (2007) revealed that older adults often use expectations or cues to guide subsequent attention so that they can prepare the implementation of distraction when confronted with an emotional cue. Concluding from the above, it is important to investigate if emotional dampening is actually an existing process in the aging group and whether possibly avoidance and distraction from negative emotions can better explain the age-related declines in negative emotional experience and increases in positive emotional experience.

#### *Strengths, Limitations & Future research*

Although most of the investigated relationships have been studied before, this is, to our knowledge, the first study among a large Dutch sample to investigate the combined effects of living situation, depressive symptoms, loneliness, life satisfaction, the preference for solitude and emotional dampening of negative emotions in older adults. However, some limitations of this study should be taken into consideration. As mentioned before, one limitation of this research might be the relatively low reliability of the EDS, which may have influenced the further analyses. If the EDS will be used in future research, it is desirable to improve its psychometrical qualities.

A second impediment of this study is that causal relationships cannot be inferred and reciprocal and reverse effects cannot be ruled out, given the cross-sectional nature of this study. Consequently, an implication for future research is to replicate the current study in a longitudinal design.

Third, for this study several ways of data collection have been used, namely structured interviewing, self-administration and a combination of both. Participants were interviewed, because it allows for the clarification of interesting and relevant issues raised by participants (Hutchinson & Skodal Wilson, 1992) and it can help participants to recall information for questions involving memory (Smith, 1992). They were offered the option of self-administration so that they might feel more private in the case of sensitive questions which could result in a higher data quality (Bowling, 2005). However, because of the inconsistent

procedure of data collection, the data might be biased. For this reason it is advised to use a consistent procedure for data collection in future research.

A fourth limitation may lie in the manner participants were recruited. A convenience sample was used, that evolved in a snowball method. This could have led to an unrepresentative sample, which might be the reason for the skewed distribution of the loneliness and depressive symptoms scores. Furthermore, the snowball method recruits people through a social network and this way socially isolated adults might unwillingly be excluded, while these people can be relevant in the current study. However, advantages of the snowball method are for example gaining trust and gaining access to older adults that would otherwise be difficult to reach (Atkinson & Flint, 2001).

Fifth, although independence of observations was assumed, this assumption was violated. Both partners of married couples have been interviewed and given their shared environment, they cannot be regarded as independent subjects. Future studies should take this shared environment of married couples into account and refrain from interviewing both partners.

Another impediment of the current study might be the fact that all questionnaires were self-report questionnaires which can be biased by social desirability. Also, some of the participants were acquaintances of the researchers, which could lead to desirable answers. However, participants were assured that their answers would stay anonymous and most older adults seemed very eager to speak openly about their lives.

A final important limitation was the fact that in this sample all sorts of assisted living were taken together as one variable ('living in a care facility'), because otherwise this group would have been too small. Very few participants lived in a nursing home where they were fully dependent on the staff. Moreover, it was very difficult to approach these nursing homes. Most nursing homes felt like they would burden their residents if they would let them participate. Others said that they recently finished a likewise research. Furthermore, a lot of nursing home residents suffer from dementia and are therefore not fit for this research.

### *Conclusion & implications*

In short, older adults who live in a care facility have a higher risk for loneliness and depressive symptoms. Although it was expected that living in a care facility is associated with lower life-satisfaction, this relationship was not found, however a trend was visible and future research in the Netherlands might prove this relationship. Future research should investigate the cultural differences in the preference for solitude and examine if emotional dampening is actually an existing process in the aging group. Maybe a decline in negative affect in (some) older adults can be explained by a higher valence of avoidance and distraction from negative emotional cue's or situations. All in all, the results of this research indicate that care facilities should improve their mental care as their residents show more depressive symptoms and are more lonely than their community dwelling peers do.

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## Appendices

### 1. Interview scheme

Proefpersoonnummer:			
<p>Allereerst wil ik u heel hartelijk bedanken dat u mee wilt werken aan ons onderzoek naar ouderen en welzijn. Zoals u misschien al weet bestaat het onderzoek uit een aantal vragen, welke ik in de vorm van een interview aan u ga stellen. Het interview zal ongeveer een uurtje duren. Voordat we beginnen, wil ik u vragen om een toestemmingsverklaring in te vullen. In dit formulier geeft u aan dat u op de hoogte bent van uw recht om het onderzoek ten allen tijden vroegtijdig te beëindigen, en dat wij de plicht hebben om uw gegevens geheel anoniem te verwerken. U mag tussendoor gerust vragen om een pauze, dat is echt helemaal geen probleem. Heeft u vooraf nog vragen, voordat we gaan beginnen? Grijze vragen niet stellen, maar zelf invullen. De vragenlijsten op pagina's 3 en 4 kunnen de participanten eventueel zelf invullen.</p>			
Geslacht:	Man		Vrouw
Woonsetting:	Thuis	Verzorgingshuis	Verpleeghuis
			Anders, namelijk:
1. Heeft u kinderen en hoeveel? Leven zij nog?			
2. Heeft u kleinkinderen en hoeveel?			
3. Heeft u broers of zussen en hoeveel? Leven zij nog?			
4. Bent u getrouwd?			
5a. Leeft uw partner nog?			
5b. Hoelang geleden is hij of zij overleden?			
6. Woont u alleen of met andere mensen? Met wie?			
7. Wat is uw hoogst genoten opleiding?			
8. Wat is de hoogst genoten opleiding van uw partner?			
9. Wat was uw beroep?			
10. Wat was het beroep van uw partner?			
11a. Waaruit bestaat uw maandinkomen?	AOW	Aanvullend pensioen (of individuele pensioensregelingen)	Inkomen uit vermogen (rente, aandelen, e.d.)
			Sociale toeslagen (zorg- en huurtoeslag, e.d.)
11b. Sociaaleconomische status:	Laag (alleen AOW of er is sprake van sociale toeslagen)	Middel (er is sprake van aanvullend pensioen)	Hoog (er is sprake van inkomen uit vermogen)
12. Wat is uw geboortedatum?			
13. Wat is uw nationaliteit?			
14a. Heeft u een godsdienst of levensovertuiging? Welke?			

14b. Hoe vaak bezoekt u een bijeenkomst of dienst?	N.V. T.	Meer dan 1 keer per week	1 keer per week	2 keer per maand	1 keer per maand	Minder dan 1 keer per maand

Aanvullende informatie:

Als u uw gevoelens van nu vergelijkt met die van vroeger, heeft u dan het idee dat deze afgevlakt zijn of zijn er evenveel pieken en dalen als vroeger?

Meer pieken en dalen	Geen verschil	Minder grote pieken en dalen	Geen pieken en dalen meer
0	1	2	3

Ik beschrijf zo meteen 12 dagelijkse situaties en dan mag u aangeven hoe u zich in deze situatie voelt. Vervolgens mag u aangeven hoe u zich vroeger zou voelen in deze situaties. U geeft dit aan door een streepje te zetten op een lijn, waarbij de linkerkant van de lijn staat voor een zeer negatief gevoel en de rechterkant staat voor een zeer positief gevoel.

Bijvoorbeeld. 'Ik krijg een snoepje', daar word ik nu een beetje blij van, dus ik zet een streepje op ongeveer de helft van de lijn. Als kleuter zou ik daar echter heel erg blij van worden van een snoepje en dus zet ik een streepje helemaal rechts van de lijn. Snapt u hoe dit werkt? We willen echter niet vergelijken met de situaties in de kindertijd, maar we willen kijken naar hoe u zich zou hebben gevoeld bij de situatie rond uw 40<sup>e</sup> levensjaar.

Laat de participant zijn antwoord geven op het losse invulformulier. Vertaal de streepjes op de schaal naar een getal tussen de 0 en 100. Verschilscore = Score van vroeger - score van nu

	Nu		Vroeger		Verschil score
1. Ik krijg een (leuk) cadeautje					
2. Iemand zegt iets aardigs					
3. Er wordt een (grappige) grap gemaakt					
4. Er komt aangenaam bezoek					
5. Ik kijk mijn favoriete tv-programma					
6. Het is mooi weer					
7. Ik zie iets vervelends op het journaal	100 -	=	100 -	=	
8. Ik laat een pot appelmoes kapot vallen	100 -	=	100 -	=	
9. Iemand zegt iets onaardigs over mij	100 -	=	100 -	=	
10. Het is slecht weer en ik moet naar buiten	100 -	=	100 -	=	
11. Ik moet lang wachten	100 -	=	100 -	=	
12. Iemand laat mij niet uitpraten	100 -	=	100 -	=	
Totaalscore:					

Er volgen nu enkele uitspraken. Deze uitspraken zijn opgetekend uit de mond van een groot aantal mensen met wie eerder uitgebreid over hun situatie is gesproken. Wilt u van elk van de volgende uitspraken aangeven in hoeverre die op u, zoals u de laatste tijd bent, van toepassing is? Zet een kruisje bij het antwoord dat op u van toepassing is.

	Ja	Min of meer	Nee
1. Er is altijd wel iemand in mijn omgeving bij wie ik met mijn dagelijkse probleempjes terecht kan			
2. Ik mis een echt goede vriend of vriendin			
3. Ik ervaar een leegte om mij heen			

4. Er zijn genoeg mensen op wie ik in geval van narigheid kan terugvallen			
5. Ik mis gezelligheid om mij heen			
6. Ik vind mijn kring van kennissen te beperkt			
7. Ik heb veel mensen op wie ik volledig kan vertrouwen			
8. Er zijn voldoende mensen met wie ik mij nauw verbonden voel			
9. Ik mis mensen om me heen			
10. Vaak voel ik me in de steek gelaten			
11. Wanneer ik daar behoefte aan heb, kan ik altijd bij mijn vrienden terecht			
Totaalscore:			

Dit gedeelte van het interview bevat vragen waarop u met ja of nee kunt antwoorden. U geeft het antwoord dat het beste weergeeft hoe u zich de afgelopen week, met vandaag erbij, heeft gevoeld. Bij het door u gekozen antwoord zet u een kruisje.

	Ja	Nee
1. Bent u innerlijk tevreden met uw leven?		
2. Bent u met veel activiteiten en interesses opgehouden (gestopt)?		
3. Hebt u vaak het gevoel dat uw leven leeg is?		
4. Verveelt u zich vaak?		
5. Hebt u meestal een goed humeur?		
6. Bent u wel eens bang dat u iets naars zal overkomen?		
7. Voelt u zich meestal wel gelukkig?		
8. Voelt u zich vaak hopeloos?		
9. Blijft u liever thuis dan uit te gaan en nieuwe dingen te doen?		
10. Hebt u het gevoel dat u meer moeite heeft met het geheugen?		
11. Vindt u het fijn om te leven?		
12. Voelt u zich nogal waardeloos op het ogenblik?		
13. Voelt u zich energiek?		
14. Hebt u het gevoel dat uw situatie hopeloos is?		
15. Denkt u dat de meeste mensen het beter hebben dan u?		
Totaalscore:		



Het volgende gedeelte bestaat steeds uit twee uitspraken. Het is de bedoeling dat u de uitspraak kiest die het beste omschrijft hoe u bent. In sommige gevallen passen geen van beide uitspraken bij u of vindt u beide uitspraken juist wel bij u passen, kies dan voor de uitspraak die het meest op u van toepassing is. Zet een kruisje onder het antwoord dat het beste bij u past.



1. Ik vind het fijn om onder de mensen te zijn.	Ik vind het fijn om alleen te zijn.
2. Ik zorg er altijd voor dat ik wat tijd voor mijzelf heb op een dag.	Ik zorg er altijd voor dat ik wat tijd doorbreng met andere mensen op een dag.

3. Een belangrijk aspect bij het kiezen van een hobby, vind ik contact met interessante mensen.	Een belangrijk aspect bij het kiezen van een hobby, vind ik dat ik alleen kan zijn.
4. Nadat ik een aantal uren heb doorgebracht met andere mensen, voel ik mij gestimuleerd en energiek.	Nadat ik een aantal uren heb doorgebracht met andere mensen, heb ik meestal de behoefte om alleen te zijn.
5. Als ik alleen ben, besteed ik mijn tijd vaak productief.	Als ik alleen ben, verspil ik vaak mijn tijd.
6. Ik voel vaak de behoefte om er alleen op uit te gaan.	Ik voel zelden de behoefte om er alleen op uit te gaan.
7. Ik hou van vakanties op plaatsen waar veel mensen zijn en waar veel te beleven is.	Ik hou van vakanties op plaatsen waar weinig mensen zijn en waar sereniteit en rust is.
8. Wanneer ik uren alleen moet zijn, vind ik dat saai en onaangenaam.	Wanneer ik uren alleen moet zijn, vind ik dat productief en aangenaam.
9. Als ik meerdere uren in een vliegtuig zou moeten zitten, zou ik graag naast iemand zitten waar ik een aangenaam gesprek mee kan voeren.	Als ik meerdere uren in een vliegtuig zou moeten zitten, zou ik deze tijd graag in stilte door willen brengen.
10. Tijd doorbrengen met andere mensen is vaak saai en oninteressant.	Tijd alleen doorbrengen is vaak saai en oninteressant.
11. Ik heb een sterke behoefte om andere mensen om mij heen te hebben.	Ik heb geen sterke behoefte om andere mensen om mij heen te hebben.
12. Er zijn vaak momenten dat ik graag alleen ben.	Er zijn zelden momenten dat ik graag alleen ben.
<b>Totaalscore:</b>	
Ik wil u vragen om een rapportcijfer aan uw lichamelijke gezondheid te geven. Hoe tevreden bent u met uw gezondheid op een schaal van 1 tot 10?	
Tot slot wil ik u vragen hoe tevreden u in het algemeen met uw leven bent. Welk rapportcijfer zou u aan het leven geven?	
Lantaarnpaalaantekeningen:	



2. VAS emotional dampening



Voorbeeld: Ik krijg een snoepje

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



1. Ik krijg een cadeautje

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



2. Iemand zegt iets aardigs

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



3. Er wordt een grap gemaakt

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



4. Er komt aangenaam bezoek

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



5. Ik kijk mijn favoriete tv-programma

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



6. Het is mooi weer

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



7. Ik zie iets vervelends op het journaal

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



8. Ik laat een pot appelmoes kapot vallen

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



9. Iemand zegt iets onaardigs over mij

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



10. Het is slecht weer en ik moet naar buiten

Nu:  \_\_\_\_\_ 



Vroeger:  \_\_\_\_\_ 



11. Ik moet lang wachten

Nu:  \_\_\_\_\_ 

Vroeger:  \_\_\_\_\_ 

12. Iemand laat mij niet uitpraten

Nu:  \_\_\_\_\_ 

Vroeger:  \_\_\_\_\_ 

### 3. Folder



De Universiteit Utrecht doet onderzoek naar het welzijn van ouderen. Wij zijn op zoek naar 70-plussers om hen hierover te interviewen. Het interview duurt ongeveer een uurtje en kan op een afgesproken plaats of bij u thuis plaatsvinden. Onder het genot van een kopje thee willen wij u dan graag wat vragen stellen.

Met het onderzoek willen wij inzicht krijgen in hoe het welzijn van ouderen verbeterd kan worden. Het interview is geheel vrijwillig en de gegevens zullen anoniem worden verwerkt.

## Gezocht: Mensen van 70 jaar en ouder voor een interview over welzijn



Aafke



Amber




Ashley



Eline

Voor meer informatie of het maken van een afspraak kunt u contact opnemen:

 [welzijninterview@gmail.com](mailto:welzijninterview@gmail.com)

 06 47 37 53 48



**Universiteit Utrecht**

#### 4. Syntax

*DATASET ACTIVATE DataSet1.*

*RELIABILITY*

*/VARIABLES=V19\_1 V19\_2 V19\_3 V19\_4 V19\_5 V19\_6*

*/SCALE('Positieve emotionele demping') ALL*

*/MODEL=ALPHA*

*/STATISTICS=DESCRIPTIVE SCALE CORR*

*/SUMMARY=TOTAL.*

*RELIABILITY*

*/VARIABLES=V19\_7 V19\_8 V19\_9 V19\_10 V19\_11 V19\_12*

*/SCALE('Negatieve emotionele demping') ALL*

*/MODEL=ALPHA*

*/STATISTICS=DESCRIPTIVE SCALE CORR*

*/SUMMARY=TOTAL.*

*RELIABILITY*

*/VARIABLES=V21\_1 V21\_2 V21\_3 V21\_4 V21\_5 V21\_6 V21\_7 V21\_8 V21\_9 V21\_10  
V21\_11 V21\_12 V21\_13*

*V21\_14 V21\_15*

*/SCALE('GDS-15') ALL*

*/MODEL=ALPHA*

*/STATISTICS=DESCRIPTIVE SCALE CORR*

*/SUMMARY=TOTAL.*

*RELIABILITY*

*/VARIABLES=V22\_1 V22\_2 V22\_3 V22\_4 V22\_5 V22\_6 V22\_7 V22\_8 V22\_9 V22\_10  
V22\_11 V22\_12*

*/SCALE('PSS') ALL*

*/MODEL=ALPHA*

*/STATISTICS=DESCRIPTIVE SCALE CORR*

*/SUMMARY=TOTAL.*

*RELIABILITY*

*/VARIABLES=V20\_1 V20\_2 V20\_3 V20\_4 V20\_5 V20\_6 V20\_7 V20\_8 V20\_9 V20\_10  
V20\_11*

*/SCALE('ALL VARIABLES') ALL*

*/MODEL=ALPHA*

*/STATISTICS=CORR.*

*CORRELATIONS*

*/VARIABLES=V18 NegEd Posed*

*/PRINT=TWOTAIL NOSIG*

*/MISSING=PAIRWISE.*

*CORRELATIONS*

*/VARIABLES=V1 V2\_a MS V13 V9 V19\_vershil V20\_totaal V21\_totaal V22\_totaal V23  
V24 leeftijd*



```

    PosEmDemp NegEmDemp
    /PRINT=TWOTAIL NOSIG
    /MISSING=PAIRWISE.
NONPAR CORR
    /VARIABLES=V1 V2_a MS V13 V9 V19_verschil V20_totaal V21_totaal V22_totaal V23
V24 leeftijd
    PosEmDemp NegEmDemp
    /PRINT=SPEARMAN TWOTAIL NOSIG
    /MISSING=PAIRWISE.

DESCRIPTIVES VARIABLES=V1 V2_a MS V9 V13 V19_verschil Lonely GDS15 PSS V23
V24 age Posed NegEd
    /STATISTICS=MEAN STDDEV VARIANCE RANGE MIN MAX KURTOSIS SKEWNESS.

DATASET ACTIVATE DataSet1.
DESCRIPTIVES VARIABLES=GDS15 PSS V23 V24 Lonely Posed NegEd
    /STATISTICS=MEAN STDDEV MIN MAX.

REGRESSION
    /DESCRIPTIVES MEAN STDDEV CORR SIG N
    /MISSING LISTWISE
    /STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP
    /CRITERIA=PIN(.05) POUT(.10)
    /NOORIGIN
    /DEPENDENT V20_totaal
    /METHOD=ENTER V1 MS V9 V13 V23 leeftijd
    /METHOD=ENTER V2_a
    /METHOD=ENTER V21_totaal V22_totaal
    /SCATTERPLOT=(*ZRESID ,*ZPRED) (*ZRESID ,*ZPRED)
    /RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID)
    /CASEWISE PLOT(ZRESID) OUTLIERS(2)
    /SAVE PRED ZPRED ADJPRED MAHAL COOK LEVER ZRESID DRESID SDRESID
SDBETA SDFIT COVRATIO.

REGRESSION
    /DESCRIPTIVES MEAN STDDEV CORR SIG N
    /MISSING LISTWISE
    /STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP
    /CRITERIA=PIN(.05) POUT(.10)
    /NOORIGIN
    /DEPENDENT V24
    /METHOD=ENTER V1 MS V9 V13 V23 leeftijd
    /METHOD=ENTER V2_a
    /METHOD=ENTER V21_totaal V22_totaal NegEmDemp
    /SCATTERPLOT=(*ZRESID ,*ZPRED) (*ZRESID ,*ZPRED)
    /RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID)
    /CASEWISE PLOT(ZRESID) OUTLIERS(2)
    /SAVE PRED ZPRED ADJPRED MAHAL COOK LEVER ZRESID DRESID SDRESID
SDBETA SDFIT COVRATIO.

```

```

REGRESSION
/DESCRIPTIVES MEAN STDDEV CORR SIG N
/MISSING LISTWISE
/STATISTICS COEFF OUTS CI(95) R ANOVA COLLIN TOL CHANGE ZPP
/CRITERIA=PIN(.05) POUT(.10)
/NOORIGIN
/DEPENDENT V21_totaal
/METHOD=ENTER V1 MS V9 V13 V23 leeftijd
/METHOD=ENTER V2_a
/METHOD=ENTER V22_totaal NegEmDemp V20_totaal
/SCATTERPLOT=(*ZRESID ,*ZPRED) (*ZRESID ,*ZPRED)
/RESIDUALS DURBIN HISTOGRAM(ZRESID) NORMPROB(ZRESID)
/CASEWISE PLOT(ZRESID) OUTLIERS(2)
/SAVE PRED ZPRED ADJPRED MAHAL COOK LEVER ZRESID DRESID SDRESID
SDBETA SDFIT COVRATIO.

```

*DATASET ACTIVATE DataSet1.*

```

REGRESSION
/DESCRIPTIVES MEAN STDDEV CORR SIG N
/MISSING LISTWISE
/STATISTICS COEFF OUTS R ANOVA COLLIN TOL CHANGE ZPP
/CRITERIA=PIN(.05) POUT(.10)
/NOORIGIN
/DEPENDENT V24
/METHOD=ENTER age V1 MS V13 V9 V23
/METHOD=ENTER V2_a
/METHOD=ENTER PSS NegEd GDS15 Lonely.

```

The syntax for the mediation analysis was not included since the PROCESS tool by Hayes did not support this function.