Life satisfaction and mental ill-being of young Poles in times of uncertainty

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Abstract:

In recent years, Europe, and especially Central and Eastern Europe, has experienced events that have profoundly impacted its economy, labour market, security, social landscape, and public health. As the geopolitical and socio-economic landscape is subject to constant change, young people are among the most heavily impacted by these consequences. Unable to predict the future, they may be prompted to ask existential questions about the meaning of life, which are closely connected with issues of life satisfaction and mental health. Recent reports confirm this trend, showing that young Poles face significant mental health challenges, even despite conflicting data regarding their general life satisfaction.

This article aims to provide insights into the factors that may influence the life satisfaction and mental ill-being of young Poles, who are at the forefront of these changes. The analyses are based on representative data for Poland from the European Social Survey. To address the research questions and test the hypotheses, Complex Sample General Linear models were used. The results show that, in general, life satisfaction is associated with the degree of control respondents perceive they have over their lives, their mental health, and the social context in which they live. Social context is especially important for young Poles. While the importance of social context is also visible for mental ill-being, the pattern of association is different compared to that observed for life satisfaction. Furthermore, health-related predictors are more important, specifically for young people, than they were for life satisfaction.

◄ Julia Curyło, *Entropy*, 2019

1. Introduction

1.1. Growing uncertainty

In recent years, the world—and especially the border region of Central and Eastern Europe—has experienced events that have profoundly reshaped the conditions in which Europeans live. The COVID-19 pandemic transformed work practices, mainstreaming remote and hybrid models that remained popular even after the lifting of restrictions and the end of enforced social isolation (Adamowicz, 2022; Pracuj.pl, 2024). The virus proved physically draining for those who recovered from it and had a lifestyle-altering impact on the broader population. However, its most profound consequences were observed in the decline in mental health. The prevalence of anxiety, depression, insecurity, and feelings of loneliness, exacerbated by social isolation and shifting economic prospects, has disproportionately affected adolescents and young adults (Almeida et al., 2022; Chi et al., 2021; Scholz, 2021; WHO, 2022).

The pandemic came to a sudden and illusory end as public attention shifted to the Russian invasion of Ukraine. Although the conflict did not pose an immediate threat to Poles and other European citizens, it led to a mass influx of immigrants, triggering changes in the labour market, housing, and the broader economy. Most importantly, it intensified the uncertainty that had already been introduced by the pandemic.

As the rules of the game have been changing constantly, adolescents and young adults remain among the most heavily impacted groups. For members of Generation Z and Millennials, the proliferation of uncertainty and the experience of multiple crises have coincided with their transition into adulthood or pivotal moments in their careers and family lives. A recent study shows that adults in Poland (aged 18–44) are most concerned about mass immigration from Africa and the Middle East and the outbreak of another world war (68% each, combining "very" and "slightly" concerned responses). Other major concerns include the concentration of power and the erosion of democracy (65%), a potential Russian invasion of Poland (62%), and the negative impact of artificial intelligence (AI) development (61%), which is potentially the next major game-changer for young people's position in the labour market (Scovil, 2025, p.4). Interestingly, in recent research (Raven et al., 2021, p. 41), only 10% of young people (aged 18–30) perceived AI as the greatest threat they face.

In ever-changing times of crisis, when it is difficult to predict the immediate future or identify clear rules and developmental paths to guide one's life decisions, questions about the meaning in life may emerge (Kozera-Mikuła, 2020, p. 10; Opozda, 2024, pp. 85–86, 89). They inevitably involve reflections on purpose-giving values and intersect with broader issues of happiness, satisfaction, and well-being (Kozera-Mikuła, 2020; Mariański, 2021, pp. 11–12; Martela et al., 2023; Opozda, 2024, 89–91; Zawadzka et al., 2017). It could then be expected that adolescents and young adults would exhibit lower levels of subjective well-being, greater difficulty in finding meaning in life, and, consequently, more severe mental health problems. And yet, some contradictory or misleading data can be found.

1.2. Overview of recent research regarding the well-being of Polish youth

Eurostat (2025) data show that in 2022, Polish youth (aged 16–29) exhibited the highest level of overall life satisfaction across the European Union (EU) countries considered. This value dropped in subsequent years, although Polish youth still had the third-highest level in 2023 and fourth-highest in 2024. A CBOS (*Centrum Badania Opinii Społecznej/Public Opinion Research Center*) flash report (Feliksiak, July 2025, p.7) revealed that when asked about emotions felt the day before, young people (aged 18–24 and 25–34) most often felt joy, happiness, and satisfaction (65% and 66%). Notably, no other age group had a larger share of people who felt these emotions the day before.

However, there is also evidence that there are serious problems with mental health among Polish youth. Raven et al.'s report (2021, pp. 21, 55) revealed that Poles aged 18–24 are less optimistic and less likely to have a sense of purpose in life than those aged 25–30. The results also show that Poles aged 18–30 experience anxiety and emotional problems related to the COVID-19 pandemic and the complexity of life in the contemporary world. According to the 2021/2022 HSBC (*Health Behaviour in School-Aged Children*) study (Cosma et al., 2023, pp. 29–32), Polish children aged 11, 13, and 15 were ranked 42nd, 43rd, and 43rd, respectively, out of 44 countries in terms of life satisfaction. Even worse results can be observed for the WHO-5 Well-being Index, as they were ranked 43rd, 44th, and 44th out of 44 countries.

Even more insights can be derived from the report that summarizes the "Młode Głowy" ("Young Heads") project, in which 184,447 students (selected through purposive sampling) aged 10–21 completed a survey about their mental health. The authors observed that 52.4% of adolescents feel unmotivated to do anything, 28% lack the will to live, 58.4% sometimes feel useless, 46% have very low self-esteem, 37.% feel lonely, 37% have sleep problems, 39.2% had suicidal thoughts, 18.6% even planned to commit suicide, 29.3% show signs of depression, and 10.5% feels that nobody truly accepts them. Notably, adolescents who felt a sense of agency were significantly less likely to exhibit signs of depression or have suicidal thoughts (Dębski & Flis, 2023, pp. 9, 14, 17, 19, 23–24, 44–45).

1.3. Correlates of well-being

The preceding reflections suggest that adolescents and young adults in Poland struggle with feelings of meaninglessness in life. Reported feelings of loneliness, not being accepted, depression, anxiety, suicidal tendencies, boredom, negative affect in general, and apathy are indicative of this (Kozera-Mikuła, 2020, p. 14; Krok, 2018, pp. 97–98; Mariański, 2021, p. 18; Opozda, 2024, p. 89; Wojtyra, 2024, p. 208). There is a substantial body of research that shows that meaning in life, life satisfaction, happiness, mental health, and, more broadly, subjective well-being, are positively correlated concepts (i.a.: Kozera-Mikuła, 2020, p. 14; Krok, 2018; Mariański, 2021, pp. 11–12; Martela et al., 2023, p. 504; Zawadzka et al., 2017). Notably, life satisfaction and meaning in life are closely linked, as one definition states: "Subjective life satisfaction—that is, perceiving purpose and meaning in life—results from a person's orientation toward values that give meaning and substance to human existence" (Opozda, 2024, p. 89). Therefore, life satisfaction should be considered the close proxy for meaning in life (Kozera-Mikuła, 2020, p. 21; Opozda, 2024, p. 88) and subjective well-being (Kopycka & Petelewicz, 2019, pp. 35–36).

Zawadzka et al. (2017, p. 65) investigated the relationship between meaning in life (dependent variable) and satisfaction with life among 3695 Polish adolescents aged 13–17[1], and found a strong association between high meaning in life and satisfaction with life. Other positive associations included family economic status and physical health. Hult et al. (2023, pp. 1, 6, 12–13) investigated the subjective well-being (a combination of happiness and satisfaction with life) of NEET (*Not*

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1   The sampling frame was not clearly defined.

in *Education, Employment or Training*) youth aged 15–29, based on ESS (*European Social Survey*) data from 34 countries between 2010 and 2018. Their results showed that for both men and women, the strongest predictor is social activity (measured by the frequency of meeting with friends, relatives or colleagues, and participation in social activities), followed by a higher-order value related to self-enhancement.

Meanwhile, using ESS Round 10 data from 31 countries for people aged 15–35, Stanojević et al. (2025, pp. 80, 83) showed that the strongest predictors of life satisfaction were marital status (married or in a relationship), employment, ethnic discrimination, and frequency of meeting friends, relatives or colleagues; age and higher education were also statistically significant.

Krok (2018) conducted two studies with participants aged 16–20 (195 in the first study, 189 in the second)[2]. The results showed that life satisfaction is moderately associated with all dimensions of personal meaning; however, this relationship is more strongly associated with the presence of meaning in life than with the search for meaning.

Chi et al. (2021, pp. 3, 6) researched indicators of mental health problems using a random sample of schools from a province in China, involving 1794 participants aged 15–18. Key predictors included gender, fear of COVID-19, physical activity, and nutrition. Santini et al. (2021, pp. 2, 9–10) used data from ESS Round 7 for 19 countries. They showed that both family conflicts and financial strain increased the likelihood of symptoms such as depression, strong dissatisfaction with life, strong unhappiness, and loneliness.

2   In the first study, the sampling frame was not clearly defined. In the second study, the author stated that participants were "randomly recruited" (p. 101)

1.4. Research questions and hypotheses

Reflecting on the considerations already presented, this article aims to answer the following questions:

1. What changes have occurred in recent years regarding life satisfaction and mental ill-being among young Polish people?
2. What current factors influence the subjective well-being (life satisfaction) and mental ill-being of young people in Poland?
3. Are there any differences between age groups in terms of factors that affect the life satisfaction and mental ill-being of young people in Poland?

Based on the recent literature, the following hypotheses are proposed:

H1: Social contacts and activities will be positively associated with life satisfaction and negatively with mental ill-being, with this association being more pronounced in the youngest group.

Social predictors are expected to be the strongest overall, especially for young Poles. Solecki's report (2023, pp. 16, 41) shows that adolescents aged 11–15 (non-random sample) prioritize love, friendship, and having a happy family. Meanwhile, using a sample of students from randomly selected high schools in Poland, Boguszewski (2022a, pp. 7, 63) found that 57% of adolescents consider love and friendship among their top three goals. Opozda (2024, p. 94), citing research from 2020/2021 on a random sample of 1003 young adults aged 18–24, reports that love, having trust and friends, and having a happy family are the top values that give life meaning.

H2: Childhood adversity will be associated with both life satisfaction and mental ill-being, with a stronger association in the youngest group.

This association was demonstrated by Santini et al. (2021), although not specifically

for Poland or differentiated by age groups, and based on older data.

H3: A strong commitment to values will be positively associated with life satisfaction and negatively with mental ill-being, with a stronger association among younger age groups.

This hypothesis is grounded in theories that link life satisfaction, mental decline, and changing values in times of uncertainty and the transition to adulthood. Thus, individuals who adhere to values are expected to experience less mental fatigue and greater life satisfaction. The more values a person adheres to, the more resilient they are likely to be. Similarly, religiosity is likely to offer strong guidance during periods of doubt.

2. Methodology

2.1. Data and weighting

To answer the research questions and test the hypotheses, ESS databases were used. ESS is a biennial cross-sectional and cross-national opinion survey conducted in European countries (and Israel) since 2001. It aims to provide high-quality data gathered through a rigorous scientific process that adheres to the highest methodological standards. Both the data and the methodological documentation are freely available on the ESS website (ESS ERIC, n.d.-a). All participating countries must follow the sampling guidelines and use random probability sampling methods to deliver samples that are representative of all people aged 15 or older (ESS ERIC, n.d.-c).

The trend analyses presented in the article are based on data from all available ESS rounds, while all inferential models (and descriptive statistics) used data only from Round 11 (2023/2024) (ESS ERIC, 2012, 2018, 2023a-e, 2025a-c). For this study, only data for Poland were analyzed. Although data were originally collected through face-to-face interviews, several countries, including Poland, switched

to self-completion in round 10 due to safety concerns during the COVID-19 pandemic (ESS ERIC, n.d.-b).

The ESS provides users with several types of weights to correct for sampling design and related errors: design weight (correcting for sampling design differences), population weight (adjusting for population size), and post-stratification weight (adjusting for auxiliary data such as age groups, gender, education, and region to reduce sampling error and non-response bias). The recommended weight is the analysis weight (anweight), which combines other weights and is therefore considered the most universal (ESS ERIC, n.d.-d; Kaminska, 2020).

The ESS documentation and datasets include these weights and necessary sample design indicators, which can be used to specify complex samples so that statistical software can correctly apply weights (Kaminska, 2020, pp. 6, 10). All analyses in this article, except for descriptive statistics, apply the anweight and complex sample design when possible. However, design indicators are not available for Poland for rounds 1–4. As a result, values counted for these rounds are weighted using analysis weight but do not benefit from the complex sample design approach. Comparisons for Rounds 5–11 show the same results whether a complex design was specified or not, so there should be no loss of accuracy for earlier rounds. This applies to the plots presented in the article.

Data preprocessing was limited to merging the main ESS data file with SDDF files (which included sample design indicators), as well as filtering out redundant variables and transforming variables.

2.2. Variables

The main analyses were conducted using the Complex Sample General Linear Models (CSGLM) method. In SPSS (*Statistical Package*

for the Social Sciences), this method performs linear regression analysis (IBM, 2021, p. 17) and thus requires a quantitative dependent variable. The analyses use two dependent variables. The first is the level of life satisfaction (LFS), measured on an 11-point scale (0–10, where 10 means "Extremely satisfied").

The second dependent variable is mental ill-being (MIB). The ESS partially adopted the 10-item short form CES-D scale (*Center for Epidemiologic Studies Depression Scale*). Six of the ten items from the short CES-D form were included in the ESS questionnaire, supplemented with two additional items from the full 20-item CES-D scale (see: Andresen et al., 1994). The ESS questionnaire includes questions about the frequency of experiencing the following within the previous week: feeling depressed, happy, lonely, or sad; feeling that doing anything requires effort; having restless sleep; enjoying life; and feeling unable to get going.

Frequency was measured on a four-point scale where 1 = "None or almost none of the time, and 4 = "All or almost all of the time". Questions about enjoying life and happiness were reverse-coded, and then all questions were decreased by 1, resulting in a 0–3 scale consistent with the original CESD-10 scale. MIB is the average score across these variables[3], ranging from 0–3.

Additionally, the same variables were used to create a binary depression (DEP) predictor. Respondents scoring 8 or above were coded as 1, indicating symptoms of depression/mental ill-being[4]. The cut-off of 8 was chosen due

to the reduced number of items compared to the regular 10-item short form (see: *Ibidem*).

For comparisons between age groups, dummy variables were created. AGE<=24 represents adolescents and young adults aged 15–24, and AGE25–34 represents young adults aged 25–34; adults aged 35 and above constitute the reference category. The first group comprises Generation Z, and the second includes the oldest members of Generation Z and the youngest Millennials. Most respondents from the younger group experienced COVID-19 during their education or at the beginning of their professional career, likely affecting their social ties and mental health. The 25–34 group mostly completed their education before COVID-19. They are entering the labour market, developing careers, and starting families; as such, they are in different life situations than the first group. The older group comprises individuals who are more settled in life. Therefore, each group may face different stressors.

Other variables, recoded into a binary form, were grouped into six categories. Household-related variables refer to childhood adversity, including the frequency of severe financial difficulties (FFD), serious family conflicts (FSC) while growing up, and the respondent's opinion on current household income (FHI).

Social variables include situations in which other people *are there for the respondent* and in which *respondents are there for others*. The first subgroup includes the frequency of participating in social activities compared to respondents' peers (PSA), the frequency of socializing with friends, relatives and colleagues (SOC), and the number of people with whom the respondent can discuss intimate and personal matters (NPD). The second subgroup includes looking after or helping other people

due to health problems or age (HOP) and volunteering for non-profit or charitable organisations (VOL). The latter subgroup is interesting, since *being there for other people* should be an important factor that contributes to the meaning in life (Kozera-Mikuła, 2020). Variables in the former group should be closely connected with mental well-being, as indicated in recent reports on issues experienced by adolescents (e.g., "Młode Głowy"). For young people, having friends and being popular is a major "currency" and frame of reference for their social position.

The faith-related group is based on the idea that faith in a higher power and adherence to related rules may provide meaning and mental resilience. Variables for this group refer to frequency of attendance at religious services (FRS) and self-assessed religiosity (SAR).

Health-related variables include self-assessed general health (SAH) and being hampered in daily activities by health problems (HDA). DEP is also included in models predicting LFS. Depending on their severity, health problems may decrease respondents' quality of life and thus affect life satisfaction and mental health. DEP clearly refers to mental health, while other variables are more general, although the wording of the HDA question includes mental health issues.

The approach to life predictors refers to the degree of control (COL) respondents have over their lives and the number of values (VAL) they strongly agree with. COL might be considered an outcome of the respondents' proactivity and resilience, while VAL reflects the strength of their guiding principles. A summary of all transformations with cut-off points is given in Table 1.

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3 *Cronbach's α* = 0.85, N = 8 items, unweighted data from ESS Round 11 for Poland. For Rounds 7, 6, and 3, *α* was above 0.8.

4 These items were provided for Rounds 3, 6, 7, and 11; however, in Rounds 3 and 6, sadness was not included. The same cut-off point remained, and the procedure was not changed when counting values

for Graph 4. Thus, the threshold for ill-being was relatively higher than in Rounds 7 and 11.
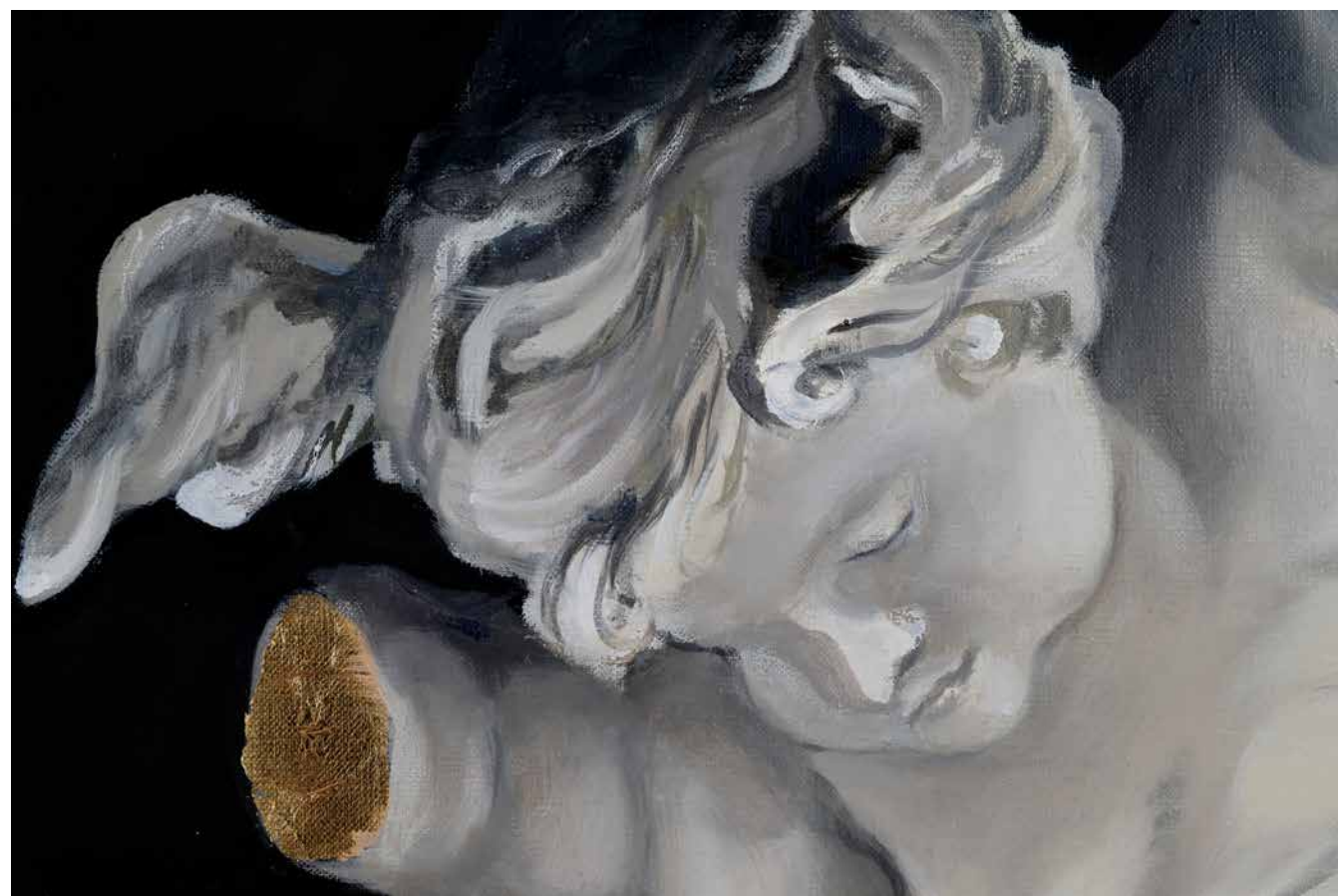
Table 1. Variables and their coding for the analysis

Variable Group	Variable new name [Variable original name]	Labels and coding for variables used in analyses
Dependent variables	LFS [stflife]	Life satisfaction (num; range: "Extremely dissatisfied" 0 – 10 "Extremely satisfied")
	MIB [see Labels…]	Mental ill-being [score based on: cldgng, fltdpr, flteeff, fltlnl, slprl, fltsd, enjlf, wrhpp; original scale: "None or almost none of the time" 1 – 4 "All or almost all of the time"; enjlf, wrhpp were reverse-coded; original scale was changed to 0–3] (mean of all recoded variables; range: 0–3)
Dummy variables	AGE<=24 [agea]	Dummy variable for group aged 24 or younger (1 = 1–24, 0 = other; reference group: respondents aged 35 or older)
	AGE25–34 [agea]	Dummy variable for group aged 25–34 (1 = 25–34, 0 = other; reference group: respondents aged 35 or older)
Demographic	GND [gndr]	Gender (1 = "Female", 0 = "Male")
	ARL [domicil]	Area where respondents live (1 = 1 "A big city" and 2 "Suburbs or outskirts of big city", 0 = other)
Household	FSC [cnfpplh]	Frequency of serious conflicts in respondents' household when growing up (1 = "Always" 1 – 3 "Sometimes", 0 = other)
	FFD [fnsdfml]	Frequency of severe financial difficulties in respondents' family when growing up (1 = "Always" 1 – 3 "Sometimes", 0 = other)
	FHI [hincfel]	Respondent's feeling about their household income (1 = 1 "Living comfortably on present income", 0 = other)
Social	HOP [hlpfmly]	Looking after or helping other people due to their long-term health problems, disability or old age (but not as part of employment) (1 = "Yes", 0 = "No")
	VOL [volunfp]	Volunteering for non-profit or charitable organisation (1 = "Yes", 0 = "No")
	PSA [sclact]	Frequency of participating in social activities compared to people in respondent's age (1 = 3 "About the same" – 5 "Much more than most", 0 = other)
	SOC [sclmeet]	Frequency of socializing with friends, relatives or colleagues (1 = 5 "Once a week" – 7 "Every day", 0 = other)
	NPD [inprdsc]	Number of people to discuss intimate and personal matters with (1 = 3 "3" – 6 "10 or more", 0 = other)
Religiosity	FRS [rlgatnd]	Frequency of attending religious service (excluding special occasions) (1 = 1 "Every day" – 4 "At least once a month", 0 = other)
	SAR [rlgdgr]	Self-assessment of respondent's religiosity [original range: "Not at all religious" 0 – 10 "Very religious"] (1 = 6–10, 0 = 0–5)
Health	SAH [health]	Self-assessment of respondent's general health (1 = 1 "Very good", 0 = other)
	HDA [hlthhmp]	Being hampered in daily activities by health problem (1 = 1 "Yes a lot" and 2 "Yes to some extent", 0 = 3 "No")
	DEP [see Labels…]	Mental ill-being – depressive symptoms [score based on: cldgng, fltdpr, flteeff, fltlnl, slprl, fltsd, enjlf, wrhpp; original scale: "None or almost none of the time" 1 – 4 "All or almost all of the time"; enjlf, wrhpp were reverse-coded; original scale was changed to 0–3; values from all variables were summed up] (range of the sum of recoded variables: 0–24; recoded to binary variable: 1 = 8-24, 0 = 0-7) Used as a predictor only in models predicting LFS.
Approach to life	COL [ctrlife]	Degree of control over life in general [original range: "No control at all" 0 – 10 "Complete control"] (1 = 8–10, 0 = 0–7)
	VAL [see: Labels…]	Number of values respondent strongly agrees with [sum based on: impdiff, impenv, impfree, impfun, imprich, impsafe, imptrad, ipadvnt, ipbhprp, ipcrtiv, ipeqopt, ipfrule, ipgdtim, iphlppl, iplylfr, ipmodst, iprspot, ipshabt, ipstrgv, ipsuces, ipudrst; original scale: 1 "Very much like me" – 6 "Not like me at all; recoded scale: 1 = 1–2, 0 = other] (range of the sum of recoded variables: 0–21; recoded to binary variable: 1 = 12–21, 0 = 0–11)

Table 2. Descriptive statistics for variables used in models

Variable groups	Variables	Age groups											
		<=24			25–34			>=35			Total		
		M	Sd	N	M	Sd	N	M	Sd	N	M	Sd	N
Dependent variables	LFS	7.28	1.70	184	7.44	1.84	183	7.45	2.01	1036	7.43	1.95	1403
	MIB	0.64	0.56	184	0.59	0.53	185	0.63	0.57	1038	0.63	0.56	1407
Demographic	GND	0.53	0.50	184	0.51	0.50	185	0.53	0.50	1045	0.53	0.50	1414
	ARL	0.23	0.42	183	0.26	0.44	185	0.24	0.43	1045	0.24	0.43	1413
Household	FSC	0.39	0.49	181	0.44	0.50	183	0.34	0.47	1028	0.36	0.48	1392
	FFD	0.21	0.41	183	0.38	0.49	179	0.46	0.50	1021	0.42	0.49	1383
	FHI	0.33	0.47	182	0.25	0.44	181	0.14	0.35	1042	0.18	0.38	1405
Social	HOP	0.29	0.46	182	0.35	0.48	183	0.34	0.47	1038	0.33	0.47	1403
	VOL	0.19	0.39	182	0.12	0.32	185	0.10	0.30	1042	0.11	0.32	1409
	PSA	0.61	0.49	184	0.58	0.49	184	0.55	0.50	1033	0.57	0.50	1401
	SOC	0.64	0.48	184	0.34	0.48	183	0.28	0.45	1042	0.33	0.47	1409
	NPD	0.76	0.43	181	0.74	0.44	184	0.68	0.47	1037	0.69	0.46	1402
Religiosity	FRS	0.43	0.50	183	0.46	0.50	182	0.61	0.49	1024	0.56	0.50	1389
	SAR	0.47	0.50	182	0.46	0.50	183	0.63	0.48	1033	0.58	0.49	1398
Health	SAH	0.44	0.50	183	0.30	0.46	185	0.14	0.35	1045	0.20	0.40	1413
	HDA	0.13	0.33	182	0.11	0.32	184	0.29	0.46	1043	0.25	0.43	1409
	DEP	0.26	0.44	184	0.24	0.43	185	0.23	0.42	1038	0.24	0.43	1407
Approach to life	COL	0.63	0.48	182	0.69	0.46	184	0.68	0.47	1038	0.67	0.47	1404
	VAL	0.48	0.50	184	0.43	0.50	185	0.48	0.50	1045	0.47	0.50	1414

Note: All the statistics and counts are unweighted. Means for variables coded 0/1 can be multiplied by 100% to get the percentage of people who were coded as 1 for this variable.

2.3. Descriptive statistics and trend analysis

Table 2 presents descriptive statistics for dependent variables and predictors, both across age groups and in total. The similar means of the life satisfaction (LFS) dependent variable across age groups (ca. 7.5) suggest that Polish people are, on average, highly satisfied with their lives. Similarly, the average score of ca. 0.6 for MIB indicates that Poles do not exhibit many or intensive symptoms of ill-being.

Nevertheless, when the cut-off point of 8 is used for depression (DEP), nearly 25% of Poles exhibit some symptoms.

Several predictors reveal clear differences between age groups. A clear positive trend with age is observed, as the proportion of people declaring they had experienced severe financial difficulties (FFD) in their household while growing up (21%, 38%, and 46% for the youngest to oldest groups, respectively). The opposite pattern (decreasing with age) can be observed for the share of people who consider their household's financial situation to be comfortable (FHI) (from 33% to 14%), participate in social activities as or more often than their peers (PSA) (from 61% to 55%), socialize with friends, relatives or colleagues at least once a week (SOC) (from 64% to 28%), and consider their general health very good (SAH) (from 44% to 14%).

There are also several instances where the two young age groups exhibit similar levels, which then differ from the oldest group: religious service attendance (FRS), 43% and 46% compared to 61%, above average self-assessed religiosity (SAR), 47% and 46% compared to 63%, and health hampering daily activities (HDA), 13% and 11% compared to 29%. Notably, it is more common for the youngest group to be involved in volunteering and work for charitable organisations (VOL) (19%) compared to the older groups (12% and 10%). The results for the number of people to discuss intimate personal matters (NPD) are also insightful, as the youngest group more frequently reports having at least three people to talk to. The results for all other variables are similar across all age groups.

Graph 1 illustrates the change in the share of people reporting high life satisfaction across age groups over 11 rounds of the ESS. The most notable trend is the change between Rounds 9 and 11. While all age groups experienced a decrease in the share of highly satisfied people, the drop and subsequent rate of recovery were most pronounced among the youngest group, with a 28% drop followed by a 24% recovery. For the older group, the figures were 19% and 24%, respectively, while for the oldest group, 11% and 21%. This indicates that only the youngest group did not exceed the pre-COVID-19 share of highly satisfied people. This suggests that these groups follow partially different patterns of recovery, suggesting that there are either different factors impacting LFS or the strength of their influence varies. Aligning this trend with reports on young Poles' mental health implies that pandemic-induced restrictions on social interactions impacted young people the most.

Corroborating evidence is visible in Graphs 2 and 3, where Rounds 9–11 are also critical. Graph 2 shows a negative difference in the drop and recovery of the share of people who participate in social activities at least as often as their peers: 12% for the youngest group, 7% for the 25–34 age group, and 2% for the oldest group. Regarding the share of respondents who have three or more close people to talk to, the shrinking difference between the two young groups is important. Both groups have similarly high percentages in Round 11, but since Round 10, the 25–34 group has experienced an increase, exceeding the values observed for the youngest group. Notably, the youngest group is the only one that experienced a drop (8%) in round 10.

The trends in Graph 4 show an increase in the share of people experiencing symptoms of depression among the youngest groups and a decrease among the oldest. Notably, as of ESS Round 11, this share among respondents aged 24 or younger exceeded the share among the respondents aged 35 or older for the first time.

Graph 1. Share of respondents with high life satisfaction by age group across ESS rounds 1-11
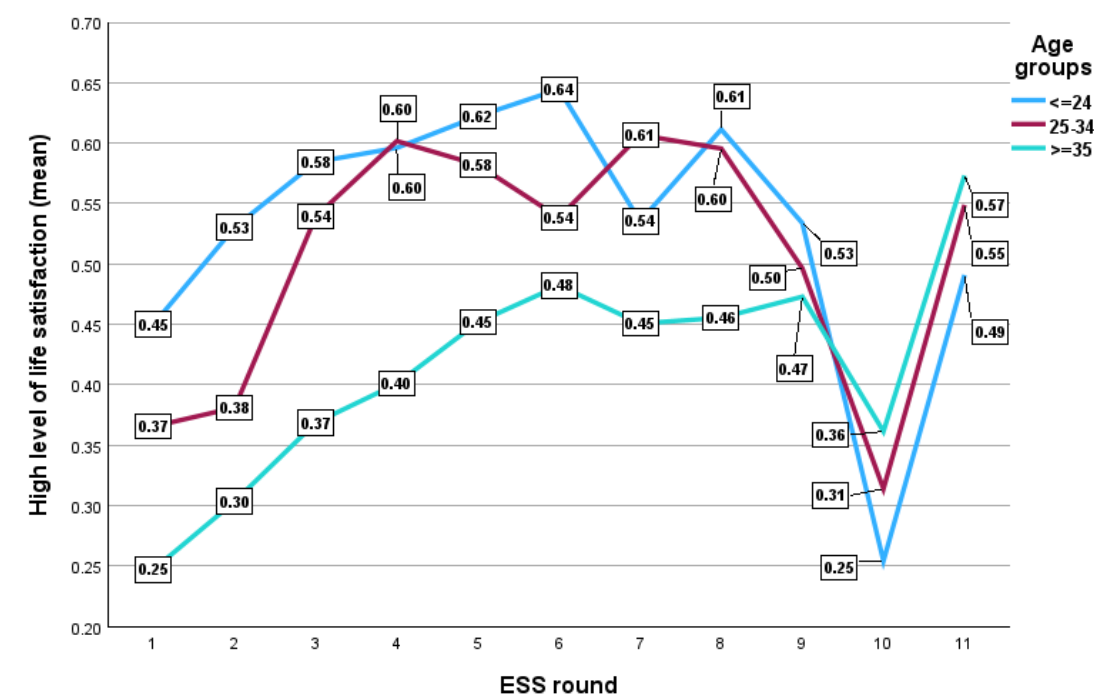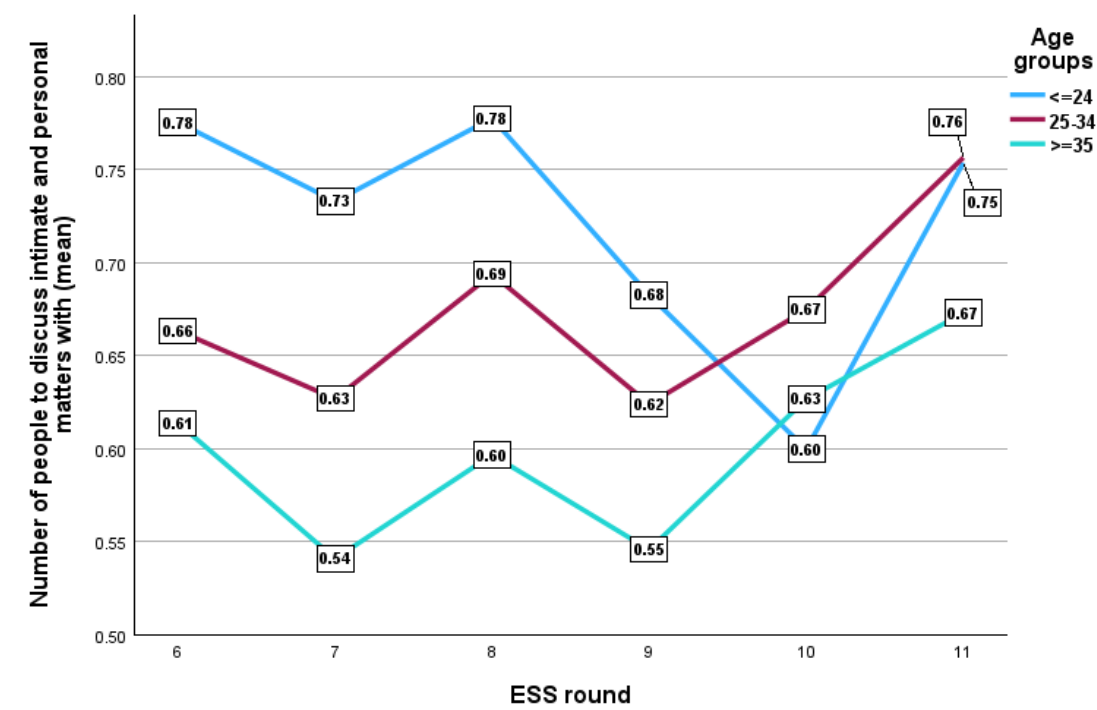

Note: Means on the graph are weighted by anweight. Unweighted range of valid Ns for each age group across all available rounds: $N_{<=24}$ = 184–455, N_{25-34} = 183–340, $N_{>=35}$ = 1008–1428. Range of original variable (stflife): "Extremely dissatisfied" 0 – 10 "Extremely satisfied" recoded to binary variable: 1 = 8–10, 0 = 0–7.

Graph 2. Share of respondents who take part in social activities as or more often than their peers by age group across ESS rounds 1-11
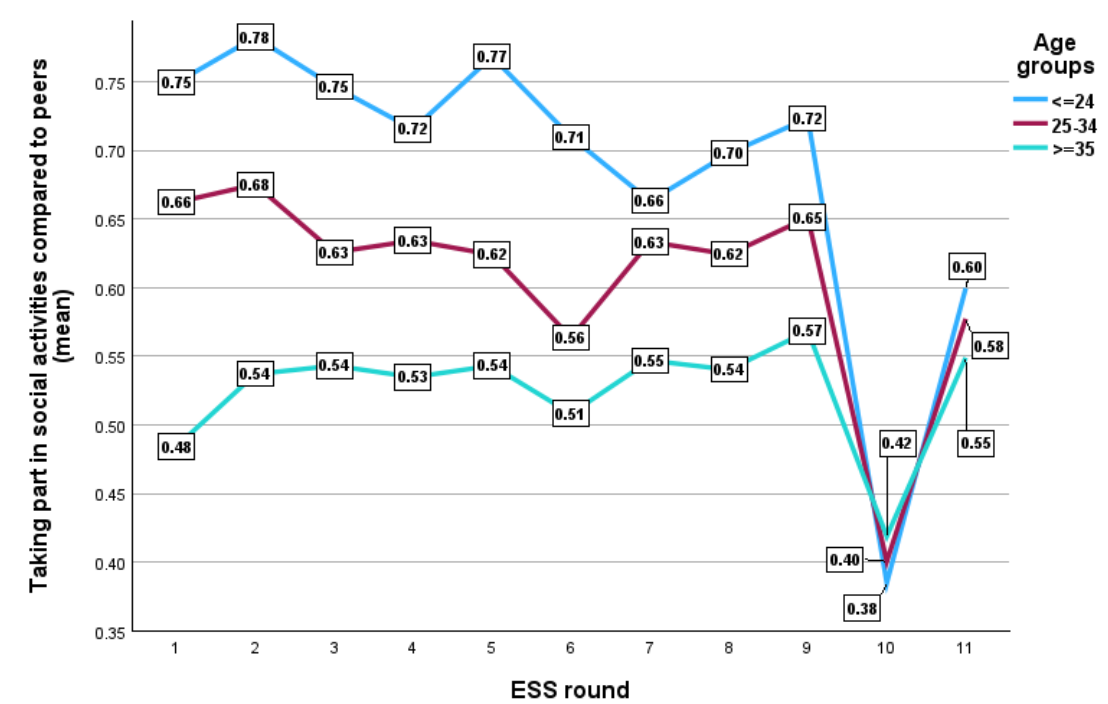
Note: Based on the PSA variable; see Table 1. Means on the graph are weighted by anweight. Unweighted range of valid Ns for each age group across all available rounds: $N_{<=24}$ = 184–457, N_{25-34} = 184–333, $N_{>=35}$ = 966–1432.

Graph 3. Share of respondents who have three or more people with whom they can discuss intimate and personal matters by age group across ESS rounds 6-11
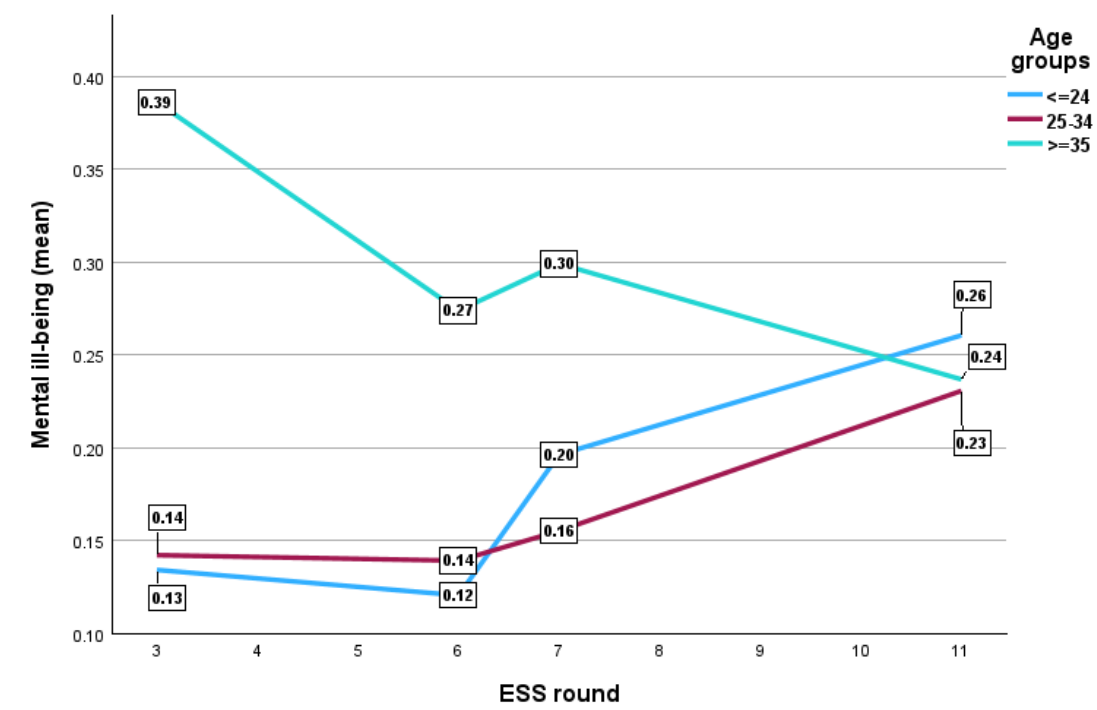

Note: Based on the NPD variable; see Table 1. Means on the graph are weighted by anweight. Unweighted range of valid Ns for each age group across all available rounds: $N_{<=24} = 181–291$, $N_{25–34} = 184–335$, $N_{>=35} = 1030–1432$.

Graph 4. Share of respondents experiencing mental ill-being (symptoms of depression) by age group in ESS rounds 3, 6, 7, and 11

Note: Based on the DEP variable; see Table 1 & Variables section. Means on the graph are weighted by anweight. Unweighted range of valid Ns for each age group across all available rounds: $N_{<=24} = 184–352$, $N_{25–34} = 185–340$, $N_{>=35} = 1038–1262$. Score for Rounds 7 and 11 contain additional variable compared to Rounds 3 and 6.

2.4. Modelling strategy and specification

The main analysis was conducted using CSGLMs, both with and without interaction terms, performed using the complex sample module in IMB SPSS 29 (as part of PS IMAGO PRO 10.0). This module utilizes the sample design plan to provide robust estimates (IBM, 2022, p. 264). For each dependent variable, 13 models were estimated.

The initial model included only age-group dummy variables. Following this, six thematic pairs of models were fitted. Each pair consisted of two models:
1. The first model in each pair included age-group dummies and a set of thematic predictors, but no interaction terms. This model investigated the associations between predictors and the dependent variable while controlling for age.
2. The second model in each pair incorporated interaction terms between the age-group dummies and the same predictors. This model tested whether the relationship between each predictor and outcome differed by age group relative to the reference group (35 or older).

In these interaction models, the reported main effect coefficients for predictors represent conditional effects and should be considered simple effects for the reference age group. For the other age groups, the simple effect is the sum of this main/conditional effect and the corresponding interaction coefficient[5]. Therefore, interaction coefficients reflect slope differences between that age group and the reference group (Jaccard & Turrisi, 2003, pp. 22–25). If an effect is statistically significant in the reference group but the interaction is not significant, this suggests no evidence that the effect of the predictor differs between the reference group and the other age groups.

Because the standard errors and test statistics for the sum of the main/conditional effect and interaction effect are not provided in the primary model output table, models showing statistically significant interactions were refitted using the corresponding age group as the reference category. The main/conditional effect for the predictor in these refitted models represents the simple effect for that age group, with correctly estimated standard errors and test statistics, indicating the predictor's impact on the outcome within that group. Table 3 presents the results of all models. Interaction coefficients come from the interaction models, while Simple effects for age groups with significant interactions (the main/conditional effects from refitted models) are provided in the text. All *β* values cited in the article are unstandardized coefficients.

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5 Example: In the interaction model, the simple effect of NPD for the reference group was estimated at *β*=0.277 (*p*>0.05). The interaction term AGE<=24 * NPD was statistically significant (*β*=1.025, *p*<0.01). This indicates that the effect of NPD is 1.025 units stronger for the 15–24 compared to the reference group. The resulting simple effect of NPD for the 15—24 age group is therefore calculated as 0.277 + 1.025 = 1.302.

Table 3. Results of the Complex Sample General Linear Models for the LFS and MIB dependent variables

Model	Predictors	Life satisfaction (LFS)		Mental ill–being (MIB)	
		β	S.e.	β	S.e.
Model 1 *Base* LFS R2 = 0.001 [N=1403] MIB R2 = 0.001 [N=1407]	*Intercept*	*7.461****	*0.072*	*0.635****	*0.018*
	AGE<=24	–0.189	0.143	0.013	0.045
	AGE25–34	–0.023	0.170	–0.056	0.042
Model 2 *Demographic* LFS R2 = 0.002 [N=1402] MIB R2 = 0.018*** [N=1406]	*Intercept*	*7.455****	*0.097*	*0.551****	*0.022*
	AGE<=24	–0.186	0.143	0.020	0.044
	AGE25–34	–0.018	0.169	–0.052	0.042
	GND	0.056	0.111	**0.129*****	**0.031**
	ARL	–0.101	0.129	0.073	0.038
Model 3 *Demographic* LFS R2 = 0.006 [N=1402] MIB R2 = 0.030*** [N=1406]	*Intercept*	*7.401****	*0.106*	*0.552****	*0.024*
	AGE<=24	0.238	0.226	–0.045	0.056
	AGE25–34	0.037	0.288	–0.003	0.062
	GND	0.114	0.136	**0.157*****	**0.036**
	AGE<=24 * GND	–0.534	0.304	–0.026	0.085
	AGE25–34 * GND	–0.000	0.322	**–0.209***	**0.084**
	ARL	0.003	0.153	0.006	0.043
	AGE<=24 * ARL	**–0.721***	**0.321**	**0.359****	**0.114**
	AGE25–34 * ARL	–0.224	0.358	**0.224***	**0.098**
Model 4 *Household* LFS R2 = 0.063*** [N=1359] MIB R2 = 0.073*** [N=1361]	*Intercept*	*7.722****	*0.088*	*0.510****	*0.023*
	AGE<=24	**–0.445****	**0.139**	0.070	0.044
	AGE25–34	–0.102	0.166	–0.068	0.040
	FSC	**–0.607*****	**0.117**	**0.211*****	**0.033**
	FFD	**–0.331****	**0.117**	**0.152*****	**0.033**
	FHI	**0.797*****	**0.130**	**–0.092***	**0.037**

Model	Predictors	Life satisfaction (LFS)		Mental ill–being (MIB)	
		β	S.e.	β	S.e.
Model 5 *Household*	*Intercept*	**7.711*****	**0.095**	**0.533*****	**0.025**
	AGE$_{<=24}$	–0.263	0.211	–0.053	0.056
LFS R2 = 0.067*** [N=1359]	AGE$_{25–34}$	–0.180	0.234	**–0.180*****	**0.054**
MIB R2 = 0.086*** [N=1361]	FSC	**–0.651*****	**0.137**	**0.185*****	**0.039**
	AGE$_{<=24}$ * FSC	–0.156	0.314	0.150	0.090
	AGE$_{25–34}$ * FSC	0.544	0.339	0.075	0.089
	FFD	**–0.310***	**0.131**	**0.155*****	**0.037**
	AGE$_{<=24}$ * FFD	0.232	0.342	–0.094	0.100
	AGE$_{25–34}$ * FFD	–0.339	0.347	0.016	0.090
	FHI	**0.912*****	**0.169**	**–0.200*****	**0.042**
	AGE$_{<=24}$ * FHI	–0.554	0.318	**0.325*****	**0.095**
	AGE$_{25–34}$ * FHI	–0.161	0.326	**0.330*****	**0.084**
Model 6 *Social*	*Intercept*	**7.006*****	**0.131**	**0.807*****	**0.036**
	AGE$_{<=24}$	**–0.377***	**0.152**	0.041	0.047
LFS R2 = 0.036*** [N=1364]	AGE$_{25–34}$	–0.044	0.164	–0.057	0.042
MIB R2 = 0.055*** [N=1368]	HOP	**–0.325****	**0.125**	0.050	0.033
	VOL	0.290	0.150	0.033	0.045
	PSA	**0.356****	**0.116**	**–0.218*****	**0.033**
	SOC	**0.330****	**0.119**	–0.014	0.036
	NPD	**0.379****	**0.133**	**–0.101****	**0.034**

Model	Predictors	Life satisfaction (LFS)		Mental ill–being (MIB)	
		β	S.e.	β	S.e.
Model 7 *Social*	*Intercept*	**6.999*****	**0.148**	**0.826*****	**0.040**
	AGE$_{<=24}$	–0.662	0.356	0.107	0.114
LFS R2 = 0.047*** [N=1364]	AGE$_{25–34}$	0.324	0.424	**–0.304*****	**0.087**
MIB R2 = 0.067*** [N=1368]	HOP	**–0.325***	**0.144**	0.053	0.038
	AGE$_{<=24}$ * HOP	0.289	0.302	–0.033	0.097
	AGE$_{25–34}$ * HOP	–0.360	0.351	–0.008	0.087
	VOL	0.345	0.193	–0.047	0.052
	AGE$_{<=24}$ * VOL	–0.530	0.375	**0.297***	**0.124**
	AGE$_{25–34}$ * VOL	0.154	0.453	0.243	0.126
	PSA	**0.494*****	**0.136**	**–0.240*****	**0.038**
	AGE$_{<=24}$ * PSA	**–0.769***	**0.308**	0.075	0.090
	AGE$_{25–34}$ * PSA	**–0.734***	**0.330**	0.166	0.090
	SOC	**0.310***	**0.143**	–0.007	0.042
	AGE$_{<=24}$ * SOC	–0.021	0.310	**–0.175***	**0.088**
	AGE$_{25–34}$ * SOC	0.217	0.337	0.067	0.096
	NPD	0.277	0.159	**–0.104****	**0.038**
	AGE$_{<=24}$ * NPD	**1.025****	**0.380**	–0.048	0.102
	AGE$_{25–34}$ * NPD	0.133	0.377	0.134	0.087
Model 8 *Religiosity*	*Intercept*	**7.013*****	**0.112**	**0.714*****	**0.028**
	AGE$_{<=24}$	–0.039	0.143	–0.010	0.044
LFS R2 = 0.028*** [N=1371]	AGE$_{25–34}$	0.102	0.164	–0.078	0.042
MIB R2 = 0.012** [N=1375]	FRS	**0.589*****	**0.158**	**–0.124****	**0.040**
	SAR	0.126	0.160	0.003	0.039
Model 9 *Religiosity*	*Intercept*	**7.085*****	**0.126**	**0.690*****	**0.032**
	AGE$_{<=24}$	–0.214	0.224	0.097	0.068
LFS R2 = 0.031*** [N=1371]	AGE$_{25–34}$	–0.196	0.251	–0.028	0.068
MIB R2 = 0.016*** [N=1375]	FRS	**0.516****	**0.191**	**–0.115***	**0.048**
	AGE$_{<=24}$ * FRS	0.213	0.375	–0.017	0.125
	AGE$_{25–34}$ * FRS	0.417	0.462	–0.055	0.119
	SAR	0.085	0.195	0.031	0.045
	AGE$_{<=24}$ * SAR	0.129	0.415	–0.195	0.121
	AGE$_{25–34}$ * SAR	0.196	0.447	–0.041	0.119

Model	Predictors	Life satisfaction (LFS)		Mental ill–being (MIB)	
		β	S.e.	β	S.e.
Model 10 *Health* LFS R2 = 0.131*** [N=1394] MIB R2 = 0.144*** [N=1403]	*Intercept*	*7.779****	*0.077*	*0.554****	*0.019*
	$AGE_{\leq24}$	**−0.395***	**0.131**	**0.173****	**0.042**
	AGE_{25-34}	−0.208	0.153	0.060	0.039
	SAH	**0.649****	**0.119**	**−0.270****	**0.033**
	HDA	−0.220	0.145	0.374***	0.038
	DEP	**−1.400****	**0.139**	–	–
Model 11 *Health* LFS R2 = 0.135*** [N=1394] MIB R2 = 0.149*** [N=1403]	*Intercept*	*7.787****	*0.082*	*0.546****	*0.020*
	$AGE_{\leq24}$	**−0.518***	**0.220**	**0.216****	**0.056**
	AGE_{25-34}	−0.250	0.213	0.097	0.050
	SAH	**0.519***	**0.176**	**−0.203****	**0.042**
	$AGE_{\leq24}$ * SAH	0.346	0.334	**−0.193***	**0.079**
	AGE_{25-34} * SAH	0.361	0.319	**−0.150***	**0.076**
	HDA	−0.157	0.156	**0.371****	**0.040**
	$AGE_{\leq24}$ * HDA	−0.569	0.456	0.175	0.130
	AGE_{25-34} * HDA	−0.671	0.486	−0.033	0.170
	DEP	**−1.444****	**0.172**	–	–
	$AGE_{\leq24}$ * DEP	0.345	0.330	–	–
	AGE_{25-34} * DEP	0.194	0.438	–	–
Model 12 *Approach to life* LFS R2 = 0.117*** [N=1394] MIB R2 = 0.043*** [N=1397]	*Intercept*	*6.352****	*0.122*	*0.810****	*0.034*
	$AGE_{\leq24}$	−0.101	0.132	−0.001	0.044
	AGE_{25-34}	0.007	0.163	−0.055	0.040
	COL	**1.348****	**0.120**	**−0.239****	**0.036**
	VAL	**0.386****	**0.105**	−0.030	0.030
Model 13 *Approach to life* LFS R2 = 0.118*** [N=1394] MIB R2 = 0.043*** [N=1397]	*Intercept*	*6.342****	*0.138*	*0.810****	*0.038*
	$AGE_{\leq24}$	−0.176	0.277	−0.032	0.088
	AGE_{25-34}	0.172	0.291	−0.027	0.090
	COL	**1.381****	**0.148**	**−0.247****	**0.042**
	$AGE_{\leq24}$ * COL	−0.030	0.303	0.075	0.095
	AGE_{25-34} * COL	−0.259	0.322	−0.003	0.099
	VAL	**0.360***	**0.126**	−0.019	0.035
	$AGE_{\leq24}$ * VAL	0.200	0.242	−0.036	0.089
	AGE_{25-34} * VAL	0.026	0.326	−0.059	0.088

Note: β – unstandardized coefficients; S.e. – standard errors; *** – p-value<0.001, ** – p-value<0.01, * – p-value<0.05; values estimated accounting for complex sample design. Models estimated using CSGLM in SPSS.

The sample size (N=1442) is large enough to benefit from the Central Limit Theorem, allowing us to assume normal distribution of residuals. While a normal distribution was assumed, residual skewness was examined: for the LFS models, skewness remained in the range of −0.593 to −0.869, while for MIB, skewness ranged from 1.151 to 1.255. Thus, these values indicate the absence of extreme skewness in the residuals.

Multicollinearity of predictors was investigated using VIF (*Variance Inflation Factor*) and Tolerance statistics, estimated via regular multiple regression analysis on weighted data (analysis weight). However, this analysis does not account for the complex design, as the Complex Samples module does not provide VIF estimates that incorporate design features. Only Model 7 (social predictors with interactions) showed values exceeding the common threshold of 5 for VIF and Tolerance values below 0.2; specifically, age group dummy variables had VIFs of 5.929 and 5.283 for LFS, and 5.929 and 5.338 for MIB. No predictor reached the more stringent VIF threshold of 10, and only one model per dependent variable exceeded the threshold of 5 for VIF and dropped below 0.2 (but not below 0.1) for Tolerance. These results are considered acceptable (Field, 2009, p. 224).

CSGLM does not support outlier detection in the same way as other SPSS procedures. To approximate standardized residuals, unstandardized residuals were manually divided by their standard deviation. The percentages of these approximated standardized residuals (ASR) for thresholds of 3, 2.5, and 2 standard deviations are 1.1%, 2.6%, and 5.3% for LFS, with a maximum value of −4.11; and 1.7%, 2.8%, and 5.1% for MIB, with a maximum value of 4.72. Only in one model for LFS and MIB did the values at two standard deviations cross the 5% threshold. The distribution of these values is consistent with the expected direction of skewness.

To assess the models' sensitivity, all were refitted after removing cases where ASRs were larger than 3 (results not shown here). Comparisons between the full-sample and the trimmed models revealed no substantive differences in effect direction, magnitude, or statistical significance for the predictors or interaction terms across both dependent variables. Cases flagged by large ASRs did not suggest measurement error or implausible dependentvariable values; therefore, exclusion from the primary sample could not be justified. The results for models based on the full sample are reported, with any instances where exclusion altered a predictor's statistical significance noted in the text. More complex outlier diagnostics were not used because they do not account for the complex sample design. Therefore, the results and interpretations should be done with caution.

Overall, these analyses are considered confirmatory, as all predictors and proposed interactions are consistent with existing theory and previous empirical findings.

3. Results

3.1. Life satisfaction

Model 1 shows no statistically significant difference in the average level of life satisfaction between the young respondent groups and the reference group aged 35 and older. Thus, age alone has no significant influence on LFS.

Adding demographic predictors (Model 2) does not change this conclusion, as neither gender nor area where respondents live (ARL) has statistically significant associations with LFS. Model 3, which includes interactions among demographic predictors, largely confirms previous results. The gender effect (GND) is not statistically significant in the reference group, nor are its interaction terms. While the ARL effect is not statistically significant in the reference group, the interaction term

for AGE<=24 is, indicating that, in this group, living in a big city or its outskirts is associated with a 0.718-point lower average level of LFS (simple effect based on the refitted model, *S.e.* = 0.290, *p*<0.05) compared to those living outside these areas. The AGE25–34 group does not significantly differ from the reference group. The fit of neither model is statistically significant, which is also reflected in low R2 values; thus, the observed effect should be treated with caution.

Both Model 4 (without interactions) and Model 5 (with interactions) investigate the association between household variables and LFS. In Model 4, AGE<=24 is statistically significant, indicating that the youngest age group is associated with a 0.445-point lower average LFS compared to those aged 35 or older. The 25–34 age group does not differ statistically significantly from the reference group. All other predictors are significantly associated with LFS. Experiencing serious conflicts (FSC) and severe financial difficulties (FFD) in the household, at least sometimes when growing up, are linked to LFS reductions of 0.607 and 0.331 points, respectively. Conversely, comfortably living on present household income (FHI) corresponds to a 0.797-point higher average LFS compared to those in poorer financial circumstances.

Model 5, with interactions, shows statistical significance for the predictors (excluding the age groups dummies) in the reference group, with no statistically significant interactions observed. Therefore, neither of the younger age groups differs from the older age group. The effects for FSC, FFD, and FHI are –0.651, –0.310, and 0.912, respectively, with FHI being the strongest predictor. This implies that the current material situation influences LFS more than past negative experiences. Furthermore, FFD becomes statistically insignificant (*p*>0.05) in the trimmed model, reinforcing FHI as the strongest predictor reflecting LFS's embedding

in the present. However, Santini et al. (2021) demonstrated that both childhood adversity variables may have a synergistic effect. Both Models 4 and 5 demonstrated a statistically significant fit to the data, although the R2 values remain below 0.1.

Both Model 6 (without interactions) and Model 7 (with interactions) investigate the association between social predictors and LFS. In Model 6, AGE<=24 is statistically significant, indicating that, compared to the reference group, the youngest respondents tend to have a 0.377-point lower average LFS. Similarly, HOP is statistically significant, implying that people who look after or help other people due to their health problems or age tend to have a 0.325-point lower average LFS. Conversely, all three social engagement variables were positively associated with LFS: participating in social activities at least as often as the respondents' peers (PSA, 0.356), socializing with friends, relatives or colleagues at least once a week (SOC, 0.330), and having three or more people to discuss intimate and personal matters with (NPD, 0.379).

In Model 7, with interactions, neither age-group dummy is statistically significant; however, in the trimmed model, AGE<= 24 is significant at p<0.05. HOP (–0.325), PSA (0.494), and SOC (0.310) effects remain statistically significant for those aged 35 or older, while NPD is non-significant. However, there is a statistically significant interaction between NPD and AGE<=24 (but not AGE25–34), indicating that the effect of having three or more confidants is stronger among the youngest respondents, and is associated with a 1.302-point higher average level LFS (simple effect based on the refitted model, *s.e.*: 0.331, *p*<0.001). This finding aligns with previous research indicating that young people value having friends and need someone to accept them. Both interactions with PSA are statistically significant, suggesting that the impact changes by age group.

However, simple effects for both groups in refitted models lost statistical significance. The PSA effect is associated with a higher average LFS in the oldest group (0.494 points) compared to the younger age groups. Models 6 and 7 demonstrate a statistically significant fit to the data, although their R2 values are below 0.1.

Both Model 8 (without interactions) and Model 9 (with interactions) investigate the association between religiosity and LFS. In Model 8, the only statistically significant predictor is religious attendance (FRS). Attending religious services at least once a month is linked to a 0.589-point higher average LFS. In Model 9, with interactions, the only statistically significant effect for FRS is for the reference group. Thus, in the oldest group, FRS is associated with a 0.516-higher average LFS. Notably, while the coefficients for the interactions with FRS are substantial, their standard errors are much larger than for the reference group, rendering the estimate unstable. These results suggest that religiosity has a similar impact on life satisfaction among the groups, and that it is the behavioural aspect of religiosity that matters. They are also consistent with theoretical considerations about the meaning of life. Models 8 and 9 demonstrated a statistically significant fit to the data, although their R2 values are below 0.05.

Both Model 10 (without interactions) and Model 11 (with interactions) investigate the association between health-related predictors and LFS. These models demonstrate the best fit to the data of all the models, with R2 = 0.131 (*p*<0.001) for Model 10 and R2 = 0.135 (*p*<0.001) for Model 11.

In Model 10, only AGE<=24, self-assessed health (SAH), and symptoms of depression (DEP) are statistically significantly associated with the level of LFS. The youngest respondents tend to have a 0.395-point lower average LFS compared to the reference group.

Assessing their own health as very good (SAH) is associated with a 0.649-point higher average LFS. However, the strongest predictor is DEP. Respondents exhibiting symptoms of depression tend to have a 1.400-point lower average LFS.

Model 11, with interactions, does not show any statistically significant interactions. The effects for AGE<=24 (–0.518), SAH, and DEP are statistically significant. SAH is associated with a 0.519-point higher average LFS among the oldest respondent group, while DEP is associated with a 1.444-point lower average LFS. Despite the lack of statistically significant interactions, it should be noted that the SAH effect size for both younger age groups is substantial and consistent in direction with the reference group. However, the standard errors are almost equally large, indicating low precision in their estimation. The effects of the other variables are not statistically significant.

Both Models 12 (without interactions) and 13 (with interactions) investigate the association between 'approach to life' predictors and LFS. These models also demonstrated a good fit to the data, with R2 = 0.117 (*p*<0.001) for Model 12 and R2 = 0.118 (*p*<0.001) for Model 13.

In Model 12, only thematic variables show a statistically significant relationship with LFS. Declaring a strong sense of control over own's life (COL) is associated with a 1.348-point higher average LFS, while agreeing strongly with 12 or more basic human values (VAL) is associated with a 0.386-point lower average LFS. Model 13, with interactions, shows that the effect of COL is statistically significant in the oldest age group, and associated with a 1.381-point higher average LFS. The same is true for VAL, although its effect is less substantial (0.360). Neither the age-group dummies nor any interactions are statistically significant. Thus, the effects of COL and VAL are not different across the three age groups.

3.2. Mental ill-being

The base model for MIB (Model 1) shows no statistically significant difference in the average level of mental ill-being between the younger groups and the oldest reference group. This indicates that age alone does not significantly influence the average level of mental ill-being. Model fit is not statistically significant.

Both Model 2 (without interactions) and Model 3 (with interactions) investigate the association between demographic predictors and MIB. In Model 2, the dummy variables AGE<=24 and AGE25–34 were not statistically significant. The area where respondents live (ARL) also lacked significance in the mail model, though it achieved significance ($p<0.05$) in the trimmed model. Gender (GND) is statistically significant, associated with a 0.129-point higher MIB.

In Model 3, with interactions, neither age-group dummy was statistically significant. The effect for GND in the reference group is statistically significant, indicating that women in this group tend to have a 0.157-point higher average MIB compared to men. Furthermore, while the interaction for the youngest group is not statistically significant, it is for the 25–34 age group, meaning that the effect of GND differs in this group compared to the reference group (–0.209). However, in the refitted model, the effect for this age group is no longer statistically significant. While the ARL effect for the oldest group is not statistically significant, it is for interactions for both younger age groups, indicating that the effect is different across age groups. Thus, living in a big city or at its outskirts is associated with a 0.365-point higher average MIB for the youngest group (simple effect based on the refitted model, *S.e.*: 0.107, $p<0.001$), and a 0.230-point higher average MIB for the 25–34 age group (simple effect based on the refitted model, *S.e.*: 0.088,

$p<0.01$). Both models demonstrated a statistically significant fit to the data, although the R2 values are below 0.05.

Both Model 4 (without interactions) and Model 5 (with interactions) investigate the association between household variables and MIB. In Model 4, neither of the age-group dummies is statistically significant (although AGE<=24 becomes significant at $p<0.05$ in the trimmed model), but all other predictors are significant. Both childhood adversity variables—family conflicts (FSC) and financial difficulties when growing up (FFD)—are associated with a higher MIB (0.211 points and 0.152 points, respectively). Household income (FHI) is linked to a 0.092-point lower average MIB.

In Model 5 (with interactions), the AGE25–34 dummy (–0.180) is statistically significant. The effects for FSC (0.185 points) and FFD (0.155 points) are statistically significant for the reference group, indicating an association with higher average MIB. The interactions for both variables are not statistically significant, although the coefficients for the FSC interactions have the same direction as the reference group. While the effect should be stronger, the relatively large standard errors indicate substantial uncertainty of the estimate.

The FHI effects for the reference group and both interactions are also statistically significant. Living comfortably is associated with a 0.200-point lower average MIB for the oldest age group. Interactions for both age groups indicate a more positive effect (higher average MIB) of FHI on MIB compared to the reference group. However, in the refitted model for each of the younger age groups, the simple effect becomes statistically non-significant, as the coefficients are closer to 0. Models 4 and 5 demonstrate statistically significant fits to the data, although their R2 values are below 0.1.

Both Model 6 (without interactions) and Model 7 (with interactions) investigate the

association between social predictors and MIB. Model 6 shows a statistically significant association of participating in social activities at least as often as the respondents' peers (PSA) and having three or more confidants (NPD) with MIB. Other predictors are not statistically significant. PSA and NPD are associated with a 0.218-point and a 0.101-point lower average MIB, respectively.

In Model 7, with interactions, the effect for AGE25–34 (–0.304) is statistically significant. While the effect of volunteering (VOL) in the reference group is not statistically significant, the interaction for AGE<=24 is. The effect of VOL in the youngest group is associated with a 0.250-point (simple effect based on the refitted model, *S.e.*: 0.114, $p<0.05$) higher average MIB. The interaction between AGE25–34 and VOL only becomes significant ($p<0.05$) in the trimmed model. There is a statistically significant effect of PSA for the reference group but not for the interactions, suggesting that PSA is associated with a 0.240-point lower average MIB among the oldest respondents. The effect of socializing with friends, relatives or colleagues at least once a week (SOC) is not statistically significant in the reference group or the interaction with AGE25–34; however, the interaction with AGE<=24.is significant. The effect of SOC in the youngest group is associated with a 0.182-point lower average MIB. (simple effect based on the refitted model, *S.e.*: 0.081, $p<0.05$). However, in the trimmed model, this interaction effect is not statistically significant. This means that the effect is unstable and should be treated with caution. There is also a statistically significant effect of NPD in the reference group, but not for the interactions. Thus, NPD is linked to a 0.104-point lower average MIB in the oldest group. Neither the effect for the reference group nor the interaction effects are statistically significant for looking after or helping other people due to their health problems or age (HOP). Both

Models 6 and 7 demonstrate a statistically significant fit to the data, although their R2 values are below 0.1.

Both Model 8 (without interactions) and Model 9 (with interactions) investigate the association between religiosity and MIB. In Model 8, the only statistically significant predictor is attending religious services (FRS). Attending a service at least once a month is associated with a 0.124-point lower average MIB. In Model 9, only the effect for FRS in the reference group is statistically significant, indicating that FRS is associated with a 0.115-point lower average MIB. In the trimmed model, AGE<=24 becomes statistically significant. Thus, religiosity models mirror trends observed for LFS, where the behavioural component of religiosity contributes to higher life satisfaction and lower mental ill-being. Both Models 8 and 9 demonstrate a statistically significant fit to the data, although their R2 values are below 0.05.

Both Model 10 (without interactions) and Model 11 (with interactions) investigate the association between health predictors and MIB. Model 10 shows statistically significant coefficients for AGE<=24, self-assessed health (SAH), and being hampered by health problems (HDA). Belonging to the youngest age group, compared with the oldest, is associated with a 0.173-point higher average MIB. SAH is also associated with a 0.270-point lower MIB. Conversely, HDA is associated with a 0.374-point higher average.

In Model 11, there are statistically significant associations for AGE<=24 (0.216), SAH and HDA in the reference group, and for the SAH effect on both younger age groups. Other predictors and interactions did not achieve statistical significance; however, in the trimmed model, AGE25–34 becomes statistically significant ($p<0.05$). HDA is associated with a 0.371-point higher average MIB for the reference group. The effect of SAH in the reference

group is linked with a 0.203 lower average MIB. The effect of SAH is particularly pronounced in younger age groups. In the youngest group, the simple effect of assessing one's own health as very good is related to a 0.395-point lower average MIB level (based on the refitted model, *S.e.*: 0.068, *p*<0.001). In the group aged 25–34, the simple effect is associated with a 0.353-point lower MIB level (based on the refitted model, *S.e.*: 0.063, *p*<0.001). These results demonstrate that maintaining good health is more impactful on the mental well-being of young people than of the oldest age group. It is likely that experiencing health issues becomes more common and normalized as people age, reducing the relative influence of very good health on their mental state compared to young people. As with the LFS, Models 10 and 11 demonstrated the best fit of the data across all MIB models, achieving the highest R2 values of 0.144 (*p*<0.001) and 0.149 (*p*<0.001), respectively.

Both Model 12 (without interactions) and Model 13 (with interactions) investigate the association between 'approach to life' predictors and MIB. In Model 12, the only statistically significant predictor is control over one's own life (COL), although in the trimmed model, basic human values (VAL) are also statistically significant (*p*<0.01). Respondents who feel they have a high degree of control over their lives tend to have a 0.239-point lower average MIB. The COL effect for the reference group (–0.247) is also the only statistically significant one in model 13, indicating that younger people do not differ from the oldest age group. In the trimmed model, VAL becomes statistically significant (*p*<0.05). The results show that control over one's life is important for mental well-being, regardless of age group. Notably, compared to LFS, there is no stable influence of VAL, which may indicate that values have a buffering effect on life satisfaction; however, their relevance diminishes in the face of

serious mental health problems. Models 12 and 13 exhibit a statistically significant fit to the data, although their R2 values are below 0.05.

4. Conclusions

4.1. Addressing the research questions and hypotheses

Answering the first research question, the overall percentage of young people reporting high life satisfaction generally increased until ESS Round 8 (2016/2017). After that point, it dropped significantly in the 2018/2019 and 2022 rounds. Critically, this decrease was more pronounced for the 15–24 age group, and the recovery rate to pre-pandemic levels was slower than for the two older age groups, who have already exceeded their pre-pandemic shares of people declaring high life satisfaction (Graph 1).

Corroborating insights from Graphs 2 and 3 indicate a stronger effect of the COVID-19 pandemic on the social life of the youngest respondents. These trends coincide with a modest but clear increase in the percentage of young people experiencing symptoms of depression that occurred between ESS Rounds 7 (2015) and 11 (2023–2024), and a simultaneous decrease in this percentage among people aged 35 or older (Graph 4). This evidence suggests that young people in Poland experience uncertainty of, and changes in, the contemporary world differently from older Poles.

The answers to the second and third research questions are based on comparing the absolute values of the coefficients for a given dependent variable[6], while accounting for their statistical significance and standard

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6 Since LFS and MIB were measured on different scales, it is inadvisable to directly compare the values of the unstandardized coefficients.

errors. Focusing on the strongest effects and tendencies, positive associations with a higher average level of life satisfaction are associated with a comfortable material situation (FHI), very good self-assessed health (SAH), attending religious services at least once a month (FRS), and above all, a strong sense of control over one's own life (COL). Conversely, LFS is negatively associated with childhood adversity (FSC and FFD), looking after or helping other people due to their health problems or age (HOP), and, above all, exhibiting symptoms of depression (DEP).

Notably, there is also a negative association between LFS and age, since respondents aged 15–24 tend to have a lower average LFS than people aged 35 or older, when controlled for household, social, and health predictors (models without interactions). The same association is not observed for respondents aged 25–34. Furthermore, except for volunteering (VOL), all social predictors are statistically significant, although their coefficients are modest in magnitude.

Two broad conclusions can be drawn from these results. First, the more control respondents have over their lives, the more likely they are to have a higher average level of LFS. COL, DEP, FRS, HOP, and VAL (Values, which is also statistically significant and positively associated with LFS), which are indications of having, gaining, or losing control over one's life. Previous research on meaning in life emphasizes religion and values as sources of guidance and certainty in life, while depression or caregiving responsibilities represent a perceived loss of control.

Second, the life satisfaction of young people appears to be strongly associated with the social context they live in. This is indicated by the significance of FSC, FFD, HOP, social participation compared to peers (PSA), socializing (SOC), and having close confidants (NPD), all of which refer to their immediate social environment.

The statistically significant interaction between NPD and AGE<=24 shows that the association between NPD and LFS is stronger for young people than for people aged 35 or older. This result supplements the interpretation of trends presented earlier. In both social and household models, young Poles were associated with a lower average LFS.

Regarding mental ill-being, positive associations (linked to higher average MIB levels) are observed with childhood adversity predictors (FSC and FFD), being hampered by health problems (HDA), and living in a big city or its outskirts (ARL). Conversely, negative associations are observed for FHI, PSA, NPD, FRS, SAH, and COL. Since there are no statistically significant interactions with VAL for either LFS or MIB, it can be concluded that Hypothesis 3 receives only partial support due to its positive association with LFS.

Two broad conclusions can also be drawn from the MIB results. First, similar to the findings of the LFS, the social context is important, although not in the same way. While the associations with FSC, FFD, PSA, and NPD are significant, the interactions provide additional insights. Big cities and their outskirts (ARL) appear to be focal points of uncertainty, where competition is more intense and material status gaps are more visible, potentially increasing pressure to fit in and decreasing the chances of being satisfied with one's own status. This potentially exacerbates mental health issues among Poles aged 15–24 and 25–34, compared to the older respondents. Moreover, volunteering (VOL) is associated with higher average levels of MIB among the youngest age group compared to the oldest. Conversely, socializing with friends, relatives or colleagues at least once a week (SOC) is associated with a lower average MIB among Poles aged 15–24 compared to those aged 35 or older.

Thus, these trends, along with those observed for LFS, suggest that when *other people*

are there for the respondents, their average LFS tends to be higher and MIB lower, and the reverse tendency is observed when *respondents need to be there for others*. This interpretation contradicts some theories (e.g., Frankl's considerations), which imply that people can find fulfilment in *being there for others* (Kozera-Mikuła, 2020, p. 13).

Overall, the results for the LFS and the MIB fully support Hypothesis 1. Hypothesis 2 receives only partial support, as FSC and FFD are associated with both the LFS and the MIB, but in opposite directions. The second conclusion is that health-related predictors are more important for the MIB than for the LFS. While SAH is associated with a lower average MIB across age groups, interactions show that this effect is weaker for respondents aged 35 or older compared to both younger age groups. Furthermore, regardless of age group, HDA is linked to higher average MIB levels.

4.2. Limitations

Several limitations in the present analyses are acknowledged. First, all the models are based on ESS Round 11, the first conducted after the COVID-19 pandemic. Thus, it is impossible to establish to what extent the results are affected by that event. Therefore, further research should compare these results with those from Rounds 7, 6, and 3 to verify their sensitivity. Second, all the predictors were binary, which results in partial data loss due to simplification. Accordingly, other coding schemes may yield different results. Third, accounting for the complex sample design limits the verification options for some method assumptions, which could lead to potential biases in the analyses. However, additional precautions, such as the use of trimmed models and ASR analysis, were implemented.

The most significant limitation is the fit of the models. Except for the base models and the two demographic models for LFS,

the models' fit was statistically significant. Nevertheless, in most cases, the R2 values remained under 0.1. This means that models with predictors were better at predicting the outcome than models with no predictors, but the difference was not substantial, and neither was the difference between the interaction and no-interaction models. The coefficient values were also generally small. Consequently, the results should be considered preliminary and interpreted with caution, and viewed as indications of general tendencies and association directions. ❧

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Adiunkt, doktor nauk społecznych w zakresie socjologia (stopień uzyskany w 2019 roku), od 2019 roku pracuje w Katedrze Metod i Technik Badań Społecznych na Wydziale Ekonomiczno-Socjologicznym Uniwersytetu Łódzkiego. W tym samym roku uzyskał również tytuł magistra prawa. Jest członkiem zespołu realizującego Europejski Sondaż Społeczny w Polsce oraz Rady Programowej Centrum Studiów Migracyjnych Uniwersytetu Łódzkiego. Publikował m.in. w czasopismach takich jak „Studia Migracyjne – Przegląd Polonijny", „Władza sądzenia" oraz „Italian Labour Law E-Journal", gdzie pełnił także funkcje redakcyjne. Na co dzień zajmuje się analizą danych w programie IBM SPSS oraz R. Jego zainteresowania badawcze koncentrują się przede wszystkim na metodologii badań sondażowych, analizie danych ilościowych, zastosowaniach uczenia maszynowego oraz analizie danych wtórnych.

Bibliography:

Adamowicz, M. (2022). COVID-19 Pandemic as a Change Factor in the Labour Market in Poland, *Sustainability*, *14*(15), 1–21. https://doi.org/10.3390/su14159197

Almeida, I. L. de L., Rego, J. F., Teixeira, A. C. G., & Moreira, M. R. (2022). Social isolation and its impact on child and adolescent development: a systematic review, *The Revista Paulista de Pediatria*, *40*, 1–9. https://doi.org/10.1590/1984-0462/2022/40/2020385

Andresen, E. M., Malmgren, J. A., Carter, W. B., & Patrick, D. L. (1994). Screening for depression in well older adults: evaluation of a short form of the CES-D, *American Journal of Preventive Medicine*, *10*(2), 77–84. https://doi.org/10.1016/S0749-3797(18)30622-6

Boguszewski, R. (2022a). Aspiracje, dążenia i plany życiowe młodzieży. In CBOS, *Młodzież 2021, raport z badań ilościowych zrealizowanych przez Fundację CBOS* (pp. 62–82). CBOS / KCPU. https://kcpu.gov.pl/wp-content/uploads/2023/01/Mlodziez-2021-raport_uzupelniony.pdf

Chi, X., Liang, K., Chen, S.-T., Huang, Q., Huang, L., Yu, Q., Jiao, C., Guo, T., Stubbs, B., Hossian, M. M., Yeung, A., Kong, Z., & Zou, L. (2021). Mental health problems among Chinese adolescents during the COVID-19: The importance of nutrition and physical activity, *International Journal of Clinical and Health Psychology*, *21*(3), 1–10. https://doi.org/10.1016/j.ijchp.2020.100218

Cosma, A., Abdrakhmanova, S., Taut, D., Schrijvers, K., Catunda, C., & Schnohr, C. (2023). *A focus on adolescent mental health and well-being in Europe, central Asia and Canada. Health Behaviour in School-aged Children international report

from the 2021/2022 survey. Volume 1*. https://iris.who.int/server/api/core/bitstreams/2e2d0d63-bd03-4c9d-aec5-64bb161bf98b/content

Dębski, M., & Flis, J. (2023). *MŁODE GŁOWY. Otwarcie o zdrowiu psychicznym. Raport z badania dotyczącego zdrowia psychicznego, poczucia własnej wartości i sprawczości wśród młodych ludzi w Polsce*, Fundacja UNAWEZA. https://mlodeglowy.pl/wp-content/uploads/2023/04/MLODE-GLOWY.-Otwarcie-o-zdrowiu-psychicznym_-Raport-final.pdf

European Social Survey European Research Infrastructure Consortium (ESS ERIC). (n.d. – a). *About ESS*. European Social Survey. https://www.europeansocialsurvey.org/about-ess

European Social Survey European Research Infrastructure Consortium (ESS ERIC). (n.d. – b). *Data Collection: Switch to Self-Completion*. European Social Survey. https://www.europeansocialsurvey.org/methodology/methodology/data-collection-sc

European Social Survey European Research Infrastructure Consortium (ESS ERIC). (n.d. – c). *Sampling*. European Social Survey. https://www.europeansocialsurvey.org/methodology/methodology/sampling

European Social Survey European Research Infrastructure Consortium (ESS ERIC). (n.d. – d). *Weighting*. European Social Survey. https://europeansocialsurvey.org/methodology/ess-methodology/data-processing-and-archiving/weighting

Feliksiak, M. (July, 2025). *Co czują Polacy?*, CBOS. https://www.cbos.pl/PL/publikacje/flashe/pliki/2025/fl_041_2025.pdf

Field, A. (2009). *Discovering statistics using SPSS (and sex and drugs and rock 'n' roll). Third Edition*. SAGE Publications Ltd

Hult, M., Kaarakainen, M., & De Moortel, D. (2023). Values, Health and Well-Being of Young Europeans Not in Employment, Education or Training (NEET*), International Journal of Environmental*

Research and Public Health, *20*(6), 1–22. https://doi.org/10.3390/ijerph20064840

International Business Machines Corporation (IBM). (2021). *IBM SPSS Complex Samples 29*, IBM, https://www.ibm.com/docs/en/SSLVMB_29.0.0/pdf/IBM_SPSS_Complex_Samples.pdf

International Business Machines Corporation (IBM). (2022). *IBM SPSS Statistics Algorithms 29*, IBM, https://www.ibm.com/docs/en/SSLVMB_29.0.0/pdf/IBM_SPSS_Statistics_Algorithms.pdf

Jaccard, J., & Turrisi, R. (2003). *Interaction effects in multiple regression. Second Edition*. SAGE Publications Inc.

Kaminska, O. (2020). *Guide to Using Weights and Sample Design Indicators with ESS Data*, European Social Survey European Research Infrastructure Consortium (ESS ERIC). https://europeansocialsurvey.org/sites/default/files/2023-06/ESS_weighting_data_1_1.pdf

Kopycka, K., & Petelewicz, M. (2019). Zróżnicowanie subiektywnego dobrostanu w krajach Europy Środkowo-Wschodniej, *Przegląd Socjologiczny*, *68*(2), 33–54. https://doi.org/10.26485/PS/2019/68.2/2

Kozera-Mikuła, P. (2020). Sens życia – analiza pojęcia w świetle nauk humanistycznych, *Psychologia Rozwojowa*, *25*(2), 9–28. https://doi.org/10.4467/20843879PR.20.009.12264

Krok, D. (2018). When is Meaning in Life Most Beneficial to Young People? Styles of Meaning in Life and Well-Being Among Late Adolescents, *Journal of Adult Development*, *25*, 96–106. https://doi.org/10.1007/s10804-017-9280-y

Mariański, J. (2021). Sens życia w świadomości młodzieży polskiej – analiza socjopedagogiczna, *CHOWANNA*, *1*(56), 1–25. https://doi.org/10.31261/CHOWANNA.2021.56.03

Martela, F., Lehmus-Sun, A., Parker, P. D., Pessi, A. B., & Ryan R. M. (2023). Needs and Well-Being Across Europe: Basic Psychological Needs Are Closely Connected With Well-Being, Meaning, and Symptoms of Depression in 27 European Countries, *Social Psychological and Personality Science*, *14*(5), 501–514. https://doi.org/10.1177/194855062211136

Opozda, D. (2024). Poczucie sensu życia i wartości młodzieży. Konteksty psychopedagogiczne, *Roczniki Pedagogiczne*, *16*(4), 85–98. https://doi.org/10.18290/rped24164.6

Pracuj.pl. (2024, July 2). Polacy stawiają na pracę hybrydową. Badanie Pracuj.pl. https://media.pracuj.pl/331481-polacy-stawiaja-na-prace-hybrydowa-badanie-pracujpl

Raven, J., Becko, L., Kaczmarek, A., Herbst, J., & Gołasa, A. (2021). *Next Generation Poland*, British Council. https://www.britishcouncil.pl/sites/default/files/next_generation_poland_full_eng.pdf

Santini, Z. I., Koyanagi, A., Stewart-Brown, S., Perry, B. D., Marmot, M., & Koushede, V. (2021). Cumulative risk of compromised physical, mental and social health in adulthood due to family conflict and financial strain during childhood: a retrospective analysis based on survey data representative of 19 European countries, *BMJ Global Health*, *6*(3), 1–14. https://doi.org/10.1136/bmjgh-2020-004144

Scholz, N. (2021). *Mental health and the pandemic*, European Union. https://www.europarl.europa.eu/RegData/etudes/BRIE/2021/696164/EPRS_BRI(2021)696164_EN.pdf

Scovil, J. (2025). *Młodzi Polacy o wyzwaniach stojących przed ich pokoleniem*, CBOS. https://www.cbos.pl/SPISKOM.POL/2025/K_056_25.PDF

Solecki, R. (2023). *Raport z badania kondycji psychicznej młodzieży 2022*, Wydawnictwo Naukowe UKEN. https://rep.up.krakow.pl/xmlui/bitstream/handle/11716/13321/Solecki%20-%20Raport%20z%20badania%20kondycji%20psychicznej%20m%C5%82odzierzy.pdf?sequence=1&isAllowed=y

Stanojević, D., Todosijević, B., & Gvozdanović, A. (2025). The Well-Being of Young People in Europe During the Pandemic: The Social Ties, Labor Market Integration, and the Social Inequalities, In C. Suter, J. Chesters, S. Fachelli (Eds.) *Well-being During the Pandemic. Comparative Perspectives from the Global North and South* (pp. 69–97), Springer Cham. https://doi.org/10.1007/978-3-031-63440-6

Wojtyra, A. (2024). Meaning in Life among Young People in Poland. A Sociological and Theological Perspective, *Studia Ełckie*, *26*(2), 207–223. https://doi.org/10.32090/SE.260214

World Health Organization (WHO). (2022, March 2) *COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide*. https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

Zawadzka, D., Stalmach, M., Oblacińska, A. M., & Tabak, I. (2017). Związek poczucia sensu życia z zadowoleniem z życia, występowaniem dolegliwości subiektywnych oraz statusem ekonomicznym rodziny w populacji uczniów gimnazjum, *Developmental Period Medicine*, *21*(1), 60–68. https://bazawiedzy.imid.med.pl/info/article/IMID205fa233e97f4c18a37b94da1fdea8e5/

Datasets[7]:

European Social Survey European Research Infrastructure (ESS ERIC). (2025a). *ESS11 – integrated file, edition 3.0* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess11e03_0

European Social Survey European Research Infrastructure (ESS ERIC). (2023). *ESS10 – integrated file, edition 3.2* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess10e03_2

European Social Survey European Research Infrastructure (ESS ERIC). (2023b). *ESS10 Self-completion – integrated file, edition 3.1* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess10sce03_1

European Social Survey European Research Infrastructure (ESS ERIC). (2023e). *ESS9 – integrated file, edition 3.2* [Data set]. Sikt – Norwegian Agency

for Shared Services in Education and Research. https://doi.org/10.21338/ess9e03_2

European Social Survey European Research Infrastructure (ESS ERIC). (2023d). *ESS8 – integrated file, edition 2.3* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess8e02_3

European Social Survey European Research Infrastructure (ESS ERIC). (2023c). *ESS7 – integrated file, edition 2.3* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess7e02_3

European Social Survey European Research Infrastructure (ESS ERIC). (2025c). *ESS6 – integrated file, edition 2.7* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess6e02_7

European Social Survey European Research Infrastructure (ESS ERIC). (2025b). *ESS5 – integrated file, edition 3.6 (Austria not included)* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess5e03_6

European Social Survey European Research Infrastructure (ESS ERIC). (2023b). *ESS4 – integrated file, edition 4.6 (Austria and Lithuania not included)* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess4e04_6

European Social Survey European Research Infrastructure (ESS ERIC). (2018). *ESS3 – integrated file, edition 3.7 (Latvia and Romania not included)* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess3e03_7

European Social Survey European Research Infrastructure (ESS ERIC). (2012). *ESS2 – integrated file, edition 3.6 (Italy not included)* [Data set]. Sikt – Norwegian Agency for Shared Services in Education and Research. https://doi.org/10.21338/ess2e03_6

European Social Survey European Research Infrastructure (ESS ERIC). (2023a). *ESS1 – integrated file, edition 6.7* [Data set]. Sikt – Norwegian Agency

---

7 Datasets for each ESS round are listed separately although they were downloaded as a single combined file via *Datafile Builder (Wizard)* functionality available at: https://ess.sikt.no/en/data-builder/.

for Shared Services in Education and Research. https://doi.org/10.21338/ess1e06_7

Eurostat. (2025). *Overall life satisfaction by sex, age and educational attainment* [Data set]. https://doi.org/10.2908/ILC_PW01

Issues related to publishing ethics

Satysfakcja z życia i złe samopoczucie psychiczne młodych Polaków w czasach niepewności

Abstrakt

W ostatnich latach Europa, a w szczególności Europa Środkowa i Wschodnia, doświadczyła wydarzeń, które wywarły istotny wpływ na jej gospodarkę, rynek pracy, bezpieczeństwo, strukturę społeczną oraz zdrowie publiczne. Ciągłe zmiany pejzażu geopolitycznego i społeczno-ekonomicznego, najsilniej dotykają młodych ludzi, którzy muszą się mierzyć z ich konsekwencjami. Nie mogąc przewidzieć przyszłości, zaczynają zadawać pytania o sens życia, które są ściśle powiązane z kwestiami satysfakcji z życia i zdrowia psychicznego. Wyniki najnowszych badań potwierdzają ten trend, pokazując, że młodzi Polacy stoją w obliczu poważnych wyzwań związanych ze zdrowiem psychicznym, pomimo danych wskazujących na ich ogólną satysfakcję z życia.

Celem niniejszego artykułu jest określenie, jakie czynniki mogą wpływać na satysfakcję z życia oraz złe samopoczucie psychiczne młodych Polaków. Analizy opierają się na reprezentatywnych danych dla Polski pochodzących z Europejskiego Sondażu Społecznego. W celu udzielenia odpowiedzi na pytania badawcze i weryfikacji hipotez zastosowano Ogólne Modele Liniowe dla Prób Złożonych (Complex Sample General Linear Models). Wyniki pokazują, że ogólnie, satysfakcja z życia jest powiązana z poczuciem kontroli nad własnym życiem, zdrowiem psychicznym oraz kontekstem społecznym, w którym żyją respondenci. Kontekst społeczny jest szczególnie istotny dla młodych Polaków. Chociaż znaczenie tego kontekstu jest widoczne również w przypadku złego samopoczucia psychicznego, wzorzec związku różni się od tego obserwowanego dla satysfakcji z życia.

Ponadto predyktory związane ze zdrowiem są ważniejsze dla złego samopoczucia psychicznego – zwłaszcza dla młodych osób – niż ma to miejsce w przypadku satysfakcji z życia.

Słowa kluczowe: satysfakcja z życia, złe samopoczucie psychiczne, młodzi ludzie, Polska, Europejski Sondaż Społeczny.