Mentalno zdravlje Riječana

Mental Health of Rijeka's citizens

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Ankica Perhat

urednica / editor
mr. sc. Kristina Dankić

autori / authors
prof. dr. sc. Igor Kardum
mr. sc. Asmir Gračanin
mr. sc. Kristina Dankić
Ankica Perhat

prijevod / translation
Dragana Čubrilo (engleski / English)

lektura i korektura teksta na hrvatskome jeziku / Croatian language editor
dr. sc. Mihaela Matešić

lektura i korektura teksta na engleskome jeziku / English language editor
Dino Krambovitis

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Željko Stojanović

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Igor Kardum – Asmir Gračanin – Kristina Dankić – Ankica Perhat

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Predgovor

Govoriti o Rijeci znači govoriti o gradu u kojem su se, kroz burnu povijest, a i danas, u trenutku ubrzanoga razvoja, povezale i povezuju kulture i vrijednosti onih kojima je Rijeka izbor za život i rad. Poput rijeke koja teče našim gradom i mora koje ju dočekuje, međusobno su se spojile i rezultirale nekim novim riječkim mentalitetom – koji nije izrastao na samo jednoj i jednoobraznoj prošlosti ili tradiciji, situaciji koja obično ometa postizanje odmaka od tradicionalizma i otvorenost prema novome u onom razmjeru kakav obilježava građane Rijeke.

Zato kada govorim o Riječanima, bez imalo zadrške i s ponosom mogu reći kako se radi o slobodoumnim, otvorenim, tolerantnim i gostoljubivim ljudima.

Čini se da ću ubuduće sa sigurnošću moći reći da su moji sugrađani i optimistični, visokoga samopoštovanja i zadovoljni svojim životom te da tek manji dio stanovnika ima probleme s depresivnošću, tjeskobom, stresom i usamljenošću – problemima s kojima se susreće sve više ljudi koji pripadaju tzv. zapadnom svijetu. Nadam se da je barem mali dio toga povezan s uvjetima života, na čijem smo poboljšanju, u proteklim godinama, naporno radili, a i nastavljamo to činiti.

Već je cijelo desetljeće Grad Rijeka dio velike mreže gradova kojima je prioritet zdravlje. Ulazeći u IV. fazu projekta kojem je jedna od središnjih tema zdravo starenje, kao izazov uočili smo nepostojanje specifičnih baza podataka o pojedinim aspektima zdravlja i njegovih odrednica. Radi se o podacima o tome kakva je subjektivna procjena građana o njihovu tjelesnom zdravlju, zatim o podacima kao što su npr.: tjelesna aktivnost, pušenje, prehrana, način korištenja lijekova, preventivni zdravstveni pregledi, zaštita pri izlaganju suncu, ponašanje u prometu, te podacima o mentalnom zdravlju stanovništva što je bio predmet istraživanja iz kojeg je proizašla i ova knjiga. Iznimno mi je drago što se Europska mreža zdravih gradova Svjetske zdravstvene organizacije u svojoj IV. fazi, uz ostalo dotiče i teme mentalnog zdravlja te se nadam da će joj u budućnosti dati i jedno od ključnih mjesta.

Cilj prikupljanja ovih podataka bila je prije svega mogućnost usporedbe s drugim europskim gradovima koji su kao svoju orijentaciju izabrali zdravlje. No vjerujem da će ovi nadasve zanimljivi i korisni podaci udovoljiti i znatiželji svih čitatelja, a da će stručnjake potaknuti na osmišljavanje projekata za zaštitu i veću kvalitetu mentalnoga zdravlja naših sugrađana, pri čemu svakako mogu računati na podršku Grada Rijeke.

Zahvaljujem stoga znanstvenicima s Odjeka za psihologiju Filozofskoga fakulteta Sveučilišta u Rijeci i njihovim studentima koji su nam prikupljanjem i analizom podataka pomogli spoznati kakvo je mentalno zdravlje građana Rijeke i omogućili nam praćenje pokazatelja mentalnog zdravlja kroz vrijeme i učinkovitije planiranje programa za unapređenje zdravlja.

mr. sc. **Vojko Obersnel**, gradonačelnik Rijeke

Foreword

To speak about Rijeka is to speak of a city in which different cultures and values of those living and working here have always intertwined. Rijeka has always remained such a city throughout its turbulent past and continues to be in these times of non-stop progress. Like the river flowing through our city and the sea welcoming it, those cultures and values have merged and blended creating a new and original mentality – Rijeka's mentality. It is unburdened by one past one that allows breaking away from tradition and openness to novelties which distinguishes the citizens of Rijeka.

Therefore, when I speak about the people of Rijeka, I can say without hesitating and with great pride the these are open-minded, welcoming, tolerant and hospitable people.

It seems so that in future I will be able to speak with great certainty of my fellow citizens as optimistic people with high level of self-esteem, great life satisfaction, and with only a minority suffering from depression, anxiety, stress and loneliness – all problems affecting more and more people in the so-called western world. I hope that at least a smaller fraction of these issues are related to living conditions, which we have continuously been improving for years now and still continue to.

Over the past decade, the City of Rijeka has been a part of the WHO European Healthy Cities Network whose priority is health. Entering the Phase IV of the European Healthy Cities Network, with healthy ageing as one of the core themes, we have identified as our challenge the obvious lack of specific databases on certain health aspects and their determinants, such as: data on physical activity, smoking, nutrition, use of medication, preventive medical check-ups, sun protection, traffic behaviour, as well as the data on subjective perception of physical health, and the data on mental health of the citizens. The mental health in Rijeka was the focal point of the research that resulted in this book. I am very pleased that the WHO European Healthy Cities Network decided to act towards mental health, among other topics, in its Phase IV, and I sincerely hope that mental health will be given an important role in future as well.

Data was collected in order to compare the findings with other European cities that have chosen health as their orientation. However, I do believe that this interesting and useful information will satisfy the curiosity of every reader, and encourage professionals to create projects for mental health protection and improvement, as they can count on the support the City of Rijeka will provide.

In conclusion, I would like to thank the scientists from the Department of Psychology Faculty of Art and Sciences, University of Rijeka and their students whose work on data collecting and data analysis has provided us with the insight on our co-inhabitants' mental health and enabled us to monitor mental health indicators, as well as plan programmes for health promotion.

Vojko Obersnel, M.Sc. Mayor of the City of Rijeka

Uvod

Svjetska zdravstvena organizacija mentalno zdravlje definira kao stanje subjektivne dobrobiti u kojem svaki pojedinac može realizirati svoje potencijale, suočavati se s uobičajenim stresnim stanjima u životu, raditi produktivno i učinkovito te biti sposoban pridonijeti svojoj zajednici. Nadalje mentalno je zdravlje bitno i za odgovarajuće obiteljsko i interpersonalno funkcioniranje. Tako shvaćeno mentalno zdravlje osnova je zdravlja općenito, a kvaliteta mentalnog zdravlja ključ je zdravoga života.

S druge strane mentalni poremećaji odnose se na zdravstvena stanja koja obilježavaju promjene u mišljenju, raspoloženju i ponašanju, koje su povezane s tjeskobom ili narušenom funkcionalnošću.

Treba naglasiti da su mentalni poremećaji ozbiljan javnozdravstveni problem. Premda se mentalnom zdravlju ne pridaje tolika briga i važnost kao tjelesnom zdravlju, mentalni su poremećaji relativno česti, javljaju se u svim dobnim skupinama, njihovo je liječenje skupo i uzrokuju preranu smrtnost. Svjetska zdravstvena organizacija procjenjuje da oko 450 milijuna ljudi ima neki mentalni poremećaj, oko milijun ljudi svake godine počini samoubojstvo, a samo od depresije pati više od 150 milijuna ljudi. Još više ljudi pati od različitih problema mentalnoga zdravlja, znakova i simptoma nedovoljnog intenziteta i trajanja da bi bili svrstani u mentalne poremećaje.

Mentalni su poremećaji među najčešćim uzrocima disfunkcionalnosti i općenito imaju snažan utjecaj na oboljele i njihove obitelji. Osobe s mentalnim poremećajima socijalno su izolirane i imaju lošiju kvalitetu života. ešće su izložene kršenju ljudskih prava, stigmatiziranju i diskriminaciji kako unutar institucija koje se bave mentalnim zdravljem tako i izvan njih. Mentalno je zdravlje usko povezano s tjelesnim zdravljem, pa su osobe s mentalnim poremećajima češće izložene i tjelesnim bolestima. Tako je primjerice depresivnost rizičan faktor za obolijevanje od karcinoma i srčanih bolesti. Nadalje mentalni poremećaji često dovode i do lošijeg ishoda pri liječenju tjelesnih bolesti.

Mentalni poremećaji negativno utječu na radnu sposobnost oboljelih i osoba koje se o njima brinu, na njihovu produktivnost i prihode, kao i na ekonomiju društva u cjelini. Kada se tome pridodaju i troškovi tretmana, procjenjuje se da se u razvijenim zemljama na

Introduction

According to the World Health Organisation, mental health is defined as a state of subjective well-being in which every individual realizes his or her own potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Furthermore, mental health is essential for adequate family and interpersonal functioning. Mental health is the basis of health in general, and mental health quality is the key to a healthy life.

On the other hand, mental disorders are health conditions that are characterized by alterations in thinking, mood, or behaviour associated with distress and/or impaired functioning.

It is important to say that mental disorders are a serious public health problem. Although mental health does not receive such attention and emphasis as physical health does, mental disorders are relatively frequent, can occur in all age groups, their treatment is expensive, and they cause premature mortality. The World Health Organisation estimates that more than 450 million people are affected by some form of mental disorder, about 1 million people commit suicide every year, and over 150 million people suffer from depression. Even more suffer from mental health problems, signs and symptoms that lack intensity and duration to be identified as mental disorders.

Mental disorders are amongst the most common causes of dysfunctionality, and in general strongly affect the ill persons and their families. Persons suffering from mental disorders are socially isolated and have a poorer quality of life. Their human rights are more likely to become violated, and the problems of social stigma and discrimination are widespread, both within the institutions dealing with mental health and beyond them. As mental health is closely related to physical health, persons with mental disorders are more prone to physical illnesses as well. For example, depression is a risk factor for carcinoma and heart disease incidence. In addition, mental disorders can lead to poorer outcomes in treatment of physical illness.

Mental disorders have adverse consequences on the work ability of ill persons and those taking care of them, their productivity and in-

osobe oboljele od mentalnih poremećaja troši između 3 i 4% bruto nacionalnog dohotka.

Nema društva, skupine ili pojedinca koji bi bili imuni na mentalne poremećaje. Međutim rizik od obolijevanja veći je kod siromašnih, nezaposlenih, slabije obrazovanih, migranata i izbjeglica, žrtava nasilja, djece i adolescenata, zlostavljanih žena i starijih ljudi o kojima se nedovoljno skrbi.

Osobe koje imaju problema s mentalnim zdravljem ili neke simptome mentalnih poremećaja treba ohrabrivati da potraže stručnu pomoć, budući da su razvijeni učinkoviti tretmani za različite vrste mentalnih poremećaja. U novije se vrijeme na području mentalnog zdravlja sve veća pozornost pridaje i preventivnim mjerama.

Problemi koji se odnose na mentalno zdravlje snažno utječu na oboljele, njihove obitelji i društvo u cjelini. Zbog toga je jedan od trajnih ciljeva Svjetske zdravstvene organizacije i ostalih organizacija koje se bave zdravljem sprečavanje mentalnih poremećaja i promicanje mentalnoga zdravlja.

come, as well as the economy in general. It is estimated that developed countries spend between 3 to 4% of their gross national product on economic costs of mental illnesses.

There is not a single society, a group or an individual immune to mental disorders. However, the most vulnerable are those with low socioeconomic status, the unemployed, people with low education, migrants and refugees, violence victims, children and adolescents, physically abused women and the elderly not receiving enough care.

People suffering from mental health problems or other mental health disorders should be encouraged to seek professional help, as they can be successfully treated. The current trend in mental health is also promoting prevention.

In conclusion, problems related to mental health strongly affect ill persons, their families and society overall. Therefore, it is one of the ongoing goals of the World Health Organisation and other health organisations to prevent mental disorders and promote mental health.

Ciljevi istraživanja

Opći cilj ovoga istraživanja bio je ispitati **kakvo je mentalno zdravlje** građana Rijeke, kako bi se efikasnije planirale aktivnosti Odjela gradske uprave za zdravstvo i socijalnu skrb Grada Rijeke usmjerene zaštiti i unapređenju mentalnog zdravlja te prevenciji mentalnih poremećaja i njihovih posljedica.

Jedan od specifičnih ciljeva ovoga istraživanja bio je identificirati **skupine građana koje imaju povećan rizik** od nastanka problema vezanih uz mentalno zdravlje. Zbog toga su ovim istraživanjem prikupljeni i mnogobrojni sociodemografski podaci o građanima.

Cilj je ovoga istraživanja bio i da se na osnovi dobivenih rezultata predlože **intervencije** za zaštitu i poboljšanje mentalnog zdravlja te prevenciju mentalnih bolesti.

Ovim je istraživanjem stvorena i početna baza podataka, kao osnova za buduća istraživanja s ciljem praćenja promjena u mentalnom zdravlju građana Rijeke i evaluacije mjera koje će Odjel gradske uprave za zdravstvo i socijalnu skrb Grad Rijeka poduzeti radi njegova poboljšanja.

Objectives

The main objective of this research was to analyse **the mental health** of the citizens of Rijeka in order to plan the activities of the City Department of Health and Social Welfare more efficiently, which are aimed at promoting mental health and the prevention of mental disorders and their effects.

One of the specific objectives of this research was to identify the **risk groups of citizens who are more prone** to problems related to mental health. Therefore, this research also obtained numerous socio-demographic data on the citizens.

Another objective of this research was to suggest **interventions** based on the data obtained, in order to improve mental health and prevent mental diseases.

Finally, this research has created a preliminary database, which could be used as a reference by future researchers in order to monitor changes in mental health of the citizens of Rijeka, with the purpose of evaluating the measures to be undertaken by the City Department of Health and Social Welfare in order to improve it further.

Metodologija istraživanja

Anketni upitnik

Anketni je upitnik konstruiran na temelju preporuka Europske komisije *The Health and Consumer Protection Directorate General* (http://ec.europa.eu/health/ph_projects/1998/monitoring/fp_monitoring_1998_annexe3_09_en.pdf) o indikatorima koje bi bilo poželjno koristiti kod procjene mentalnog zdravlja.

Anketnim su upitnikom ispitani sljedeći pokazatelji mentalnog zdravlja: depresivnost, anksioznost, usamljenost, stresni životni događaji, percepcija stresnosti, percipirana socijalna podrška, optimizam, samopoštovanje, osjećaj dobrobiti i zadovoljstvo životom.

Pri tome su korišteni različiti psihologijski mjerni instrumenti koji po svojim metrijskim karakteristikama (pouzdanost, objektivnost, valjanost i osjetljivost) zadovoljavaju visoke kriterije znanstvene metodologije. To znači da uglavnom točno i objektivno mjere ono što bi trebali mjeriti, kao i da dobro diferenciraju ispitanike.

Method

Questionnaire

The questionnaire was designed following the recommendations of the European Commission, The Health and Consumer Protection Directorate General (http://ec.europa.eu/health/ph_projects/1998/monitoring/fp_monitoring_1998_annexe3_09_en.pdf) on indicators for evaluating mental health.

The questionnaire was used to evaluate the following indicators of mental health: depression, anxiety, loneliness, stressful life events, perception of stress, perceived social support, optimism, self-esteem, subjective well-being, and life satisfaction.

In addition, various psychological measures were used that meet the high criteria of scientific methodology in their metrical features (i.e. reliability, objectivity, validity, and sensitivity). In other words, they measure what they are designed to measure in an accurate and objective manner, as well as differentiating the participants appropriately.

Upitnikom su prikupljeni i mnogobrojni sociodemografski podaci koji se u stručnoj literaturi najčešće povezuju s mentalnim zdravljem. Međutim neki od njih nisu uzeti u daljnju analizu jer nisu zadovoljavali statističke kriterije (npr. u nekim slučajevima nije se pojavio dovoljan broj mogućih odgovora, već je većina dala iste odgovore).

U analize su uključeni sljedeći sociodemografski pokazatelji: spol, dob, obrazovanje, radna aktivnost, bračno stanje, broj članova kućanstva, broj djece, mjesto stanovanja i prihodi kućanstva. Uz sociodemografske ispitani su i sljedeći pokazatelji tjelesnoga zdravstvenog stanja: invalidnost, kronična bolest, teža bolest i subjektivna percepcija zdravlja.

Ispitanici i postupak

Podatke su tijekom studenoga i prosinca 2007. godine prikupljali prethodno podučeni anketari, većinom studenti psihologije. Ispitivanje je provedeno na velikom uzorku građana (N=1.002 osobe) izabranom tako da što bolje i točnije reprezentira (predstavlja) populaciju građana Rijeke u dobi od 18 godina naviše.

Reprezentativan uzorak podrazumijeva stratifikaciju i kvote s obzirom na neke demografske i geografske parametre, te slučajan izbor ispitanika unutar tih okvira. Nastojalo se naime da s obzirom na važnije demografske varijable (spol, dob, obrazovanje) uzorak ispitivanih građana po proporcijama odgovara podacima o svim stanovnicima Rijeke iz posljednjeg popisa stanovništva (Popis stanovništva, 2001). Također, odnos broja ispitanika svakoga mjesnog odbora i ukupnog uzorka usklađen je s odnosom ukupnog broja stanovnika toga mjesnog odbora i ukupnog broja stanovnika grada.

Unutar mjesnih odbora slučajnim su postupkom izabirane ulice, a također i ispitanici (uz uvjet da se uklapaju u zadane okvire), koje su potom anketari, uz njihov dragovoljan pristanak, ispitali u njihovim kućanstvima. Kako bi se osigurala što veća iskrenost u odgovaranju, ispitanicima je jamčena anonimnost, a kad god je za to postojala mogućnost, samostalno su i odgovarali na postavljena pitanja. Anketiranje je trajalo oko jedan sat.

Takav postupak omogućio je da se rezultati dobiveni na ovom uzorku ispitanika mogu generalizirati na cjelokupnu populaciju stanovnika Rijeke u dobi od 18 godina i više.

Furthermore, the questionnaire was a means of collecting numerous socio-demographic data that is often related to mental health in reference books. However, some did not fulfil the statistic criteria (e.g. in some cases there was not an adequate number of possible answers, but most subjects answered in the same way).

The analysis included the following socio-demographic indicators: sex, age, education, economical activity, marital status, household members, number of children, place of residence, and household income. Along with the socio-demographic, the following indicators of physical health status were also analysed: disability, chronic disease, severe illness, and subjective perception of health.

Subjects and method

The data was collected in November and December of 2007 by educated interviewers, most of them being psychology students. The research was carried out on a large sample of citizens (N=1,002 persons) selected in such a way that they can represent the population of the city of Rijeka from the age 18 and over, in the best and the most accurate way possible.

The term *representative sample* includes stratification and quotas relevant to certain demographic and geographic parameters, and random sample of subjects from within that framework. Given the more important demographic variables (i.e. sex, age, education), the data on all the citizens from the last census (Census, 2001) matched our sample study proportions. Furthermore, the ratio of number of subjects in each local district to the overall sample is in proportion to the ratio of residents of the local district to the overall number of citizens.

The streets were randomly chosen within the local districts, as well as the participants (providing they were compatible with the given quotas), who were then interviewed in their homes, obviously with their consent. In order to obtain answers that are as honest as possible, the subjects were guaranteed anonymity, and whenever it was possible, they answered questions independently. The interviewing procedure lasted for about an hour.

This procedure enabled the findings on this sample of subjects to be generalised to the population of age of 18 and over in the city of Rijeka.

Pokazatelji sociodemografskoga i zdravstvenog statusa građana Rijeke

Opći podaci

U istraživanju je sudjelovalo ukupno 1.002 ispitanika u dobi od 18 do 90 godina starosti. Prosječna životna dob ispitanih građana iznosi 46 godina. Ženskoga je spola 53,2% ispitanih građana, a muškoga 46,8%.

Obrazovanje i radna aktivnost

Najveći broj ispitanika ima završenu trogodišnju ili četverogodišnju srednju školu za zanimanja (49,5%), zatim fakultet uključujući i one s magisterijem i doktoratom (16,3%), slijede oni bez škole ili sa završenom samo osnovnom školom (14,6%), te ispitanici sa završenom gimnazijom (10,5%), dok najmanji broj građana ima završenu višu školu (9,1%).

U prosjeku ispitani građani imaju 18 godina i 8 mjeseci radnog iskustva, pri čemu određeni broj (13,5%) građana nema nikakvo radno iskustvo, a kao najveći broj godina radnog iskustva navodi se 49 godina.

S obzirom na radni status, najviše ih je zaposleno (50,5%), nezaposleno je 10,4%, dok je među ispitanim građanima 39,1% radno neaktivnih.

Od ukupnog broja zaposlenih najviše ih radi kod poslodavca u bilo kojem sektoru vlasništva (88,2%), slijede oni koji samostalno obavljaju djelatnost u vlastitom poduzeću, obrtu ili slobodnom zanimanju i ne zapošljavaju radnike (4,5%), građani koji samostalno obavljaju djelatnost u vlastitom poduzeću, obrtu ili slobodnom zanimanju i zapošljavaju radnike (2,6%), građani koji rade samo po ugovoru o djelu, autorskom ugovoru i sl. (3%), dok je među ispitanima najmanji broj onih koji kao pomažući članovi obitelji rade u poduzeću nekog od članova obitelji (1,6%).

Najveći broj zaposlenih ispitanika radi u punom radnom vremenu (93,3%), 4,3% ispitanih građana radi u nepunom radnom vreme-

Sociodemographic and health status indicators of the citizens of Rijeka

General data

The research involved a total of 1,002 participants aged 18 – 90. The average age of the participants was 46. 53.2% of participants were women and 46.8% were men.

Education and economical activity

Most participants have finished vocational schools (ISCED, Level 3A, 3B, 3C) (49.5%), followed by university graduates (ISCED, Level 5A), including those with a master's degree and doctorates (ISCED, Level 6) (16.3%), then come those who have no formal education or have completed primary schooling (ISCED, Levels 1 and 2) (14.6%), and grammar school (ISCED, Level 3A) (10.5%), whereas the least citizens are 2-year university graduates (ISCED, Level 5B) (9.1%).

On average, the citizens have 18 years and 8 months of work experience, where a certain number of citizens (13.5%) have no work experience; the longest work experience recorded is 49 years.

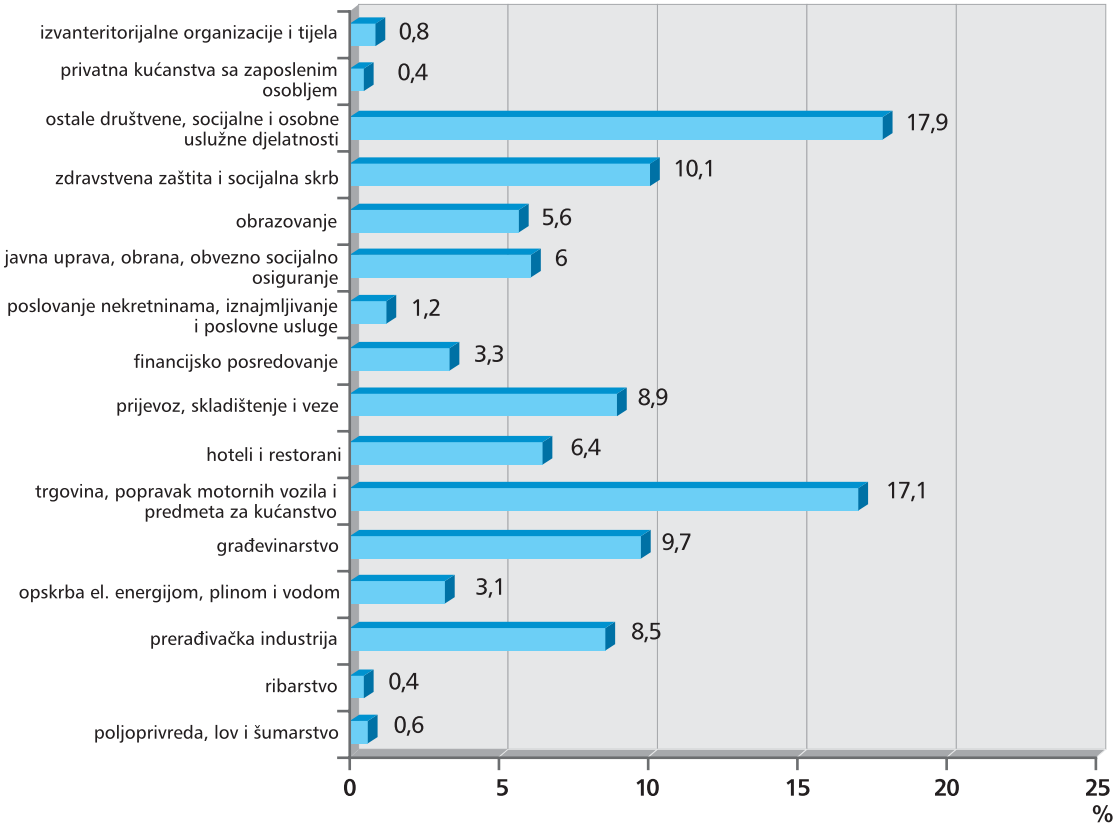
Given economical activity, most are employed (50.5%) and 10.4% of the participants are unemployed, whereas 39.1% of those interviewed belong to the economically inactive population.

Of those employed, most work for an employer in any ownership sector (88.2%), followed by those who are self-employed and do not hire workers (4.5%), citizens who are self-employed and hire workers (2.6%), and citizens who have a temporary service contract, author's contract and similar (3%), whereas the lowest number of participants work in a family member's business as assisting family members (1.6%).

nu, a ostali rade u skraćenome radnom vremenu zbog uvjeta rada (1,3%), odnosno zbog bolesti ili invalidnosti (1,1%). Zaposleni ispitanici u prosjeku rade 41 sat na tjedan. Minimalan broj radnih sati na tjedan iznosi tri sata, dok se kao najveći broj sati rada na tjedan navodi 84 sata.

Slijedi prikaz djelatnosti u kojima rade ispitanici koji su u trenutku ispitivanja bili zaposleni.

Djelatnost u kojoj ispitanici rade

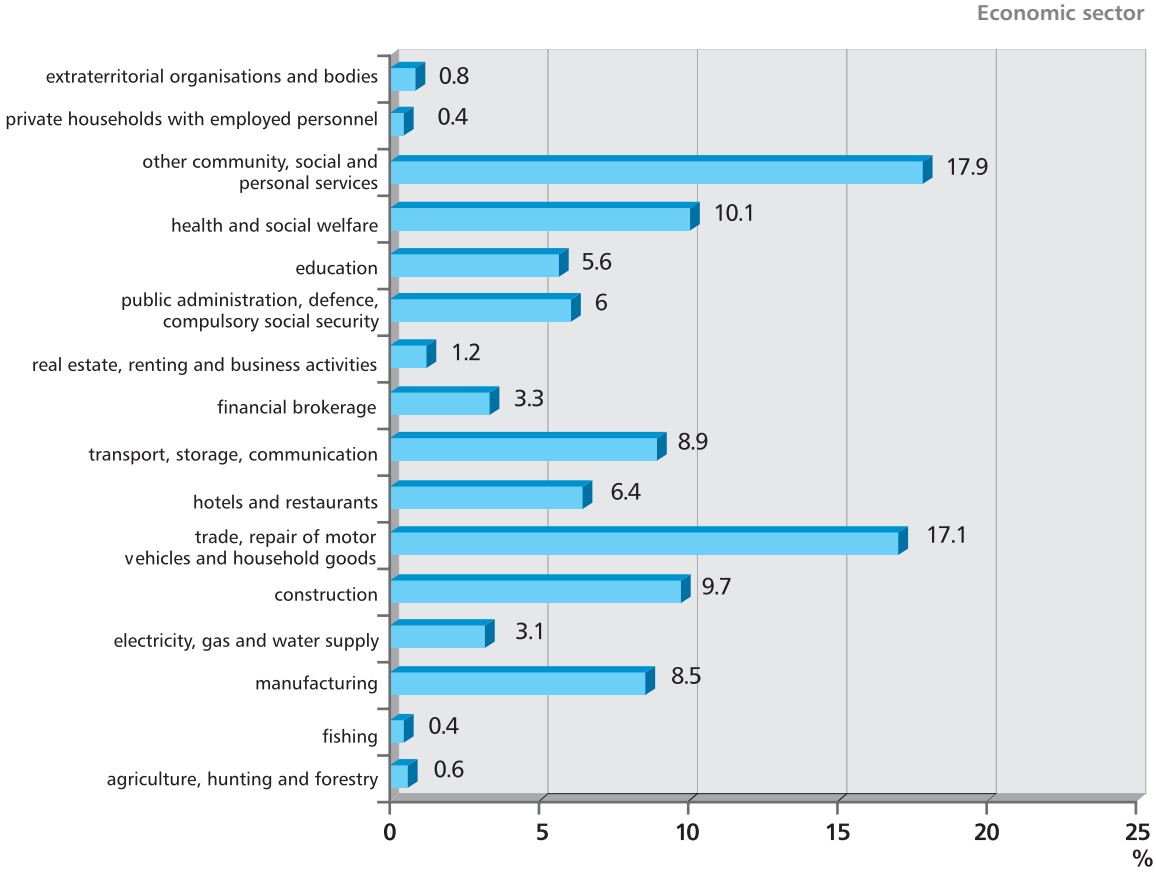


U ukupnom broju nezaposlenih ispitanika najveći broj navodi da je nezaposlen i da ponovno traži posao (52%), 24% prvi put traži posao, a preostalih 24% ne svrstava se ni u jednu od tih dviju kategorija.

U ukupnom broju radno neaktivnih ispitanika najviše je umirovljenika (60,9%), potom učenika i studenata (27,6%), a zatim slijede kućanice (10,2%), te nesposobni za rad (0,8%) i ostali (0,5%).

Most working participants have a full-time job (93.3%), 4.3% work part-time, and 1.3% work part-time due to specific working conditions, illness or disability (1.1%). Working participants work 41 hours a week on average. The minimum working hours a week is 3, and the maximum is 84.

The following chart shows the economic sectors in which participants were working at the time of the interview.



In total, of those unemployed, most are unemployed and are looking for a new job (52%), 24% are looking for work for the first time, and the remaining 24% do not fit into either of these two categories.

Of the economically inactive participants, the majority are retired (60.9%), followed by students (27.6%), housewives (10.2%), those unable to work (0.8%) and other (0.5%).

Od ukupnog broja zaposlenih te učenika i studenata, 88,1% ih kao mjesto rada ili školovanja navodi grad Rijeku, dok 11,9% radi ili se školuje izvan Rijeke.

Od onih koji rade ili se školuju izvan Rijeke, 66,1% ih se u Rijeku vraća svakodnevno, 7,1% tjedno, 12,5% mjesečno, 12,5% ih se vraća sezonski, dok ih se rjeđe od toga u Rijeku vraća 1,8%.

Bračno i obiteljsko stanje

S obzirom na bračno stanje najviše je ispitanih građana oženjeno odnosno udano (57,7%), neoženjeno/neudano je 27,2% ispitanih građana, 8,7% su udovci/udovice, a 6,4% ih je rastavljeno.

Broj članova kućanstava kreće se od jednog do sedam članova, s prosjekom od tri člana.

U prosjeku ispitani građani imaju jedno dijete, pri čemu treba istaknuti da 30,9% uopće nema dijete.

Regarding those employed and students, 88.1% of them work or study in Rijeka, whereas the remaining 11.9% do so outside the city of Rijeka.

Among those participants who work or study outside Rijeka, 66.1% of them commute to Rijeka daily, 7.1% of them weekly, 12.5% monthly, 12.5% return to Rijeka as seasonal workers or students, whereas 1.8% of participants return to Rijeka less often than that.

Marital and family status

Taking marital status into consideration, the majority of participants are married (57.7%), whereas 27.2% are single, 8.7% are widowed, and 6.4% are divorced.

The number of people living in a single household ranges from one to seven, and the average number of people living in a household is three.

On average, the participants have one child. It should be pointed out that 30.9% of participants do not have a child at all.

Stanovanje

Najveći broj ispitanih građana živi u isključivo ili pretežito stambenim zgradama s tri i više stanova (80,7%), zatim u isključivo ili pretežito stambenim zgradama s dva stana (8,11%), te isključivo ili pretežno stambenim zgradama s jednim stanom (8%). U pretežito nestambenim zgradama živi 1,3%, a u stanovima u zgradi domova i sl. stanuje 1,8% ispitanih građana.

Ispitani građani žive u stanovima površine od 8m^2 do 250m^2, odnosno u prosjeku u stanovima od 67m^2. Prosječna površina stana po članu kućanstva iznosi 28,8m^2, a raspon površine stana po članu kućanstva kreće se od minimalno 1,5m^2 do maksimalno 200m^2.

Najveći broj ispitanika živi u stanovima koji su u vlasništvu privatnih osoba (86,4%), dok ostalih 13,6% stanuje u stanovima koji nisu u privatnom vlasništvu. Nadalje, 75,1% ih navodi da je osnova korištenja stana u kojem stanuju privatno vlasništvo ili suvlasništvo, 4,3% su najmoprimci sa slobodno ugovorenom najamninom, 8,9% ih je u srodstvu s vlasnikom ili najmoprimcem stana, 2% su najmoprimci sa zaštićenom najamninom, dok 7,1% ispitanih građana unajmljuje dio stana (podstanari), a 2,6% navodi neku drugu nespecificiranu osnovu korištenja stana u kojem stanuju.

Most participants live in a block of flats with three or more apartments (80.7%), followed by those living in buildings with two flats (8.11%), then those living in houses with one apartment (8%). 1.3% of the participants live in houses that are not residential, and 1.8% of the citizens interviewed live in flats, homes and similar accommodation.

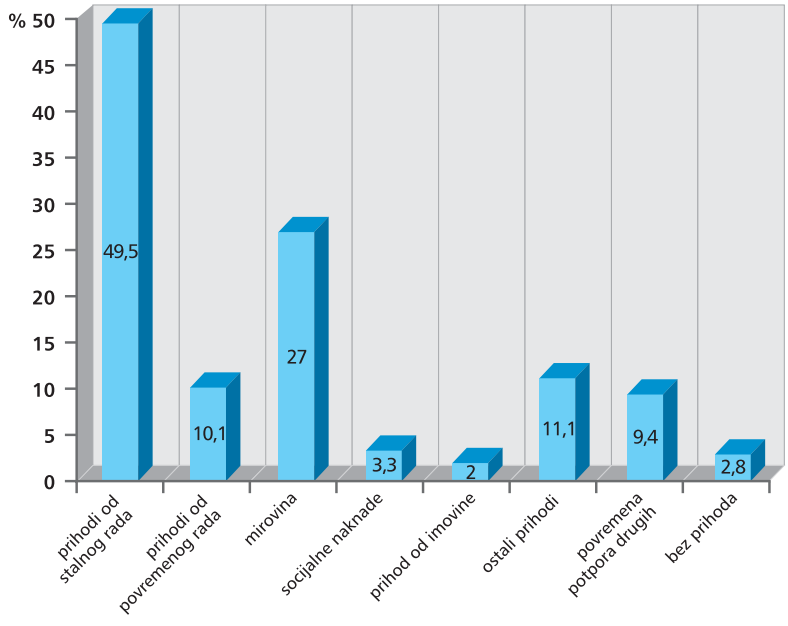
Participants live in flats that range from 8m^2 to 250m^2, the average being 67m^2. The average flat area per household member is 28.8m^2, and ranges from 1.5m^2 per household member to 200m^2.

Most participants live in private property flats (86.4%), whereas the remaining 13.6% live in flats that are not private property. Furthermore, 75.1% say that the basis of using the flat they live in is either private property or co-ownership, 4.3% are tenants with an agreed rent, 8.9% are related with the owner or the tenant, 2% are tenants with protected rent, whereas 7.1% of the participants rent a part of a flat (subtenants), and 2.6% state another unspecified basis of using the flat they live in.

Prihodi

Slijedi prikaz glavnih izvora sredstava za život kod ispitanih građana.

Glavni izvori sredstava za život

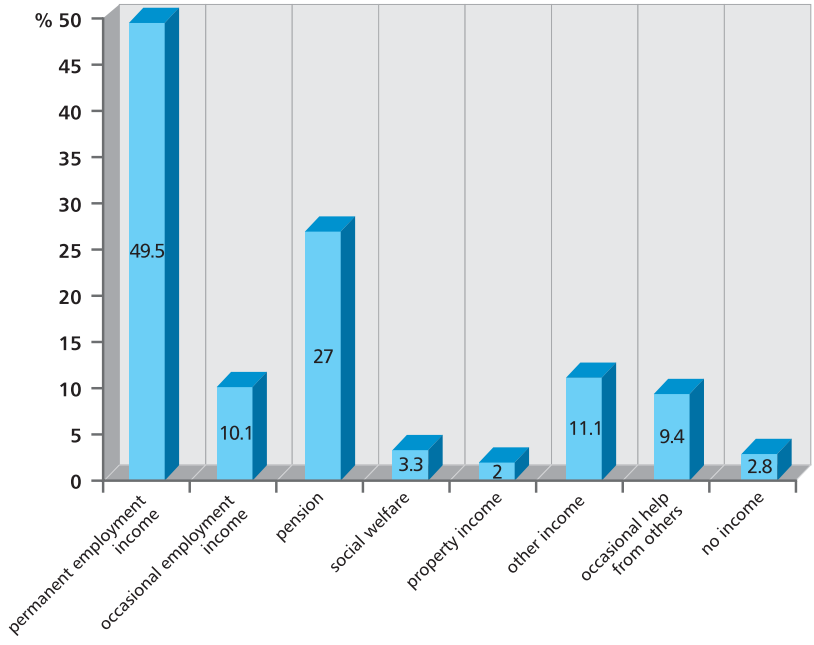


Kao što je vidljivo iz grafičkoga prikaza, najvećem je broju ispitanih građana glavni izvor prihoda prihod od stalnog rada, a najmanji broj građana kao glavni izvor sredstava za život navodi prihod od imovine.

Main sources of livelihood

The following chart shows main sources of livelihood of the participants.

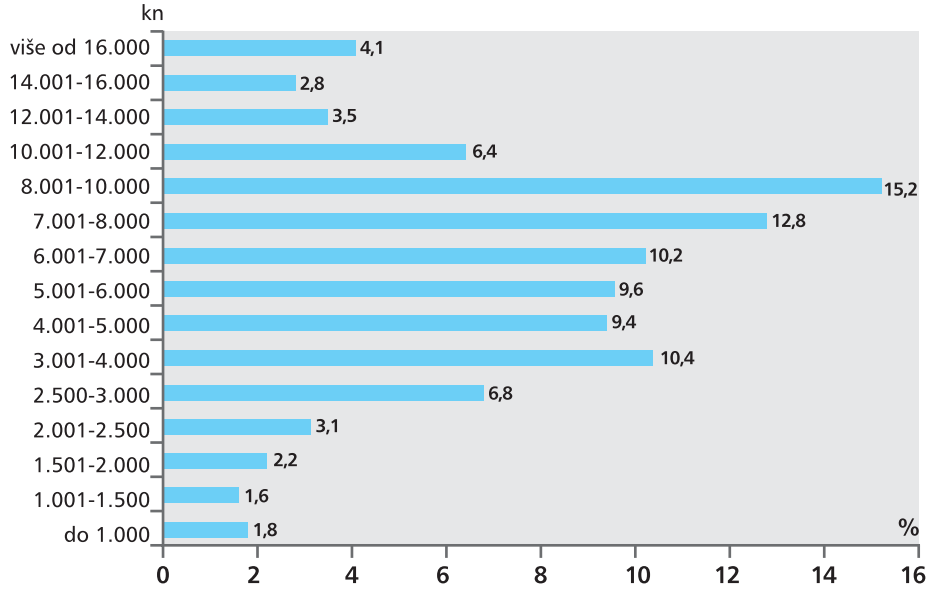
Main sources of livelihood



As shown in this chart, most participants earn their income from permanent employment, and the least number of citizens state that property is their main source of livelihood.

Najveći broj ispitanih građana kao ukupne mjesečne prihode svih članova kućanstva (koje u prosjeku ima tri člana) navodi prihode u rasponu od 8.001,00 do 10.000,00 kuna (15,2%), dok najmanji broj kao ukupne prihode svojega kućanstva navodi prihode u rasponu od 1.001,00 do 1.500,00 kn (1,8%).

Prihodi građana



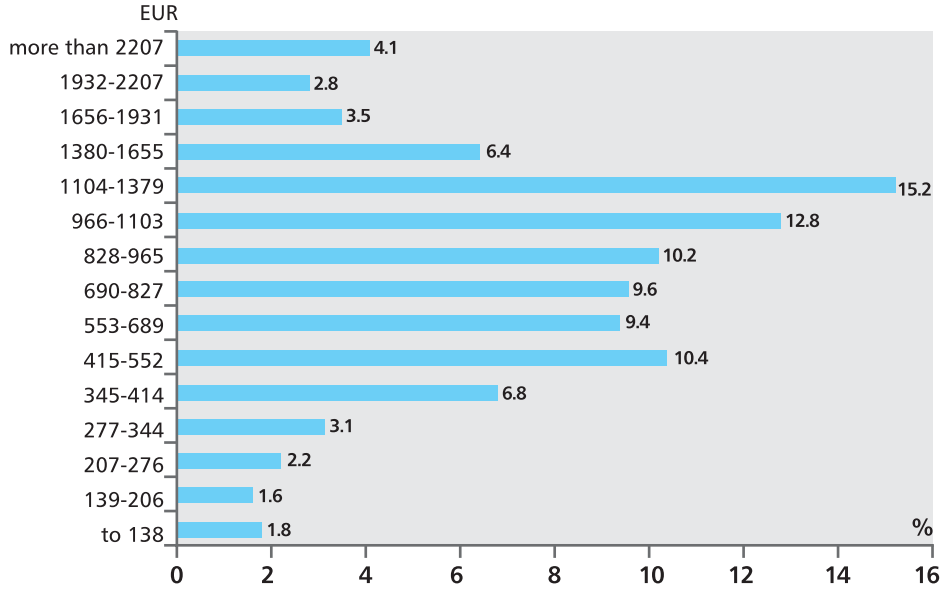
Invaliditet i bolest

Od ukupnog broja ispitanih građana 14,4% ih ima neki oblik trajnog oštećenja zdravlja (invaliditet), pri tome ih je 81,4% sasvim pokretno, 16,4% ih je trajno ograničeno pokretno uz pomoć štaka, štapa, hodalice, a uz pomoć invalidskih kolica kreće ih se 2,1%. Kao najčešći uzrok svojega invaliditeta ispitanici su naveli bolest (48,2%), potom rad (14,6%), rat i njegove posljedice (11,7%), prometne nesreće (8%), dok 7,3% od rođenja ima neki oblik invaliditeta, a 10,2% ih navodi neki drugi uzrok svojega invaliditeta, ali ga ne specificira.

Da boluje od neke kronične tjelesne ili mentalne bolesti, navodi 22,1% ispitanih građana. Nadalje, 14,8% ih navodi da boluje ili je preboljelo neku težu bolest.

Most participants' household income (15.2%) ranges from 1100 EUR to 1380 EUR (i.e. the monthly income of all household members with 3 members on average), whereas the least participants say their monthly income ranges from 138 EUR to 210 EUR (1.8%).

Income



Disability and illness

Of the total number of participants, 14.4% have some kind of permanent health damage (disability), of which 81.4% are completely mobile; 16.4% have permanently limited mobility and use walking aids (e.g. crutches, walking stick, walking frame), and 2.1% use a wheel chair. As the most common cause of their disability, the participants said it was due to illness (48.2%), followed by work (14.6%), war and its consequences (11.7%), traffic accidents (8%), while 7.3% of them have some form of disability since birth, and 10.2% state another, unspecified, cause of their disability.

22.1% of participants mention they suffer from a chronic physical or mental disease. Furthermore, 14.8% say they suffer or have suffered from a severe illness.

Subjektivna procjena zdravlja

Kao indikatori zdravlja, uz medicinski verificirane simptome vrlo se često koriste i subjektivni tjelesni simptomi. Osnovni razlog tome je postojanje povezanosti između subjektivne procjene zdravlja i objektivnoga zdravstvenog statusa. Naime izvještavanje o simptomima jedna je od ključnih komponenti održavanja zdravlja budući da ona djelomično determinira nečiju odluku o traženju medicinske pomoći. Korištenje tjelesnih simptoma kao mjere zdravstvenog stanja važno je i zbog toga što se liječnici često oslanjaju na opise simptoma da bi postavili dijagnozu i da bi pacijente uputili na dodatna objektivna zdravstvena ispitivanja kako bi došli do točnijega zaključka o nečijem zdravstvenom statusu.

Za mjerenje subjektivnih tjelesnih simptoma u ovom istraživanju korišten je Pennebakerov inventar limbičke iscrpljenosti (PILL, Pennebaker, 1982). Taj upitnik mjeri stupanj izraženosti različitih tjelesnih simptoma i senzacija. Sastoji se od 54 simptoma, a ispitanici procjenjuju izraženost svakog od njih na ljestvici od pet stupnjeva (1 – uopće ne; 2 – malo; 3 – umjereno; 4 – prilično; 5 – jako).

Slijedi prikaz učestalosti doživljavanja svakoga pojedinog tjelesnog simptoma u posljednjih godinu dana kod građana Rijeke.

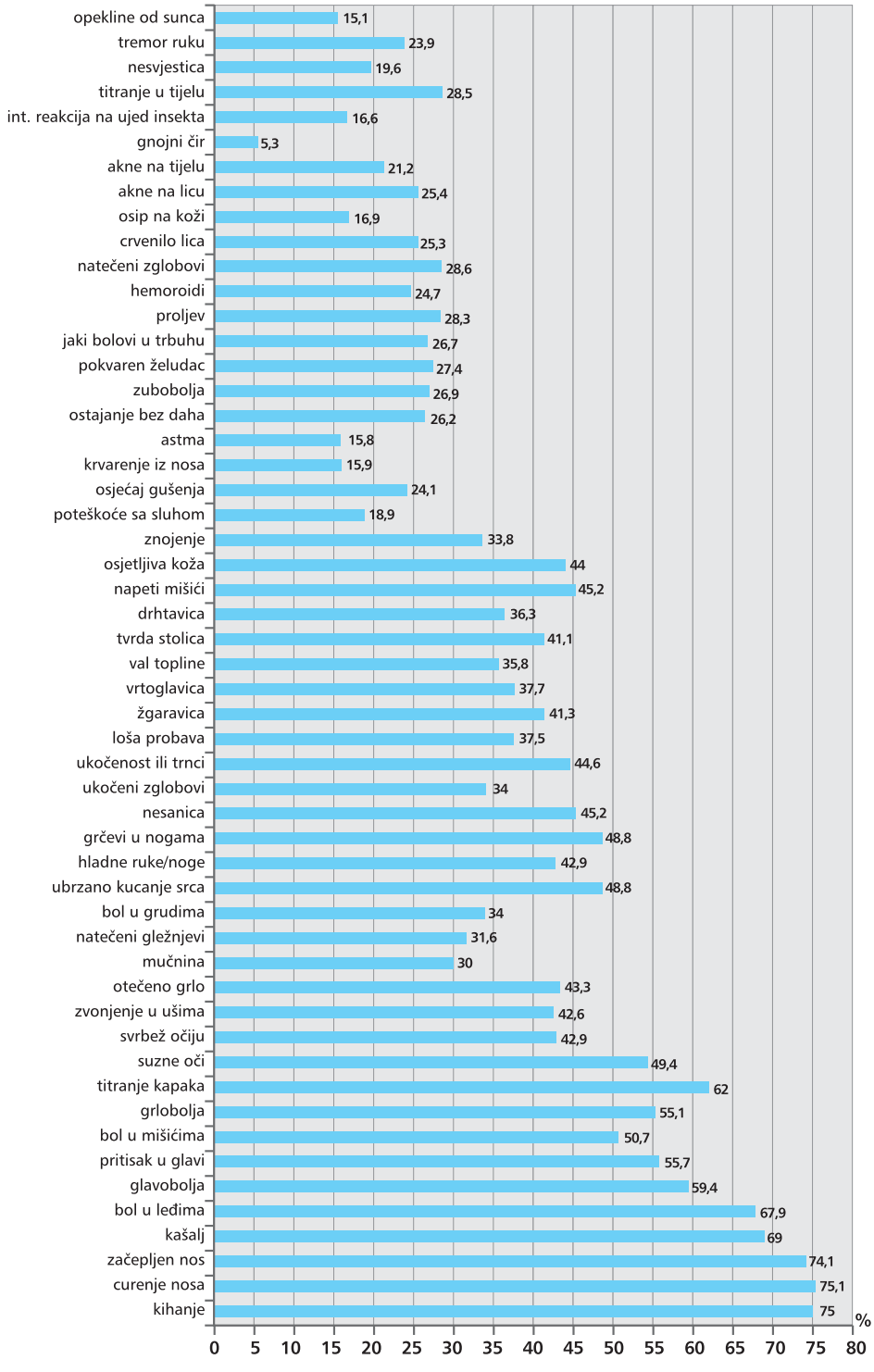
Subjective health estimate

The subjective physical symptoms are often used as health indicators, along with medically verified symptoms. The main reason for that is the existing link between the subjective health estimate and the objective health status. Reporting on symptoms identified is one of the key factors in maintaining good health, as it determines to an extent one's decision on asking for medical help. Furthermore, using physical symptoms as a measure of health status is important, as doctors often rely on the symptom description not only to make a diagnosis, but also to direct patients to other objective health tests in order to reach a conclusion on one's health status as accurately as possible.

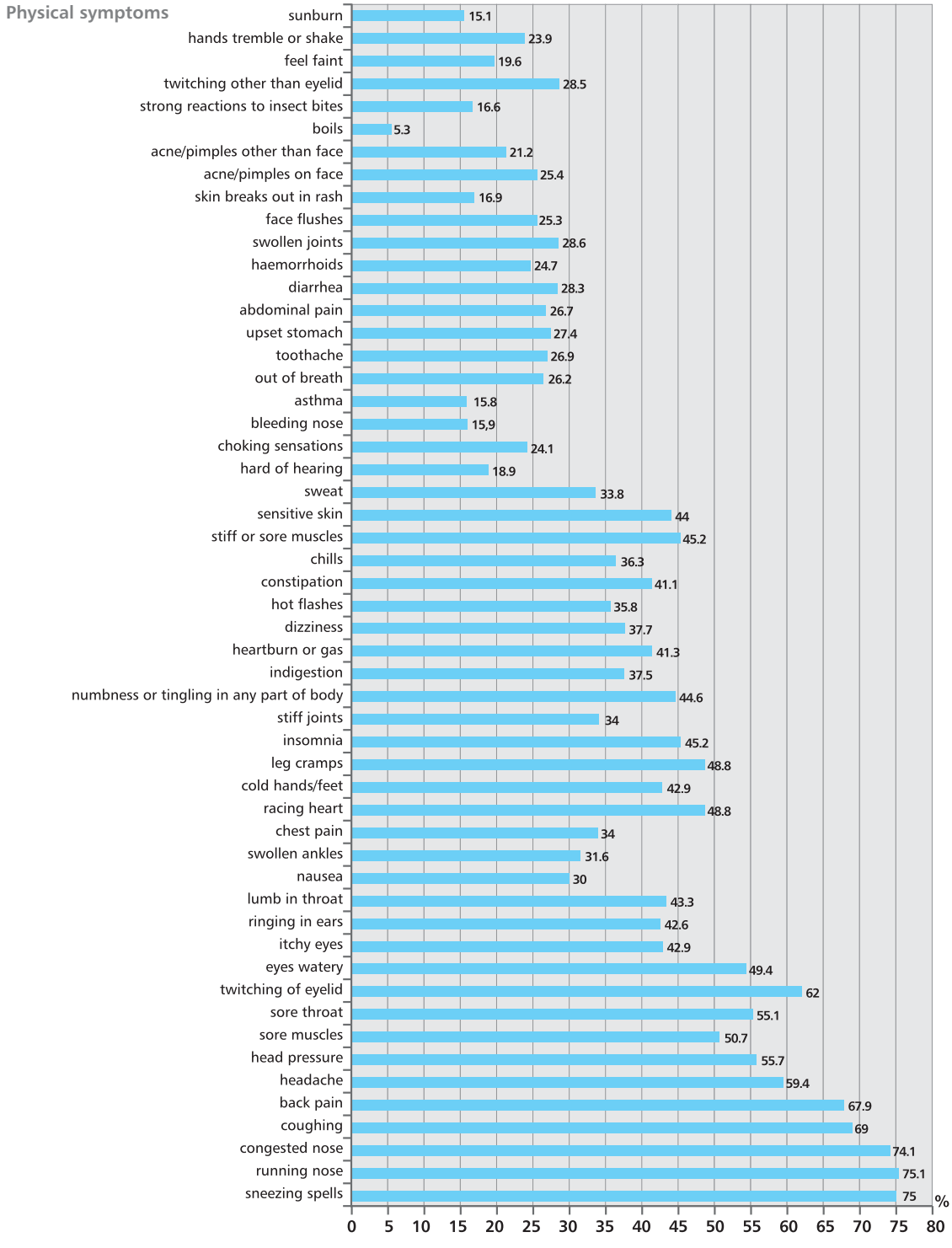
For the purposes of this research, Pennebaker's inventory of limbic languidness was used in order to measure the subjective physical symptoms (PILL, Pennebaker, 1982). This questionnaire measures the level of prominence of various physical symptoms and sensations. It consists of 54 symptoms and the participants estimate each on a 5-point scale (1 – not at all; 2 – little; 3 – moderately; 4 – quite; 5 – very).

The following chart shows the frequency of each physical symptom among the citizens of Rijeka over the past year.

Tjelesni simptomi

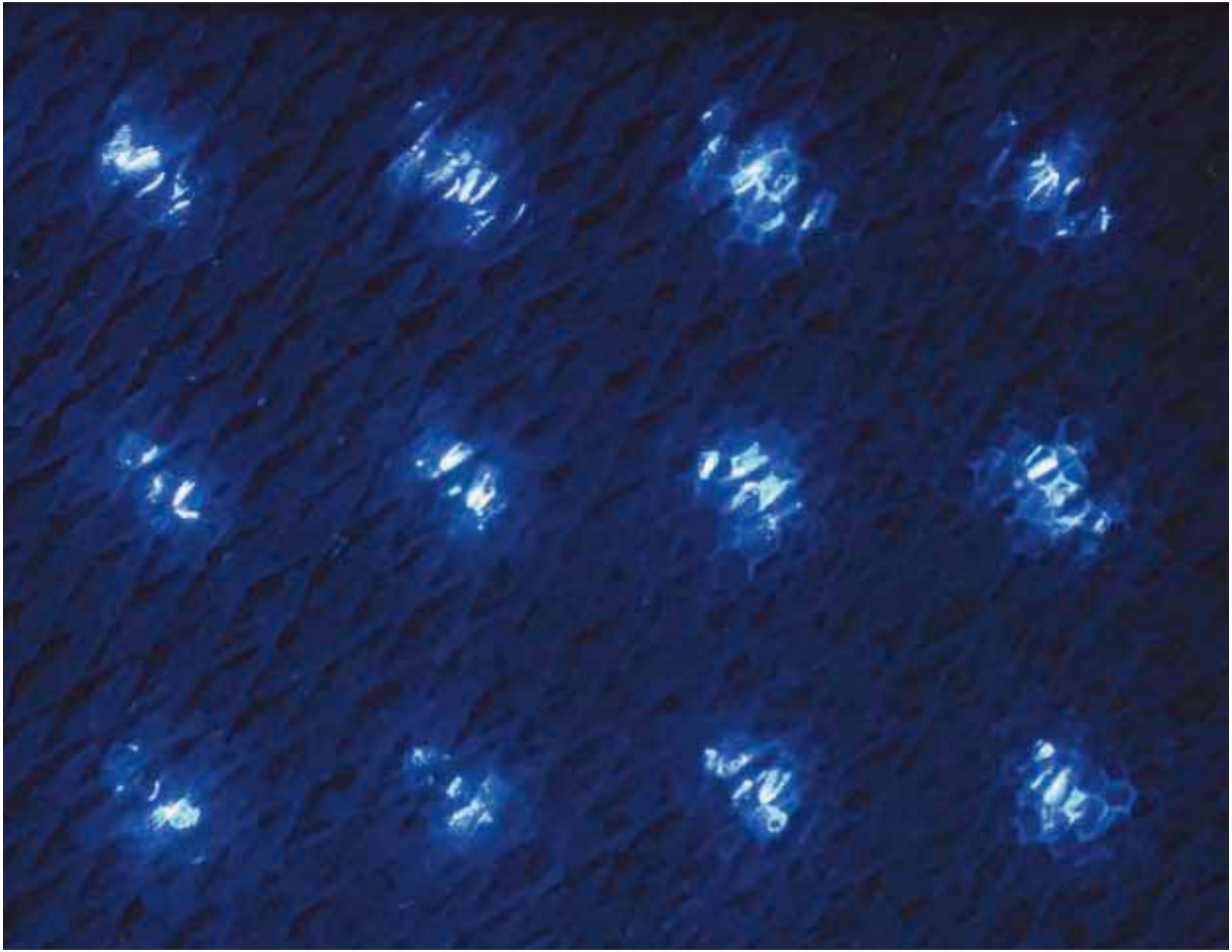


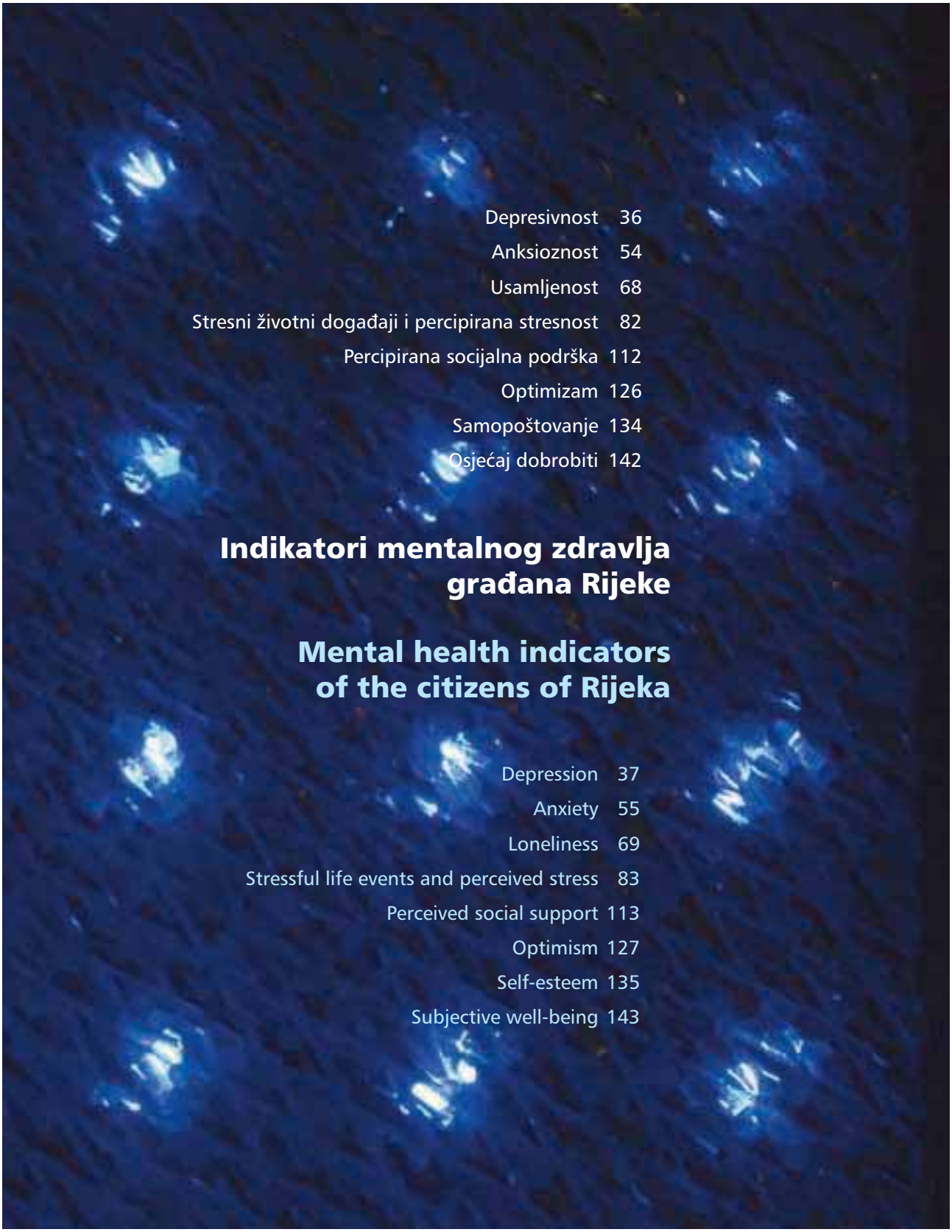
Physical symptoms



Kao što se može vidjeti iz prethodnih slika, najčešće se doživljavaju respiratorni simptomi, kao što su kihanje, curenje nosa i sl., dok su među najrjeđima dermatološki simptomi (akne, osip, čir i sl.).

As the previous charts show, the symptoms most often experienced are respiratory symptoms, such as sneezing spells, running nose etc., whereas the least common are dermatological symptoms (e.g. acne, skin breaks out in rash, boils etc.).





Indikatori mentalnog zdravlja građana Rijeke

Mental health indicators of the citizens of Rijeka

Depresivnost

Svatko se povremeno osjeća tužno i nesretno, ali ako takvi osjećaji zavladaju nečijim životom, u smislu njihove stalne prisutnosti ili ometanja normalnog funkcioniranja, štoviše kada dovedu do fizičkog ili mentalnog propadanja osobe, tada već govorimo o depresivnosti.

Depresivnost predstavlja emocionalno stanje ili raspoloženje za koje su karakteristični izraziti osjećaji tuge i razočaranja uz manjak energije, smanjen interes za nečim u čemu je osoba ranije uživala, slaba koncentracija, poremećene navike hranjenja i spavanja, osjećaji beznadnosti i beskorisnosti i/ili krivnje i suicidalne misli. U ozbiljnim slučajevima, osoba može gotovo u potpunosti izgubiti sposobnost za rad, odnose s drugim ljudima, pa čak i za brigu o samoj sebi.

Depression

Every once in a while everyone feels sad or unhappy, but if these feelings prevail and proceed to take control of one's life, they might disrupt normal functioning, or even lead to the physical or mental deterioration of a person. When this happens, we have to speak about depression.

Depression is an emotional state or mood that features extreme feelings of sadness and disappointment, along with lack of energy, reduced interest in something that a person used to enjoy, poor concentration, eating and sleeping disorders, a feeling of hopelessness and helplessness, and/or guilt combined with suicidal thoughts. In serious cases, a person can almost completely lose their working ability, destroy their relationships with other people, and even neglect taking care of himself or herself. A depressive disorder is manifested on physical, emotional, cognitive and behavioural levels.

In general, about 5% of the overall population suffer from clinical depression. It is more common in women than in men; it can develop at any age, from childhood to old age, but on average, the signs of depression are manifested in the mid - or late twenties.

Causes of depression are complex and cannot yet be entirely explained. Usually it is a combination of biological, psychological and environmental factors.

Genes make some people more prone to the feelings of depression. More than 60% of the people who have been treated for depression have someone in their family who used to be depressive. There is a 15% chance that biological relatives of a depressive person will also develop depression. In addition, research on twins support inherited predisposition towards depression. Scientists have also found that depression is related to certain imbalances in chemicals (i.e. neurotransmitters) in the brain that transmit messages among brain cells. Furthermore, depression is linked to the imbalance of cortisol, a hormone secreted by suprarenal gland. Other physiological factors that depression is sometimes related to are the following: viral infections, low level of thyroid gland functioning and biological rhythms, among which the most common is the menstrual cycle (i.e. depression is a common symptom of the premenstrual syndrome).

Depresivni poremećaj manifestira se na tjelesnoj, emocionalnoj, kognitivnoj i ponašajnoj razini.

Općenito, oko 5% populacije klinički je depresivno. Depresivnost je češća kod žena nego kod muškaraca. Može se pojaviti u bilo kojoj životnoj dobi, od djetinjstva do starosti, ali se u prosjeku javlja sredinom ili krajem 20-ih godina života.

Uzroci depresivnosti su složeni i još uvijek nisu u potpunosti objašnjeni. Obično se radi o kombinaciji bioloških, psiholoških i okolinskih čimbenika.

Genetsko naslijeđe čini neke osobe sklonijima osjećaju depresivnosti. Više od 60% ljudi koji su liječeni od depresije imaju nekoga u obitelji tko je nekada bio depresivan. Utvrđeno je da postoji vjerojatnost od 15% da će neposredni biološki srodnici depresivne osobe također razviti depresivnost. Istraživanja provedena na blizancima također podržavaju postojanje genetske predispozicije za depresiju. Znanstvenici su također našli da je depresija povezana s neravnotežom pojedinih kemijskih spojeva (neuroprijenosnici) u mozgu koji prenose poruke između živčanih stanica. Depresija je također povezana s neravnotežom hormona kortizola koji izlučuje nadbubrežna žlijezda. Od ostalih fizioloških čimbenika depresivnost se ponekad dovodi u vezu s virusnim infekcijama, niskom razinom funkcioniranja štitne žlijezde te s biološkim ritmovima, od kojih najčešće s menstrualnim ciklusom žene (depresivnost je čest simptom predmenstrualnog sindroma).

Dakle sasvim je izgledno da biološki čimbenici čine neke osobe disponiranima ili sklonima depresivnim poremećajima, ali su za njezin nastanak često "odgovorne" upravo vanjske okolnosti. Životni događaji, uključujući razvojne traume (npr. zlostavljanje i zanemarivanje u djetinjstvu i adolescenciji), zdravstvene probleme (npr. teže bolesti kao što su karcinom, AIDS i druge), smrt bliske osobe, probleme u intimnim odnosima, gubitak posla i razne druge gubitke, mogu biti "okidači" depresije kod nekih osoba.

Prema klasičnoj psihoanalitičkoj teoriji, depresija je posljedica gubitka nekoga zbog smrti ili napuštanja i potiskivanja pratećih osjećaja bijesa i ljutnje. Prema bihevioristički usmjerenim teoretičarima, poveznica je između navedenih i sličnih negativnih događaja nestanak izvora nagrađivanja. Kognitivisti pak tvrde da depresivne osobe ra-

To conclude, it is very clear that biological factors make some people more prone to depressive disorders, bur external circumstances are the cause for their onset. Life events, including development traumas (e.g. abuse and neglect in childhood and adolescence), health problems (e.g. severe illnesses such as carcinoma, AIDS and other), the death of a close person, problems in personal relationships, losing a job and many other losses can act as 'triggers of depression' in some people.

According to the classic psychoanalytical theory, depression is the direct result of losing someone due to death or abandonment, and then suppressing the accompanying feelings of anger and resentment. Behavioural theorists say the link between the events mentioned and similar negative events is the absence of a rewarding source. On the other hand, cognitive psychologists claim that depressive persons develop a destructive thinking pattern, which includes

zvijaju destruktivan način razmišljanja, koji uključuje okrivljavanje samog sebe za sve loše što se događa, fokusiranje na negativnu stranu događaja i sklonost ka izrazito pesimističnom zaključivanju. Jedno od psihologijskih objašnjenja depresiju promatra kroz koncept naučene bespomoćnosti, odnosno gubitka kontrole nad vlastitim životom. Primijećeno je da je ta pojava osobito relevantna u slučajevima depresije kod žena.

U stručnoj literaturi navode se dvije osnovne kategorije depresivnog poremećaja – velika depresivna epizoda i distimični poremećaj. Kada govorimo o velikoj depresivnoj epizodi, obično se radi o umjerenom do ozbiljnom akutnom depresivnom poremećaju, visoka intenziteta, ali kratka trajanja (najčešće dva ili više tjedana). Za razliku od toga, distimični poremećaj zapravo je kronična depresija, koja traje najmanje dvije, a vrlo često i više godina (prosječno traje 16 godina). Obično nastaje postupno tako da osoba često i ne može odrediti kada se počela osjećati depresivno. Radi se o blagoj ili umjerenoj depresiji, koja može rasti i padati, tako da se osoba koja od nje boluje može u nekim razdobljima osjećati potpuno nedepresivno.

Stručnjaci koji se bave mentalnim bolestima poznaju još nekoliko različitih podvrsta depresije (npr. manična depresija, ciklotimni poremećaj, sezonski afektivni poremećaj) koje imaju pojedine karakteristične simptome prema kojima se postavlja specifična dijagnoza.

Mnoge osobe koje pate od depresije nisu toga svjesne, već za svoje loše psihičko stanje okrivljavaju stres i tjelesne tegobe. Podrazumijeva se da onda i ne traže pomoć. Od onih koji potraže i dobiju pomoć, bilo putem psihoterapije, lijekova ili jednog i drugog, 80% ih doživi poboljšanje, često u samo nekoliko tjedana. Dokazano je da je psihoterapija efikasna kod osoba s blagom ili umjerenom depresijom, dok se onima s ozbiljnijom depresijom i onima kod kojih su se razvili tjelesni simptomi savjetuje liječenje lijekovima. U današnje se vrijeme osobe s depresijom najčešće tretiraju psihoterapijom od 12 do 16 tjedana. Metode koje se koriste ovise o različitim pravcima i terapeutovu izboru. Tako se kognitivno bihevioralna terapija usmjerava na pomoć pacijentu da identificira i izmijeni negativne obrasce razmišljanja. Obiteljski terapeuti rade na jačanju strategija koje će osobi pomoći poboljšati odnose s drugim ljudima. Bihevioralna terapija podrazumijeva praćenje nečijih aktivnosti i njihovo modificiranje putem sustava potkrepljenja i nagrada.

blaming oneself for all the bad things that happen, focusing on the negative aspects of an event, and have a tendency towards reaching extremely pessimistic conclusions. One of the psychological explanations analyses depression through the concept of learnt helplessness, or losing control over one's life. It has been noticed that this occurrence is especially relevant in cases of depression in women.

Two main categories of depressive disorders can be found in reference books – major depressive episodes and dysthymic disorders. When discussing a major depressive episode, it is usually a moderate to serious acute depressive disorder, with high intensity, but short in duration (i.e. often lasts for two or more weeks).The dysthymic disorder, however, is indeed chronic depression that lasts for a minimum of two years, but often longer than that (on average, 16 years). It usually develops gradually, and is sometimes impossible for someone to determine when they started feeling depressive. This is mild or moderate depression, which can rise and fall and the person can even experience periods free of depressive feelings.

Experts in mental diseases can distinguish several other various subtypes of depression (e.g. manic depression, cyclothymic disorder, seasonal affective disorder) with some typical symptoms, according to which a specific diagnosis can be established.

There are many people suffering from depression and unaware of the fact, and blame stress and physical difficulties for their poor mental condition. It goes without saying that they do not seek help even then. Among those who do ask for and receive help, be it psychotherapy, drugs, or both, 80% of them experience an improvement, and often in just a matter of a few weeks. Psychotherapy has proven efficient among people with mild or moderate depression, whereas those suffering from severe depression and those with physical symptoms are advised to undergo drug treatment. Nowadays, people suffering from depression are most often treated with psychotherapy for 12 to 16 weeks. The methods used depend on the various schools of thought and the therapists themselves. Cognitive-behavioural therapy is directed towards helping the patient to identify and alter their own negative patterns of thinking. Family therapists focus on reinforcing strategies that will help improve relationships with other people. Behavioural therapy is about monitoring one's activities and modifying them by using the reinforcement and reward system.

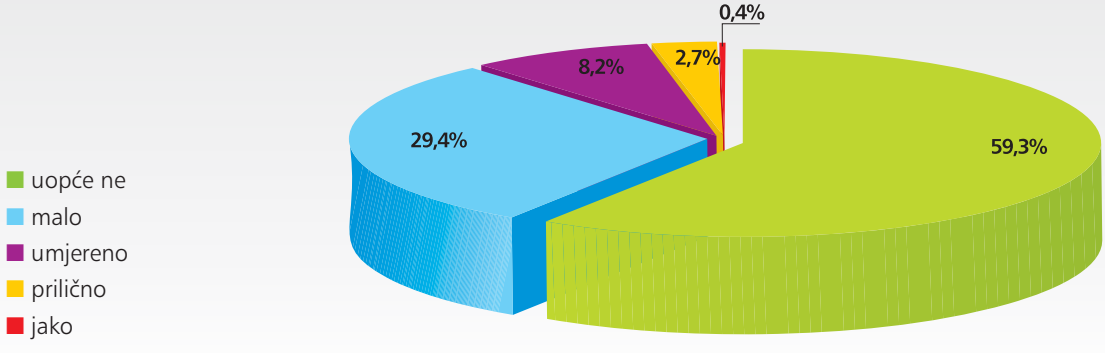
Lijekovi koji se koriste u liječenju depresije djeluju na pojedine ranije spomenute neuroprijenosnike u mozgu (norepinephrin, dopamin i serotonin).

Kad god je to moguće, osoba koja ima simptome depresije treba što prije zatražiti stručnu pomoć. Kao prvi korak preporučuje se detaljan tjelesni pregled kod liječnika opće medicine ili internista, kako bi se utvrdilo radi li se samo o simptomima sličnima depresiji, koji su možda uzrokovani određenim lijekovima ili zdravstvenim stanjem ili je ipak riječ o simptomima depresije koji zahtijevaju daljnju dijagnostiku i tretman stručnjaka za mentalno zdravlje.

U ovom istraživanju depresivnost je mjerena **podljestvicom depresivnosti iz upitnika Symptom Checklist 90-R** (SCL-90-R; Derogatis, 1977). Ta se podljestvica sastoji od 12 različitih simptoma depresivnosti (npr. "Misli o vlastitoj smrti", "Sklonost samookrivljavanju"). Ispitanici su procjenjivali koliko je intenzivno svaki od simptoma depresivnosti kod njih bio izražen u posljednjih godinu dana, koristeći se skalom procjene od 1 do 5 (1 – uopće ne, 2 – malo, 3 – umjereno, 4 – prilično i 5 – jako).

Rezultati pokazuju da je prosječna razina depresivnosti kod građana Rijeke relativno niska, odnosno da se Riječani osjećaju depresivno u rasponu od uopće nedepresivno do malo depresivno. Uopće se ne osjeća depresivno 59,3% Riječana, 29,4% ih se osjeća malo depresivno, 8,2% ih se osjeća umjereno depresivno, 2,7% ih je prilično depresivno, a 0,4% jako depresivno.

Depresivnost

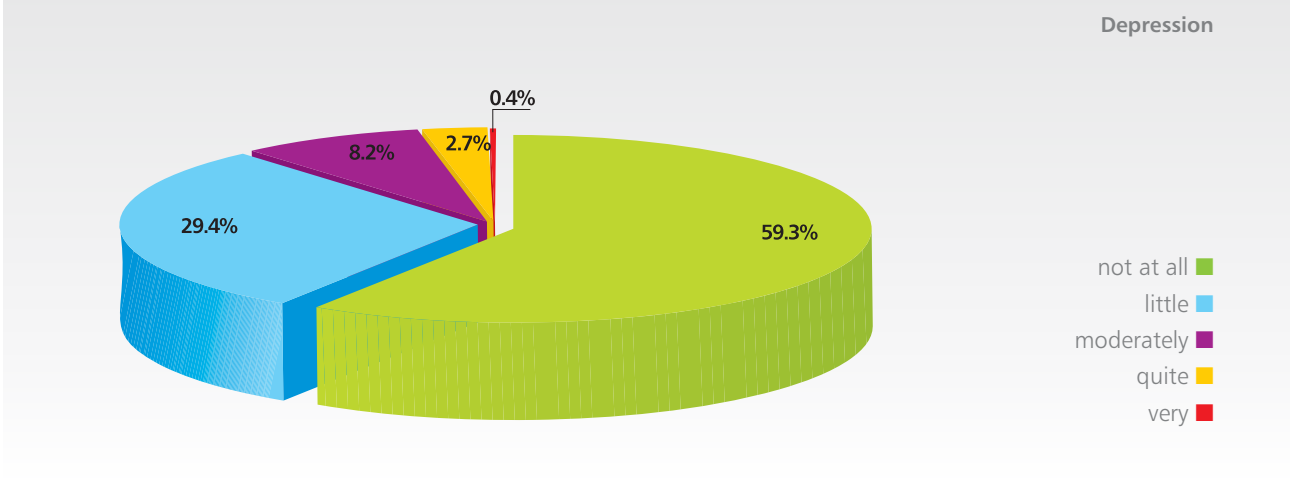


Medication used in treatment of depression affect the aforementioned neurotransmitters in the brain (norepinephrine, dopamine and serotonin).

A person with symptoms of depression should ask for professional help as soon as possible, whenever possible. The first step should be to have a medical examination performed by a general practitioner or an internist in order to determine whether those symptoms that are similar to depression were caused either by certain drugs or a health condition, or whether they are indeed symptoms of depression that need to be further diagnosed and treated by a mental health specialist.

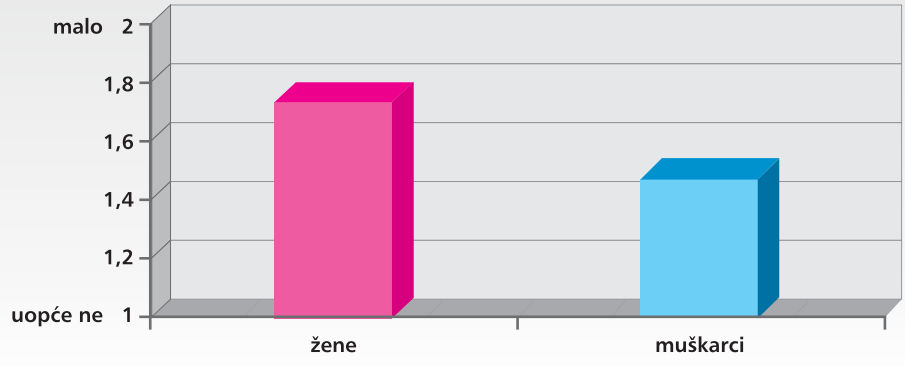
In this research, depression was measured by using a **subscale of depression from the Symptom Checklist 90-R questionnaire** (SCL-90-R; Derogatis, 1977). This subscale consists of 12 various symptoms of depression (e.g. "Thoughts about own death", "Tendency to blame oneself"). Participants estimated the intensity of prominence of each symptom over the past year by using the 5-point rating scale (1 – not at all, 2 – little, 3 – moderately, 4 – quite and 5 – very).

The results indicate that the average level of depression among the citizens of Rijeka is relatively low. In other words, the feelings of depression among the people of Rijeka range from not at all depressive to a little depressive. 59.3% of the citizens of Rijeka do not feel depressive at all, 29.4% feel a little depressive, 8.2% moderately depressive, 2.7% quite depressive, and 0.4% of them feel very depressive.



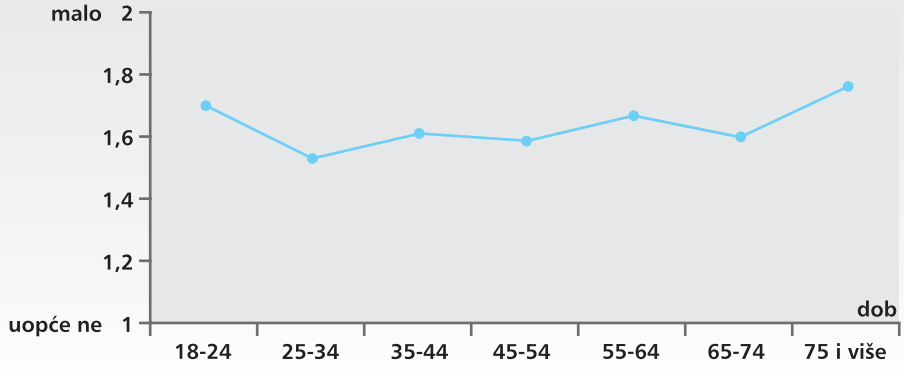
Žene su općenito značajno depresivnije nego muškarci.

Depresivnost i spol



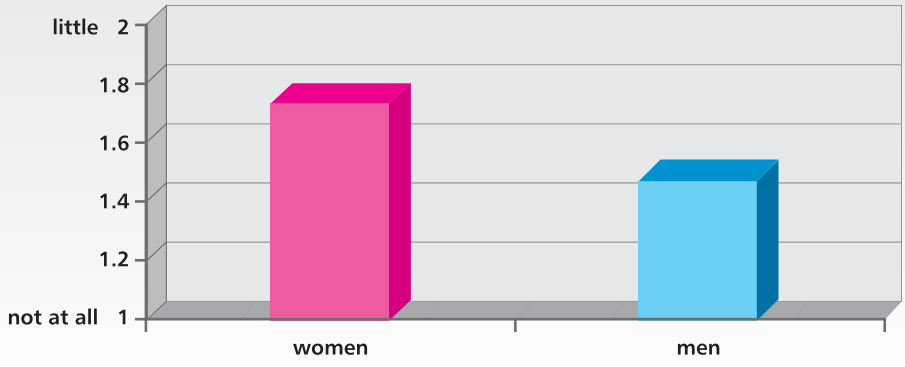
Utvrđene su i razlike između pojedinih dobnih skupina građana Rijeke u depresivnosti. Najdepresivniji su Riječani u dobi od 75 i više godina i oni najmlađi, u dobi od 18 do 24 godine.

Depresivnost i dob



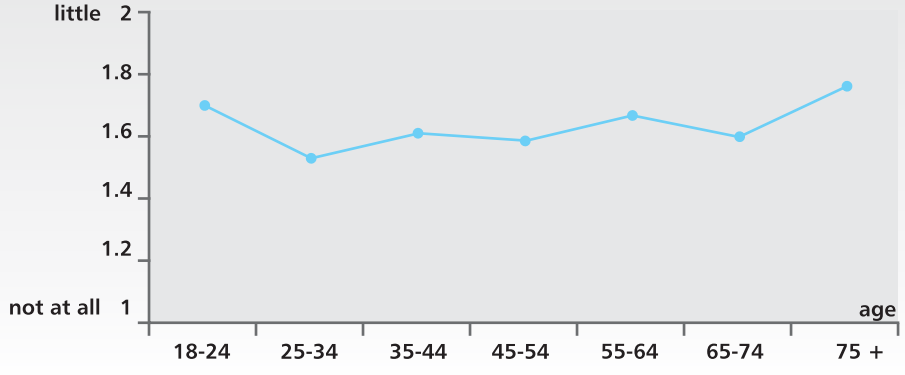
In general, women feel significantly more depressive than men.

Depression and sex

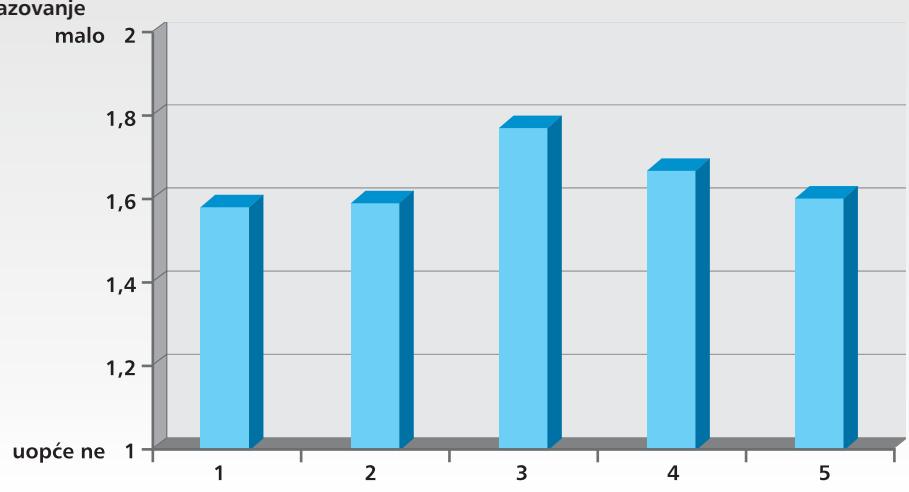


A difference in depression has been established among certain age groups of the citizens of Rijeka. The most depressed are those aged 75 and more, and the youngest age group – 18 to 24 years of age.

Depression and age



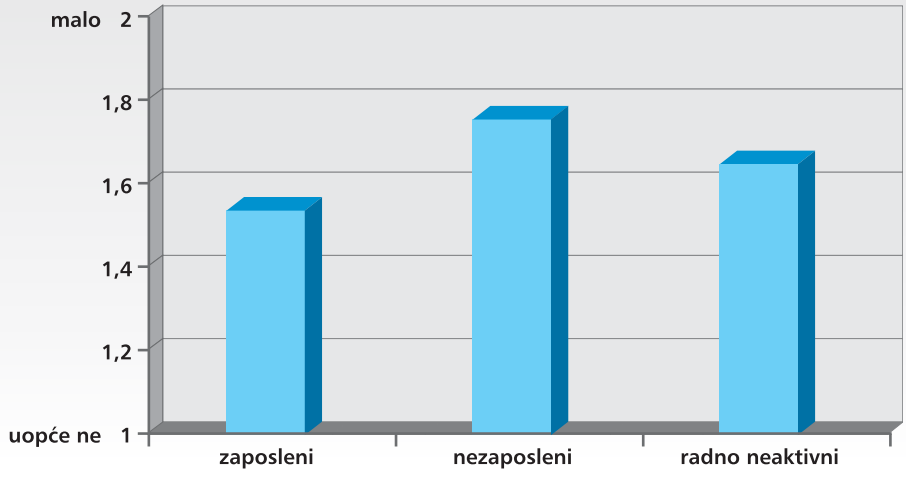
Depresivnost i obrazovanje



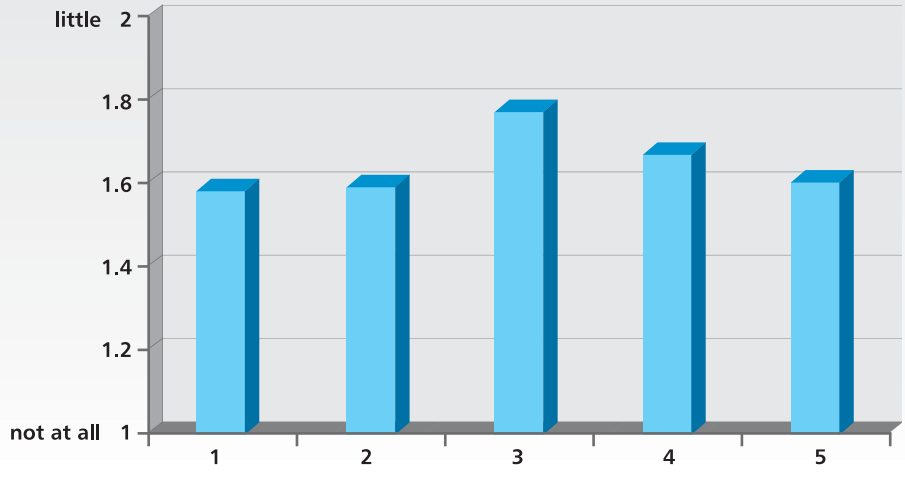
1–bez OŠ/OŠ
2–škole za zanimanja
3–gimnazija
4–viša škola
5–fakultet/mr. i dr.

S obzirom na obrazovanje, najdepresivniji su građani koji su završili gimnaziju, dok je razina depresivnosti kod ostalih podjednaka.

Depresivnost i radna aktivnost



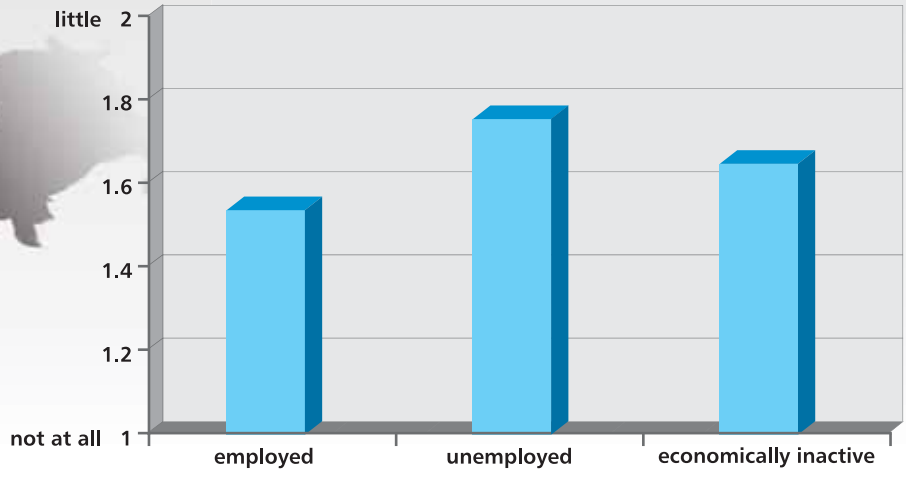
Depression and education



Given the level of education, the most depressive are the citizens who have finished grammar schools, whereas the level of depression in others is equal.

1–no formal education/primary s.
2–vocational school
3–grammar school
4–college
5–university/MA. & PhD.

Depression and economic activity

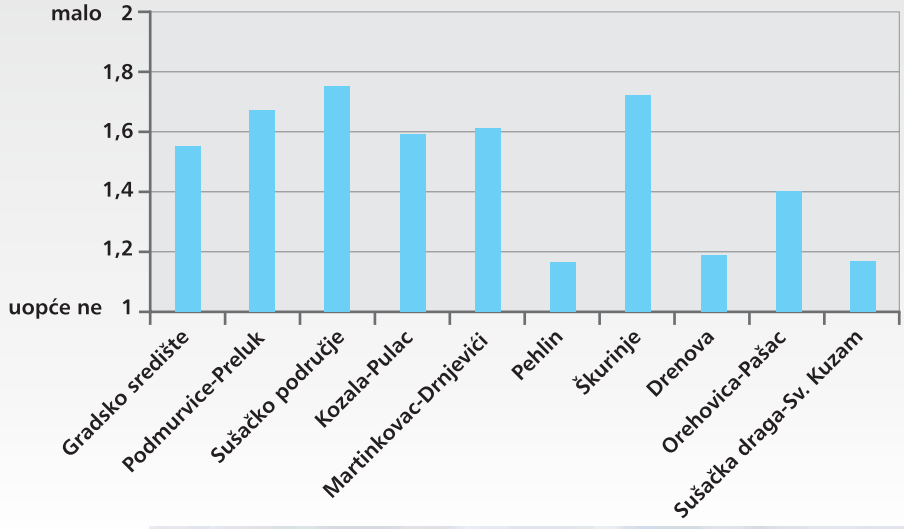


Nezaposleni su depresivniji od zaposlenih i radno neaktivnih građana, a radno neaktivni depresivniji od zaposlenih građana.

Osobe različita bračnog stanja (neoženjeni/neudani, oženjeni/udani, udovci/udovice, rastavljeni) međusobno se ne razlikuju s obzirom na razinu depresivnosti. Isto tako, bez obzira na broj članova kućanstva u kojima žive i broj djece koju imaju, građani se ne razlikuju u tome koliko se osjećaju depresivno.

Kada se radi o mjestu stanovanja, najdepresivniji su građani koji žive na područjima prostornih cjelina Sušačko područje i Škurinje, dok su najmanje depresivni građani koji žive na područjima prostornih cjelina Drenova, Pehlin i Sušačka draga-Sv. Kuzam.

Depresivnost i mjesto stanovanja

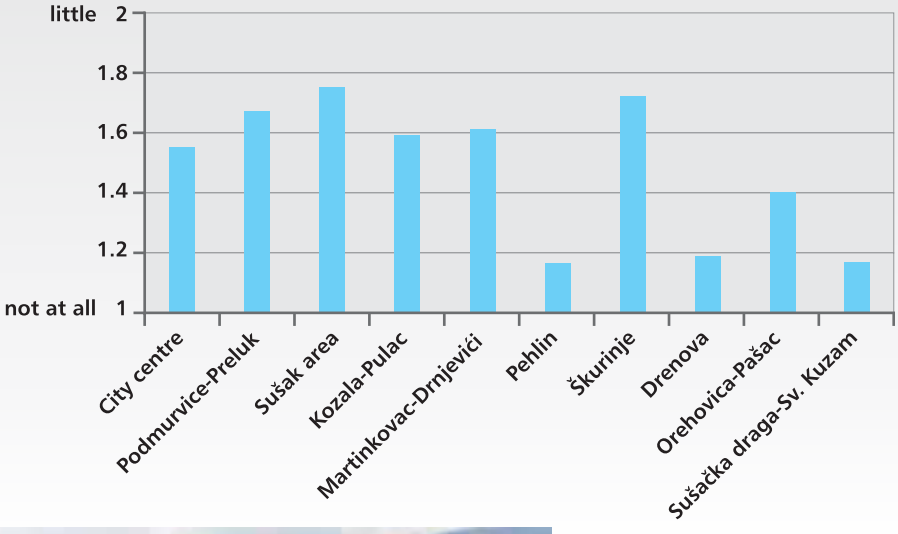


The unemployed are more depressed than both the employed and the economically inactive citizens, whereas the economically inactive are more depressed than the employed citizens.

There is no difference in depression level among people of various marital status (i.e. single, married, widowed, divorced). Furthermore, regardless of the number of family members in a household and the number of children, the citizens cannot be differentiated regarding feelings of depression.

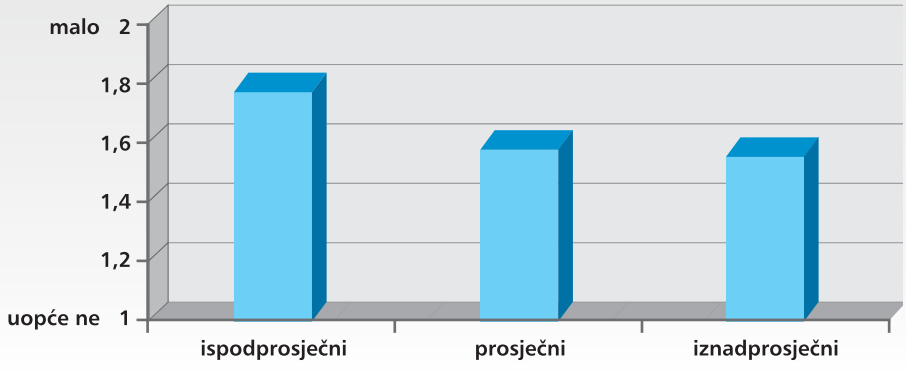
Taking the place of residence into consideration, the most depressive are the citizens living in city areas of Sušak and Škurinje, whereas the least depressive are citizens living in city areas of Drenova, Pehlin and Sušačka draga-Sv. Kuzam.

Depression and place of residence



Doživljaj depresivnosti niži je kod onih koje imaju prosječne i iznadprosječne ukupne mjesečne prihode kućanstva u usporedbi s onima koji imaju ispodprosječne mjesečne prihode.

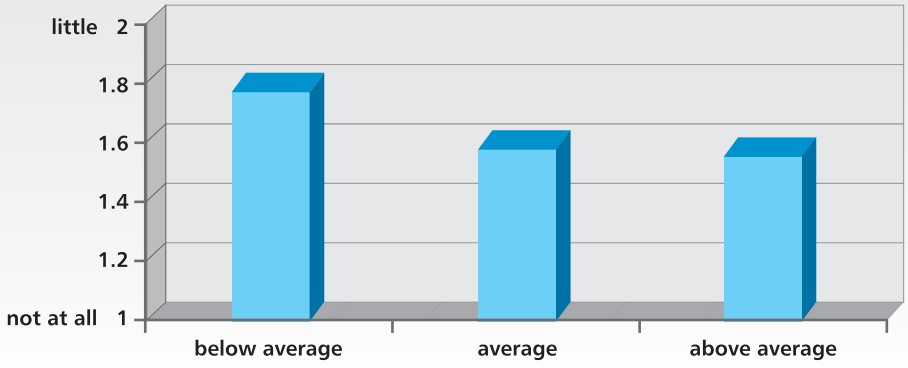
Depresivnost i prihodi kućanstva



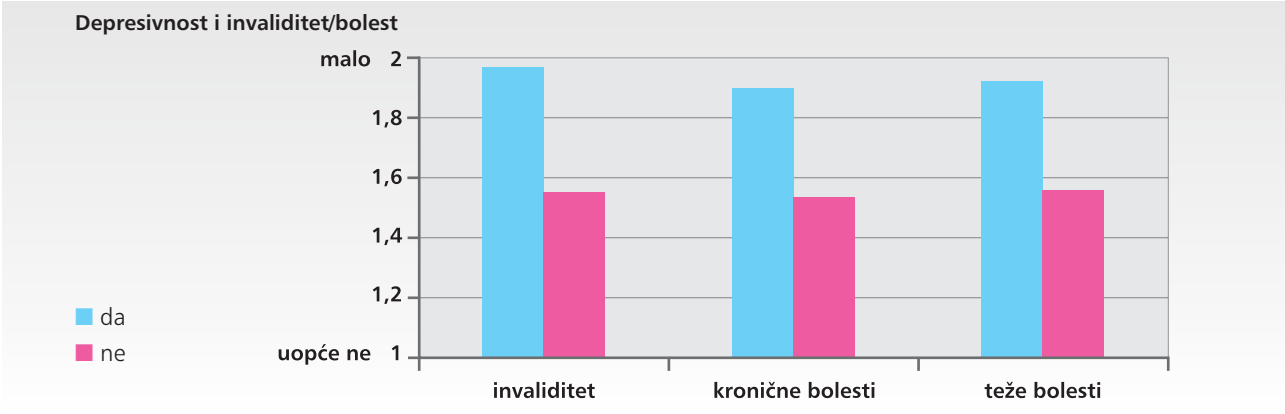
S obzirom na invaliditet postoje razlike u depresivnosti. Naime osobe s invaliditetom značajno su depresivnije od onih bez invaliditeta, a i građani koji imaju neku kroničnu tjelesnu ili mentalnu bolest te oni koji su preboljeli kakvu težu bolest značajno su depresivniji od osoba koje ne boluju od kroničnih bolesti i onih koji nisu preboljeli neku od težih bolesti.

The feeling of depression is less distinctive among those with average and above average monthly household income when compared to those with below average monthly income.

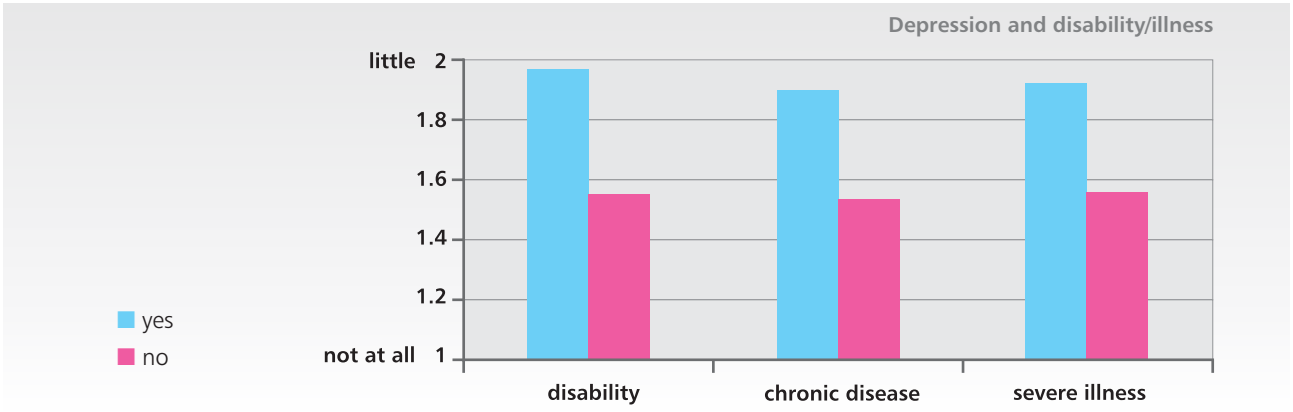
Depression and household income



Regarding disability, there are differences in depression, where the disabled are significantly more depressed than those who are not. Citizens with a chronic physical or mental disease, and those who have suffered from a severe illness are significantly more depressed than those not suffering from chronic diseases and those who have never suffered from a severe illness.



Treba istaknuti da je i na uzroku građana Rijeke potvrđena povezanost između subjektivne percepcije tjelesnog zdravlja (intenziteta doživljavanja različitih tjelesnih simptoma) i depresivnosti. Što je netko depresivniji, intenzivnije doživljava i različite tjelesne simptome (npr. bol u leđima, glavobolju, ubrzano kucanje srca i slične simptome). Štoviše, od svih ispitivanih pokazatelja mentalnog zdravlja upravo je depresivnost najviše povezana sa subjektivnom percepcijom zdravlja.



It should be pointed out that the connection between the subjective perception of physical health (i.e. intensity of experiencing various physical symptoms) and depression has been confirmed on the sample of the citizens of Rijeka as well. The more a person is depressed, the more intensely they experience physical symptoms (e.g. backache, headache, racing heartbeat and similar symptoms). Furthermore, among all the mental health indicators tested, it was depression that was related the most to the subjective perception of health.

Anksioznost

Anksioznost je jedan od najčešćih mentalnih poremećaja, a može se definirati kao patološki oblik straha koji se manifestira na fiziološkoj, emocionalnoj, kognitivnoj i ponašajnoj razini. Kod patološke anksioznosti intenzitet, trajanje i učestalost tjeskobe i zabrinutosti pretjerani su u odnosu na aktualnu opasnost i njezin potencijalni učinak. Dok je u slučaju svima svojstvene emocije straha ili adaptivne anksioznosti opasnost očigledna (npr. pad ispita, financijski dug, bolest), kod anksioznog poremećaja opasnost se najčešće uopće ne može identificirati (osoba je npr. svjesna da osjeća strah, ali ne i od čega), preuveličava se ili je čak iracionalna (osoba je npr. zabrinuta za svoje zdravlje iako svi zdravstveni nalazi govore suprotno).

Kod anksioznog poremećaja pretjerana tjeskoba i zabrinutost zbog različitih događaja i aktivnosti, traje većinu dana u zadnjih šest mjeseci. To je stanje obilježeno i nemogućnošću kontrole osjećaja tjeskobe i zabrinutosti te simptomima kao što su: nemir, otežana koncentracija, razdražljivost, napetost ili bolovi u mišićima, lako umaranje i poremećaji spavanja (teškoće prilikom uspavljivanja ili spa-

Anxiety

Anxiety is one of the most common mental disorders identified. It can be defined as a pathological form of fear that is manifested on a physiological, emotional, cognitive and behavioural level. With pathological anxiety, the intensity, duration and frequency of both apprehension and concern are exaggerated, when compared to the actual danger and its potential effects. While the danger is obvious when experiencing emotions of fear or adaptive anxiety which are common to everyone (e.g. failing an exam, financial debt, illness), with an anxiety disorder the danger cannot be usually identified (e.g. a person is aware of feeling fear but not of its cause); it is exaggerated or irrational even (e.g. a person is worried about their own health, even though all the medical tests indicate the opposite).

With the anxiety disorder, exaggerated apprehension and concern over various events and activities last for most people from mere days to over six months. What features this condition is also the inability to control feelings of apprehension and concern, as well as symptoms such as restlessness, poor concentration, irritability, tense or painful

vanja te nedostatno spavanje). Mogu se javiti i drugi simptomi kao što su: drhtavica, trzanje, znojenje tijela ili dlanova, osjećaj hladnoće, ubrzano kucanje srca, suhoća usta, crvenilo, povraćanje, proljev, učestalo mokrenje, otežano gutanje i sl., a česti su i ranije spomenuti depresivni simptomi. Broj simptoma i njihova ozbiljnost variraju od osobe do osobe. Simptomi anksioznosti mogu biti vrlo neugodni i zastrašujući sami po sebi, stoga anksiozne osobe često zaključuju kako nešto nije u redu s njihovim tijelom. Simptomi anksioznosti popratna su pojava tjelesnih procesa koji u normalnim okolnostima potpomažu naše suočavanje sa stvarnim opasnostima. Problem s patološkom anksioznosti u tome je što zbog pogrešne percepcije opasnosti anksiozna osoba pretjerano usmjerava pozornost na vlastito tijelo i nelagodu. Osoba koja pati od anksioznog poremećaja često ima i značajne smetnje u socijalnom, radnom ili drugim oblicima funkcioniranja.

Skupinu anksioznih poremećaja čine generalizirani anksiozni poremećaj, paničan napadaj, agorafobija, obične fobije, socijalna fobija, opsesivno-kompulzivni poremećaj, akutni stresni poremećaj te posttraumatski stresni poremećaj. Spomenute poremećaje karakterizira: pojavljivanje u relativno ranoj životnoj dobi; kroničnost; smjenjivanje razdoblja poboljšanja stanja, ponovnog aktiviranja poremećaja te razdoblja potpune nesposobnosti odnosno pogoršanja tijekom stresnih životnih situacija.

Iako više od polovice osoba koje se zbog anksioznosti javljaju za pomoć navode da je ona započela u djetinjstvu ili adolescenciji, odnosno da su cijeloga života osjećale tjeskobu i nervozu, anksioznost nerijetko započinje i nakon 20. godine života.

Podaci pokazuju da stopa prevalencije anksioznosti u populaciji iznosi 5%. Taj je poremećaj nešto češći kod žena nego kod muškaraca, što potvrđuju i klinički podaci prema kojima oko 55-60% osoba sa smetnjama čine žene, ali i epidemiološka istraživanja prema kojima su približno dvije trećine osoba s anksioznim poremećajima također osobe ženskoga spola. Još se pouzdano ne zna zašto se kod žena taj poremećaj češće pojavljuje nego kod muškaraca, iako postoje određeni pokušaji objašnjenja utjecaja spolnih razlika.

Smatra se da anksiozne poremećaje uzrokuje kombinacija životnog iskustva, psiholoških karakteristika i/ili genetskih faktora. Utvrđeno

muscles, fatigue and sleeping disorders (difficulties with falling asleep or inadequate sleep). Other symptoms may develop, such as a tremor/shivering fit, twitching, perspiration of body or palms, feeling cold, racing heartbeat, dry mouth, redness, vomiting, diarrhea, frequent urinating, difficulties when swallowing etc, along with the aforementioned common symptoms of depression. The number of symptoms and their severity vary from person to person. Anxiety symptoms can be extremely unpleasant and terrifying per se. Therefore, anxious people often conclude there is something wrong with their bodies. Anxiety symptoms are side effects of the physical processes that in normal circumstances help us handle real danger. The problem with pathological anxiety is that due to the wrong perception of danger, anxious persons focus their attention on their body and uneasiness. A person suffering from an anxiety disorder often has considerable difficulties in social, work or other forms of functioning.

The group of anxiety disorders consists of generalized anxious disorder, panic attack, agoraphobia, ordinary phobia, social phobia, obsessive-compulsive disorder, acute stress disorder, and posttraumatic stress disorder. What is typical of these disorders is that they occur relatively early in life, their chronic feature, episodes of improvement and recurrence, and periods of complete inability, or deterioration of the condition during stressful periods of life.

Even though more than half the people asking for help due to anxiety report it started in childhood or adolescence, in other words, that they have always felt anxiety and nervousness, the anxiety symptoms often develop even after the age of 20.

Data show that the anxiety prevalence rate in the general population is 5%. This disorder is somewhat more common among women than it is among men, which is supported by clinical data, according to which 55-60% of people with disorders are women. The same has been established by epidemiological research, according to which almost two thirds of people with anxious disorders are also female. It is not yet quite certain why this disorder is more common among women than men, although certain attempts at explaining these differences between the sexes do exist.

It is believed that anxious disorders are caused by the combination of life experience, psychological traits and/or genetic factors. It has been

je da je kod nekih poremećaja iz te skupine genetska osnova osobito snažna, poput primjerice kod paničnog poremećaja. Za pojavu drugih čini se, više su odgovorni stresni životni događaji.

Postoji nekoliko glavnih psihologijskih objašnjenja za tu skupinu poremećaja: psihodinamsko, bihevioralno i kognitivno. Iz perspektive psihodinamske teorije, anksioznost obično odražava neriješene konflikte u intimnim odnosima ili ekspresiju bijesa. Suvremenije bihevioralne teorije objašnjavaju pojavu anksioznosti putem procesa učenja te je smatraju naučenim ponašanjem (npr. oponašanjem nečije reakcije na neki podražaj koji izaziva strah). Kognitivne teorije objašnjavaju anksioznost uz pomoć kognitivnih čimbenika, kao što su percepcija i pažnja koja npr. može intenzivirati ili oslabiti reakciju i sl. Suvremeni psihologijski modeli anksioznosti podrazumijevaju i genetske i stečene predispozicije za pojavu anksioznosti.

Anksiozni poremećaj tretira se nekim od oblika savjetovanja, psihoterapije, medikamentoznom terapijom ili njihovom kombinacijom. Prije uključivanja osobe u tretman anksioznosti potrebno je na temelju anamneze, laboratorijskih nalaza i tjelesnog pregleda isključiti povezanost simptoma s nekim drugim zdravstvenim problemom (npr. hipertireoza, feokromocitom), fiziološkim učinkom neke psihoaktivne tvari (npr. droge, lijekovi, kava, otrovi) ili postojanje kojega drugog psihičkog poremećaja kojem je svojstven neki od simptoma anksioznosti.

U današnje vrijeme za tretiranje anksioznih poremećaja najčešće se primjenjuju kognitivne i bihevioralne intervencije koje su usmjerene na smanjenje simptoma i reduciranje izbjegavajućeg ponašanja. Medikamentozna terapija obično se primjenjuje u slučajevima ozbiljnijih ili dugotrajnije prisutnih simptoma.

Za mjerenje anksioznosti u ovom istraživanju korištena je **Spielbergerova ljestvica anksioznosti** (State-Trait Anxiety Inventory, STAI, Spielberger, 1983) koja se sastoji od 20 tvrdnji koje opisuju različite simptome anksioznosti (npr. "Previše brinem o zapravo nevažnim stvarima", "Propuštam dobre mogućnosti jer se ne mogu dovoljno brzo odlučiti"). Ispitanici su procjenjivali koliko često općenito doživljavaju svaki od simptoma anksioznosti na ljestvici procjene od 1 do 5 (1 – nikada; 2 – rijetko; 3 – ponekad; 4 – često i 5 – gotovo uvijek).

Rezultati pokazuju da građani Rijeke u prosjeku rijetko ili ponekad doživljavaju različite simptome anksioznosti. Nikada se ne osjeća ank-

established that genes are a very sound basis for some disorders from this group, i.e. panic disorder. It seems that stressful life events have an important effect on the occurrence of other anxiety disorders.

There are several main psychological explanations of this group of disorders: psychodynamic, behavioural and cognitive. From the perspective of psychodynamic theory, anxiety usually reflects unsolved conflicts in personal relationships or expression of anger. Modern behavioural theories explain anxiety through the process of learning and perceive it as learnt behaviour (e.g. modelling someone's reactions to a stimulus that causes fear). Cognitive theories interpret anxiety with the help of cognitive factors, such as perception and attention that can, for example, intensify or weaken a reaction. Modern psychological models of anxiety include genetic and acquired predispositions for occurrence of anxiety.

The anxiety disorder is treated with a form of counselling, psychotherapy, medicaments, or the combination of all the above. Before a person can be treated for anxiety, it is necessary to eliminate symptoms of some other health problems (e.g. hyperthyroidism, feochromocitome), the physiological effects of psychoactive substances (e.g. drugs, medicines, coffee, poisons), or some other mental disorder that is followed by some of the anxiety symptoms. It can be done so by using the case history, laboratory results and physical examination.

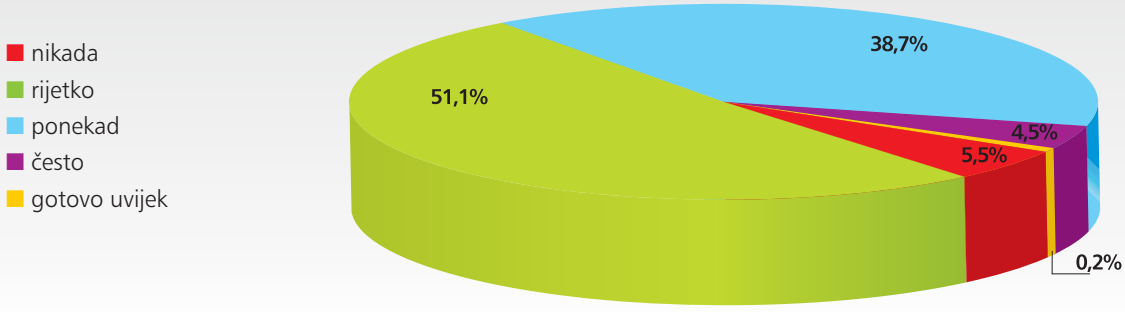
Nowadays, the cognitive and behavioural interventions are commonly used for treating anxiety disorders. Those interventions are directed towards alleviating the symptoms and reducing anti-social behaviour. Medicament therapy is usually used for cases of serious or long lasting symptoms.

The **State-Trait Anxiety Inventory** (STAI, Spielberger, 1983) was used to measure anxiety in this research, which contains 20 statements describing various anxiety symptoms (e.g. "I worry too much over something that really doesn't matter", "I'm missing out on good opportunities because I can't make a decision quickly enough"). Participants estimated the frequency of experiencing each of the anxiety symptoms on the 5-point rating scale (1 – never; 2 – rarely; 3 – sometimes; 4 – often and 5 – almost always).

The results indicate that the citizens of Rijeka rarely to sometimes experience various anxiety symptoms. 5.5% of citizens never feel anx-

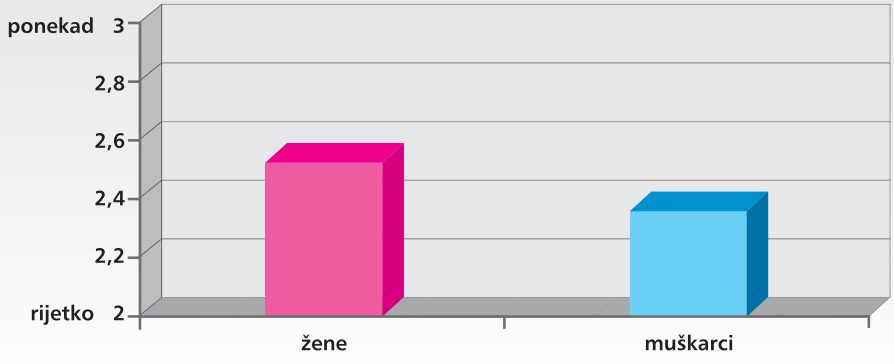
siozno 5,5% građana, rijetko 51,1%, ponekad 38,7%, 4,5% ih se često osjeća anksiozno, a 0,2% gotovo uvijek anksiozno.

Anksioznost Riječana



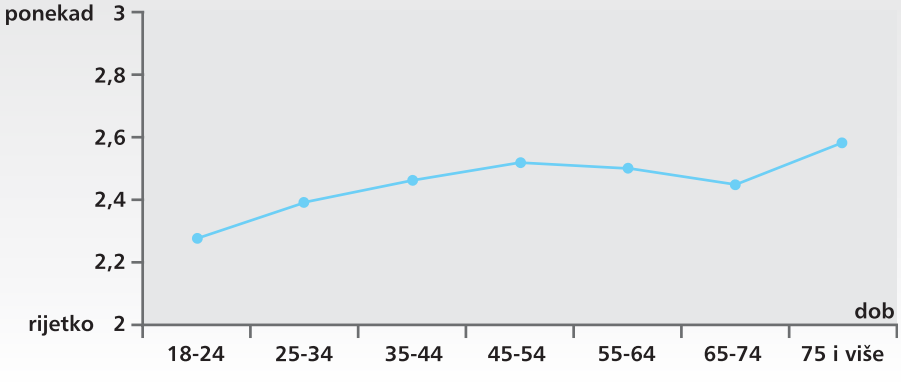
Žene su značajno anksioznije od muškaraca.

Anksioznost i spol

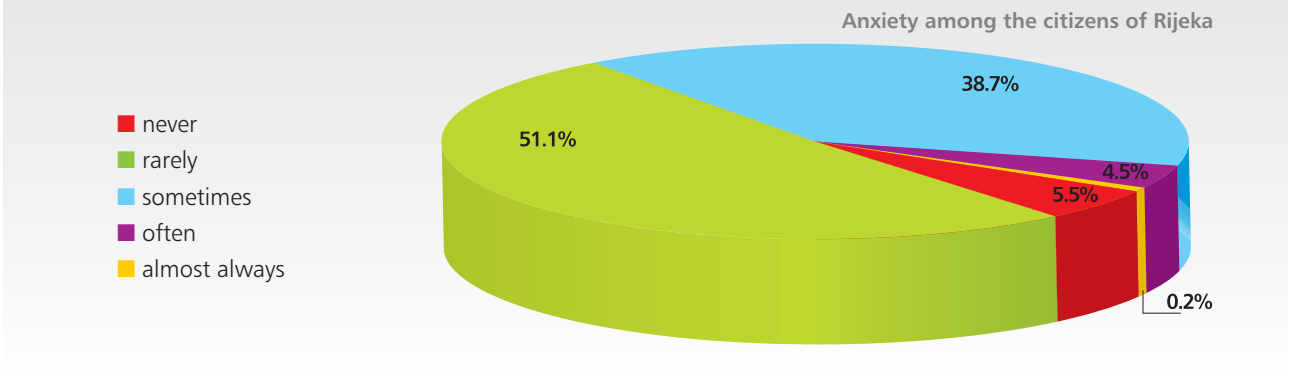


Postoji i značajna razlika s obzirom na dob, pri čemu se učestalost doživljavanja anksioznosti povećava s dobi. Najrjeđe su anksiozne osobe u dobi od 18 do 24 godine, a najčešće one u dobi od 75 i više godina.

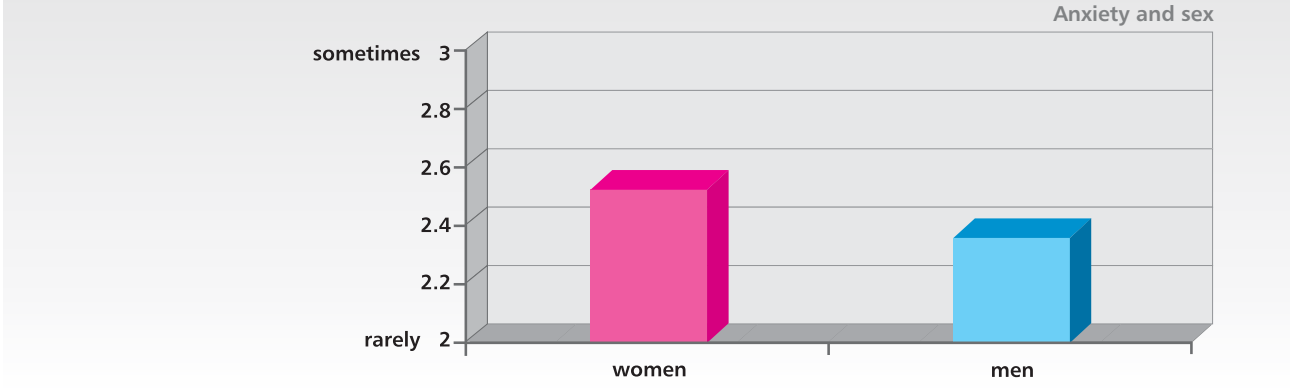
Anksioznost i dob



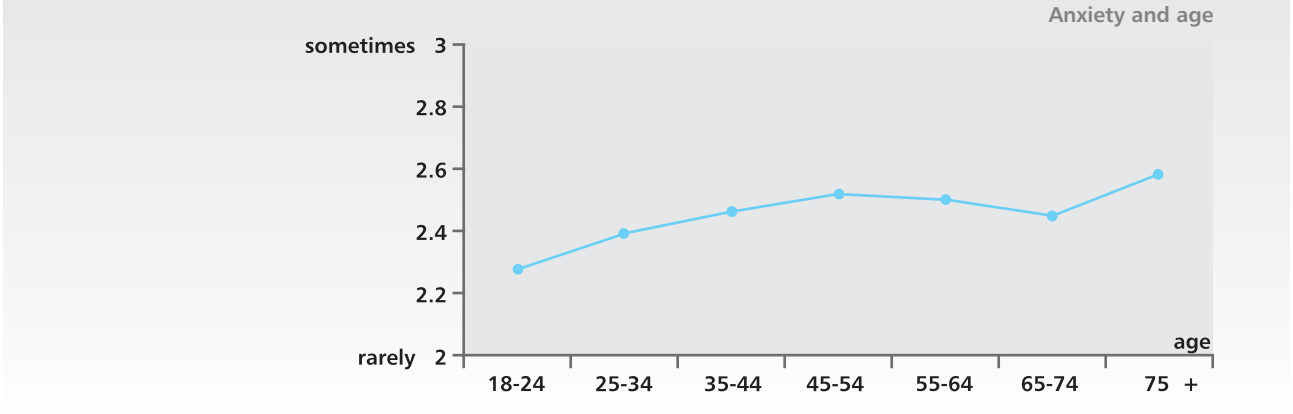
ious, 51.1% feel that way rarely, 38.7% sometimes, 4.5% often feel anxious, and 0.2% are almost always anxious.



Women are significantly more anxious than men.

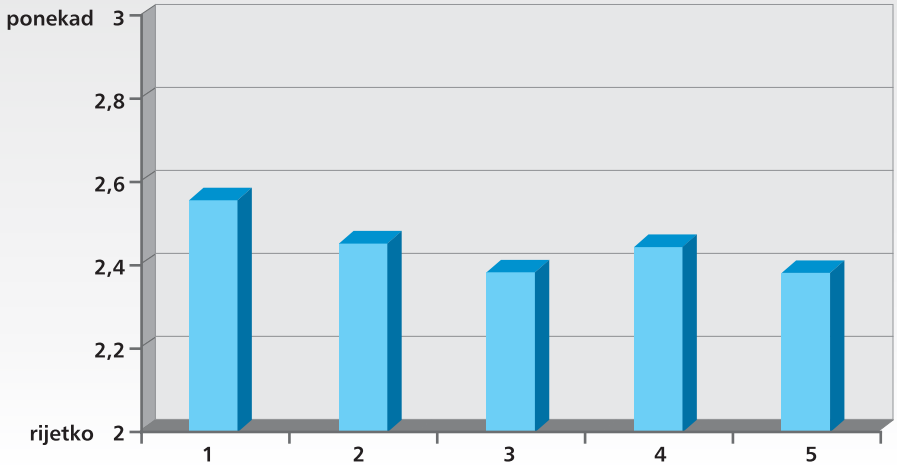


There is also a significant difference given age, where the frequency of experiencing anxiety increases with age. The least anxious persons are in the 18 – 24 age group and the most anxious persons belong to the 75 + age group.



Nađene su i razlike u učestalosti doživljavanja anksioznosti s obzirom na obrazovanje, pri čemu su najčešće anksiozni oni bez škole ili sa završenom OŠ, a najrjeđe oni sa završenom gimnazijom i fakultetom, uključujući one s magisterijem i doktoratom.

Anksioznost i obrazovanje

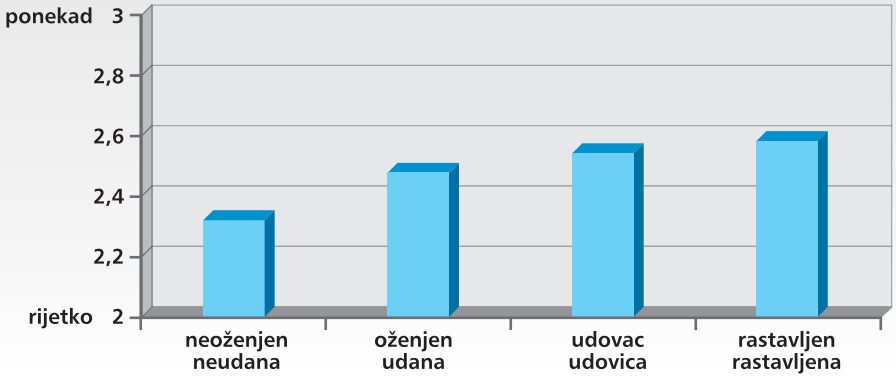


1–bez OŠ/OŠ
2–škole za zanimanja
3–gimnazija
4–viša škola
5–fakultet/mr. i dr.

Zaposleni, nezaposleni i radno neaktivni građani podjednako su često anksiozni.

S obzirom na bračno stanje, anksioznost najrjeđe doživljavaju neoženjeni i neudane, dok ostali anksioznost doživljavaju podjednako često.

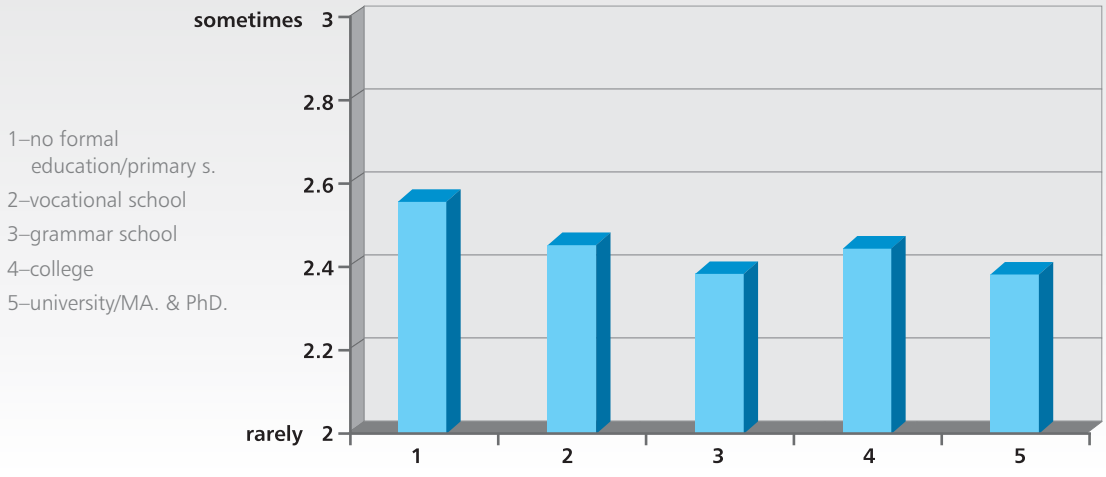
Anksioznost i bračno stanje



S obzirom na broj članova kućanstva nisu utvrđene značajne razlike u učestalosti doživljavanja anksioznosti, ali jesu s obzirom na broj

Differences in the frequency of experiencing anxiety have been found regarding educational background as well, where the most anxious are people without formal education or having finished just primary school, and the least anxious are those having finished grammar schools and those with a university degree, including those with a master's degree and a doctorate.

Anxiety and education

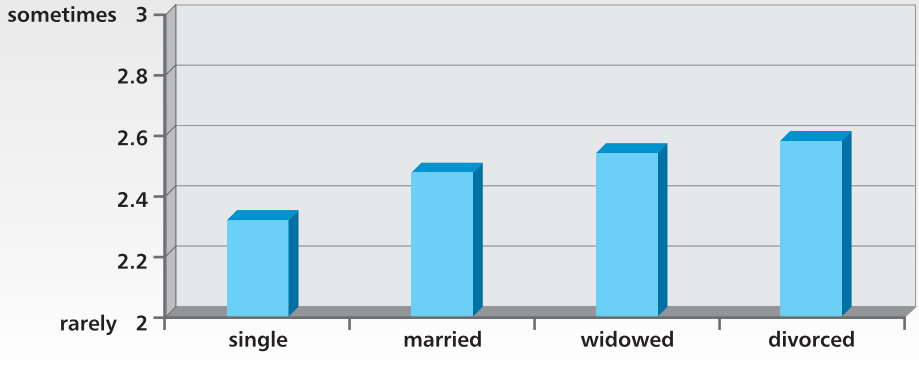


1–no formal education/primary s.
2–vocational school
3–grammar school
4–college
5–university/MA. & PhD.

The employed, the unemployed and the economically inactive citizens feel anxiety with the same frequency.

Given the marital status, anxiety is least experienced by single persons, whereas others experience anxiety equally often.

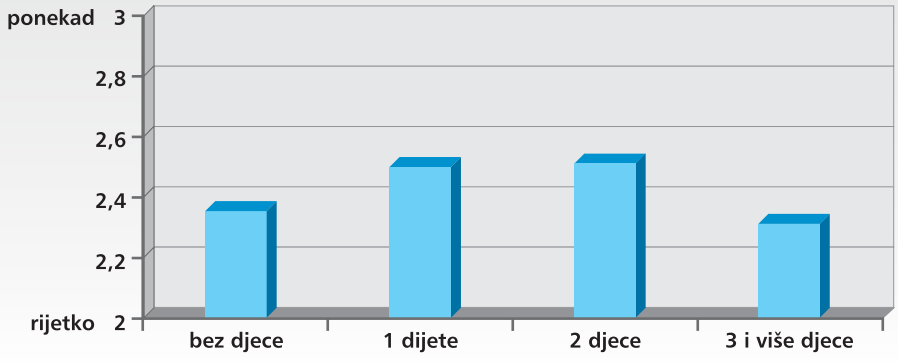
Anxiety and marital status



Taking the number of household members into account, significant differences in the frequency of experiencing anxiety were not established, but there were given the number of children. People without

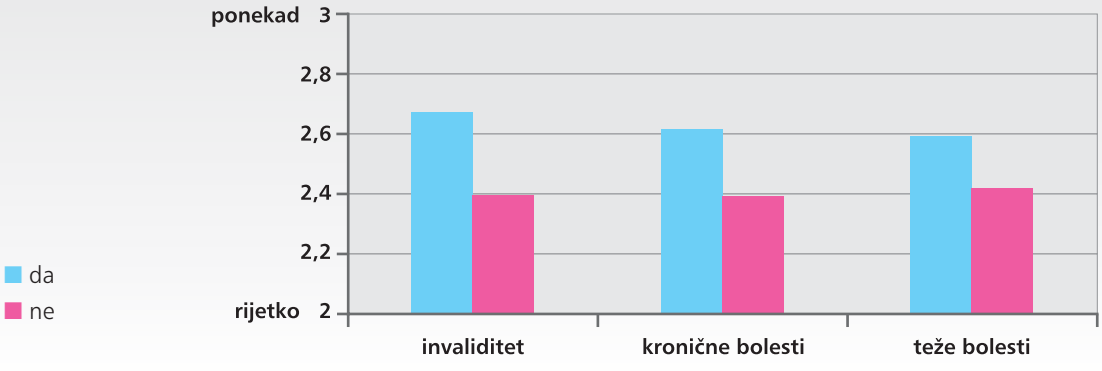
djece. Rjeđe su anksiozne osobe bez djece te s troje i više djece, nego oni s jednim i s dvoje djece.

Anksioznost i broj djece



Osobe s invaliditetom, s kroničnim bolestima i one koje su preboljele neku težu bolest značajno su češće anksiozne od onih koji nemaju invaliditet, ne boluju od kroničnih bolesti i nisu preboljeli neku težu bolest.

Anksioznost i invaliditet/bolest

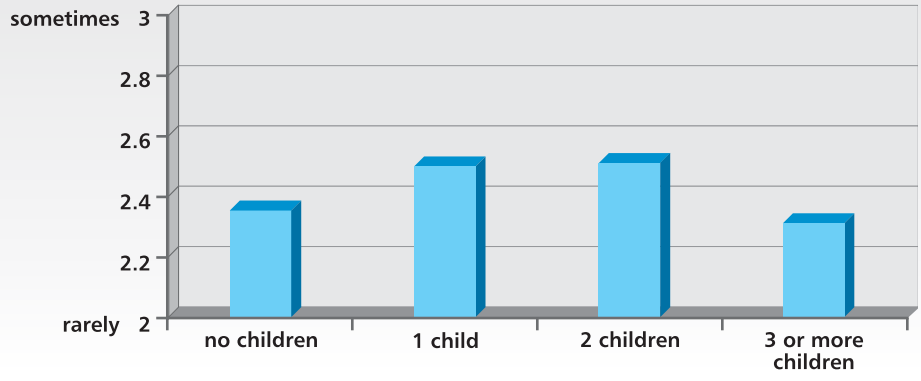


Što je netko češće anksiozan, intenzivnije doživljava i razne tjelesne simptome.

Kada se analizira anksioznost s obzirom na mjesto stanovanja, najčešće su anksiozni građani koji žive na području sljedećih prostornih cjelina grada Rijeke: Sušačko područje, Podmurvice – Preluk i Sušačka draga – Sv. Kuzam, a najrjeđe građani koji žive na području prostorne cjeline Drenova.

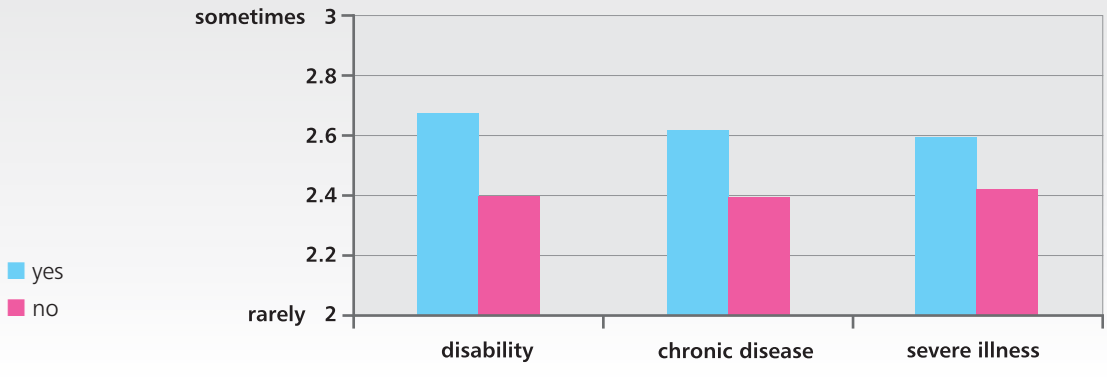
children or with three and more children are less often anxious than those with one child or two children.

Anxiety and number of children



Disabled persons, persons with a chronic disease and those who have suffered from a severe illness are significantly more anxious than those without a disability, persons who are not suffering from a chronic disease, and those who have never suffered from a severe illness.

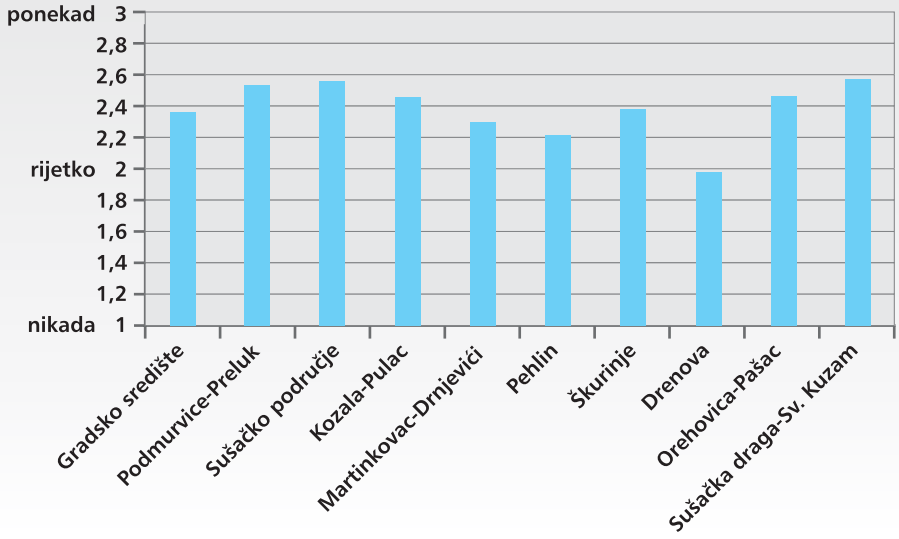
Anxiety and disability/illness



The more a person is anxious, the more intensely they experience different physical symptoms.

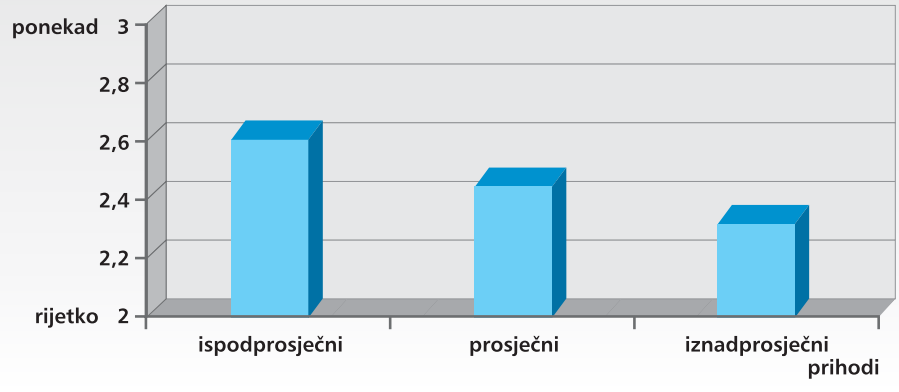
When anxiety is analysed given the place of residence, the most anxious citizens live in the following city areas: the area of Sušak, Podmurvice – Preluk and Sušačka draga – Sv. Kuzam, and the least often are those living in the city area of Drenova.

Anksioznost i mjesto stanovanja

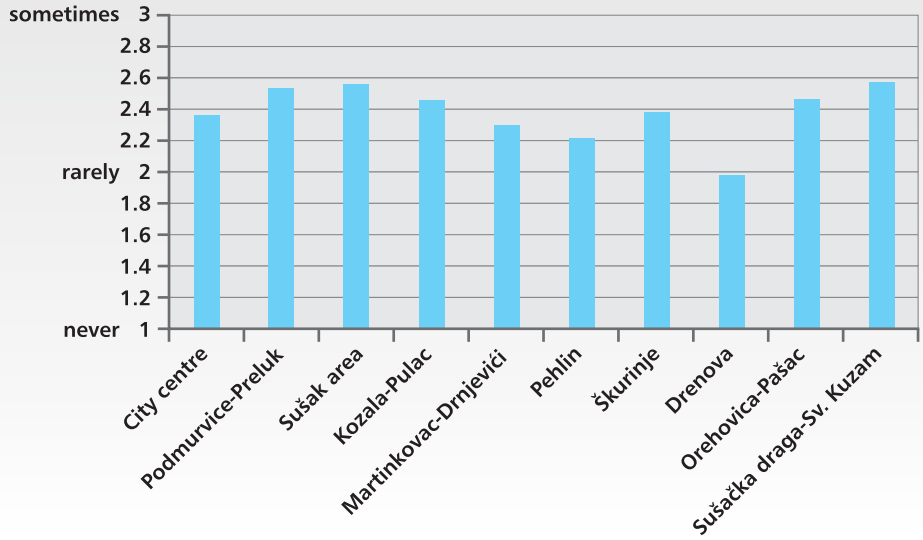


Što se tiče prihoda, anksioznost najčešće doživljavaju osobe čiji su ukupni mjesečni prihodi kućanstva ispodprosječni, dok je najrjeđe doživljavaju građani s iznadprosječnim prihodima.

Anksioznost i prihodi kućanstva

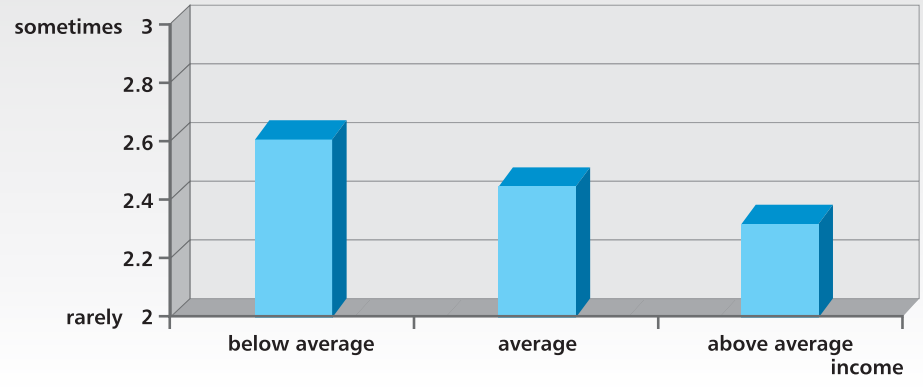


Anxiety and the place of residence



As far as income is concerned, anxiety is most often experienced by people whose monthly household income is below average, whereas it is the least experienced among citizens with above average income.

Anxiety and household income



Usamljenost

U određenim životnim razdobljima gotovo svi smo se ponekad osjećali usamljenima. Međutim iako je usamljenost univerzalni fenomen, njezin intenzitet i trajanje mogu biti vrlo različiti. Kod nekih je pojedinaca to relativno kratkotrajno stanje slabog intenziteta, dok kod drugih usamljenost može biti dugotrajna i takva intenziteta da narušava ostale aktivnosti. Usamljenost je neugodno, čak stresno iskustvo koje je praćeno nizom drugih neugodnih doživljaja. Treba napomenuti da usamljenost nije sinonim za "biti sam" budući da se ona može javiti bez obzira na to jesu li socijalni odnosi uspostavljeni ili nisu. Naime mnogo se ljudi osjeća usamljeno iako su u braku i okruženi su s puno ljudi. S druge strane, osobe koje žive same nisu nužno usamljene jer mogu primjerice imati mnogo prijatelja. Dakle, za pojavljivanje osjećaja usamljenosti nije bitan samo broj socijalnih veza, nego i njihov značaj i kvaliteta. Jedna

Loneliness

Almost everyone has felt lonely at certain stages of their life. However, even though loneliness is a universal phenomenon, its intensity and duration can be very different. Some people experience it as a relatively short state with low intensity, whereas for others loneliness can be a long lasting phenomenon and with such intensity that it impedes performing other activities. Loneliness is an unpleasant experience, stressful even, which is accompanied by a series of other unpleasant events. It should be pointed out that loneliness is not a synonym for "being alone", as it can occur regardless of whether social relations are established or not. The fact is that many people feel lonely despite being married and surrounded by other people. On the other hand, people living alone are not necessarily lonely as they can have lots of friends. Therefore, for the feeling of loneliness to occur, it is not only the number of social relationships that is relevant, but

definicija usamljenosti upravo naglašava da je usamljenost psihološko stanje koje nastaje iz razlike između željenih i ostvarenih socijalnih odnosa. Najčešće korištena definicija navodi da je usamljenost relativno trajno stanje emocionalnog stresa koje nastaje kada se osoba osjeća izolirano i odbačeno od drugih, kada osjeća da je drugi ne razumiju i da nema prikladnih socijalnih partnera za željene aktivnosti, posebno one koje joj daju osjećaj socijalne integracije i pružaju priliku za emocionalnu intimnost. Osjećaj usamljenosti još se više pogoršava kada je osoba okružena ljudima koji nisu usamljeni i kada usamljena osoba ima nisko samopoštovanje.

Posebnu težinu tome problemu daje i činjenica da je usamljenost još uvijek tabu, te iako je ona danas češća nego u prethodnim generacijama malo je ljudi spremno priznati da pate od tog problema.

Dosadašnja istraživanja pokazuju da su najrizičnije skupine za razvoj osjećaja usamljenosti: samci, rastavljeni, starije osobe, adolescenti, osobe s niskim primanjima, lošije obrazovane osobe i alkoholičari.

Da bi se razvio osjećaj usamljenosti, moraju postojati određene predispozicije (karakteristike pojedinca i situacija, vrijednosti u određenoj kulturi) i izazivajući faktori (posljedice nekoga specifičnog događaja, kao što su npr. preseljenje ili prekid ljubavne veze).

Mnogi ljudi imaju određene karakteristike koje im otežavaju uspostavljanje i održavanje socijalnih veza. Neki su ljudi npr. jako sramežljivi, što im otežava upoznavanje novih ljudi, sudjelovanje u različitim skupinama, pokretanje socijalnih aktivnosti itd. I osobe koje imaju izražen osjećaj da su različite od drugih i da ih drugi ne razumiju, osobe s nedostatkom komunikacijske prilagodljivosti i lošijim socijalnim vještinama te nerealističnim socijalnim percepcijama i disfunkcionalnim stavovima, kao što su npr. sumnja u sposobnost pronalaženja zadovoljavajućih socijalnih veza, strah od odbacivanja i negativno vrednovanje sebe, kao i one koje nisu u mogućnosti razviti prisne odnose i privrženost (npr. ljudi bez bračnog ili seksualnog partnera) sklonije su osjećaju usamljenosti.

Pojedine situacije i životne okolnosti također djeluju na razvoj osjećaja usamljenosti, naprimjer nedostatak vremena, novca te prostorna udaljenost od drugih. Osim toga, u okolini može biti teško pronaći ljude prikladne za druženje (npr. starija osoba koja živi u zgradi

their significance and quality as well. One of the definitions of loneliness stresses the importance of that very aspect, saying that it is a mental state which stems from the difference between the desired and the realised social relationships. The definition used most often states that loneliness is a relative state of emotional stress that occurs when a person is feeling isolated and rejected by others, when they feel the others do not understand them and that there are not suitable social partners for desired activities, especially those that give them a feeling of social integration and an opportunity for emotional intimacy. The feeling of loneliness is even more prominent when a person is surrounded by people who are not lonely, and when a lonely person has low self-esteem.

The full weight of this problem is that loneliness is still a taboo, and despite the fact that it is more common than in previous generations, there are few people willing to admit they suffer from this problem.

Recent research shows that the risk groups for developing the feeling of loneliness are singles, divorcees, elderly people, adolescents, people with low income, poor education and alcoholics.

In order for the feeling of loneliness to develop, certain predispositions have to exist (personality traits and situations, values of a certain culture), as well as contributing agents (results of a certain event, such as moving or ending a relationship).

Many people have certain personality traits that make establishing and fostering social relationships more difficult. For instance, some people are very shy, which prevent them from meeting new people, taking part in various groups, initiating social activities etc. Furthermore, people with a strong feeling that they are different from others and that people do not understand them are more prone to feeling lonely. On the same note, people lacking communicational adaptability, with poor social skills and an unrealistic social perception combined with dysfunctional attitudes, such as doubting their own ability of finding satisfactory social relationships, fear of being rejected and negative self-evaluation, as well as those who are unable to develop close relationships and loyalty (e.g. people without a spouse or sexual partner) are more likely to feel lonely.

In addition, certain life situations and circumstances lead to loneliness, such as lack of time, money, and spatial distance from others.

s uglavnom mlađim bračnim parovima). Treba reći i da neke kulture, poput zapadnih, potiču nezavisnost i individualizam, a mobilnost u suvremenim urbanim zajednicama toliko je velika da dovodi do toga da često i ne znamo kako nam se zove prvi susjed. Dodatno, različita tehnološka dostignuća omogućavaju nam obavljanje sve većeg broja aktivnosti i poslova bez izravnoga kontakta s drugim ljudima (npr. kupovina i financijske transakcije putem računala i telefona). Nadalje, mnogi događaji u životu nad kojima često nemamo nikakvu kontrolu mogu dovesti do osjećaja usamljenosti, kao što su npr. smrt bračnog partnera, razvod, preseljenje i sl. Isto tako, iako se osjećaj usamljenosti, kao što je ranije napomenuto, ne javlja kao nužna posljedica samačkog života, mnogo osoba koje žive same osjećaju se usamljeno. Važno je to istaknuti u kontekstu porasta broja samačkih kućanstava u zapadnim zemljama. Dodatni važni faktori koji uzrokuju doživljaj usamljenosti jesu i prisilna izolacija (npr. hospitalizacija, nemogućnost izlaska iz kuće zbog zdravstvenih razloga, slaba prometna povezanost) i dislociranost (npr. česta putovanja i izbivanja iz kuće, odlazak od kuće zbog novog posla ili školovanja).

Treba naglasiti da je usamljenost povezana s anksioznošću, depresivnošću, samoubojstvima i suicidalnim mislima. Veću usamljenost prati i veća konzumacija alkohola, maloljetnička delinkvencija, lošije samopoimanje, niže samopoštovanje i osjećaj dosade i nezadovoljstva. Usamljenije osobe češće doživljavaju osjećaj krivnje zbog nekih događaja i ponašanja iz prošlosti te imaju rigidne i preidealističke ciljeve za budućnost. One češće obolijevaju od bolesti koje se povezuju s negativnim djelovanjem stresa i od različitih psiholoških poremećaja, te zbog toga imaju veći mortalitet. Tako je npr. usamlje-

Apart from that, it can be difficult to find someone to spend time with in one's surroundings (e.g. an elderly person living in a building with mostly younger married couples). It should be mentioned that in certain cultures, the western for example, independence and individualism are encouraged. Furthermore, mobility in modern urban communities is so great that it leads us to not even knowing the name of our next-door neighbour. Furthermore, various technological advances enable us to perform an ever-growing number of activities and jobs without direct contact with other people (e.g. shopping and financial transactions via computers and phone). Moreover, many life events over which we often have no control whatsoever can lead to feeling lonely (e.g. death of a spouse, divorce, moving etc). On the same note, even though the feeling of loneliness, as previously mentioned, is not an inevitable consequence of living as a single, there are many people who live alone and feel lonely. It is important to stress this in the context of the growing number of single households in western countries. Additional important factors that cause feelings of loneliness are involuntary isolation (e.g. hospitalisation, impossibility of leaving one's home due to medical reasons, poor traffic system) and dislocation (e.g. frequent trips and staying away from home, leaving home due to new job or study).

It should be pointed out that loneliness is linked to anxiety, depression, suicide and suicidal thoughts. Stronger feelings of loneliness are followed by more alcohol consumption, juvenile delinquency, poor self-concept, lower self-esteem, and feeling of boredom and dissatisfaction. Lonelier persons more often feel guilt about certain events and behaviour from the past and have a rigid and overidealised future goals. They are more prone to illnesses that are related to negative

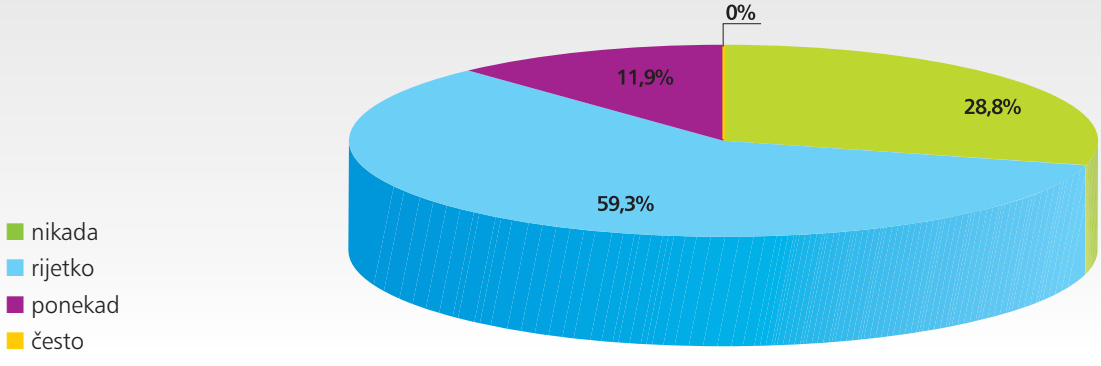
nost povezana s bolestima srca, slabijim imunološkim funkcioniranjem, većom učestalošću karcinoma, poremećajima spavanja i sl. Ljudi koji se ne osjećaju usamljeno duže ostaju zdravi i brže se oporavljaju nakon što se razbole.

Da bi se izbjegla usamljenost, ljudi moraju imati prilike za ostvarenjem emocionalne bliskosti te moraju imati osjećaj integracije s drugima. Intervencije koje pomažu i ublažavaju problem usamljenosti uključuju kognitivno-bihevioralnu terapiju, učenje socijalnih vještina i razvoj mreže socijalne podrške. Jedan od načina smanjenja osjećaja usamljenosti je i pomaganje drugima kroz aktivnosti u različitim humanitarnim društvima i udrugama građana (npr. Crveni križ, Caritas i sl.). Na taj se način kod osobe koja pomaže stvara osjećaj ponosa i korisnosti, a kroz te se aktivnosti mogu stvoriti i dugotrajni odnosi s drugim ljudima. Za osobe koje se osjećaju usamljeno preporučuje se i pronalaženje bilo kakve aktivnosti u kojoj uživaju i bavljenje njome ili udomljavanje kućnog ljubimca i sl.

U ovom istraživanju za mjerenje usamljenosti korištena je **UCLA ljestvica usamljenosti** (Russell, Peplau i Cutrona, 1980). Ona se sastoji od 20 pitanja koja se odnose na osjećaj usamljenosti i socijalne izolacije (npr. "Koliko se često osjećate sami?", "Koliko se često osjećate blisko s drugima?"). Na svako pitanje ispitanici su odgovarali uz pomoć ljestvice čestoće od 4 stupnja (1 – nikada; 2 – rijetko; 3 – ponekad; 4 – često).

Građani Rijeke u prosjeku su rijetko usamljeni. Nikada se ne osjeća usamljeno 28,8% građana, rijetko se osjeća tako 59,3% građana, ponekad se usamljenima osjeća 11,9% građana, a često usamljeno – nitko od građana Rijeke.

Usamljenost Riječana



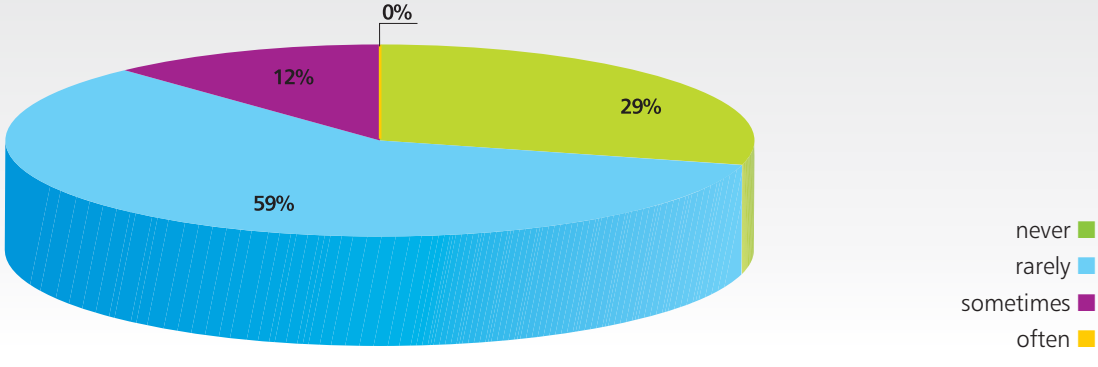
stress effects and various mental disorders, and therefore have higher mortality. Thus, loneliness is related to heart diseases, lower immunity, higher incidence of carcinoma, sleeping disorders etc. Persons who do not feel lonely stay healthy longer and recover from illnesses more quickly.

In order to avoid loneliness, people must have an opportunity for achieving emotional intimacy, and they must feel integrated with others. Interventions that help and alleviate the problem of loneliness include cognitive-behavioural therapy, learning social skills and developing a social support network. One of the ways of reducing this feeling of loneliness is by helping others through activities in various charity organisations and citizen associations (e.g. Red Cross, Caritas etc.). In that way, a person who is helping feels proud and useful and some lasting relationships with other people can develop as well. People who are feeling lonely should find any activity which they can enjoy doing, or even a pet to take care of.

The UCLA scale of loneliness was used to measure loneliness for the purposes of this research (Russell, Peplau and Cutrona, 1980). It consists of 20 questions referring to the feeling of loneliness and social isolation (e.g. "How often do you feel alone?", "How often do you feel close to others?"). To each question the participants answered by using the 4-point frequency scale (1 – never; 2 – rarely; 3 – sometimes; 4 – often).

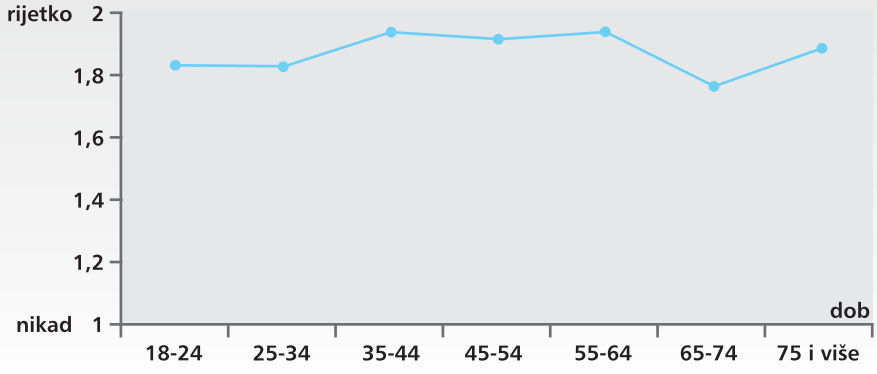
On average, the citizens of Rijeka are rarely lonely. 28.8% of the citizens never feel lonely, 59.3% rarely feel that way, 11.9% of them sometimes feel lonely, and none of the citizens of Rijeka often feel lonely.

Loneliness among the citizens of Rijeka



Žene i muškarci podjednako se često osjećaju usamljeno. S obzirom na dob, češće se usamljeno osjećaju osobe između 35 i 64 godine života.

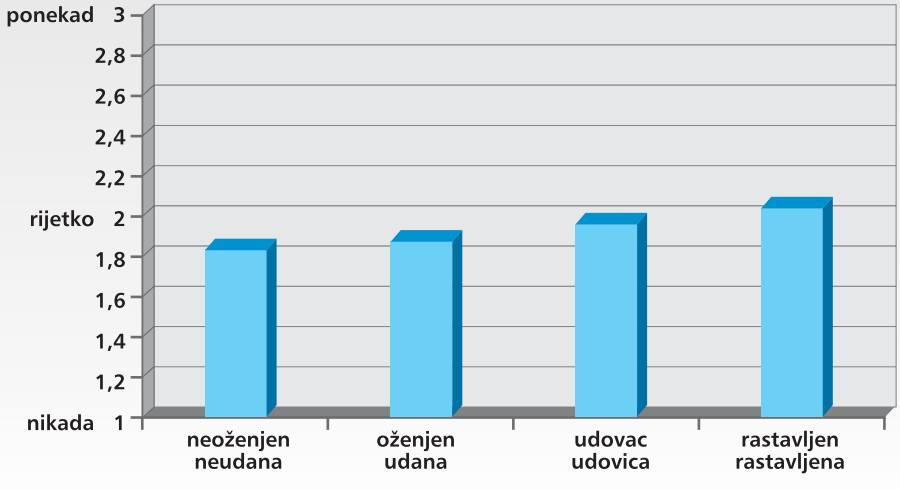
Usamljenost i dob



Riječani različita obrazovanja međusobno se ne razlikuju s obzirom na čestoću doživljavanja usamljenosti, kao niti zaposleni, nezaposleni i radno neaktivni građani.

Međutim postoje značajne razlike u čestoći doživljavanja usamljenosti s obzirom na bračno stanje. Najusamljenije se osjećaju rastavljene osobe, dok se ostali podjednako često osjećaju usamljenima.

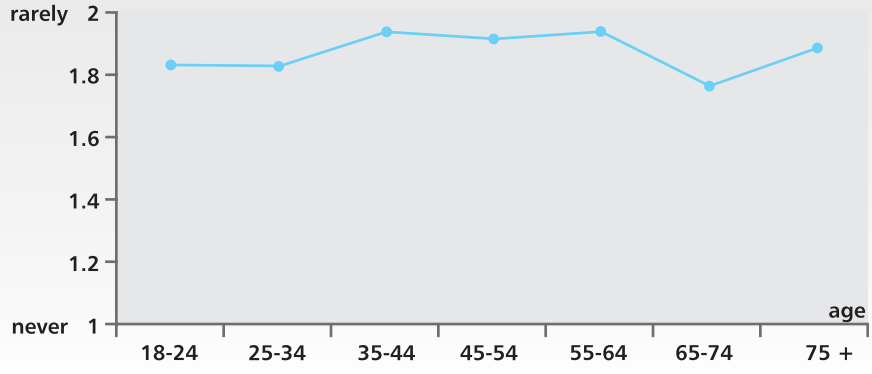
Usamljenost i bračno stanje



Postoji tendencija da se osobe koje žive u samačkim kućanstvima osjećaju usamljenijima od onih koji žive u višečlanim kućanstvima.

Men and women feel equally lonely. Given age, people in the 35 – 64 age groups feel lonely more often.

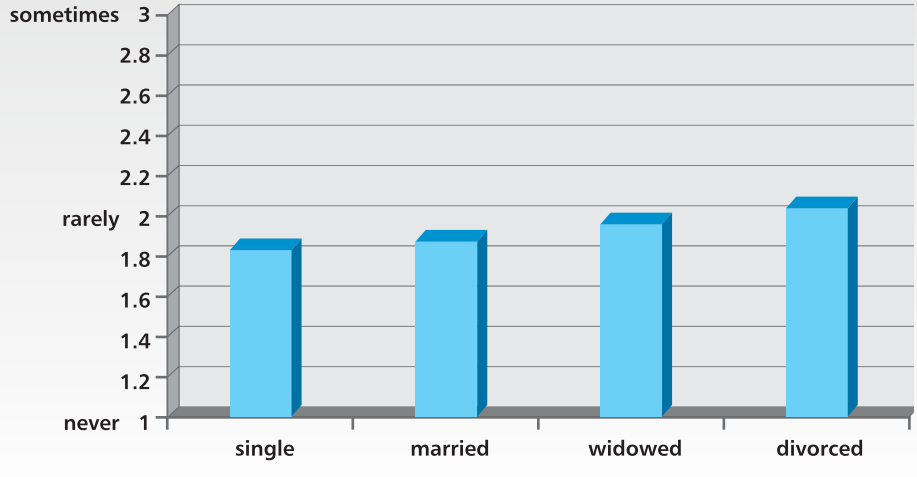
Loneliness and age



Citizens with different educational backgrounds cannot be differentiated given the frequency of loneliness, nor can the employed, the unemployed or the economically inactive citizens.

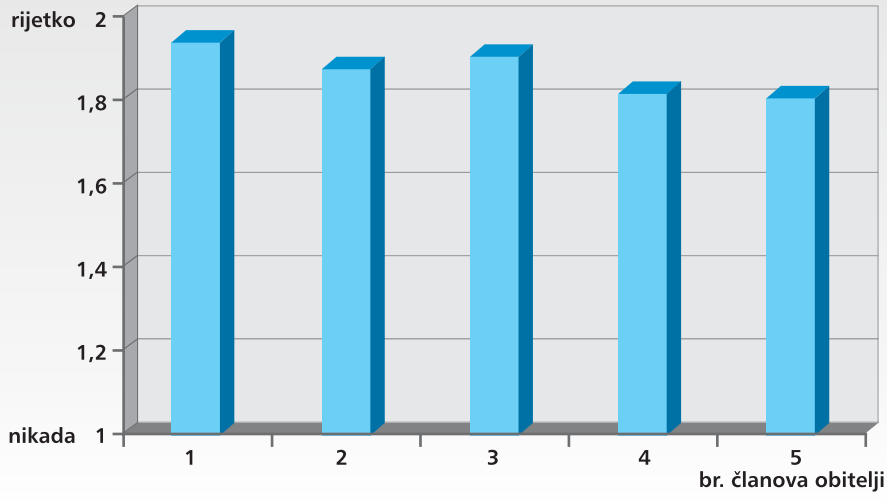
However, there are significant differences in the frequency of loneliness given the marital status. The loneliest are the divorced, whereas others feel lonely equally often.

Loneliness and marital status



There is a tendency that people living in single households feel lonelier than those living in households with more members.

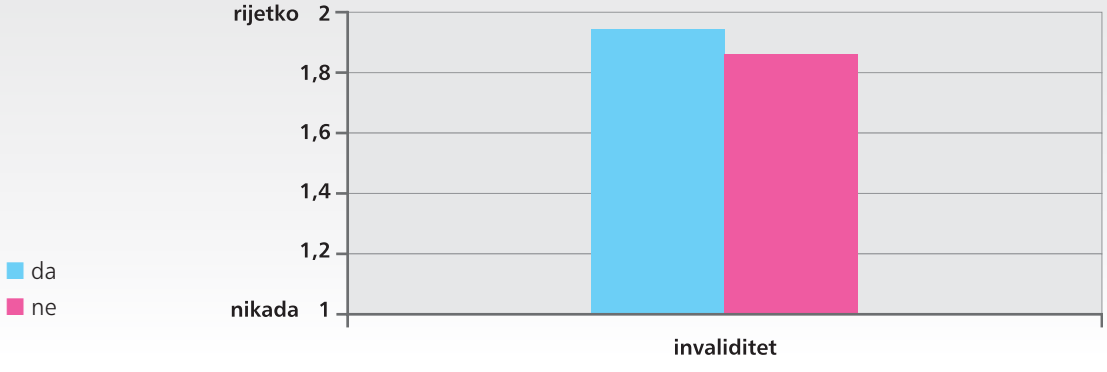
Usamljenost i broj članova kućanstva



Osobe s različitim brojem djece podjednako često doživljavaju usamljenost.

Osobe s invaliditetom nešto su usamljenije od osoba bez invaliditeta. Kronično bolesne osobe i one koje su preboljele teže bolesti ne osjećaju se usamljenijima od onih koji ne boluju od kroničnih bolesti i onih koji nisu preboljeli težu bolest.

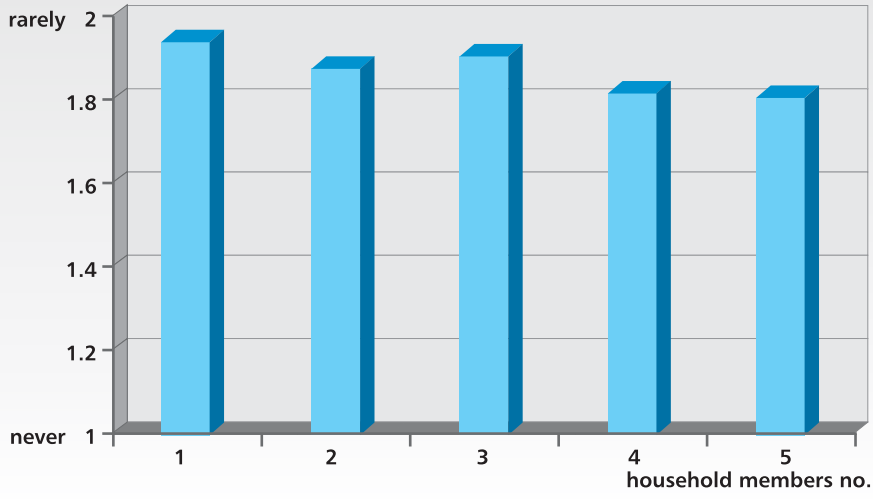
Usamljenost i invaliditet



Treba znati da što je netko češće usamljen, intenzivnije doživljava i tjelesne simptome.

Najčešće se usamljenima osjećaju građani koji stanuju na područjima prostornih cjelina Sušačka draga-Sv.Kuzam i Sušačko područje, a najrjeđe stanovnici prostornih cjelina Pehlin i Drenova.

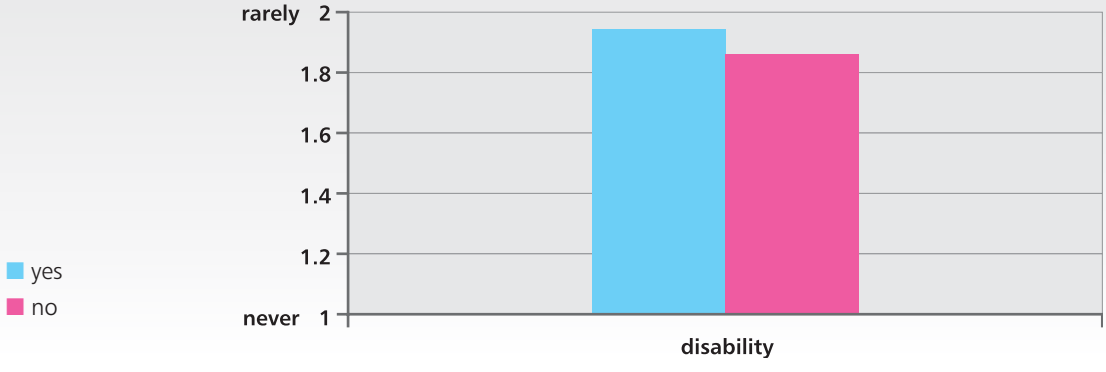
Loneliness and number of household members



Persons with different number of children experience loneliness equally.

Disabled people are somewhat lonelier than those without disability. People with chronic disease and those who have suffered from severe illness do not feel lonelier when compared to those who do not suffer from a chronic disease and those who have never had a severe illness.

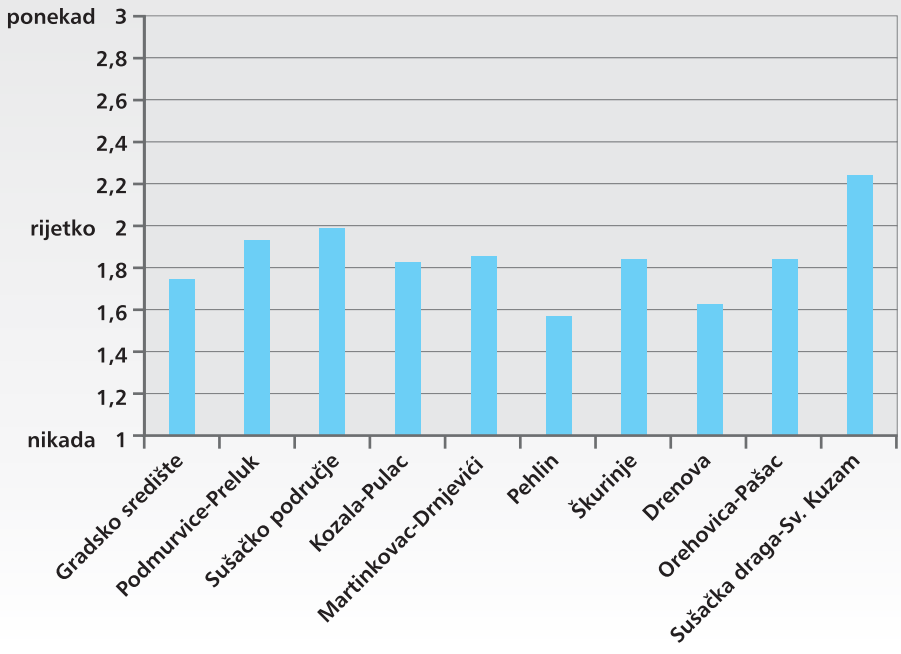
Loneliness and disability



We should be aware of the fact that the more often a person feels lonely, the more intensely they experience physical symptoms, too.

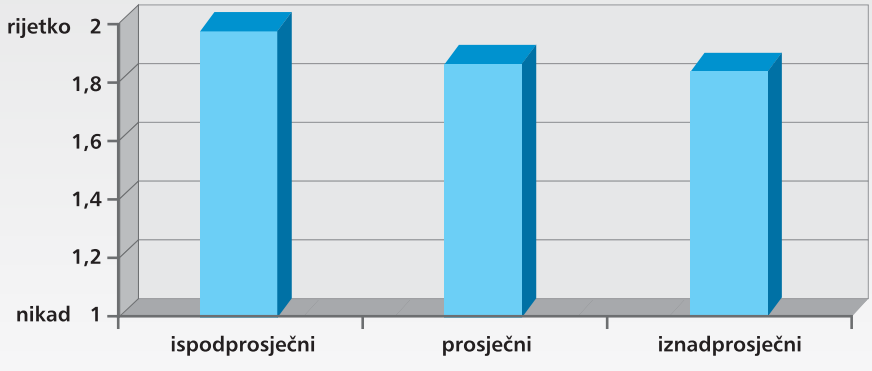
Citizens living in the city areas of Sušačka draga-Sv.Kuzam and the area of Sušak feel loneliness the most, whereas the citizens of city areas of Pehlin and Drenova feel lonely the least often.

Usamljenost i mjesto stanovanja

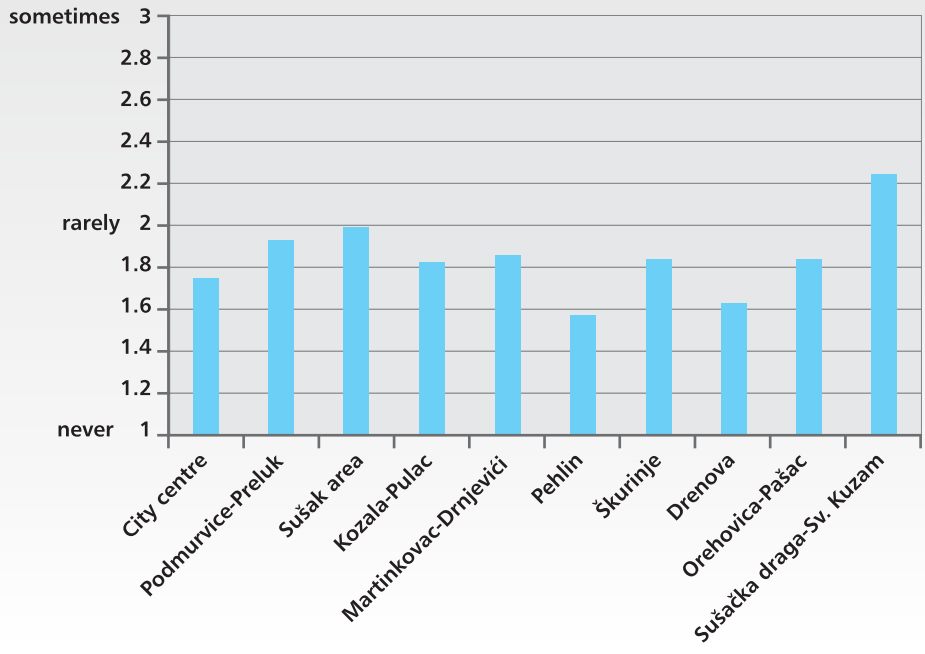


Usamljenost češće doživljavaju osobe koje imaju ispodprosječne mjesečne prihode nego one koje imaju prosječne i iznadprosječne prihode.

Usamljenost i prihodi kućanstva

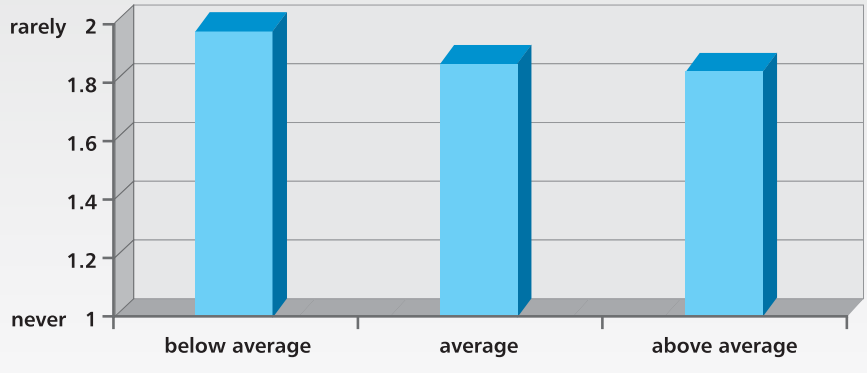


Loneliness and place of residence



Loneliness is experienced more often by people whose income is below average than those who have average or above average income.

Loneliness and income



Stresni životni događaji i percipirana stresnost

Stres se odnosi na doživljaj tjelesne, mentalne i emocionalne napetosti koja nastaje onda kada su zahtjevi koji se postavljaju pred nas prijeteći ili veći od naših sposobnosti prilagođavanja. Dakle doživljaj prijetnje javlja se onda kada se u okolini pojave događaji koji su po svojim karakteristikama izvan granica onoga što je za osobu uobičajeno.

Podražaji ili događaji koji dovode do stresnog odgovora organizma nazivaju se stresorima ili stresnim podražajima. U najširem smislu stresni podražaj može se shvatiti kao bilo koji podražaj koji prekida uobičajenu aktivnost organizma, odnosno kao bilo koji izazov ili prijetnja njegovim normalnim procesima ili integriranim funkcijama.

Jedna je od najčešćih kategorizacija tipova stresnih situacija koje rezultiraju doživljajem psihološkog stresa ona koja uključuje: 1. traumatske događaje (prirodne i tehnološke katastrofe, ratne situacije, osobne traume i sl.), 2. kronične stresne događaje (nezaposlenost, svađe u obitelji i sl.), 3. velike životne promjene (vjenčanje, završetak škole, smrt voljene osobe i sl.) i 4. svakodnevne stresne situacije (žurba, gužva, neljubaznosti ljudi i sl.). Te se stresne situacije razlikuju s

Stressful life events and perceived stress

Stress applies to the physical, mental and emotional strain that occurs when demands imposed on us are threatening or greater than our adaptation skills. Therefore, people experience threat when the events happening are unknown and unusual to them.

Stimuli or events leading to this stressful response of an organism are called stressors or stressful stimuli. In the widest sense of the phrase, a stressful stimulus can be regarded as any other stimulus interrupting the usual activity in an organism, i.e. as any challenge or threat to its normal processes or integrated functions.

The most common categorisations of stressful situations that result in experiencing stress include: 1. traumatic events (e.g. natural and technological catastrophes, wars, personal traumas etc), 2. chronic stressful events (e.g. unemployment, family arguments etc), 3. major life changes (e.g. marriage, end of school, death of beloved ones etc), and 4. everyday stressful situations (e.g. rush, crowd, unkind people etc). These stressful situations are different in intensity and duration. Traumatic events are stimuli of a relatively short duration, but very high

obzirom na intenzitet stresnosti i trajanje. Traumatski događaji su podražaji relativno kratka trajanja, ali vrlo visoka intenziteta jer im je jedna od glavnih karakteristika prijetnja životu. Za razliku od trauma, kronični stresni događaji su dugotrajni, ali nižega intenziteta. Velike životne promjene mogu biti različita trajanja, a razlikuju se od kroničnih stresnih događaja jasno definiranim završetkom djelovanja. Svakodnevne stresne situacije kratka su trajanja i niska intenziteta, premda mogu biti i visoka intenziteta ako se događaju istodobno s kroničnim stresnim događajima.

Kako ćemo reagirati na stresne događaje, ovisi o različitim čimbenicima. Jedan su takav čimbenik karakteristike osobe. Osobe koje su npr. ekstravertirane, imaju visoko samopoštovanje i uvjerene su u vlastitu efikasnost, češće primjerenije odgovaraju zahtjevima stresne situacije nego osobe koje su neurotične, imaju nisko samopoštovanje i nisku percepciju vlastite kompetentnosti. S druge strane, važnu ulogu imaju i karakteristike stresnog događaja, kao što su njegova novost, nejednoznačnost itd. Zahtjevi koji su teški, dvosmisleni, nenajavljeni i/ili dugotrajni, oni na koje se osoba nije pripremila i/ili nalažu rad pod vremenskim pritiskom, vjerojatnije će dovesti do doživljaja stresa nego lagani zadaci i oni za koje se osoba može pripremiti. Izgleda da mogućnost predviđanja nekoga stresnog događaja umanjuje njegove posljedice, čak i kada znamo da ih ne možemo kontrolirati. Predvidljivost pomaže pripremi za nešto što će se dogoditi i dozvoljava planiranje načina suočavanja sa stresnom situacijom. Zbog

in intensity, as one of their main features is threat to life. Unlike traumas, chronic stressful events are long-term, but not with high intensity. Major life changes can be of varying duration and are different from chronic stressful events as they have a clearly defined ending. Everyday stressful situations are short in duration and low in intensity, although they can have high intensity if they occur simultaneously with chronic stressful events.

The way we react to stressful events depends on various factors. One such factor is personality traits. Persons who are extraverted have high self-esteem and are convinced in their own effectiveness, react to the demands of a stressful situation more appropriately than persons who are neurotic, have low self-esteem and low perception of their own competence. On the other hand, features of stressful events play an important role as well (e.g. novelty, ambiguity etc). Demands that are difficult, ambiguous, unannounced and/or long in duration, those that a person is not ready for and/or require working under tight deadlines, are more likely to lead to stress than easy tasks and those that a person can prepare for. It seems that the possibility of predicting a stressful event diminishes its effects, even if we know that we cannot control them. Predictability helps to prepare for something that is about to happen and allows planning ways to deal with a stressful situation. That is why the amount of stress caused by a request, for example, to give a speech right now in front of a wide

toga je količina stresa uzrokovana npr. zahtjevom da upravo sada održimo govor pred puno ljudi, mnogo veća od količine stresa kojem smo podložni kada nam se takav zahtjev uputi nekoliko dana ranije.

Stres izaziva brojne promjene u različitim tjelesnim sustavima, od kojih su najvažnije promjene u središnjem i perifernom živčanom sustavu, te promjene u neuroendokrinom i imunosnom funkcioniranju.

Učinci stresa na naše cjelokupno tjelesno i psihološko funkcioniranje mogu biti neposredni i odgođeni. Neposredni učinci manifestiraju se u obliku emocionalnih reakcija (uglavnom uključuju negativne emocionalne doživljaje poput anksioznosti, ljutnje, tuge, a mogu biti prisutna i neka druga emocionalna stanja kao što je npr. krivnja) i procjene zadovoljstva vlastitim reagiranjem, dok se odgođeni učinci, koji se manifestiraju nakon dužega razdoblja odnose na tjelesno i mentalno zdravlje, socijalno funkcioniranje i opću dobrobit osobe.

Iako se često smatra da stres ima isključivo negativne posljedice, točnije je reći da on ima aktivacijski učinak na organizam, koji je često negativan, međutim ovisno o kontekstualnim faktorima ponekad može biti i pozitivan. Uz to, određena razina stresa normalan je dio svakodnevnog života. Ona odražava naša nastojanja da se prilagodimo neizbježnim promjenama u svojoj fizičkoj i socijalnoj okolini. Međutim kronični stres često dovodi do poremećaja u cjelokupnom funkcioniraju osobe i utječe na gotovo sve aspekte života.

audience, is much greater than the amount of stress we are prone to when the same is asked from us a few days earlier.

Stress causes numerous changes in various physical systems, among which the most significant are changes in the central and peripheral nervous system, and changes in the neuroendocrine and immune functioning.

Stress affects on our overall physical and mental functioning can be immediate or delayed. On the one hand, immediate effects are manifested as emotional reactions (they mostly include negative emotional sensations such as anxiety, anger, sadness, along with some other emotional states – guilt, for example) and the appraisal of satisfaction with a personal reaction. On the other hand, delayed effects, which are manifested after a longer period of time, are related to physical, mental and social functioning and the general well being of a person.

Even though it is often believed that stress has only negative effects, it is more accurate to say that it has an activational effect on the organism, which is often negative. However, given the contextual factors, it can sometimes be positive. Apart from that, a certain level of stress is a normal part of everyday life. It reflects our attempts to adapt to the inevitable changes in our physical and social environment. However, chronic stress often leads to disorders in the overall functioning of a person, and it affects almost all aspects of life.

Kardiolog Wolff je još 1950. godine primijetio da pacijenti godinu dana prije pojave neke bolesti izvještavaju o češćim stresnim životnim događajima kao što su: gubitak posla, razvod braka, rođenje djeteta, preseljenje u drugi grad, gubitak bliske osobe i sl. Danas se zna da je psihosocijalni stres rizičan faktor za kardiovaskularne bolesti i kod zdravih i kod oboljelih osoba. Uz to, niz istraživanja jasno pokazuje povezanost između psihološkog stresa i bolesti vezanih uz funkciju imunosnog sustava, poput povećane podložnosti infekcijama respiratornog trakta, astme, autoimunih bolesti i karcinoma.

Dijagnostički i statistički priručnik mentalnih poremećaja (*Diagnostic and Statistical Manual of Mental Disorders* – DSM-IV) definira psihosocijalni stresor kao bilo kakav životni događaj ili životnu promjenu koja može biti vremenski (i možda uzročno) povezana s nastankom ili pogoršanjem mentalnog poremećaja.

Procjenjuje se da je stres glavni čimbenik koji dovodi do povećanja zdravstvenih troškova. Stručnjaci za javno zdravstvo smatraju da je 90% svih oboljenja i poremećaja u SAD-u na neki način povezano sa stresom.

Nadalje, stres ima važnu ulogu u nastanku i održavanju brojnih socijalnih problema, kao što su zlostavljanje djece i starijih, nasilje na radnom mjestu, maloljetnički kriminal, samoubojstvo, zloporaba sredstava ovisnosti itd. Također, stres dovodi do smanjene radne uspješnosti i produktivnosti.

Nasreću, danas postoji veliki broj programa namijenjenih efikasnijem upravljanju i suočavanju sa stresom, a koji uključuju ne samo

Cardiologist Wolff noticed a long time ago (in 1950) that patients report on more frequent stressful events such as losing a job, divorce, gaining a new family member, moving to a different city, the death of a close person etc, a whole year before a disease occurs. Today we know that psychosocial stress is a risk factor for cardiovascular diseases in both healthy and ill persons. In addition, research clearly shows the connection between psychological stress and diseases related to the immune system function, such as increased proneness of the respiratory infections, asthma, autoimmune diseases and carcinoma.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines a psychosocial stressor as any life event or life change that can be time-related (or even cause-related) to the development or deterioration of a mental disorder.

It is estimated that stress is the main factor of the increase in medical expenses. Public health experts believe that 90% of all illnesses and disorders in the USA are in some way related to stress.

Furthermore, stress plays an important role in creating and maintaining numerous social problems, such as child abuse and abuse of the elderly, harassment in a workplace, juvenile crime, suicide, drug

korištenje medikamenata nego i različitih psihoterapijskih postupaka i učenje tehnika opuštanja.

Pokušavši izmjeriti intenzitet doživljenoga stresa izazvan velikim životnim promjenama, Holmes i Rahe (1967) konstruirali su standardiziran popis stresnih događaja nazvan **Ljestvica procjene socijalne prilagodbe** (*Social Readjustment Rating Scale*, SRRS). Ta je ljestvica korištena i u ovom istraživanju. Ona se sastoji od 43 stresna događaja, među kojima su ispitanici trebali izabrati one koji su im se dogodili u posljednjih godinu dana. Ona uključuje vrlo intenzivne stresne događaje kao što su smrt djeteta ili bračnog partnera (100 jedinica promjene), razvod braka (73 jedinice promjene), ali i blage stresne događaje kao što su odlazak na godišnji odmor ili putovanja (13 jedinica promjene) i manji problemi sa zakonom (prometni prekršaji i sl.) (11 jedinica promjene). Ovakvo mjerenje stresa polazi od pretpostavke da pojedini stresni životni događaji kod svih osoba izazivaju jednak intenzitet stresnog doživljaja izražen jedinicama promjena.

Međutim različite osobe različito reagiraju na isti stresni događaj. Naime stupanj doživljenog stresa povezan s nekim događajem odražava značenje koje taj događaj ima za pojedinca. Trudnoća npr. može biti pozitivan ili negativan događaj, ovisno o tome želimo li je ili ne. Dakle jedan te isti događaj kod različitih će osoba dovesti do vrlo različita intenziteta doživljaja stresa. Zbog toga je za procjenu doživljenog stresa korišten i **Upitnik percipiranog stresa** (Perceived Stress Scale, Cohen, Kamarck i Mermelstein, 1983). On se sastoji od 10 pitanja o tome koliko često je u posljednjih mjesec dana netko imao različite negativne stresne doživljaje (npr. "Koliko ste često u proteklih mjesec dana bili uznemireni zbog nečega što se dogodilo nepredviđeno?"). Odgovaralo se uz pomoć sljedeće ljestvice čestoće od pet stupnjeva: 1 – nikada; 2 – rijetko; 3 – ponekad; 4 – često; 5 – gotovo uvijek.

Stresni životni događaji

U prosjeku su građani Rijeke u posljednjih godinu dana doživjeli četiri stresna životna događaja. Raspon stresnih događaja koje su doživjeli kreće se od nijednog do najviše 23 stresna životna događaja (od mogućih 43). Slijedi prikaz učestalosti doživljavanja svakoga pojedinog stresnog životnog događaja kod građana Rijeke

abuse etc. In addition, stress leads to diminished work efficiency and productivity.

Luckily, there is a vast number of programmes designed for coping with stress more efficiently that include not only using drugs, but various psychotherapeutic methods and relaxing techniques as well.

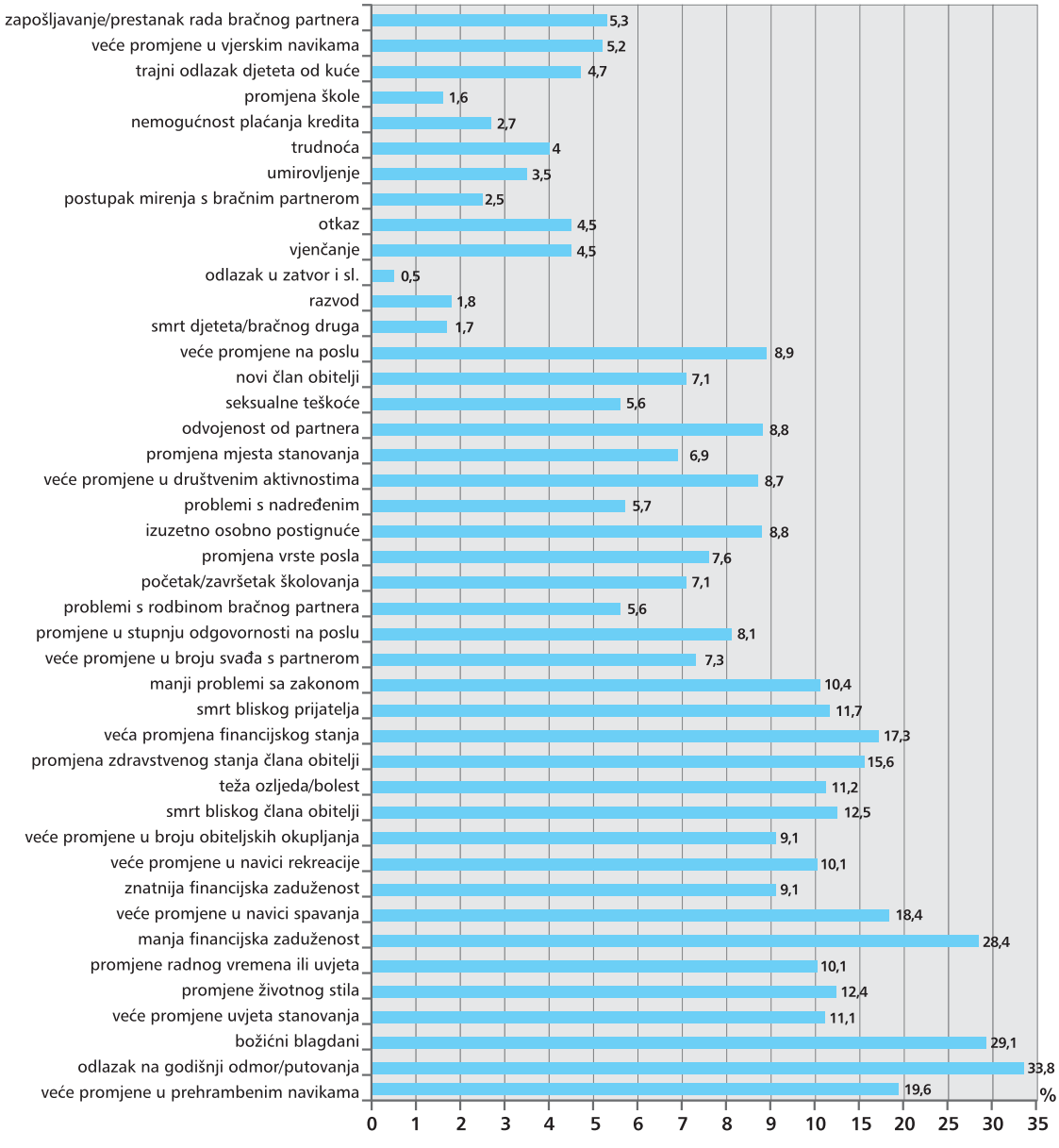
When trying to measure the intensity of stress caused by major life changes, Holmes and Rahe (1967) constructed a standardized list of stressful events called **Social Readjustment Rating Scale** (SRRS). This scale was used in this research as well. It consists of 43 stressful events, out of which the participants had to choose the ones they had experienced over the past year. It includes very intense stressful events such as the death of a child or a spouse (100 change units), divorce (73 change units), but also mild stressful events such as going on a holiday or a trip (13 change units) and minor legal incidents (e.g. traffic offences) (11 change units). This measure of stress is based on the fact that certain stressful events cause an equal intensity of stressfulness in everyone, and it is measurable in change units.

However, different people react to the same stressful event in different ways. In other words, the level of stress experienced related to an event reflects the significance of the event to the person. For instance, pregnancy can be a positive as well as a negative event, depending on whether it was wanted or not. Therefore, the same event will create a different intensity of stress experience in different people. This is why the **Perceived Stress Scale** was used (Cohen, Kamarck and Mermelstein, 1983) for estimating the experienced stress. It has 10 questions on frequency of experiencing various negative stressful events over the last month (e.g. "How often have you felt disturbed over something that happened out of your control over the past month?"). Answers were given by using the following 5-point frequency scale: 1 – never; 2 – rarely; 3 – sometimes; 4 – often; 5 – almost always.

Stressful life events

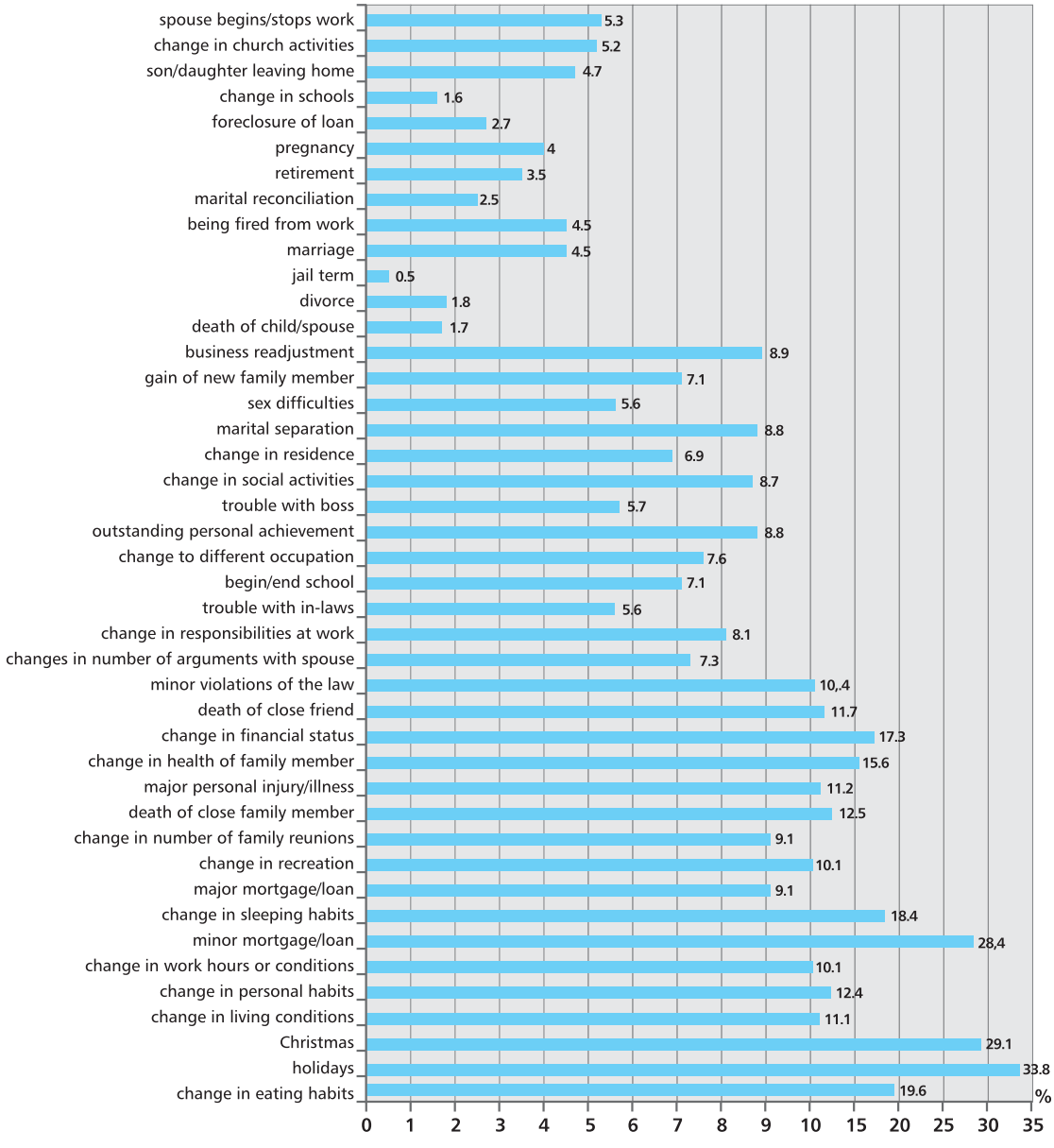
On average, the citizens of Rijeka experienced four stressful life events over the past twelve months. The range of stressful events they experienced is from none to a maximum of 23 stressful life events (out of a possible 43). The following graph shows the frequency of each stressful life event among the citizens of Rijeka.

Stresni životni događaji



Svaki od navedenih životnih događaja izaziva različit intenzitet stresa, koji može varirati od minimalno 11 do maksimalno 100 jedinica promjene za stresni događaj.

Kada se ukupan intenzitet doživljenog stresa izrazi kao zbroj jedinica promjene za sve stresne događaje koje je ispitanik doživio, pri-

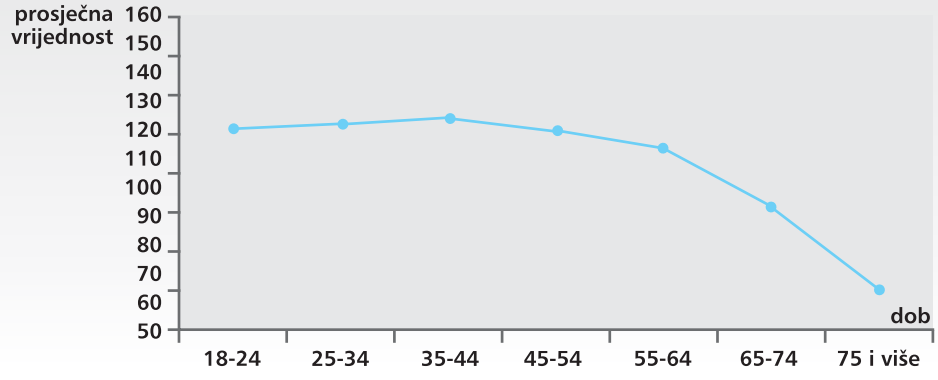


Each of the mentioned life events causes different stress intensity, which can vary from a minimum 11 to a maximum 100 change units for a stressful event.

When the total intensity of experienced stress is expressed as a sum of change units for every stressful event the participants have expe-

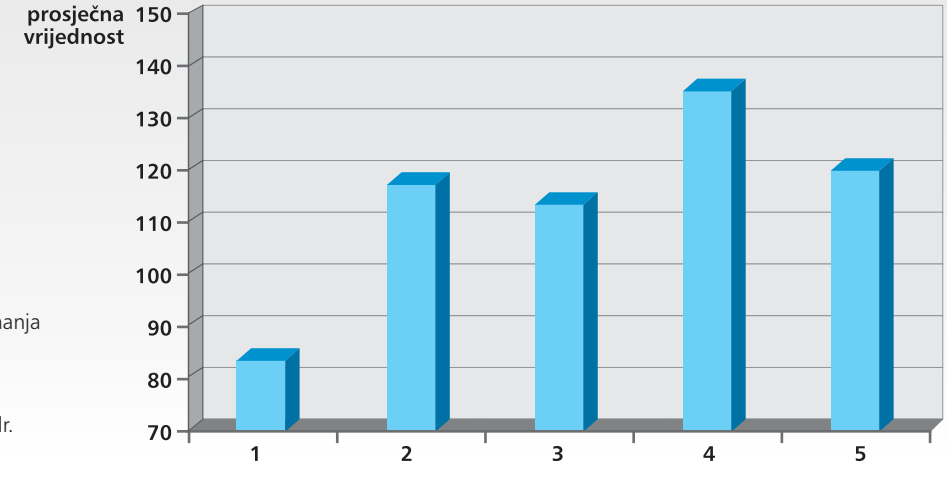
mjećuje se da je intenzitet doživljenog stresa kod žena i muškaraca podjednak. S obzirom na dob, osobe starije od 55 godina, posebice one starije od 75 godina, doživljavaju stresne događaje čiji je ukupan intenzitet niži (manji broj jedinica promjene) nego kod ostalih dobnih skupina.

Stresni životni događaji i dob



S obzirom na obrazovanje, intenzitet doživljenih stresnih životnih događaja najniži je kod onih bez škole i sa završenom osnovnom školom.

Stresni životni događaji i obrazovanje

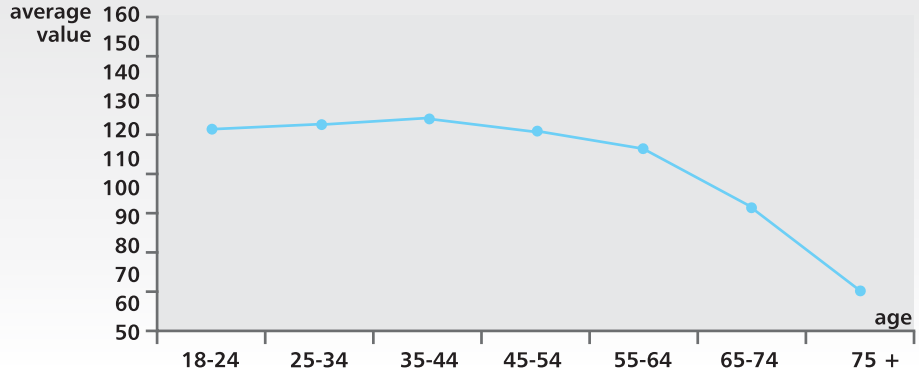


1–bez OŠ/OŠ
2–škole za zanimanja
3–gimnazija
4–viša škola
5–fakultet/mr. i dr.

Kada se radi o radnoj aktivnosti, radno neaktivni Riječani doživljavaju manje intenzivne stresne životne događaje u odnosu na zaposlene i nezaposlene građane.

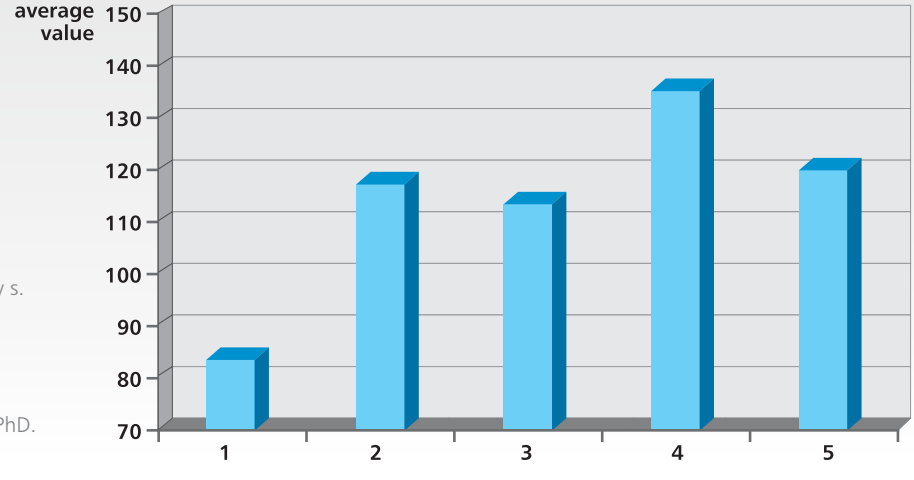
rienced, it is evident that the intensity of experienced stress among women and men is the same. Given age, people older than 55, and especially those older than 75, experience stressful events with lower total intensity (i.e. smaller number of change units) than people in other age groups do.

Stressful life events and age



Given the educational background, the intensity of experienced stressful life events is the lowest among people without formal education and those with having finished primary school.

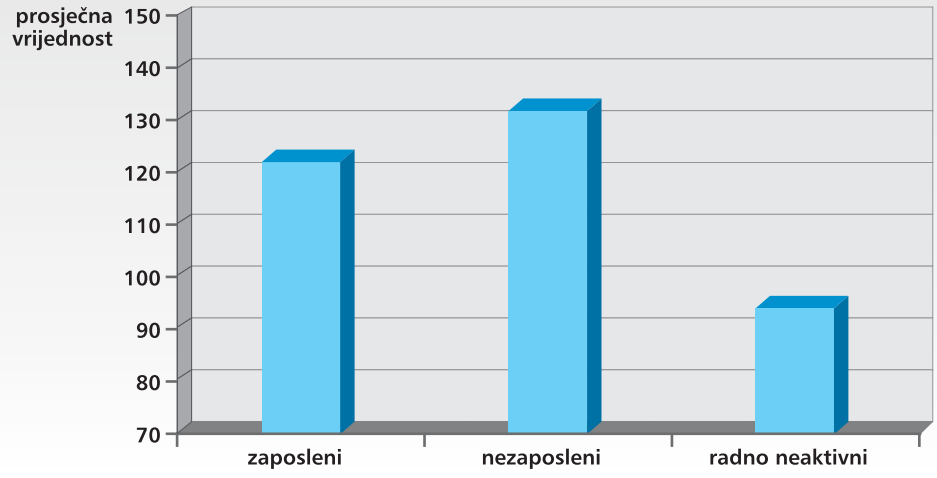
Stresful life events and education



1–no formal education/primary s.
2–vocational school
3–grammar school
4–college
5–university/MA. & PhD.

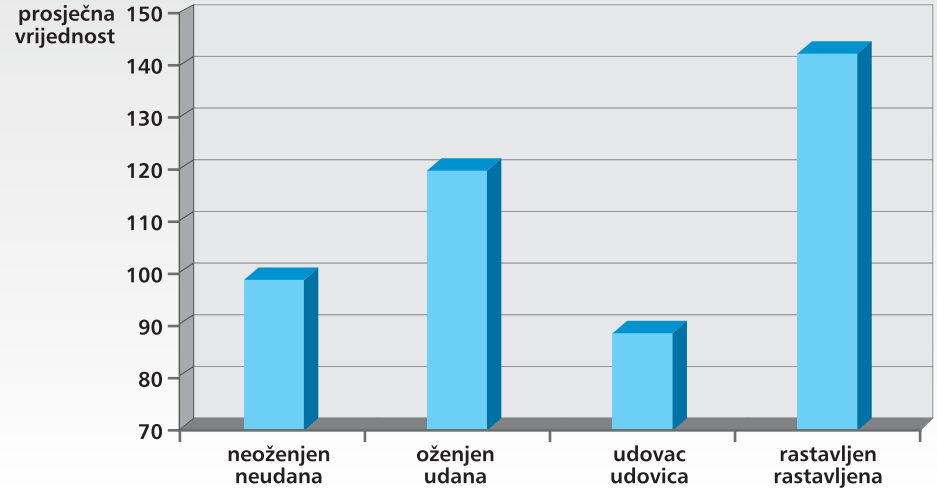
When we analyse economic activity, economically inactive citizens experience a lower intensity of stressful life events when compared to both employed and unemployed citizens.

Stresni životni događaji i radna aktivnost



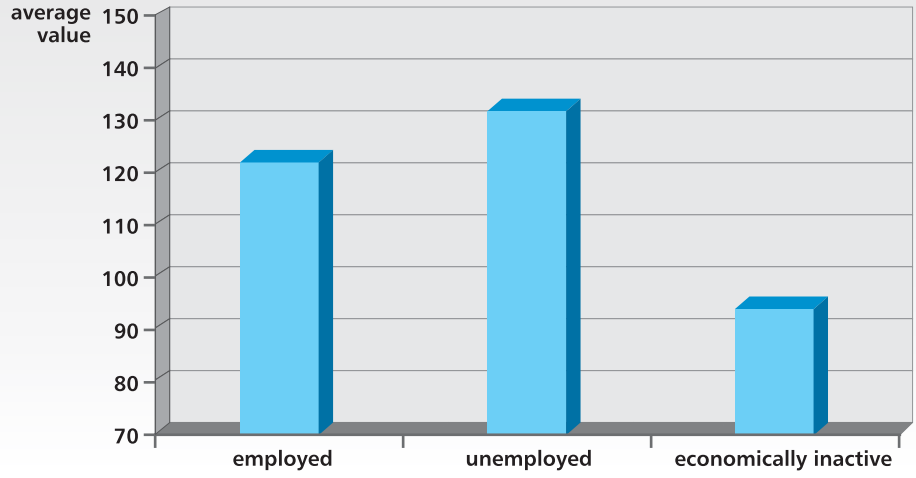
Isto tako, značajne razlike postoje i s obzirom na bračno stanje: intenzitet doživljenih stresnih životnih događaja najniži je kod udovaca i udovica, a najviši kod rastavljenih osoba.

Stresni životni događaji i bračno stanje



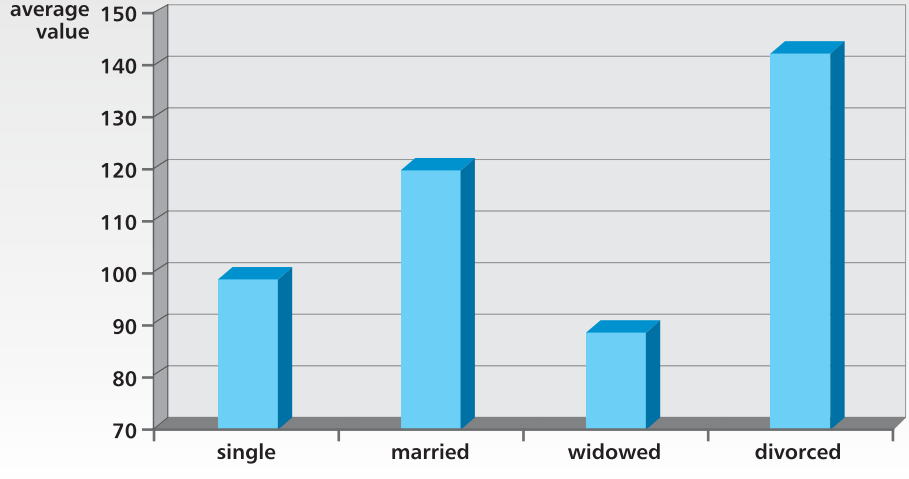
Između osoba koje žive u kućanstvima različitim po broju članova nisu utvrđene razlike u intenzitetu doživljenih stresnih životnih događaja. Zanimljivo je da osobe koje imaju jedno dijete doživljavaju intenzivnije stresne događaje od svih ostalih (onih koji nemaju dijete ili imaju dvoje, troje i više djece).

Stressful life events and economic activity



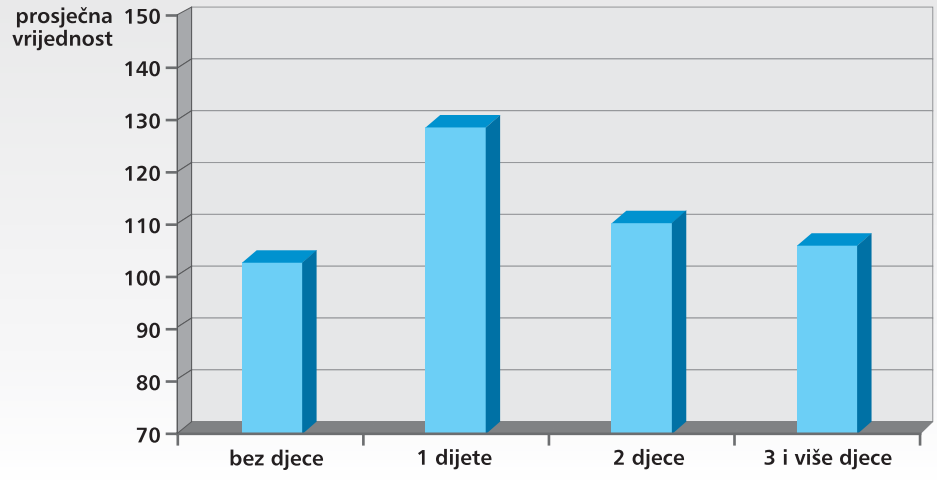
In addition, there are significant differences given the marital status, where the intensity of experienced stressful life events is the lowest amongst widowers and widows and highest amongst divorcees.

Stressful life events and marital status



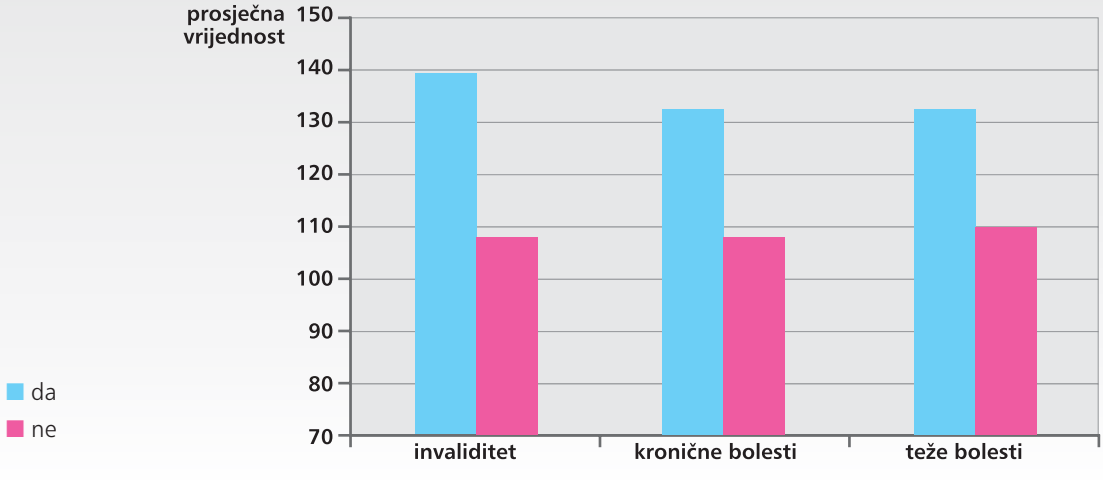
No differences were established between people living in households with a different number of members when it comes to intensity of stressful life events. It is interesting to note that persons with one child experience more intense stressful events than others (i.e. those without a child or with two, three or more children).

Stresni životni događaji i broj djece



Osobe s invaliditetom doživljavaju intenzivnije stresne životne događaje nego osobe bez invaliditeta, a kronično i teže bolesne osobe intenzivnije nego one koje ne boluju od kroničnih bolesti ili nisu preboljele neku težu bolest.

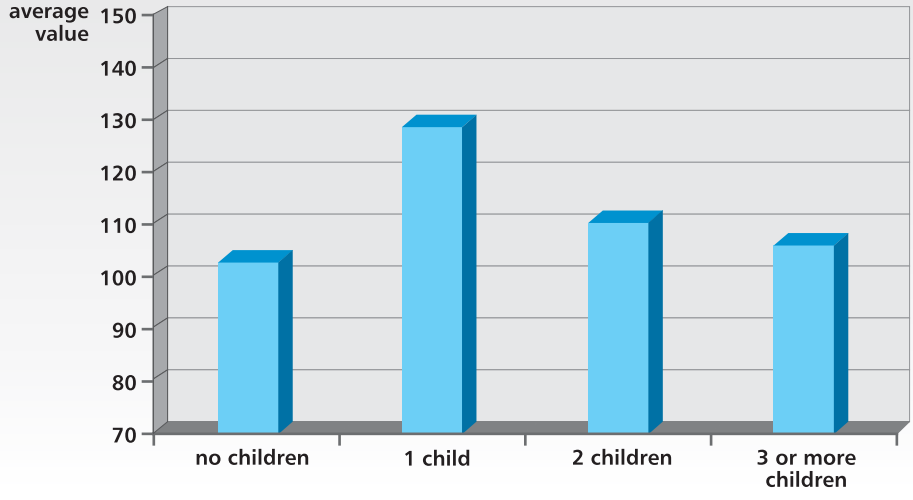
Stresni životni događaji i invaliditet/bolest



Osobe koje doživljavaju intenzivnije stresne životne događaje, intenzivnije doživljavaju i razne tjelesne simptome.

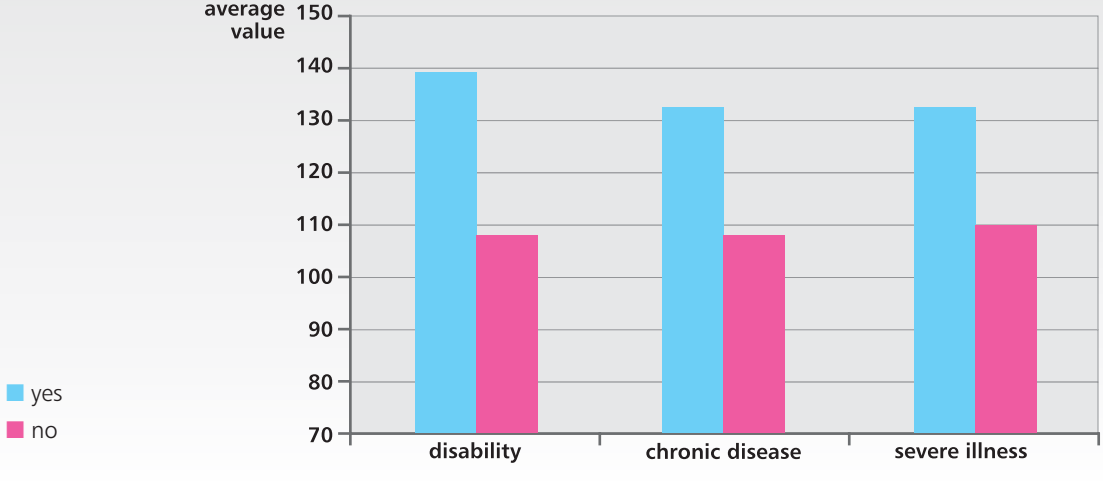
Intenzitet doživljenih stresnih događaja najviši je kod građana koji stanuju na području prostornih cjelina Pehlin i Orehovica-Pašac, a

Stressful life events and number of children



Disabled people experience more intense stressful life events than persons without a disability, and people with chronic diseases and those with a severe illness experience it more intensely than those who do not suffer from a chronic disease or have never had a severe illness.

Stressful life events and disability/illness

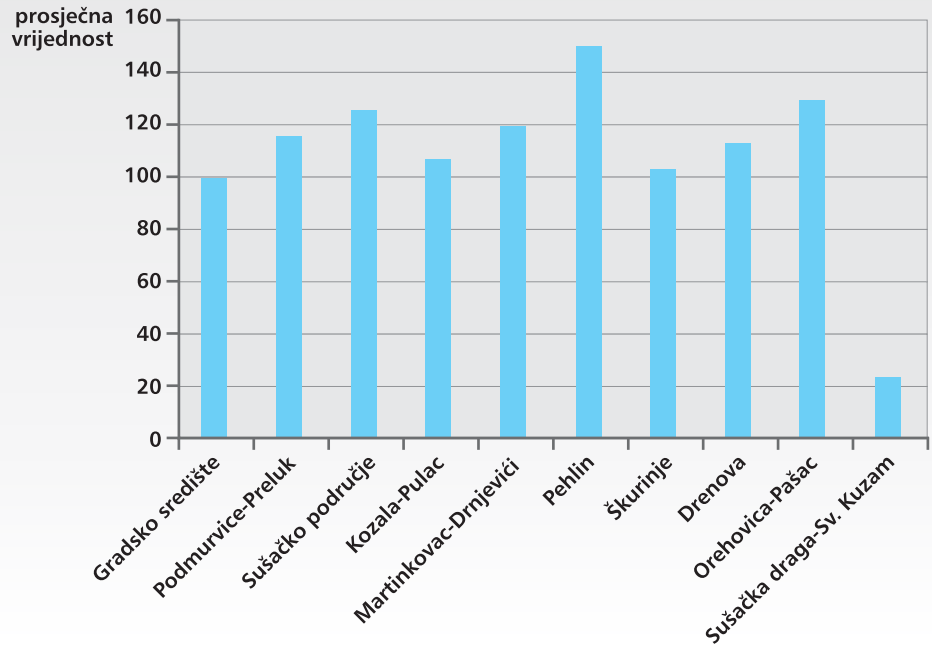


Those who experience more intense stressful life events, also experience various physical symptoms more intensely.

The intensity of experienced stressful events is the highest among the citizens living in the city areas of Pehlin and Orehovica-Pašac, and

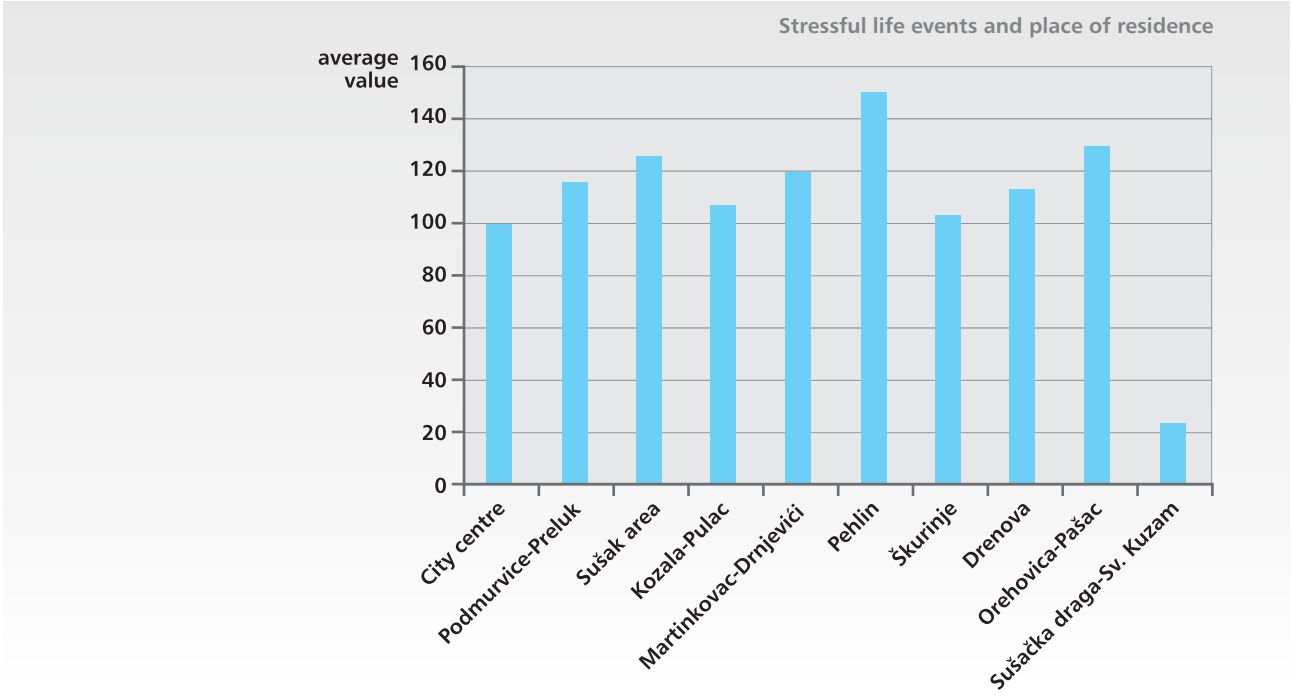
najniži kod onih koji žive na području prostorne cjeline Sušačka draga-Sv. Kuzam.

Stresni životni događaji i mjesto stanovanja



Visina ukupnih mjesečnih prihoda kućanstva nije povezana s intenzitetom doživljenih stresnih životnih događaja.

the lowest among those living in the city area of Sušačka draga-Sv. Kuzam.

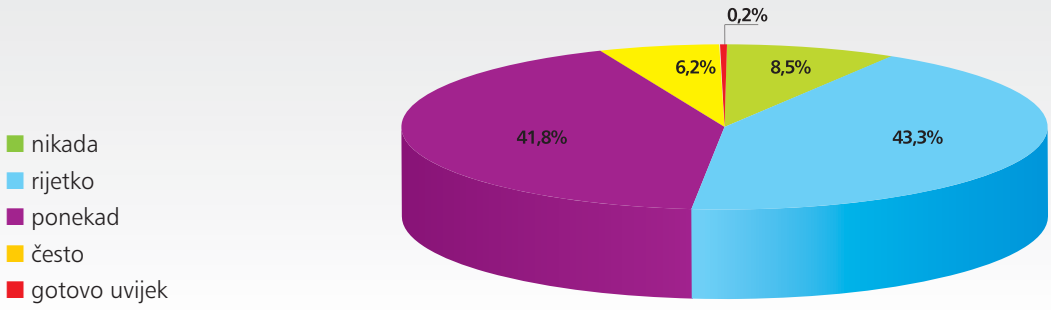


The monthly income of a household does not affect the intensity of the experienced stressful life events.

Percepcija stresnosti

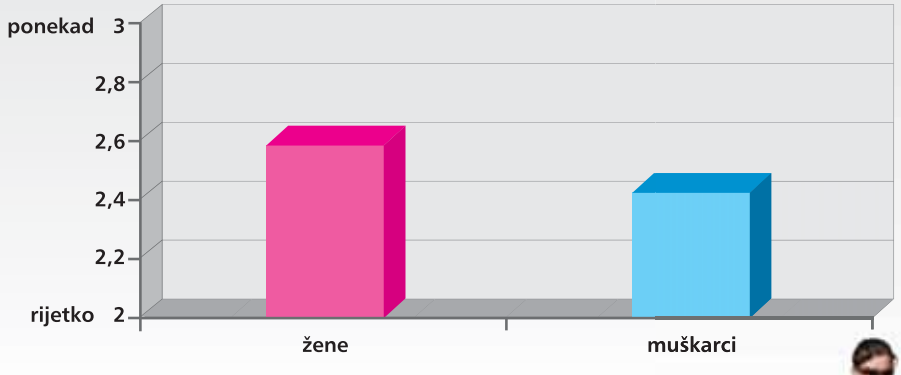
U prosjeku Riječani rijetko do ponekad osjećaju da su pod stresom. U posljednje vrijeme stres uopće nije doživljavalo 8,5% građana, rijetko ga je doživljavalo 43,3%, ponekad 41,8%, često 6,2%, a gotovo uvijek 0,2% građana.

Percepcija stresnosti kod Riječana



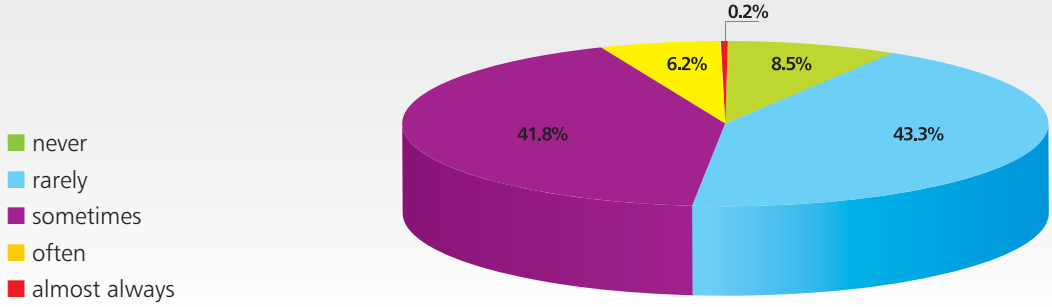
Žene značajno češće nego muškarci doživljavaju stres.

Percepcija stresnosti i spol



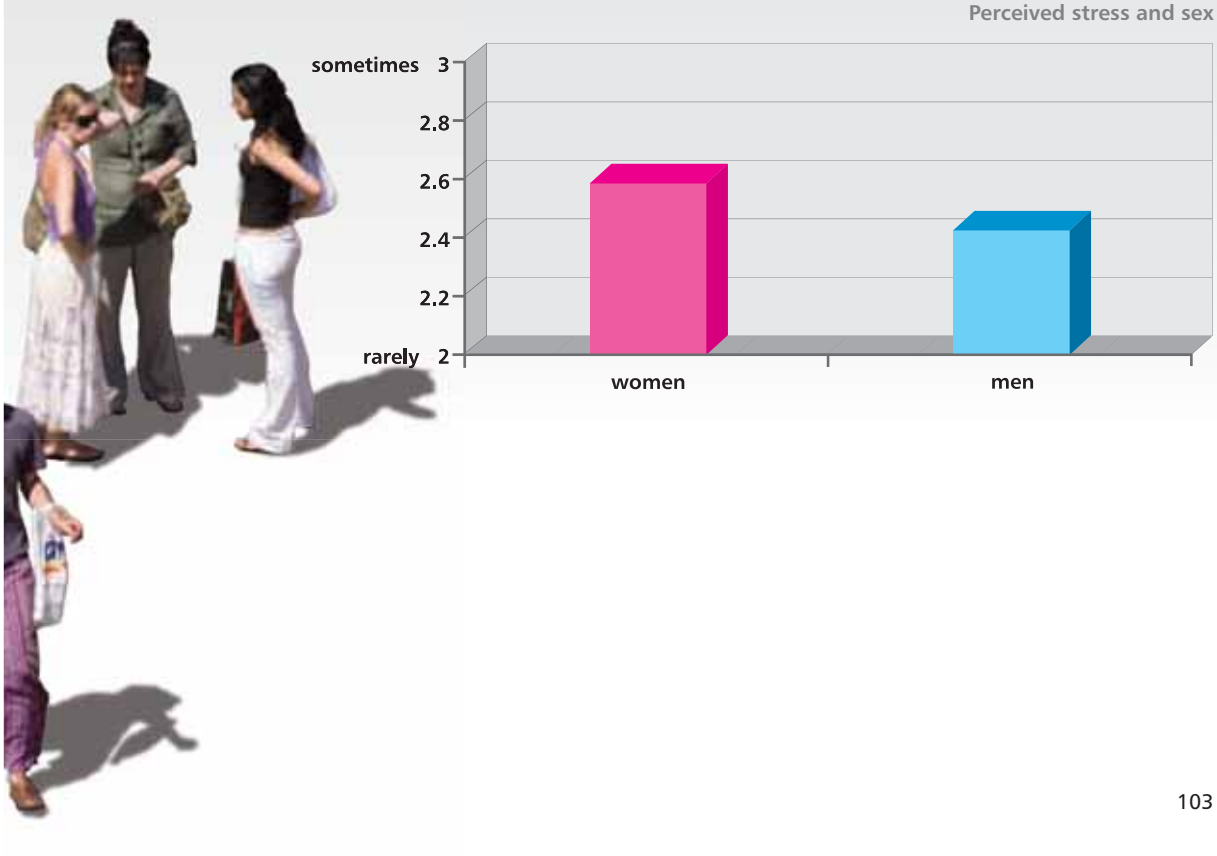
On average, the citizens of Rijeka rarely to sometimes feel stressful. Recently, stress was not experienced by 8.5% of citizens; it was rarely experienced by 43.3% of citizens, sometimes by 41.8%, often by 6.2%, and almost always by 0.2% of citizens.

Perceived stress among the citizens of Rijeka



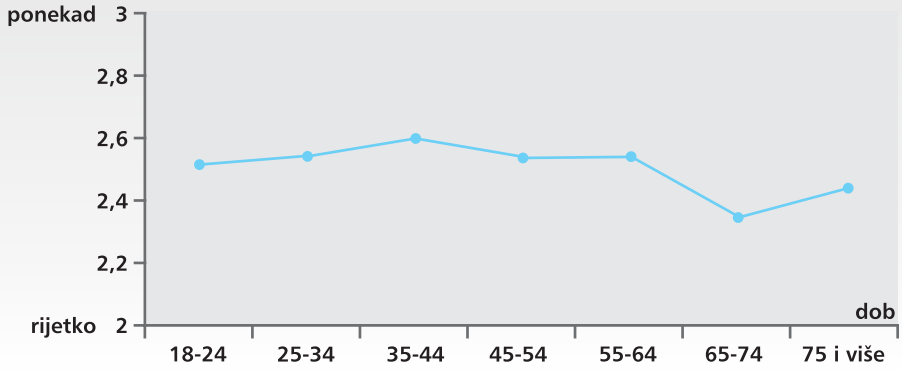
Women experience stress significantly more often than men do.

Perceived stress and sex



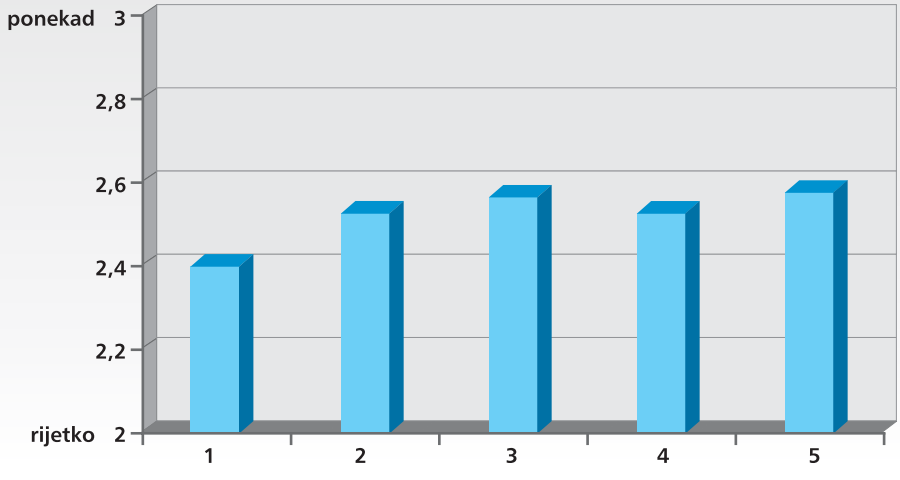
Postoje značajne dobne razlike u čestoći doživljavanja stresa, pri čemu stres najrjeđe doživljavaju osobe u dobi od 65 do 74 godine starosti, dok ga ostale dobne skupine doživljavaju podjednako često.

Percepcija stresnosti i dob



S obzirom na obrazovanje, stres najrjeđe doživljavaju osobe bez škole ili sa završenom osnovnom školom, a najčešće osobe sa završenim fakultetom.

Percepcija stresnosti i obrazovanje

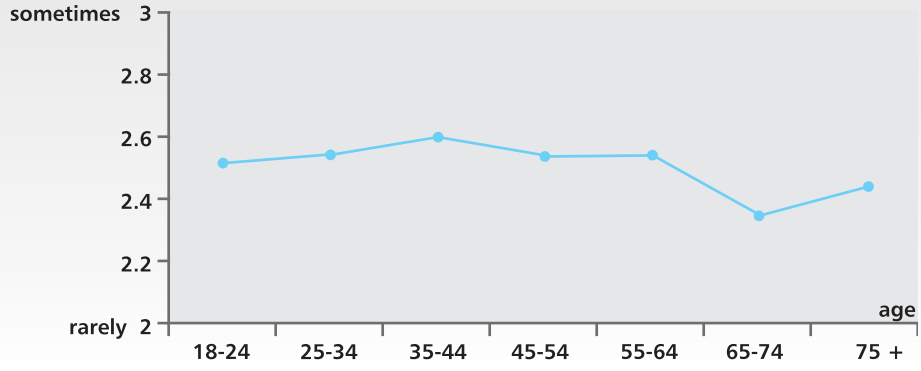


1–bez OŠ/OŠ
2–škole za zanimanja
3–gimnazija
4–viša škola
5–fakultet/mr. i dr.

Kada se radi o radnoj aktivnosti građana i percepciji stresnosti, značajna je razlika između nezaposlenih i radno neaktivnih, pri čemu nezaposleni češće doživljavaju stres nego radno neaktivni. Postoji tendencija da zaposleni rjeđe doživljavaju stres od nezaposlenih, ali češće od radno neaktivnih.

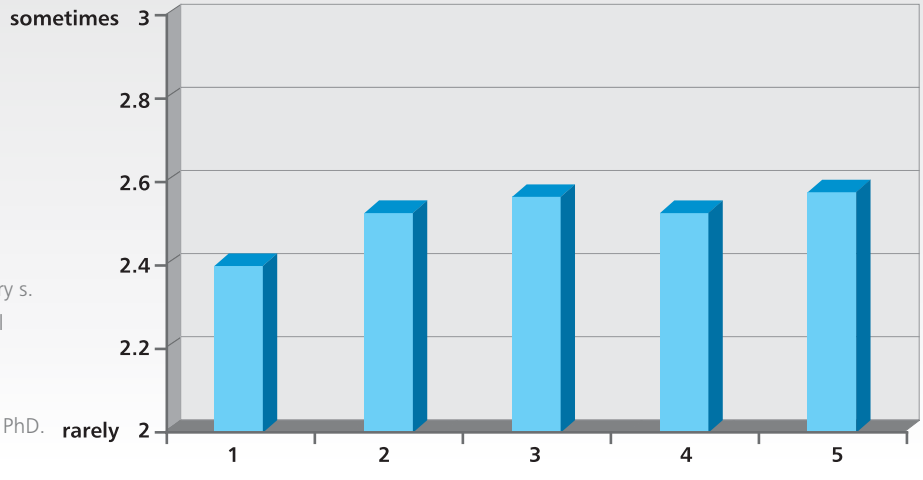
Significant age difference has been established in the frequency of experiencing stress, where the least stress is experienced in the 65 – 74 age group, whereas other age groups experience it equally often.

Perceived stress and age



Given the educational background, stress is least often experienced by people without formal education or having finished just primary school, and most often by persons with a university degree.

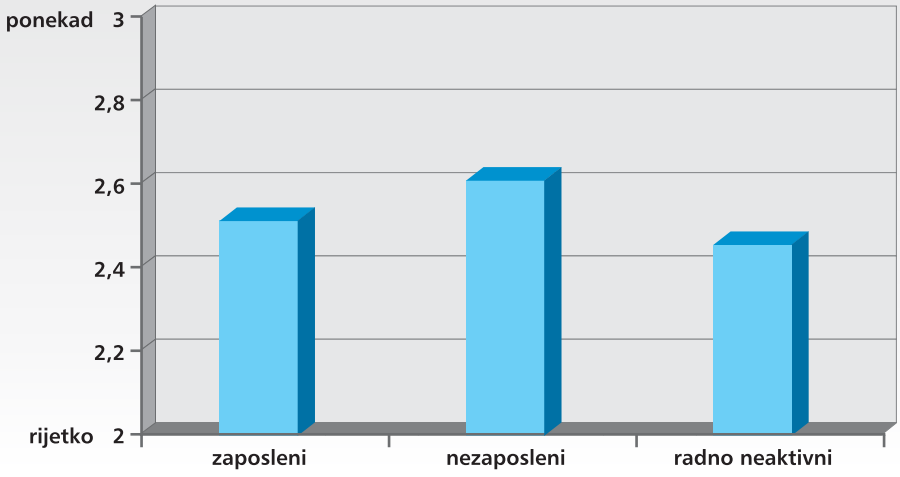
Perceived stress and education



1–no formal education/primary s.
2–vocational school
3–grammar school
4–college
5–university/MA. & PhD.

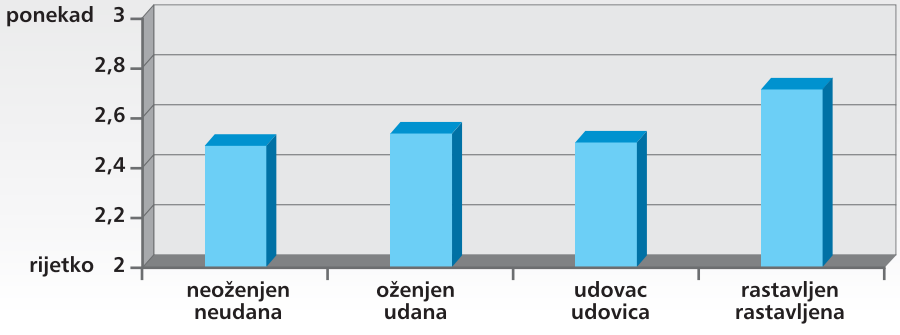
When discussing the economic activity of citizens and perceived stress, there is a significant difference between the unemployed and the economically inactive, where the unemployed experience stress more often than the economically inactive. There is a tendency for the employed to experience stress less often than the unemployed, but more often than the economically inactive.

Percepcija stresnosti i radna aktivnost



Rastavljeni češće doživljavaju stres od neudanih/neoženjenih, udanih/oženjenih i udovaca/udovica.

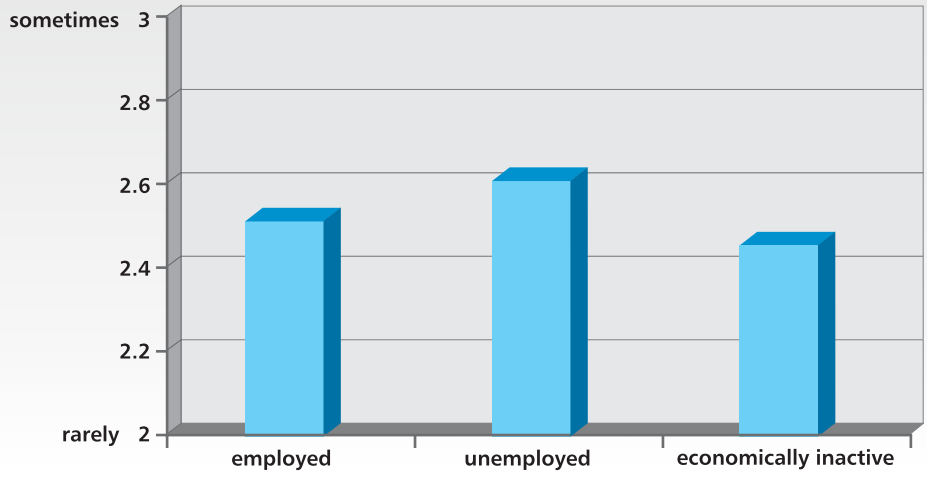
Percepcija stresnosti i bračni status



Nema razlika u čestoći doživljavanja stresa s obzirom na broj članova obitelji i broj djece, odnosno podjednako ga često doživljavaju građani koji žive u kućanstvima s različitim brojem članova, te oni koji uopće nemaju djece ili imaju različit broj djece.

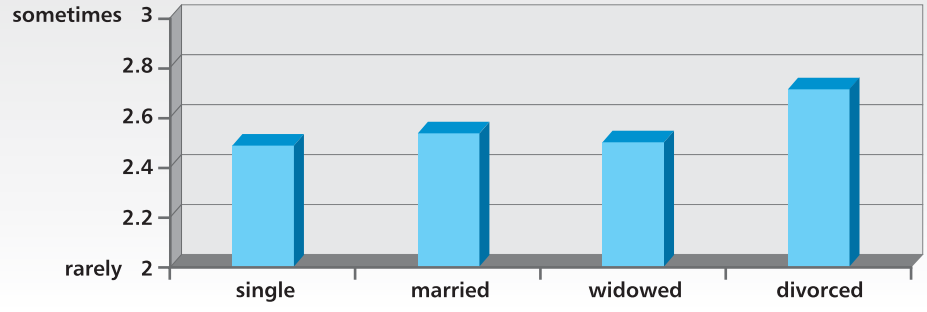
Međutim osobe s invaliditetom značajno češće doživljavaju stres nego osobe bez invaliditeta. Zanimljivo je da se osobe s nekom kroničnom tjelesnom ili mentalnom bolešću, kao i oni koji su preboljeli neku težu bolest, ne razlikuju u čestoći doživljavanja stresa od onih koji ne boluju od kroničnih bolesti ili onih koji nisu preboljeli neke teže bolesti.

Perceived stress and economic activity



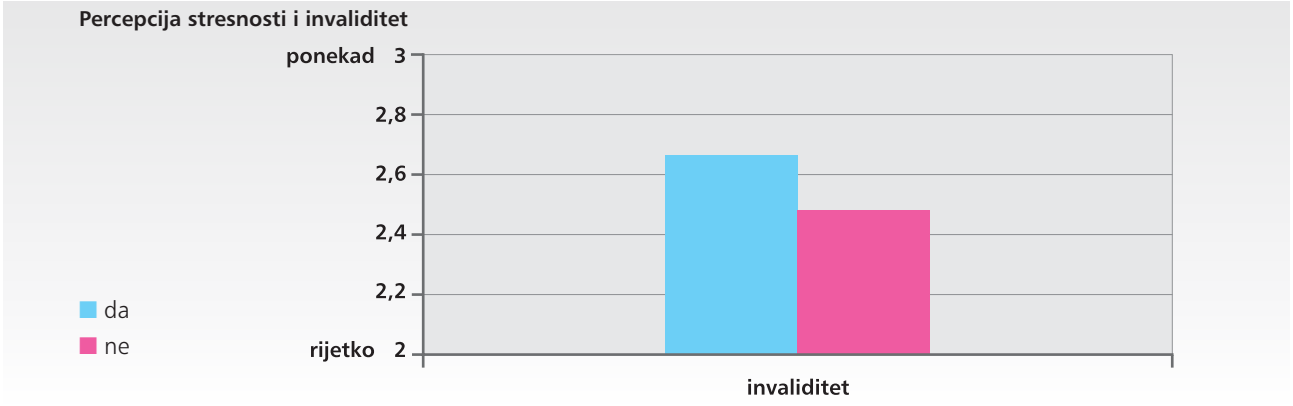
The divorced experience stress more often than the single, the married and the widowed do.

Perceived stress and marital status



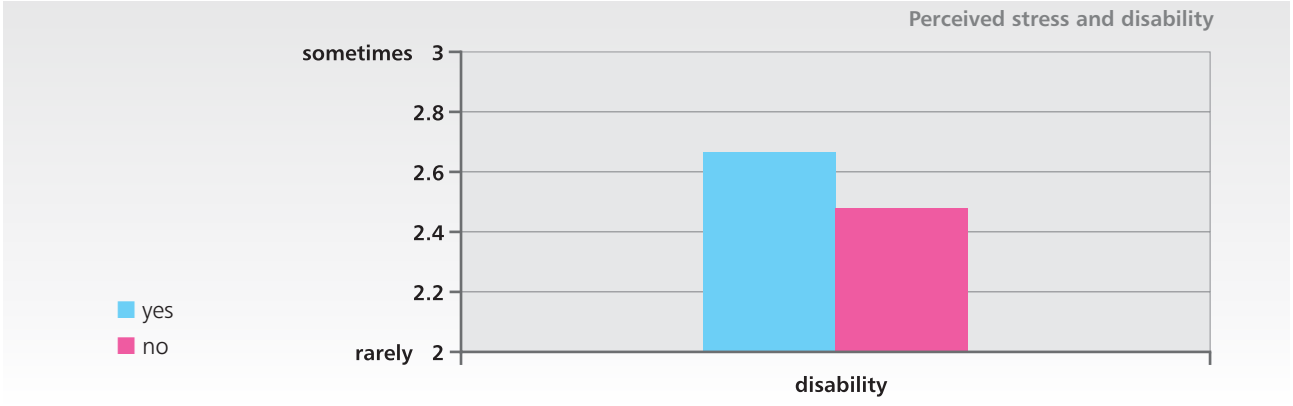
There are not any differences in the frequency of experiencing stress given the number of family members and children, or in other words, it is equally perceived by citizens living in households with different number of members, as well as by those who have no children or have a different number of children.

However, disabled persons experience stress significantly more often than persons who are not disabled. It is interesting to note that people with a chronic physical or mental disease, as well as those who have had a severe illness, cannot be differentiated in the frequency of experiencing stress from those who do not suffer from chronic disease or those who have never had a severe illness.



Oni koji češće doživljavaju stres intenzivnije doživljavaju i različite tjelesne simptome.

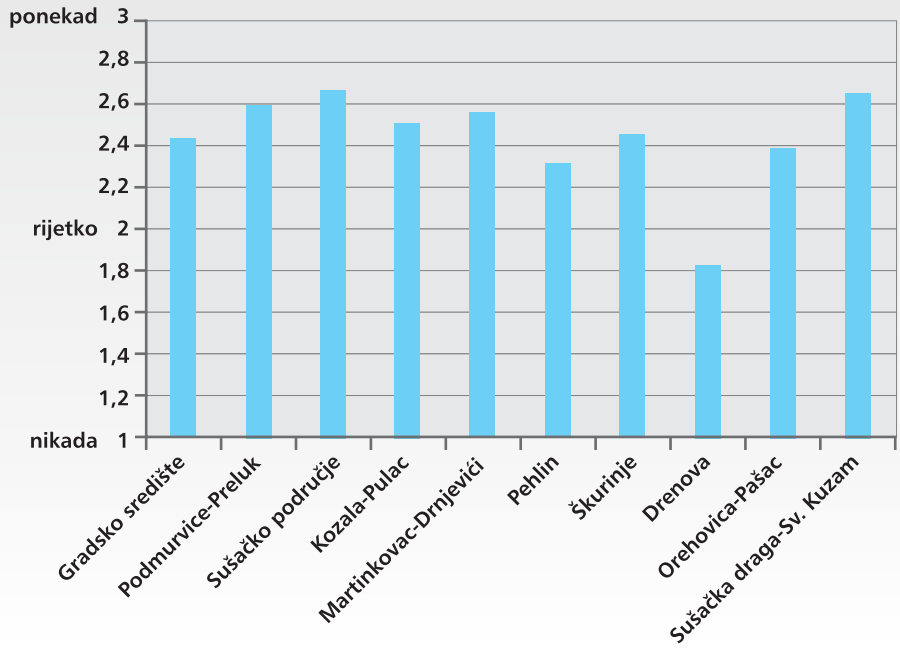
Stres najčešće doživljavaju stanovnici Sušačkog područja i Sušačke drage-Sv. Kuzma, a najrjeđe stanovnici Drenove.



Those who experience stress more often, experience other physical symptoms more intensely as well.

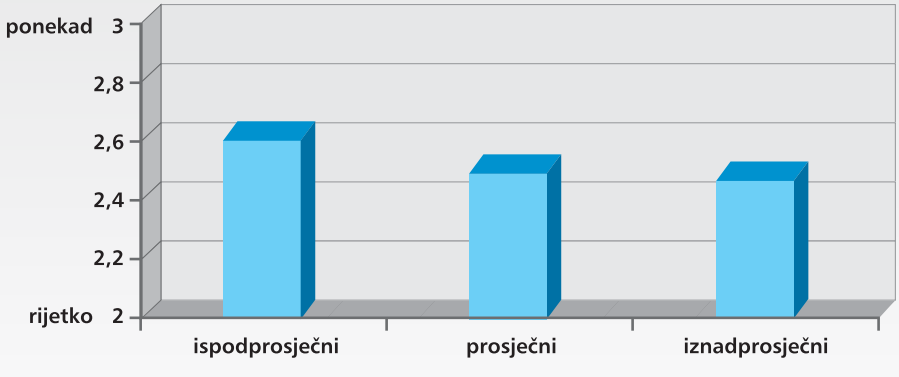
Stress is the most common among the citizens in the Sušak area and Sušačka draga-Sv. Kuzam, and it is the least common among the citizens of Drenova.

Percepcija stresnosti i mjesto stanovanja

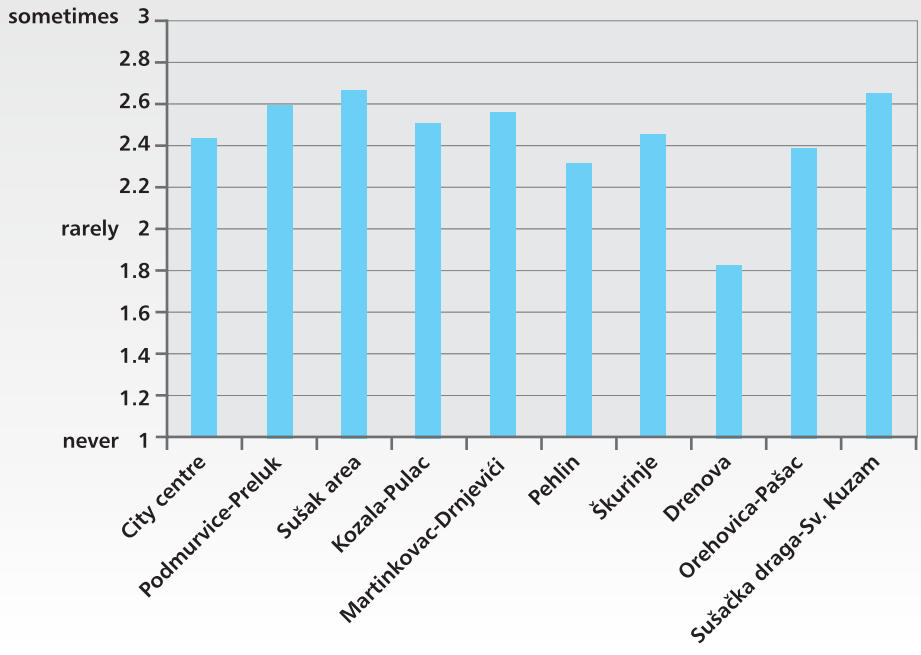


Stres rjeđe doživljavaju oni s prosječnim i iznadprosječnim ukupnim mjesečnim prihodima nego oni koji imaju ispodprosječne mjesečne prihode kućanstva.

Percepcija stresnosti i prihodi kućanstva

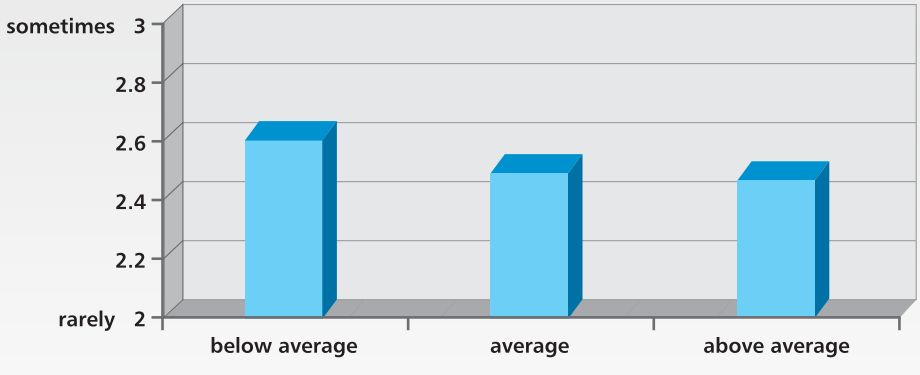


Perceived stress and place of residence



Stress is rarely experienced by people with average or above average total monthly household income than those who have below average monthly household income.

Perceived stress and household income



Percipirana socijalna podrška

Osjećaj pripadnosti i povezanosti s drugima jedna je od osnovnih ljudskih potreba. Zbog toga bismo socijalnu podršku najšire mogli definirati kao stupanj u kojem su nam zadovoljene osnovne socijalne potrebe. Socijalna podrška obično uključuje više komponenti: brigu i ljubav koju dobivamo od drugih, dijeljenje intimnosti s drugima, osjećaj da nas drugi ljudi cijene i smatraju vrijednima, mogućnost druženja, komunikacije i uzajamnih obaveza s drugima, osjećaj pripadanja, dobivanje informacija, savjeta i materijalne pomoći od drugih i sl. Socijalnu podršku možemo dobiti od članova obitelji, prijatelja, susjeda, osoba koje su članovi istih socijalnih skupina kao i mi, odnosno od svih osoba s kojima se možemo družiti i kojima se možemo obratiti kada nam je to potrebno. Izvori socijalne podrške mijenjaju se ovisno o spolu, dobi i drugim faktorima.

U sociološkim se istraživanjima socijalna podrška najčešće mjeri različitim pokazateljima socijalne integracije, kao što su broj socijalnih kontakata, gustoća socijalne mreže, broj uloga, sudjelovanje u različitim aktivnostima i slično, dok psiholozi češće mjere percepciju osobe da će joj drugi ljudi dati podršku u situaciji kada će joj to biti potrebno, odnosno tzv. percipiranu socijalnu podršku.

Iako se mora reći da je percipirana socijalna podrška pod znatnim utjecajem trenutnih okolnosti u kojima se osoba nalazi, odnosno pod utjecajem stvarne razine primljene podrške, postoje podaci koji govore da se ona može shvatiti i kao relativno stabilan pogled osobe na to koliko su ljudi u njezinoj socijalnoj okolini dostupni i željni joj pomoći, kao i pogled na vlastitu prihvaćenost.

Smatra se da veća razina roditeljske brige i obiteljske podrške u djetinjstvu predstavlja jedan od faktora koji dovode do veće percipirane socijalne podrške u odrasloj dobi.

Među ljudima postoje velike razlike s obzirom na mogućnost stvaranja sredine koja će ih prihvatiti i dati im podršku. Treba napomenuti da postoji znatna korespondentnost između prihvaćanja sebe i osjećaja prihvaćenosti od drugih osoba. Sramežljive i suzdržane osobe imaju neadekvatnu mrežu socijalne podrške i prihvaćanja, dok visoko samopoštovanje i povjerenje u sebe omogućavaju dobivanje

Perceived social support

The feeling of belonging and a connection to others is a basic human need. Because of that, social support could, in wider terms, be defined as the level in which all our basic social needs can be fulfilled. Social support usually includes a few components: love and care that we receive, sharing intimacy, feelings of appreciation and admiration, possibility of contact and communication, mutual commitment, feelings of belonging, obtaining information, advice and material help from others, and so on. We can get social support from family members, friends, neighbours, members of the same social groups, in other words, from all the people we keep contact with and turn to when we are in need. Sources of social support change in relation to sex, age and other factors.

In sociological studies, social support is usually measured by different indicators of social integration, i.e. number of social contacts, density of social network, number of roles, participation in different activities etc. However, psychologists more often measure perception of a person by support given to him or her by others in a situation when it is needed, that is, by the perceived social support.

It must be said that even though perceived social support is subject to significant influence of someone's current circumstances, that is, under the influence of the real level of received support, data indicates that the perceived social support can also be seen as a relatively stable perception of a person on how much people in his/her social environment are available and willing to help, as well as a perception of his or her acceptance.

It is considered that a greater level of parental care and family support in childhood represents one of the factors that lead to a greater perceived social support in adult age.

There are big differences among people considering the possibility of creating an environment that will accept them and give them support. It should be mentioned that there is a significant correspondence between the acceptance of oneself and the feeling of acceptance by others. Shy and inhibited persons have inadequate social support and acceptance network, while those with high self-esteem

visoke razine socijalne podrške. Posjedovanje efikasnih i adaptivnih socijalnih vještina privlači druge ljude.

Zašto nam je uopće važna socijalna podrška? Naime još je krajem 19. stoljeća sociolog Emile Durkheim primijetio da je raspad obitelji kao i raspad interpersonalnih odnosa na radnom mjestu koji se javljaju uslijed migracija u industrijska područja štetan za psihološku dobrobit. On npr. navodi veću učestalost samoubojstava među ljudima koji imaju manje socijalnih veza. Mnogobrojna istraživanja izvedena nakon toga potvrđuju da osobe koje su izgubile svoje socijalne veze imaju veći broj ponašajnih, emocionalnih i zdravstvenih problema.

Nasuprot tome, od štetnog djelovanja stresnih životnih događaja zaštićenije su one osobe koje smatraju da je njihova komunikacija s drugima zadovoljavajuća, da osobe koje su im važne o njima brinu, vole ih, cijene i poštuju, te da pripadaju socijalnoj mreži koja dijeli zajedničke odgovornosti. Takva shvaćanja olakšavaju suočavanje sa stresom i prilagodbu, pa stoga djeluju zaštitno. Osobe kojima članovi njihove socijalne okoline daju konzistentne informacije o tome što se od njih očekuje, podržavaju ih i pomažu im, imaju znatno manje negativnih posljedica nakon stresnih životnih događaja. Neka istraživanja pokazuju da je i povjeravanje, kao odraz povjerenja, koje upućuje na to da netko uspostavlja intimne i kvalitetne odnose s nekom osobom, važan aspekt koji utječe na mentalno i tjelesno zdravlje.

Dostupnost socijalne podrške smanjuje negativan doživljaj prijetnje, što dovodi do manje intenzivnih emocionalnih reakcija na stresni događaj. Na taj način percipirana socijalna podrška može djelovati smirujuće te omogućiti pozitivnije fiziološke i ponašajne reakcije.

and who believe in themselves ensure getting high levels of social support. Having efficient and adaptive social skills, as well as good health, attracts other people.

Why is social support so important to us? At the end of 19th century it was noticed by Emile Durkheim that family breakdown and the collapse of interpersonal relations at work that appear during migrations to industrial areas are harmful to the psychological well-being. For example, he comments on the greater frequency of suicides among people who have fewer social contacts. Numerous research studies that followed confirm that persons who have lost their social contacts have a greater number of behavioural, emotional and health problems.

Contrary to that, those who think that their communication with others is satisfactory, that persons, who they find important take care of them, love, appreciate and respect them and that belong to a social network that shares common responsibilities, are more protected from the harmful effects of stressful life events. This perception facilitates coping with stress and adjustment, and therefore acts protectively. Those who are given consistent information about what is expected from them by members of their social environment, those who are supported and helped, experience significantly fewer negative outcomes after stressful life events. Some studies have shown that confiding, as a reflection of trust that indicates intimate and a qualitative relationship with someone, is an important aspect that influences both mental and physical health.

The availability of social support diminishes the negative perception of threat, which leads to less intensive emotional reactions to a stressful event. In that way, perceived social support can soothe and enable more positive physiological and behavioural reactions.

Mnogi podaci pokazuju da socijalna podrška utječe i na veličinu rizika od obolijevanja, napredovanje i oporavak od tjelesnih bolesti. Tako npr. socijalna podrška potiče zdravlju usmjerena ponašanja - može potaknuti tjelesno vježbanje, češće odlaženje na zdravstvene preglede, a povezana je i s manjom konzumacijom alkohola, te olakšava apstinenciju nakon prestanka pušenja. Primjera radi, socijalno integriranije osobe manje su podložne herpesu, infektivnim bolestima gornjih dišnih putova i srčanom infarktu, a žene koje percipiraju višu socijalnu podršku imaju i manje komplikacija pri porođaju.

Nadalje, rezultati niza istraživanja pokazuju da socijalno integriranije osobe imaju duži životni vijek, duže vrijeme preživljavanja nakon različitih bolesti, manju vjerojatnost vraćanja bolesti (karcinom), te da su osobe koje više sudjeluju u svojoj lokalnoj ili široj društvenoj zajednici mentalno zdravije nego izolirane osobe. Osobe koje su zadovoljne svojom socijalnom podrškom imaju nižu razinu osjećaja depresivnosti, anksioznosti i hostilnosti. Ujedno su i optimističnije, imaju više samopoštovanje i izvještavaju o znatno pozitivnijim životnim iskustvima i većoj kontroli nad životnim događajima od osoba koje socijalnu podršku percipiraju niskom.

Međutim treba i napomenuti da, iako visoka socijalna podrška najčešće ima pozitivne učinke na tjelesno i mentalno zdravlje, ponekad može imati i negativne posljedice. Naime podijeliti stres s bliskom osobom samo po sebi može biti stresno, a pomaganje osobi u stresu može smanjiti vlastitu sposobnost učinkovita suočavanja u stresnim situacijama.

Za mjerenje percipirane socijalne podrške za potrebe ovoga istraživanja korištena je **Ljestvica procjene socijalne podrške** (Social Support Appraisals Scale – SS-A), čiji su autori Vaux, Phillips, Holly, Thompson, Williams i Stewart (1986.). Ta se skala sastoji od 24 čestice od kojih se osam odnosi na percipiranu socijalnu podršku obitelji (npr. "Pouzdajem se u članove svoje obitelji"), osam na percipiranu socijalnu podršku prijatelja (npr. "Jako sam povezan sa svojim prijateljima") i osam na percipiranu socijalnu podršku kolega (npr. "Osjećam se blizak/bliska s kolegama na poslu"). Građani su svaku tvrdnju procjenjivali na ljestvici slaganja od 5 stupnjeva: 1 – uopće se ne odnosi na mene; 2 – uglavnom se ne odnosi na mene; 3 – niti se odnosi niti se ne odnosi na mene; 4 – uglavnom se odnosi na mene; 5 – u potpunosti se odnosi na mene.

Furthermore, numerous data indicate that social support influences the degree of risk of becoming ill, as well as progression and recovery from a physical illness. For instance, social support stimulates health-beneficial behaviour; it can encourage physical training and more frequent medical examinations. It is connected to lesser consumption of alcohol and facilitates abstinence after quitting smoking. For example, socially more integrated persons are less subjected to herpes, infective diseases of the upper respiratory tract and heart failure. Also, women who perceive more social support have fewer complications at birth.

Moreover, the results of numerous research indicate that socially more integrated persons have a longer life span, have a longer life expectancy after surviving from different high-mortality diseases, less probability of recurring diseases (e.g. carcinoma), and that persons who are more active in their local or wider community are mentally healthier than those who are more isolated. Persons who are satisfied with their social support have a lower level of depression, anxiety and hostility. At the same time, they are more optimistic, have more self-esteem and report a significantly more positive life experience and greater control over life events than persons with low perceived social support.

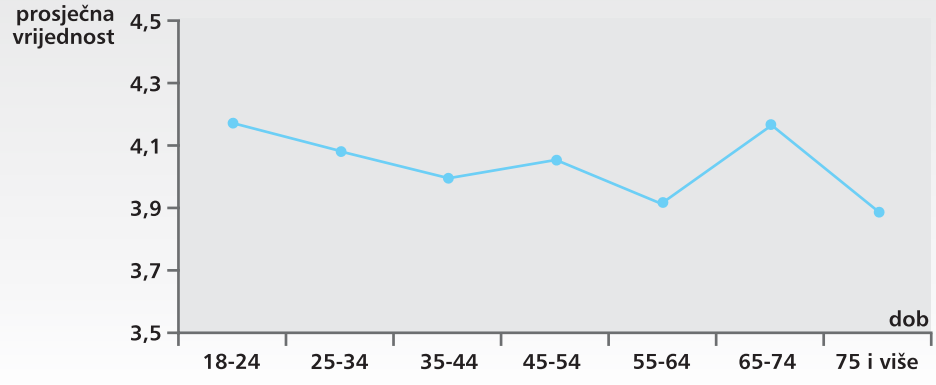
Nevertheless, it should be mentioned that, even if high social support nearly always has positive effects on physical and mental health, sometimes it may also have negative consequences. Sharing stress with a close person can be a stressful experience on its own, and helping a stressed person can diminish our own ability of effectively coping with stressful situations.

For the measurement of perceived social support in this research we used the **Social Support Appraisals Scale – SS-A** – by Vaux, Phillips, Holly, Thompson, Williams and Stewart (1986). This scale consists of 24 items, eight of which relate to perceived social support in family (e.g. "I rely on members of my family"), eight to perceived social support of friends (e.g. "I'm strongly connected to my friends"), and eight to perceived social support of colleagues (e.g. "I feel close to colleagues at work."). Every statement has been estimated on 5-point scale: 1 – it does not relate to me at all, 2 – it mostly does not relate to me, 3 – it does and does not relate to me; 4 – it mostly relates to me; 5 – it completely relates to me.

Percepcija podrške prijatelja, obitelji i kolega kod Riječana je iznadprosječno visoka. Prosječan rezultat koji građani Rijeke postižu iznosi 4, na skali procjene od 1 do 5. Najniži mogući rezultat tj. 1 postiže 0,2% građana, a najviši mogući tj. 5 postiže 20% građana.

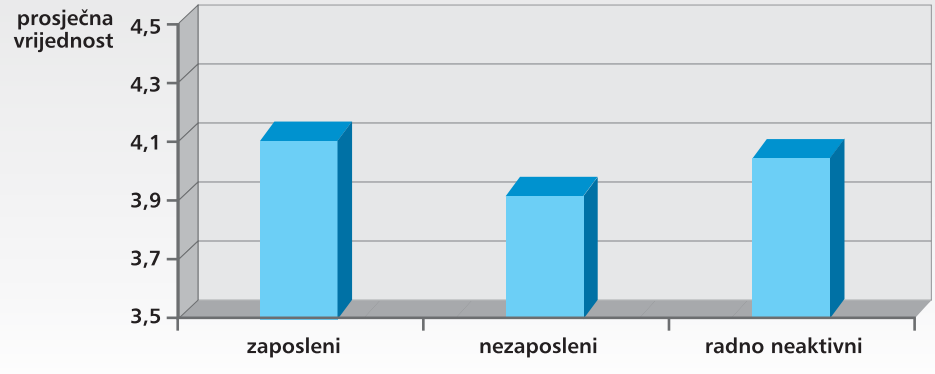
Žene i muškarci osjećaju podjednaku razinu socijalne podrške, ali postoje određene razlike među osobama različite dobi. Najvišu razinu socijalne podrške osjećaju osobe u dobi od 18 do 24 godine i u dobi od 65 do 74 godine, a najnižu osobe u dobi od 55 do 64 i od 75 godina i više.

Percipirana socijalna podrška i dob



Nisu nađene značajne razlike u razini doživljene socijalne podrške među osobama različita obrazovanja, ali postoje razlike s obzirom na radnu aktivnost. Nezaposleni doživljavaju nižu razinu socijalne podrške nego zaposleni i radno neaktivni građani.

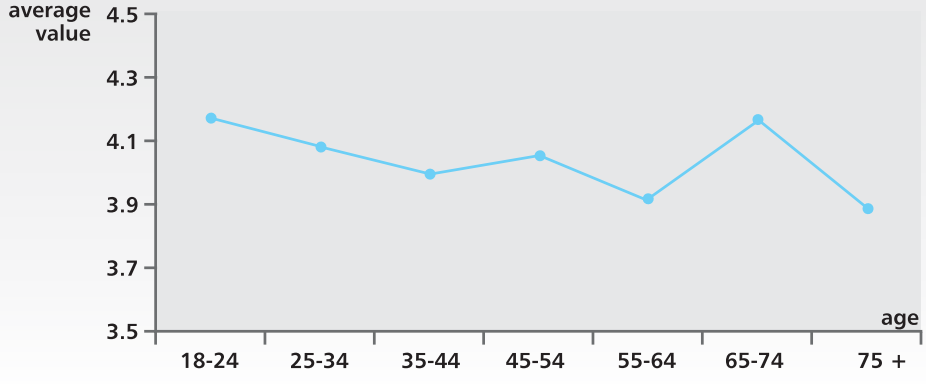
Percepirana socijalna podrška i radna aktivnost



The perception of support from friends, family and colleagues among the citizens of Rijeka was above average. The average score that the citizens of Rijeka achieve is 4, on the scale of 1 to 5. The lowest possible score, i.e. 1, was reported by only 0.2% of the citizens, and the highest, i.e. 5 by 20%.

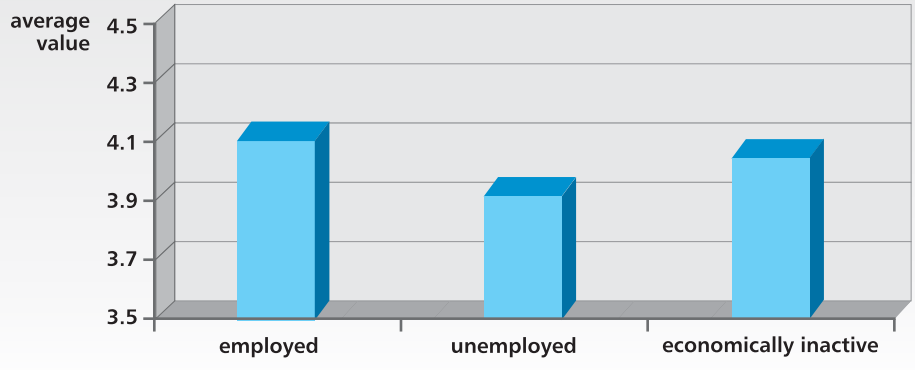
Women and men feel the same level of social support, but there are some differences among persons of different ages. The highest level of social support is perceived by persons in the age groups between 18 and 24, and between 65 and 74, whereas the lowest by persons in the 55 – 64 age group, and 75 years and more.

Perceived social support and age



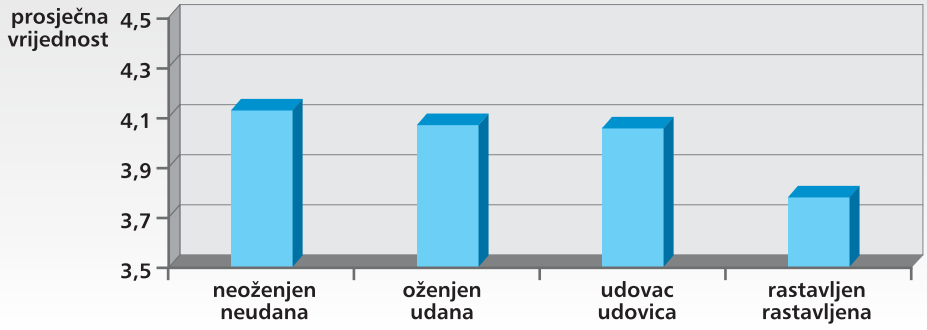
Significant differences in the level of perceived social support among persons of different education were not found, but certain differences considering economic activity were. Unemployed persons perceive a lower level of social support than employed and economically inactive citizens.

Perceived social support and economic activity



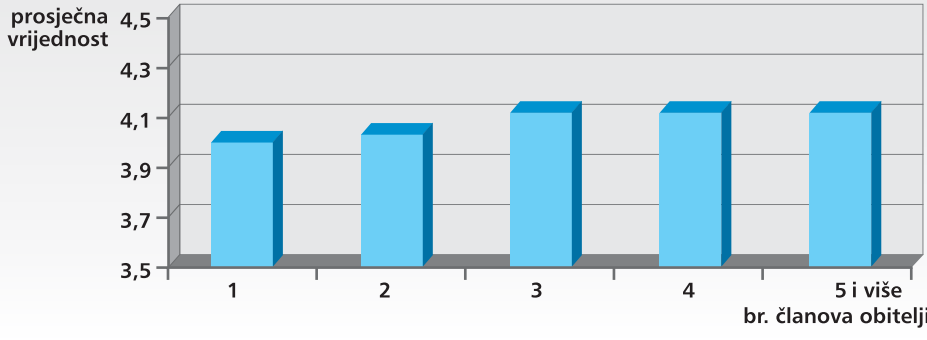
Rastavljene osobe doživljavaju nižu razinu socijalne podrške od neoženjenih/neudanih, oženjenih/udanih i udovaca/udovica.

Percipirana socijalna podrška i bračno stanje



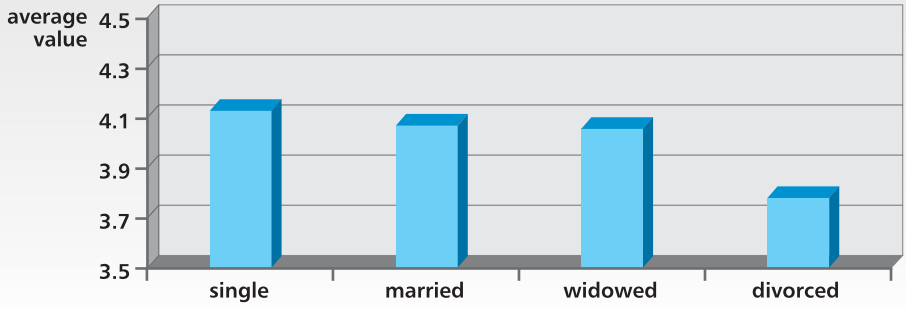
Nešto nižu socijalnu podršku osjećaju samci nego osobe koje žive u višečlanim kućanstvima, dok s obzirom na broj djece koju netko ima nije utvrđena razlika u razini doživljene socijalne podrške.

Percipirana socijalna podrška i broj članova obitelji



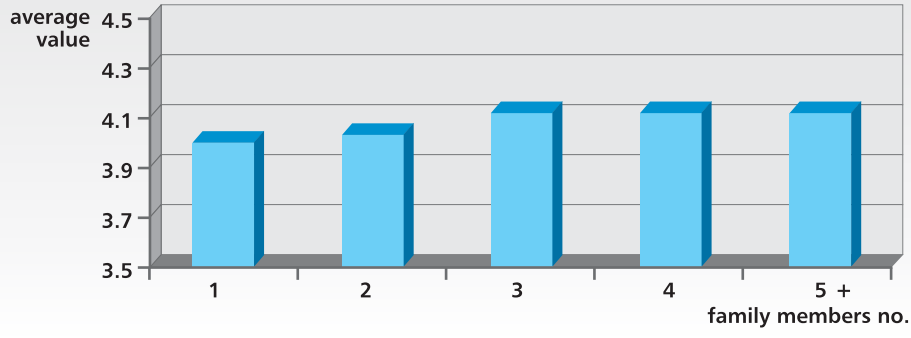
Divorced persons perceive a lower level of social support than those single, married and widowed do.

Percieved social support and marital status



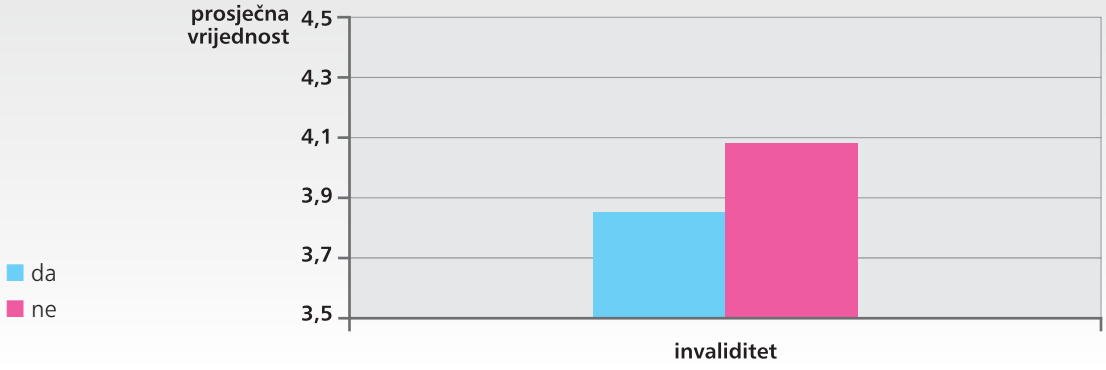
Single persons feel somewhat lower social support than persons who live in multi-member households, but considering the number of children, there have not been any differences in levels of perceived social support.

Perceived social support and number of family members



Osobe s invaliditetom imaju nižu razinu doživljene socijalne podrške od onih bez invaliditeta, dok između kronično oboljelih i onih bez kroničnih bolesti te onih koji jesu preboljeli težu bolest i onih koji nisu nema značajnih razlika u percepciji socijalne podrške.

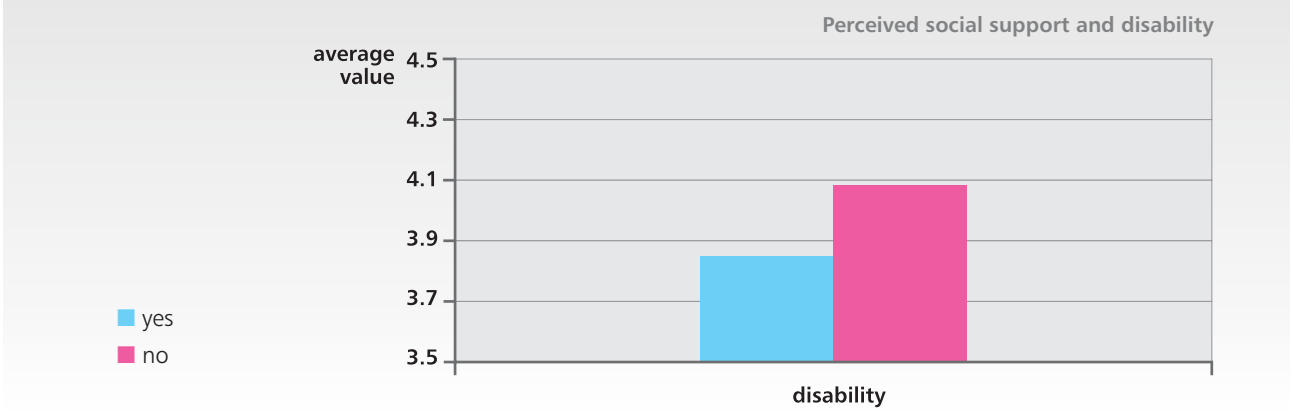
Percipirana socijalna podrška i invaliditet



Što netko ima slabiji osjećaj socijalne podrške, tjelesne simptome doživljava intenzivnije.

Percipirana socijalna podrška najviša je kod građana koji stanuju na području prostorne cjeline Drenova, a može se reći da visoku razinu doživljaja socijalne podrške imaju i građani koji stanuju na područjima Gradsko središte, Kozala-Pulac i Martinkovac-Drnjevići. Najnižu razinu doživljene socijalne podrške imaju žitelji prostornih cjelina Pehlin i Sušačka draga-Sv.Kuzam.

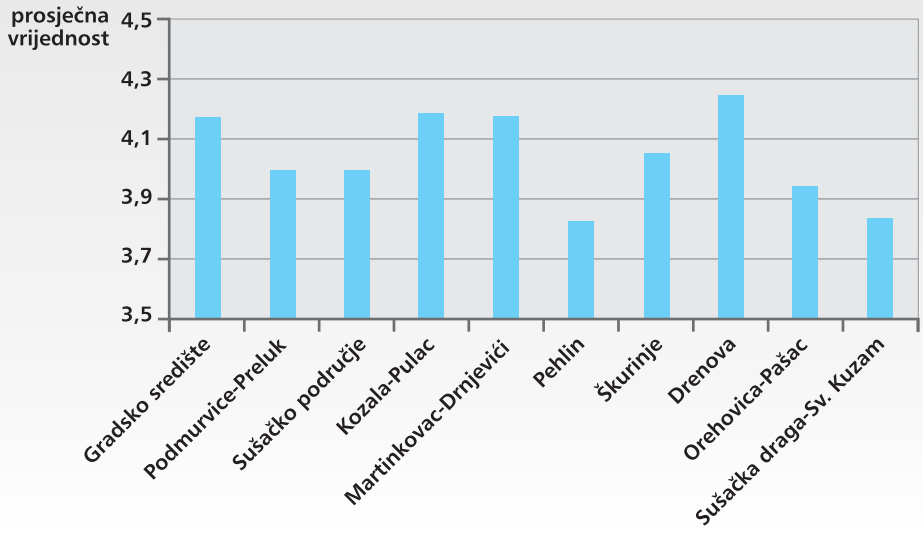
Disabled persons have a lower level of perceived social support than those without disability. However, there is not a significant difference in perceiving social support among the chronically ill and those without chronic diseases, nor those who have suffered from a severe illness and those who have not.



The lower the perceived social support is, the more intensive are the physical symptoms that a person experiences.

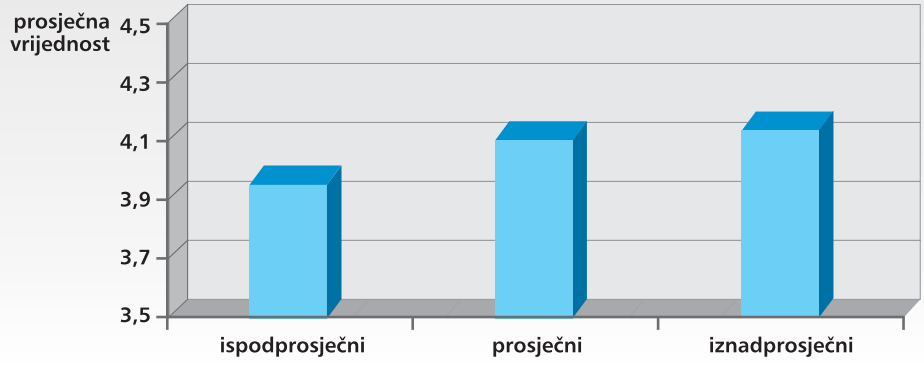
The highest perceived social support is recorded by citizens who live in the area of Drenova, and it is also safe to say that persons that live near the city centre, in the area of Kozala-Pulac and Martinkovac-Drnjevići have a high level of social support. The citizens living in the area of Pehlin and Sušačka Draga-Sv. Kuzam recorded the lowest level of perceived social support.

Percipirana socijalna podrška i mjesto stanovanja

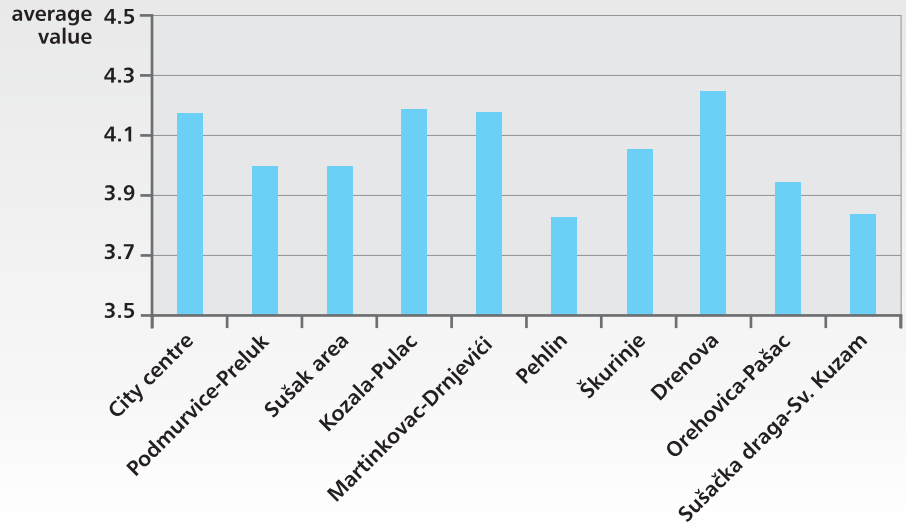


Osobe s ispodprosječnim ukupnim mjesečnim prihodima kućanstva imaju nižu razinu doživljene socijalne podrške od onih s prosječnim i iznadprosječnim prihodima.

Percipirana socijalna podrška i prihodi kućanstva

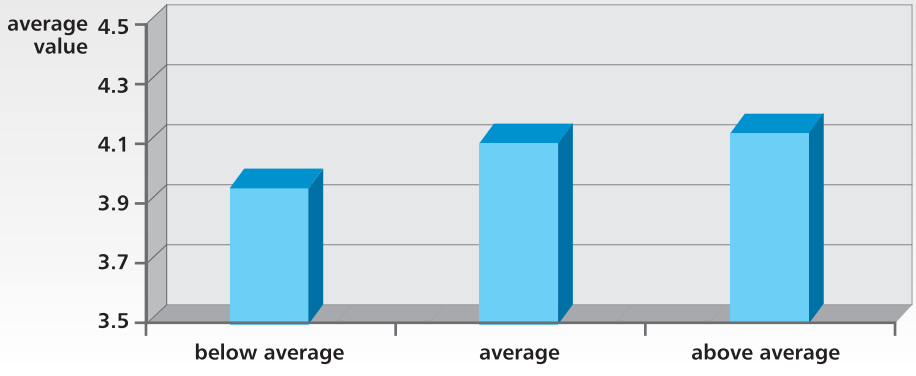


Perceived social support and place of residence



Persons with below average monthly household income have a lower level of perceived social support than those with average and above average income.

Percieved social support and household income



Optimizam

Optimizam se najčešće definira kao očekivanje koje dovodi do precjenjivanja vjerojatnosti pozitivnih budućih događaja, odnosno do podcjenjivanja vjerojatnosti negativnih budućih događaja. To očekivanje dovodi do mnogobrojnih razlika između optimista i pesimista.

Optimisti, koje karakterizira očekivanje pozitivnih događaja u budućnosti češće ustraju u namjeri da ostvare svoje ciljeve, dok pesimisti, koji očekuju loše ishode, u većoj mjeri pokazuju pasivne reakcije i odustajanje od ostvarenja postavljenih ciljeva. Optimisti smatraju da mogu kontrolirati događaje u svojem životu. Kada se i dogodi nešto loše, oni nisu obeshrabreni, nego donose plan djelovanja, slijede ga i brzo djeluju da im situacija ne bi izmakla kontroli. Loše stvari koje im se događaju optimisti vide kao izdvojene događaje, a ne kao opći trend ili pravilnost u svom životu. Događaje i okolnosti interpretiraju sebi u korist. Optimisti ne odustaju lako, a na budućnost gledaju kroz "ružičasto obojene naočale". Smatraju da će imati sretan život i dobro zdravlje, a ako se i dogodi nešto loše, da će biti sposobni riješiti taj problem. Naravno, i optimisti ponekad doživljavaju neuspjehe, međutim s njima se suočavaju znatno bolje od pesimista.

S druge strane, pesimisti razmišljaju u terminima "sve ili ništa", oni situacije procjenjuju ekstremno, te bilo kakav neuspjeh obično smatraju pokazateljem osobne neadekvatnosti. U situacijama koje su po svim svojim obilježjima pozitivne pronalaze negativne detalje i usmjeravaju se na njih. Pesimisti uveličavaju važnost negativnih događaja i neuspjeha, precjenjuju veličinu problema i podcjenjuju svoje sposobnosti rješavanja i suočavanja s problemima. Oni najčešće zanemaruju pozitivne aspekte situacija, često su skloni pretjeranoj generalizaciji, odnosno uvjereni su da nikada ne mogu učiniti ništa dobro te da ih drugi ljudi ne vole. Zaključke donose pretjerano brzo, oslanjajući se uglavnom na negativne aspekte situacije.

Većina psihologa smatra da su pesimizam i optimizam uglavnom naučena ponašanja, a ima dokaza da se manjim dijelom i nasljeđuju. Obično se uče rano tijekom života, u interakciji s obiteljskom i ostalom okolinom.

Različita očekivanja optimista i pesimista imaju utjecaja na gotovo sve aspekte života. Tako je npr. optimizam često povezan s boljim

Optimism

Optimism is commonly defined as anticipation that leads to overestimating the probability of positive future events, or to underestimate the probability of negative future events. This anticipation is responsible for the numerous differences between optimists and pessimists. Optimists, who are characterized by anticipation of positive events in the future, often persist in their intentions to accomplish their goals, whereas pessimists, who expect negative outcomes, express passive reactions to a larger extent, as well as giving up on their goals. Optimists feel that they can control the events in their life. They are not discouraged, even when bad things happen, but make an action plan, adhere to it and act quickly to keep the situation under control. The way optimists see bad things happening to them is as isolated events, not a general trend or a pattern in their life. They interpret events and circumstances to their best advantage. Optimists do not give up easily, and their future looks "rosy". They believe their life will be a happy one, their health good, and even if something bad does happen, they will be able to deal with it. It is only natural that even optimists experience failure at times. However, they confront such situations much better than the pessimists do.

For comparison, this optimistic approach is juxtaposed with a pessimistic point of view, where pessimists evaluate situations in terms 'everything or nothing' and in an extreme fashion, who see any kind of failure as an indicator of their own personal inadequacy. In situations that are in all their features positive, they find negative details and focus on them. Pessimists overemphasize the significance of negative events and failure, overestimate a problem and underestimate their own abilities of facing the problems and dealing with them. They tend to overlook positive aspects of events and over-generalize, that is, they are convinced they can never do anything well and the others do not like them. They reach conclusions too quickly, relying mostly on negative aspects of a situation.

Most psychologists believe that pessimism and optimism are mainly learnt behaviour, and there is evidence that they are inherited to a smaller extent. They are usually adopted at an early stage of life, through interaction with family and other social contacts.

školskim uspjehom i povećanom radnom produktivnošću. Nadalje optimističniji se studenti brže prilagođavaju na studentske uvjete života i rada - doživljavaju manje stresa, manje su depresivni i usamljeni te imaju bolju socijalnu podršku nego pesimističniji studenti. Optimisti su uspješniji i u različitim sportskim aktivnostima, a pokazuju i veće zadovoljstvo brakom. Optimizam je povezan i s uspješnošću u politici. Npr. istraživanja pokazuju da je u 9 od 10 američkih predsjedničkih izbora od 1948. do 1984. godine kandidat koji je procijenjen kao pesimističan izgubio izbore. Može se reći da je optimizam adaptivan jer nam omogućava suočavanje sa životnim problemima i olakšava ostvarenje važnih životnih ciljeva.

Ipak, najvažniji životni ishodi povezani s optimizmom i pesimizmom jesu oni koji se odnose na tjelesno i mentalno zdravlje. Optimizam i pesimizam imaju važnu ulogu u mnogim poremećajima mentalnog zdravlja, posebno poremećajima raspoloženja. Pesimistične osobe zbog negativnih očekivanja češće doživljavaju negativne emocije, a imaju i povećani rizik od razvoja simptoma anksioznosti i depresije. Pesimizam često utječe na lošije zdravlje jer dovodi do kroničnog uzbuđenja povezanog s anksioznošću, pasivnošću i bespomoćnošću.

Optimisti se bolje suočavaju sa stresnim životnim događajima, kod njih prevladavaju pozitivne emocije te doživljavaju manje subjektivnih tjelesnih simptoma (npr. glavobolja, vrtoglavica, trnci u tijelu i sl.). Optimističniji pacijenti brže se oporavljaju nakon operativnih zahvata i brže se vraćaju svakodnevnim aktivnostima. Optimističnije trudnice rađaju težu djecu. Istraživanja izvršena na ispitanicima zaraženima HIV-om najčešće pokazuju da je optimizam povezan s boljim, a pesimizam s lošijim imunološkim funkcioniranjem. Nadalje, optimisti pokazuju pozitivnija zdravstvena ponašanja nego pesimisti. Tako npr. optimističnije žene češće same pregledavaju grudi, kada su trudne češće vježbaju, što je povezano s dužom gestacijskom dobi i većom tjelesnom težinom novorođenčadi.

Na kraju također treba napomenuti da iako je pesimizam često negativan, povremeno može biti i pozitivan. Jedan je takav primjer strategija koja se naziva defanzivni pesimizam. Ona uključuje pripremanje za loše ishode iako znamo da je vjerojatniji pozitivan ishod. Defanzivni pesimizam uključuje postavljanje nerealno niskih očekivanja kako bi se pripremili za mogući neuspjeh. Ta strategija

Different expectations of optimists and pessimists influence almost all aspects of their lives. For instance, optimism is often related to better academic success and increased work productivity. Furthermore, more optimistic students adapt more quickly to working and studying conditions – experience less stress, are less depressed and lonely, and have better social support than more pessimistic students. In addition, optimists are more successful in different sports activities, and are more satisfied in marriage. Moreover, optimism is related to political success. Research shows that 9 out of 10 American presidential elections in the period from 1948 to 1984, the candidate perceived as being pessimistic lost the election. It is safe to say that optimism is adaptive, as it enables us to confront life problems and facilitates accomplishing important life goals.

Nevertheless, the most important life events related to optimism and pessimism are those relevant to physical and mental health. Optimism and pessimism play a vital role in numerous mental health disorders, especially in mood disorders. Pessimistic persons tend to experience negative emotions more often due to negative expectations, and they have an increased risk of developing anxiety and depression symptoms. Pessimism often has an impact on poor health, as it brings about chronic arousal that is related to anxiety, passive behaviour and helplessness.

Optimists are better at coping with stressful life events as positive emotions prevail and they experience less subjective physical symptoms (e.g. headache, dizziness, tingling sensations etc). Optimistic patients recover more quickly after undergoing surgery and return sooner to their daily activities. More optimistic pregnant women give birth to heavier children. Research on participants affected by HIV most often show that optimism is related to better and pessimism to poorer immune functioning. Moreover, optimists show more positive health behaviour than the pessimists. For example, optimistic women tend to self-examine their breasts more frequently, when pregnant they exercise more often, and that is directly related to a longer gestation age and more weight in newborns.

Furthermore, it should be pointed out that even though pessimism is often negative, occasionally it can even be positive. One such example is the strategy called defensive pessimism. It includes preparing for adverse outcomes, even though we know a positive outcome

može biti pozitivna u situacijama koje su rizične, a pozitivna je i ako osobu motivira da se više trudi kako bi izbjegla potencijalni neuspjeh. Međutim iako kratkotrajno pozitivna, ova strategija najčešće ima negativne dugotrajne učinke.

Također valja reći da iako je optimizam općenito adaptivan, optimistične osobe nemaju točnu percepciju stvarnosti. One npr. sebe vide ljepšima, šarmantnijima i pametnijima nego što ih procjenjuju njihovi najbliži. Čini se da su za adekvatno funkcioniranje nužne iluzije koje uključuju prenaglašavanje vlastite važnosti i vrijednosti te precijenjenu percepciju kontrole nad vlastitim životom. Pretjerani optimizam je ipak negativan. Naime on može dovesti do toga da se precjenjuju svoje mogućnosti djelovanja u prijetećim i rizičnim situacijama te da se zanemaruju potencijalni rizici i opasnosti sve dok ne bude prekasno.

Optimizam se najčešće mjeri korištenjem **LOT upitnika** (The Life Orientation Test; Scheier i Carver, 1985), koji je korišten i u ovom istraživanju. Taj se upitnik sastoji od 12 tvrdnji vezanih uz optimizam (npr. "Kada ne znam kakav će biti ishod, obično očekujem najbolje", "Ako nešto može poći po zlu, poći će"). Ispitanici procjenjuju stupanj svojega slaganja sa svakom tvrdnjom, koristeći se ljestvicom procjene od 5 stupnjeva (1 – uopće se ne slažem; 2 – uglavnom se ne slažem; 3 – niti se slažem niti se ne slažem; 4 – uglavnom se slažem; 5 – u potpunosti se slažem).

Građani Rijeke iznadprosječno su optimistični. Prosječan rezultat koji postižu iznosi 3,75, pri čemu je najmanji mogući broj bodova 1 (nema ga nitko od građana Rijeke), a maksimalan 5 (postiže ga 4,5% građana).

Između žena i muškaraca nema razlike u optimizmu, a također niti među osobama različite dobi.

Nadalje, nisu utvrđene razlike u optimizmu s obzirom na obrazovanje, radnu aktivnost, bračno i obiteljsko stanje te broj djece koju netko ima.

Razlike u optimizmu nisu utvrđene ni između onih s invaliditetom i bez njega, između osoba koje boluju i koje ne boluju od neke kronične bolesti, kao ni između onih koji jesu i koji nisu preboljeli kakvu težu bolest. Međutim što je netko veći optimist, manje intenzivno doživljava tjelesne simptome.

is more likely. Defensive pessimism includes setting unrealistically low expectations in order to prepare for a possible failure. This strategy can prove positive in situations that are risky, and it is positive if a person is thus motivated to work harder towards avoiding the potential failure. However, no matter how positive in the short run it may be, this strategy most often has negative long-lasting effects.

In addition, it is fair to say that even though optimism is generally adaptive, optimists do not have a correct perception of reality. For example, they see themselves as more beautiful, more charming and more intelligent than the people close to them see them. For adequate functioning, so it seems, it is necessary to have illusions that include exaggeration of self-importance and self-worth, and an overestimated perception of control over their own life. Exaggerated optimism is still negative. Namely, it can lead to overestimating personal abilities of action in threatening and risk situations, and to ignore potential risks and threats until it is too late.

Optimism is commonly measured by using **The Life Orientation Test** (Scheier and Carver, 1985), which was used in this research as well. The questionnaire consists of 12 statements related to optimism (e.g. "When I do not know what the outcome will be, I usually expect the best", "If something can go wrong, it will"). Participants estimate the level of their agreement with each statement, by using the 5-point rating scale (1 – I completely disagree; 2 – I mostly disagree; 3 – I neither agree nor disagree; 4 – I mostly agree; 5 – I completely agree).

The optimism level of the citizens of Rijeka is above average. Their average score is 3.75, where the minimum score is 1 (none of the citizens of Rijeka has this score), and maximum 5 (4.5% of citizens).

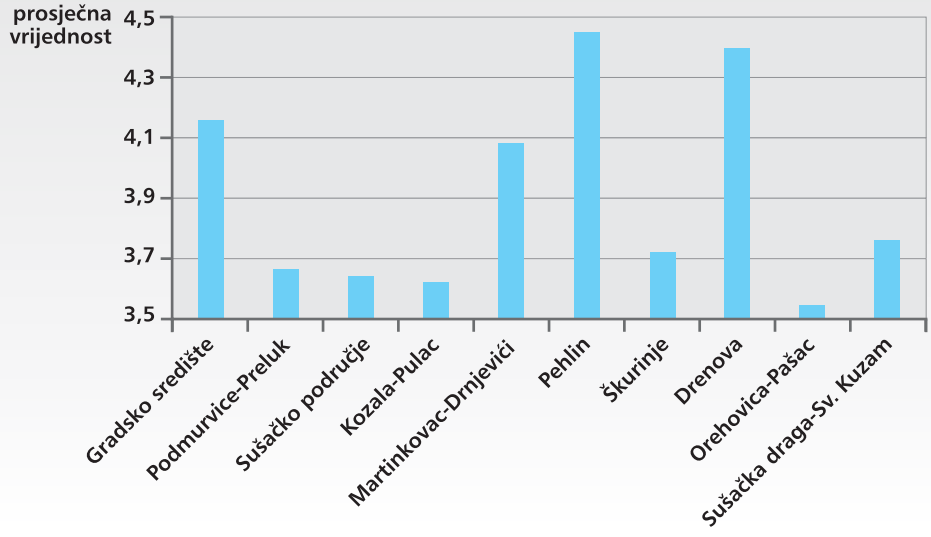
There are not any differences between women and men in optimism, nor are there between persons of different age.

Furthermore, no differences were established given the educational background, economical activity, marital and family status and the number of children.

A difference in optimism was not even established among those with and without disability, between persons suffering and not suffering from a chronic disease, nor between those who have and have not suffered from a severe illness. However, the greater an optimist a person is, the less intensely he or she experiences physical symptoms.

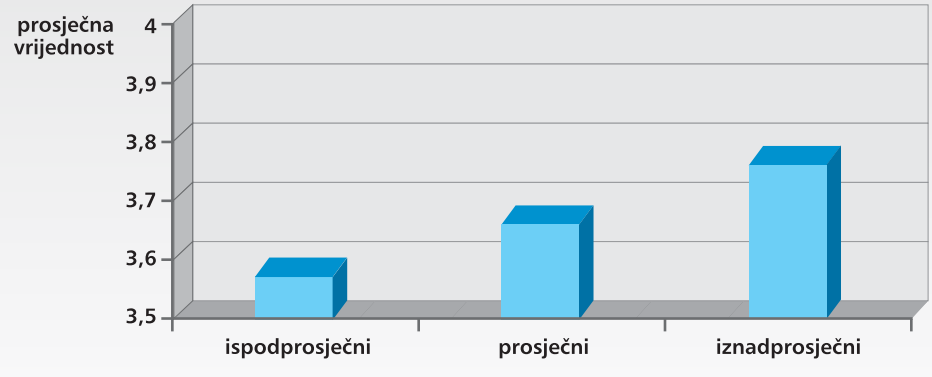
Najvišu razinu optimizma pokazuju građani koji žive na područjima prostornih cjelina Pehlin i Drenova, dok su najmanje optimistični oni koji žive na području prostornih cjelina Orehovica-Pašac, Podmurvice-Preluk, Sušačko područje i Kozala-Pulac.

Optimizam i mjesto stanovanja



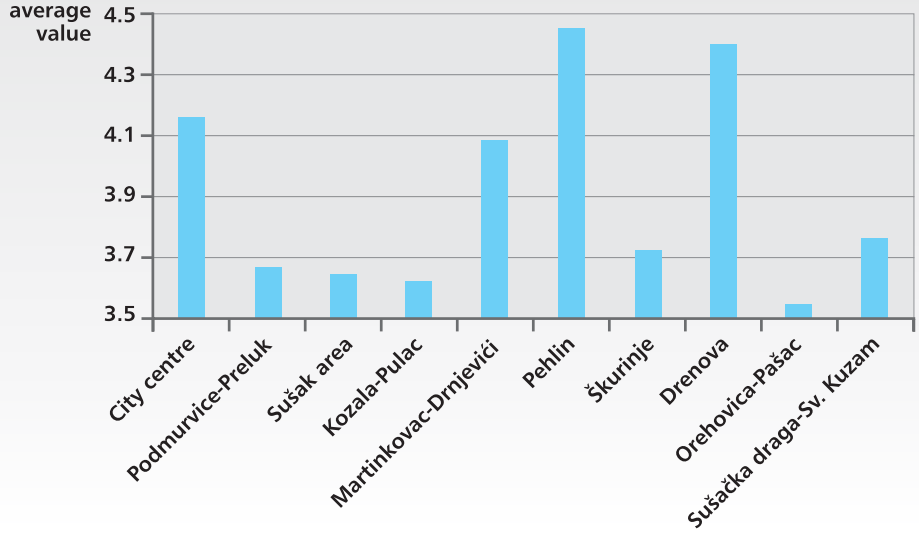
Razina optimizma viša je kod osoba koje imaju iznadprosječne ukupne mjesečne prihode kućanstva nego kod osoba koje imaju prosječne i ispodprosječne prihode.

Optimizam i prihodi kućanstva



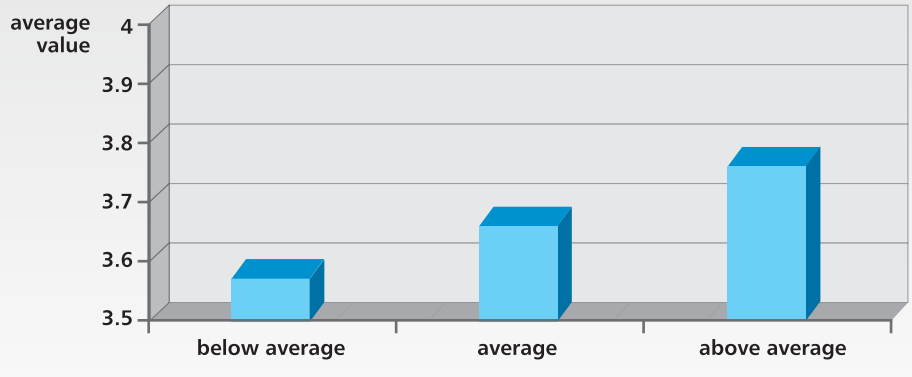
The highest level of optimism is shown by the citizens living in the city areas of Pehlin and Drenova, while the least optimistic are those living in the city areas of Orehovica-Pašac, Podmurvice-Preluk, Sušak and Kozala-Pulac.

Optimism and place of residence



The level of optimism is higher among persons with above average monthly household income than those with average or below average income.

Optimism and household income



Samopoštovanje

Sklonost ka vrednovanju onoga što nas okružuje svojstvena je svakome od nas – neka žena je lijepa ili ružna, glazba je ugodna ili neugodna, poslovni suradnici sposobni ili nesposobni, vlada je uspješna ili beskorisna itd. Naravno, da smo i sami predmet vlastite potrebe za vrednovanjem. Pri tome neki vide sami sebe kao pametne, sposobne, privlačne, dobro prilagođene ili popularne, a drugi se vide potpuno drugačije od toga. Prvima je samopoštovanje visoko, a drugima nisko.

U psihološkoj literaturi samopoštovanje se obično definira kao prilično trajan skup uvjerenja o vlastitoj vrijednosti ili važnosti, kompetentnosti i sposobnosti interakcija s drugima. Podrazumijeva istodobno i samopouzdanje i prihvaćanje samoga sebe.

Samopoštovanje se smatra važnom komponentom psihičkog zdravlja. Odsutnost zdravog osjećaja samopoštovanja ukazuje na disfunkcionalnu osobnost. Naime osobe koje se liječe zbog psihičkih problema, često imaju nisko samopoštovanje.

Većina znanstvenika koji se bave samopoštovanjem slažu se da su ljudska bića motivirana da održe, zaštite i unapređuju stupanj svojega samopoštovanja, da je visoko samopoštovanje u pravilu poželjnije nego nisko jer je povezano s mnogim psihološkim dobicima te da podizanje niskog samopoštovanja unapređuje pojedinčevu psihološku dobrobit i dovodi do poželjnih promjena u njegovu ponašanju.

Opće je poznato da pozitivan pogled na sebe ili stav o sebi donosi mnogobrojne koristi. I svi bi ga, kada bi mogli birati, željeli imati.

Self-esteem

The tendency to evaluate what is around us is something we all have in common – a woman is beautiful or ugly, music is pleasant or unpleasant, business associates are competent or incompetent, the government is successful or useless etc. Needless to say, it is only natural that we are also an object of our need to evaluate. Some perceive themselves as intelligent, competent, attractive, well-adjusted or popular, while others see themselves in a completely different light. The first are high self-esteem people and the second are low self-esteem people.

In psychological literature self-esteem is usually defined as a quite lasting set of beliefs of self-worth or self-importance, competence and ability to interact with others. At the same time it includes self-confidence and self-acceptance.

Self-esteem is regarded as an important factor of mental health. The lack of a healthy feeling of self-esteem indicates a dysfunctional personality. Namely, persons treated for mental problems often have low self-esteem.

Most scientists dealing with self-esteem agree that human beings are motivated to pursue, protect and increase the level of their self-esteem; that high self-esteem in general is more beneficial than low self-esteem, as it is in connection to many psychological benefits; the increase of a low self-esteem improves one's psychological well-being, and that it also brings about desirable changes in their behaviour.

Moreover, it is a common fact that a positive outlook on oneself or beliefs people hold about themselves is multi-beneficial. And every-

Osobe s visokim samopoštovanjem dobro se osjećaju "u svojoj koži", vješto se suočavaju s izazovima i negativnim povratnim informacijama, motivirane su za postignuća, imaju izraženu potrebu za odobravanjem i želju za kontrolom, visoku razinu pozitivnog afekta i uvjerene su da ih ljudi iz njihova socijalnog okruženja poštuju. Te osobe imaju i bolje socijalne vještine, na primjeren način se otvaraju drugim ljudima, imaju sposobnost vođenja skupine, manje su skloni složiti se s tuđim neispravnim mišljenjem i vrlo vjerojatno će ustrajati na svojim principima. Većina osoba s visokim samopoštovanjem živi sretno i produktivno. Nasuprot tome osobe niskoga samopoštovanja promatraju svijet kroz puno negativniji "filter", a njihovo generalno nesviđanje spram sebe samih "boji" i njihovu percepciju svega što ih okružuje. Osobe niskoga samopoštovanja češće su depresivne, socijalno anksiozne, sramežljive i usamljene. Također, sklonije su poremećajima hranjenja, zlouporabi alkohola i droga te uključivanju u devijantne socijalne skupine. Nije teško zaključiti da samopoštovanje kao stav o sebi ima veze s cjelokupnim pojedinčevim životom.

Samopoštovanje se usvaja tijekom razdoblja razvoja, u najranijem djetinjstvu od roditelja, nešto kasnije od vršnjaka, kroz školski sustav, a u kasnijoj adolescenciji samopoštovanje uvelike ovisi o odnosima sa suprotnim spolom. Izgrađuje se polako kroz osobno iskustvo, te je stoga stabilno.

Mnogobrojne teorije pokušavaju objasniti kako nastaje samopoštovanje, a među njima je jedna od najpopularnijih ona koja se zasniva na našem "ogledavanju" u drugima i internaliziranju onoga što smo o sebi vidjeli kroz druge. Nisko samopoštovanje objašnjava se kao posljedica odbijanja, omalovažavanja ili ignoriranja od osoba koje su za nas ključne (članovi obitelji, prijatelji, vršnjaci itd.). Postoje i određeni dokazi da se samopoštovanje manjim dijelom nasljeđuje.

U ovom istraživanju mjereno je jednom od najčešće korištenih mjera samopoštovanja. Radi se o **Rosenbergovoj ljestvici samopoštovanja** (Rosenberg, 1965), koja sadrži deset tvrdnji koje se odnose na procjenu vlastite vrijednosti i prihvaćanje vlastite ličnosti. Ispitanici trebaju odgovoriti koliko se s njima slažu, odnosno u kojoj se mjeri one odnose na njih. Stupanj slaganja izražava se pomoću ljestvice procjene od 1 do 5 (1 – uopće se ne odnosi na mene; 2 – uglavnom

one, if they could choose, would like to have it. People with high self-esteem feel good "in their own skin", can handle challenges and negative feedback competently, are motivated achievers, have a strong need for approval and the desire to control, a high level of positive affect and hold a strong belief they are accepted and respected by their peers in their social surroundings. Furthermore, they have better social skills, open to other people adequately, have leadership qualities, are less prone to agreeing with someone's wrong ideas, and are very likely to adhere to their own principles. Most high self-esteem persons lead happy and productive lives. Contrary to that, low self-esteem persons look at the world through a much more negative filter and their general dislike of themselves "distorts" their perception of everything around them. Low self-esteem people suffer from depression more frequently, are more socially anxious, shy, and lonely. Furthermore, they are more prone to eating disorders, alcohol and drug abuse, and joining deviant social groups. It is not difficult to see that self-esteem as an attitude to self is relevant to every aspect of someone's life.

Self-esteem is adopted during the development stage, in early childhood from parents, later from peers, through education, and in later adolescence self-esteem greatly depends on relationships with the opposite sex. It is formed slowly by personal experience, and therefore it is stable.

Numerous theories have tried to explain how self-esteem is developed. One of the most popular is one stemming from our "mirroring" in others, and internalising what we see about ourselves through others. Low self-esteem is explained as a consequence of rejection, depreciation or being ignored by persons very important to us (e.g. family members, friends, peers etc). There is certain evidence that self-esteem is, to a lesser degree, inherited.

In this research self-esteem was measured with one of the most widely used self-esteem scales. It is the **Rosenberg Scale of Self-esteem** (Rosenberg, 1965), which consists of ten statements referring to the evaluation of self-value and acceptance of one's personality. Participants should answer to what degree they agree with the statements, that is, to which extent they apply to them. The level of agreement is expressed by the 5-point rating scale (1 – it does not apply to me; 2 – it

se odnosi na mene; 3 – niti se odnosi niti se ne odnosi na mene; 4 – uglavnom se odnosi na mene; 5 – u potpunosti se odnosi na mene).

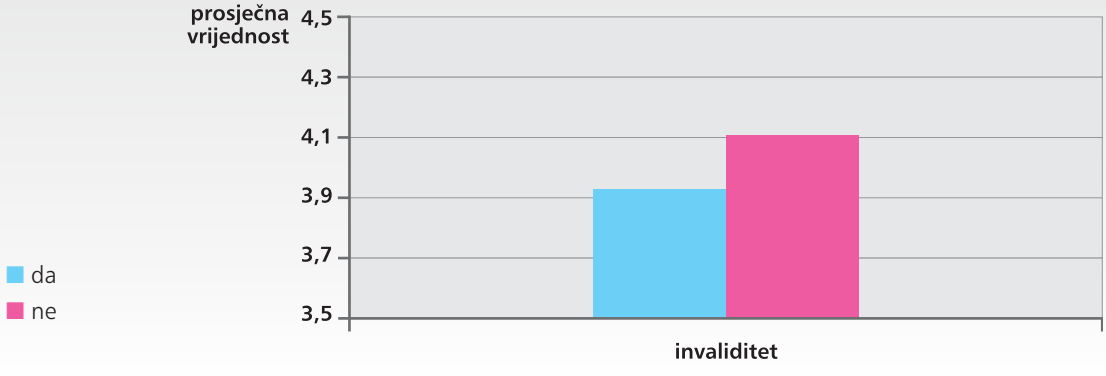
Riječani u prosjeku imaju relativno visoko samopoštovanje, tj. postižu u prosjeku rezultat od 4,2. Minimalni mogući rezultat je 1 (nije ga postigao niti jedan ispitani građanin Rijeke), a maksimalan 5 (ima ga 23,9% građana).

Među ženama i muškarcima nema razlike u razini samopoštovanja, kao niti između osoba različite dobi.

Isto tako, nisu nađene razlike u samopoštovanju građana s obzirom na stupanj obrazovanja, radnu aktivnost, bračno stanje, broj članova kućanstva i broj djece. Svi imaju podjednaku razinu samopoštovanja.

Osobe koje imaju neki oblik invaliditeta imaju značajno niže samopoštovanje nego one bez invaliditeta, dok se oni koji boluju od nekih kroničnih bolesti ili su preboljeli težu bolest ne razlikuju po samopoštovanju od onih koji ne boluju od kroničnih bolesti ili nisu preboljeli neku težu bolest.

Samopoštovanje i invaliditet/bolest



Osobe s višim osjećajem samopoštovanja imaju manje intenzivan doživljaj različitih tjelesnih simptoma.

S obzirom na mjesto stanovanja, najniže samopoštovanje imaju stanovnici prostornih cjelina Sušačka draga-Sv.Kuzam, Podmurvice-Preluk i Sušačko područje, dok najviše samopoštovanje imaju žitelji prostornih cjelina Drenova, Pehlin, Gradsko središte i Martinkovac-Drnjevići.

mostly does not apply to me; 3 – it neither applies nor it does not apply to me; 4 – it mostly applies to me; 5 – it completely applies to me).

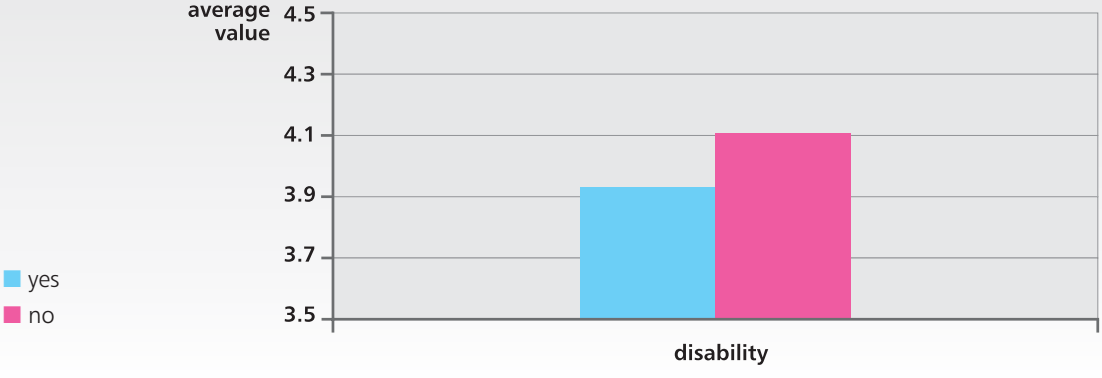
The citizens of Rijeka have a relatively high average self-esteem (i.e. 4.2), where minimal possible score is 1 (not achieved by any tested citizen of Rijeka), and maximum is 5 (in 23.9% of citizens).

Women and men have equal self-esteem, as do people of all age groups.

Furthermore, no differences in self-esteem were established given the educational background, economical activity, marital status, number of household members and number of children. They all indicated an equal level of self-esteem.

Persons with a disability have a significantly lower self-esteem than those without a disability, whereas those suffering from a chronic disease or those who have suffered from a severe illness do not differ in their self-esteem from those not suffering from a chronic disease or those who have never suffered from a severe illness.

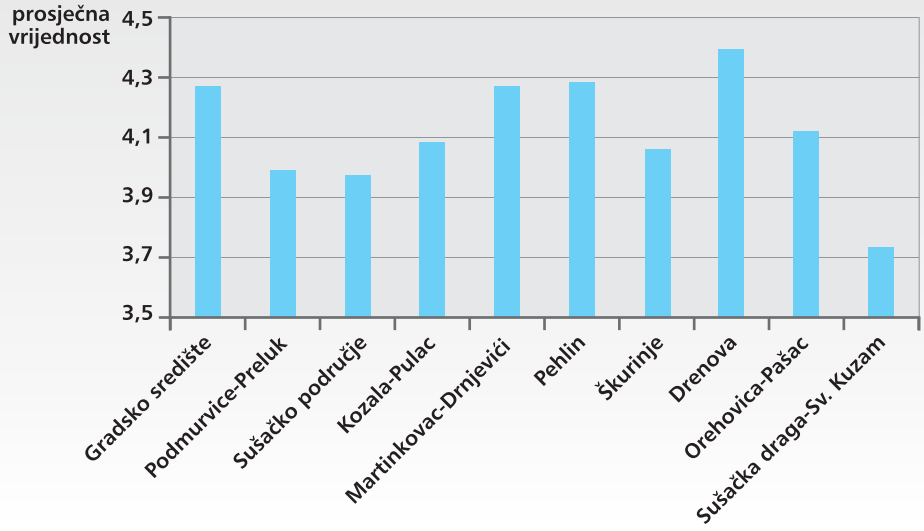
Self-esteem and disability/illness



Persons with a higher self-esteem have less intensive experience of various physical symptoms.

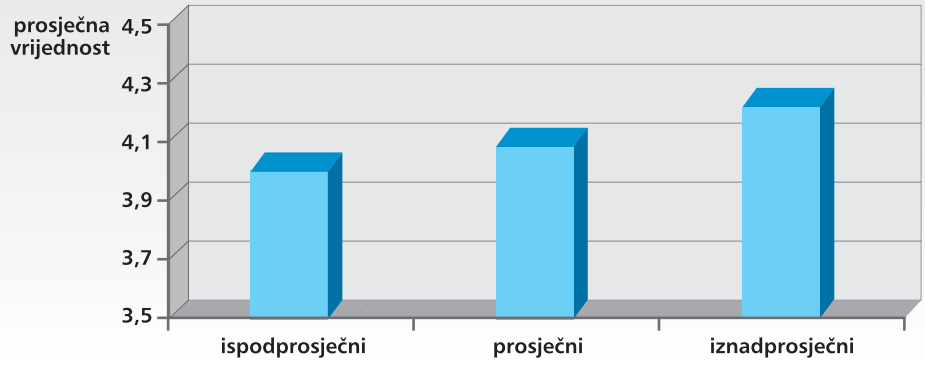
Given the place of residence, the lowest self-esteem is among the citizens of city areas of Sušačka draga-Sv.Kuzam, Podmurvice-Preluk and area of Sušak, whereas the highest self-esteem is among people living in Drenova, Pehlin, city centre and Martinkovac-Drnjevići.

Samopoštovanje i mjesto stanovanja

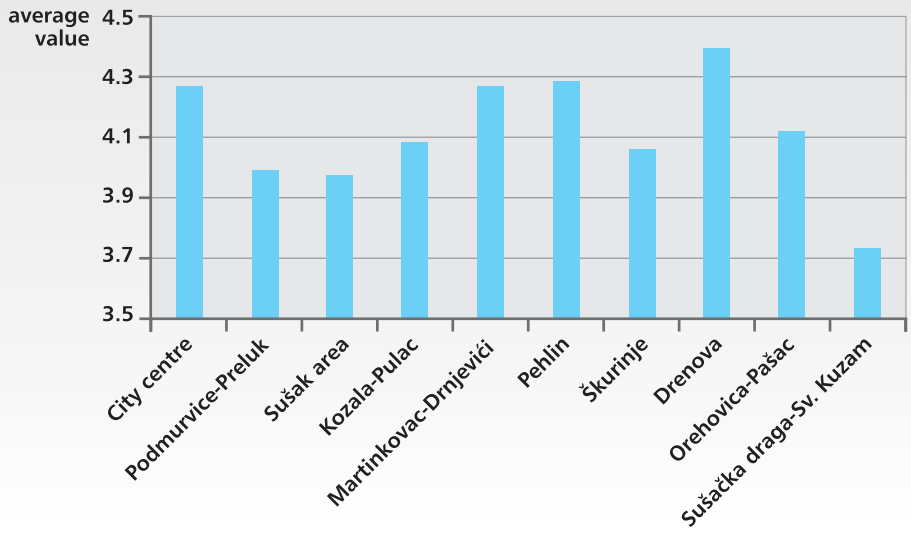


S obzirom na mjesečne prihode, najviše samopoštovanje imaju osobe s iznadprosječnim ukupnim mjesečnim prihodima kućanstva.

Samopoštovanje i prihodi kućanstva

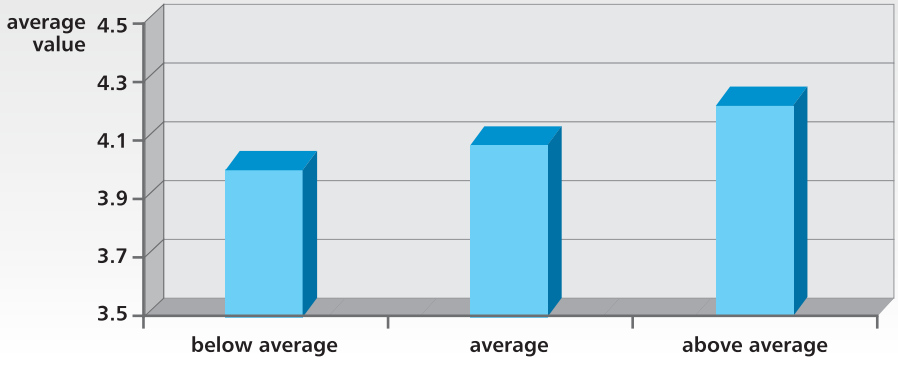


Self-esteem and place of residence



Considering monthly income, persons with above average household monthly income have the highest self-esteem.

Self-esteem and household income



Osjećaj dobrobiti

Dok se, kao što smo mogli vidjeti, samopoštovanje odnosi na vrednovanje samoga sebe, subjektivni osjećaj dobrobiti podrazumijeva vrednovanje vlastitog života. Na emocionalnoj razini manifestira se kao učestalo doživljavanje radosti, ponosa i sličnih pozitivnih emocija te rijetko doživljavanje negativnih emocija kao što su tuga, tjeskoba, sram, krivnja ili ljutnja, a na kognitivnoj razini odražava se kao opće zadovoljstvo životom ili nekim njegovim dijelom, primjerice bračnim životom ili vlastitim poslom.

Raspon subjektivnog osjećaja dobrobiti varira od krajnje agonije do ekstaze kao druge krajnosti, iako većina ljudi ima umjereno pozitivnu razinu dobrobiti.

Kako se ovdje radi o vrlo subjektivno "obojenom" uvjerenju o vlastitoj dobrobiti, psiholozi taj indikator, u kontekstu procjene nečijega mentalnog ili psihološkog zdravlja, nikada ne razmatraju zasebno. Primjerice osoba s deluzijom (iskrivljena slika realnosti kod nekih psihičkih poremećaja), može biti sretna i zadovoljna svojim životom, pa ipak se ne može reći da je mentalno zdrava. Isto tako, osoba koja nije u kontaktu sa svojim vlastitim motivima i emocijama može se osjećati sretno, ali niti za nju ne možemo reći da je potpuno psihološki zdrava osoba. Dakle, iako je subjektivni osjećaj dobrobiti važan za mentalno zdravlje, ne može ga se izjednačavati s njime. Radi se samo o jednoj njegovoj komponenti.

Iako se još uvijek ne može sa sigurnošću reći da se radi o dimenziji koja je ključna za mentalno zdravlje, mnogi je smatraju veoma poželjnom karakteristikom i važnim indikatorom kvalitete života i mentalnog zdravlja.

Postoji tendencija da pojedinci doživljavaju sličnu razinu dobrobiti u različitim aspektima života (npr. u braku, prijateljstvu, na poslu itd.). Osobe s visokim osjećajem subjektivne dobrobiti, iako možda objektivno ne doživljavaju više pozitivnih događaja, zasigurno percipiraju sve događaje pozitivnijima nego što to čine osobe s niskim subjektivnim osjećajem dobrobiti. Postoje dokazi o tome da nečija subjektivna razina dobrobiti varira tijekom vremena, ali i da pokazuje svojevrsnu konstantnost tijekom duljega razdoblja.

Subjective well-being

As we were able to see before, self-esteem refers to self-evaluation, whereas subjective well-being implies the evaluation of one's own life. On an emotional level, it is manifested as a frequent experience of joy, pride, and similar positive emotions, and a rare experience of negative emotions, such as sorrow, anxiety, shame, guilt or anger. On a cognitive level, it manifests as general satisfaction with life or one of its parts, for example with one's marriage or career.

The range of subjective well-being covers the full spectrum from extreme agony to ecstasy, although the majority of people just experience average positive subjective well-being.

As we are discussing a rather subjectively 'coloured' perception of personal well-being, psychologists never consider the evaluation of one's mental or psychological health as a separate indicator. For example, though a delusional person (having a distorted image of reality due to a mental disorder) may be happy and content with his or her life, we cannot say that that person is mentally healthy. Accordingly, for a person who is not in touch with his or her personal motives and emotions and yet is still feeling happy, we cannot affirm that person to be a completely mentally healthy person either. Hence, although subjective well-being is important for mental health, one cannot be identified with the other. Mental health is only one of its components.

Even though we cannot claim with certainty that subjective well-being is a key dimension for mental health, many consider it a rather desirable characteristic and an important life-quality and mental–health indicator.

There is a tendency in certain individuals to experience similar levels of well-being in different aspects of life (e.g. in marriage, friendship, at the workplace etc). Likewise, persons with an elevated perception of subjective well-being, even though they do not necessarily objectively experience more positive events, certainly perceive all events to be more positive in comparison to persons with low subjective well-being. Furthermore, there is evidence that one's subjective level of well-being varies over time, but it can also have certain constancy over a longer period of time.

Čime je uvjetovan nečiji subjektivni osjećaj dobrobiti? Sa sigurnošću se može reći da objektivni događaji utječu na naš subjektivni osjećaj dobrobiti, iako njihovi učinci nisu duga vijeka. Skoriji događaji imaju veći utjecaj na osjećaj dobrobiti nego ono što se dogodilo ranije u prošlosti. Nađeno je npr. da osobe koje su nedavno ostale bez bračnog partnera imaju niži osjećaj dobrobiti od onih čiji je bračni partner davno umro. Slično je i s oženjenima – skorije vjenčani pokazuju veći osjećaj sreće i dobrobiti od osoba koje su duže u braku. Čak je i kod osoba s invaliditetom utvrđena slična pojava, tako oni koji od rođenja imaju neki oblik invaliditeta, imaju viši osjećaj dobrobiti od onih koji su invaliditet stekli tijekom života. Ipak, treba reći da općenito osobe s invaliditetom, pa i one koje ga imaju od rođenja, imaju niži osjećaj dobrobiti od osoba bez invaliditeta.

Životni uvjeti i sociodemografske karakteristike (spol, dob, rasa, bračno stanje, obrazovanje i prihodi) relativno su slabo povezani s osjećajem dobrobiti. Ipak, neka su obilježja konzistentno povezana sa subjektivnim osjećajem dobrobiti. Tako su npr. osobe u braku sretnije nego one koje nikada nisu bile u braku, one koje su se razvele ili žive razdvojeno od bračnog partnera. Također, nađena je razlika u subjektivnom osjećaju dobrobiti kod osoba čiji su se roditelji razveli i onih koji su ostali u braku. Djeca iz razvedenih i jako konfliktnih brakova iskazuju niže zadovoljstvo životom. Jedna je od mogućih interpretacija da odrastanje u takvu okruženju otežava nečije kasnije odnose s drugima, kroz usvojene neadekvatne kognitivne predloške za odnose s drugim osobama.

A što je s novcem i osjećajem dobrobiti – donosi li novac sreću? Osobe koje žive u siromašnim društvima pokazuju prosječan ili nešto ispodprosječan osjećaj subjektivne dobrobiti. Bogatije države, koje imaju veću razinu slobode i ljudskih prava, te one koje naglašavaju individualizam, imaju i građane s visokim do izrazito visokim subjektivnim osjećajem dobrobiti.

Nadalje, podaci sugeriraju da starenje nužno ne podrazumijeva smanjenje razine subjektivnog osjećaja dobrobiti, ako osoba razvije određene mehanizme za njezino održavanje.

Kako su uglavnom dobiveni mali efekti izvanjskih i socio-demografskih značajki na osjećaj dobrobiti, znanstvenici su preusmjerili svoju pozornost na psihološke čimbenike poput karakteristika ličnosti, vrijednosti, ciljeve i sl. Nađeni su dokazi da temperament ima snažan utjecaj na individualne razlike u subjektivnom osjećaju dobrobiti, te da su određene crte ličnosti (ekstraverzija, neuroticizam i sl.)

What influences one's subjective well-being? We can assert, with certainty, that objective events influence our subjective well-being, although their effects are not long-lasting. Recent events have a greater influence on subjective well-being compared to those that happened in the past. It has been found, for example, that persons who recently experienced a loss of a spouse have a lower perception of well-being than those whose spouse died long ago. It is similar with married couples – recently married couples experience more joy and well-being than couples with a longer marital status. An analogous phenomenon has been recorded with disabled persons - those whose disability is congenital have a higher feeling of well-being than those who were afflicted with some form of disability during their life. However, we should say that disabled persons in general, including those with congenital disability, have a lower feeling of well-being than those without a disability.

Life conditions and socio-demographic characteristics (sex, age, race, marital status, education and income) are relatively poorly linked with the feeling of well-being. Nevertheless, some features are consistently connected with subjective well-being. For example, married persons are happier than those who have never been married, the divorced or those who are separated from their partners. Furthermore, there is a difference in subjective well-being in persons whose parents divorced and those whose parents remained married. Divorcee children or children from conflict-filled marriage express a lower satisfaction with their life. One possible interpretation is that growing up in such an environment makes future relationships difficult due to acquired inadequate cognitive relationship models.

What about money and the feeling of well-being? Could money bring happiness? Persons living in poor societies show average or somewhat below average perception of subjective well-being. Richer countries, with a higher level of freedom and human rights, as well as those that value individualism, have citizens with a high or markedly higher subjective well-being.

Moreover, data suggests that ageing does not necessarily imply lower level of subjective well-being, if the person develops certain mechanisms for its maintenance.

Since external factors and socio-demographic components proved to have little effect on the feeling of well-being, scientists shifted

povezane sa subjektivnim osjećajem dobrobiti. Naime iako svi mi često slično reagiramo na slične događaje, intenzitet i trajanje reakcije vjerojatno su uvjetovani našom ličnošću. Na primjer gubitak voljene osobe izaziva kod većine osjećaje tuge i žaljenja, ali se s obzirom na naše ličnosti intenzitet i trajanje tih emocija i način suočavanja s tom osobnom "dramom" razlikuju. Nadalje, viši osjećaj dobrobiti imaju religiozne osobe u odnosu na nereligiozne osobe, zbog svojega uvjerenja u dublji smisao života. Viši osjećaj dobrobiti imaju i oni koji su usmjereni na dostižne ciljeve, kao i oni koji su optimistični u vezi sa svojom budućnosti.

Kao što je prije rečeno, subjektivni osjećaj dobrobiti, uz emocionalnu komponentu (viša razina pozitivnih i niža razina negativnih emocija), sadrži i kognitivnu komponentu koja se naziva zadovoljstvo životom. Kada govorimo o zadovoljstvu životom, mislimo na procjenu vlastitog života na temelju svojih osobnih kriterija. Što je slaganje između percepcije vlastitih životnih okolnosti i osobnih kriterija više, viši je i nečiji osjećaj zadovoljstva životom.

Niti jedan faktor zasebno ne čini nekoga zadovoljnim ili nezadovoljnim životom, radi se o mnogo složenijem osjećaju. Jedan od najvažnijih aspekata koji određuje nečije zadovoljstvo i sreću su odnosi s drugim ljudima. Zadovoljnije su osobe koje imaju bliske prijatelje i obitelj, koji ih podržavaju, dok su oni koji ih nemaju vrlo vjerojatno nezadovoljni svojim životom. Izvor zadovoljstva za mnoge ljude je i njihov posao ili obrazovanje, odnosno neka životna uloga u kojoj se osjećaju važno. Kada osoba uživa u onome što radi, bilo to plaćeno ili ne, i pri tom se osjeća važno i korisno, zasigurno osjeća zadovoljstvo. Za razliku od toga nezadovoljstvu životom doprinosi nemogućnost ispunjavanja ciljeva koje je netko sebi postavio, nemogućnost obavljanja posla zbog loših okolnosti ili zbog toga što posao nije u skladu s nečijim sposobnostima. Važan izvor zadovoljstva životom čine i osobni faktori – zadovoljstvo samim/samom sobom, religiozni

their attention to psychological factors like personality characteristics, values, goals etc. It has been proven that temperament has an important influence on subjective well-being, and that certain personality traits (e.g. extraversion, neuroticism, etc) are in connection with subjective well-being. Namely, although we all often similarly react to similar events, the intensity and the duration of the reaction are probably influenced by our personality. For example, the loss of a loved one will, in the majority of cases, cause feelings of sorrow and grief, but in regards to our personality, the intensity and the duration of these emotions and the way we face the personal 'drama' will differ. Similarly, religious persons have higher subjective well-being in comparison with non-religious ones because of their firm belief in a deeper meaning of life. Those who are focused on attainable goals, as well as those who are optimistic regarding their future, also have a higher subjective well-being.

As we said earlier, subjective well-being, together with an emotional component (i.e. higher level of positive and lower level of negative emotions), contains a cognitive component that we call life satisfaction. When we talk about life satisfaction, we have in mind the evaluation of our personal life based on our personal criteria. The greater the congruence between perception of personal life circumstances and personal criteria, the greater will be our life satisfaction.

No single factor will make someone content or discontent in life. We are talking about a much more complex feeling. One of the most important aspects that determines one's satisfaction and happiness are relationships. Those who are more satisfied have close friends and a family who support them, while those who have none will probably have little satisfaction with their life. The source of satisfaction for many people is their work or education, too, in other words some life role in which they feel important. When a person enjoys what he or she does, regardless of whether it is remunerated or not, and achieves a feeling of being important and useful as a result, will

ili duhovni život, učenje i napredovanje te slobodno vrijeme. Kada je netko na tom planu frustriran, vrlo će vjerojatno biti izrazito nezadovoljan životom.

Što se tiče sociodemografskih obilježja, zadovoljstvo životom ne ovisi o spolu ili dobi, ali je u vezi s bračnim stanjem tako da su udane i oženjeni zadovoljniji životom. Zadovoljstvo životom povezano je i sa zdravstvenim stanjem, pa su tako osobe s manje zdravstvenih tegoba zadovoljnije životom.

U istraživanjima je potvrđeno da je niže zadovoljstvo životom povezano s depresivnošću, negativnim emocijama, anksioznošću, nižim samopoštovanjem, doživljajem stresa i neuroticizmom. Nasuprot tome veće zadovoljstvo životom povezano je s pozitivnim emocijama i ekstraverzijom.

Zadovoljstvo životom umjereno je stabilno obilježje, što znači da se djelomično i mijenja s obzirom na životne okolnosti.

Postoji velik broj dokaza o korisnosti subjektivnog osjećaja dobrobiti u nekim važnim područjima života. Stoga je važno raditi na poboljšanju toga pozitivnog stanja funkcioniranja.

Pokazalo se da su zaposlenici koji izražavaju viši stupanj zadovoljstva vlastitim životom i svojim poslom kooperativniji i spremniji pomoći svojim suradnicima nego drugi, učinkovitiji su i, između ostaloga, duže ostaju raditi u svojim tvrtkama nego oni nezadovoljni. Na razini radnih organizacija, one koje imaju veći broj zaposlenika koji iskazuju višu razinu osjećaja dobrobiti, izvještavaju o većem stupnju zadovoljstva i lojalnosti svojih kupaca ili korisnika, profitabilnije su, produktivnije, duže zadržavaju zaposlenike itd.

Nadalje, dokazano je da subjektivni osjećaj dobrobiti štiti od tjelesnih bolesti u odrasloj dobi, od razvijanja različitih oblika disfunkcionalnosti te preranog mortaliteta. Postoje neki dokazi da unapređuje funkcioniranje imunološkog sustava. Kada je razina subjektivnog osjećaja dobrobiti niska, raste rizik od pojave depresivnosti i njezina najgoreg mogućeg ishoda – samoubojstva.

Istraživanja su pokazala da je subjektivni osjećaj dobrobiti povezan i s građanskom odgovornošću, pružanjem emocionalne i materijalne podrške drugima, boljom međugeneracijskom komunikacijom

surely experience satisfaction. On the other hand, lack of life satisfaction impedes the fulfilment of goals a person has set to themselves, prevents work completion due to bad circumstances or even because the work in question is not in accordance to that person's abilities. Another important source of life satisfaction are personal factors – self-satisfaction, religious or spiritual life, learning and promotion, as well as free time. If a person is frustrated in these areas, that person will probably be discontent with his or her life.

Taking sociodemographic factors into consideration, life satisfaction does not depend on sex or age, but is influenced by marital status, in a way that married persons are more satisfied with life. Life satisfaction is also linked to health status - persons with less health problems experience more life satisfaction.

Numerous research studies have proven that low satisfaction with life is linked to depression, negative emotions, anxiety, lower self-esteem, the experience of stress and neuroticism. On the other hand, higher life satisfaction is associated with positive emotions and extraversion.

Life satisfaction is a moderately stable feature, which means that it partly changes in regard to life circumstances.

There is extensive evidence on the usefulness of subjective well-being in various important areas of life, which indicate the importance of work for the improvement of the positive state of functioning.

In the area of work, it has been established that employees who express a higher level of satisfaction with their life and work are more cooperative in addition to being ready to help their colleagues, are more efficient and also remain longer in their companies than others who are not satisfied. On the company level, the companies with a higher number of employees who express higher satisfaction, report a higher level of satisfaction and loyalty from their clients or customers, and in turn have higher profits, are more productive, and keep their employees longer, etc.

Furthermore, it has been proven that subjective well-being protects from physical illnesses in adulthood, from different forms of dysfunctions and premature mortality. There is proof that it enhances immune system. When the level of subjective well-being is low, the risk of depression increases, as well as its worst outcome, suicide - is also higher. Research has shown the link between subjective well-be-

(prenošenje vještina i resursa među generacijama), većom uključenošću u lokalnu zajednicu kao i s volonterstvom.

Osjećaj dobrobiti u ovom istraživanju mjeren je **Skalom afektivne ravnoteže** (*Affect Balance Scale*, Bradburn, 1969.). Ta se skala sastoji od deset pitanja u vezi sa specifičnim osjećajima (npr. "Jeste li se proteklih nekoliko mjeseci osjećali zadovoljno zbog nečega što ste postigli?") na koja su građani trebali odgovoriti jesu li se tako osjećali ili ne tijekom proteklih nekoliko mjeseci.

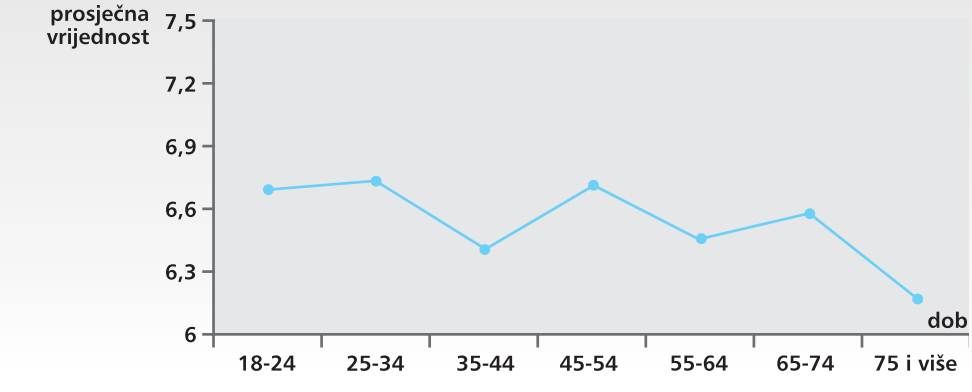
Za mjerenje zadovoljstva životom u ovom istraživanju korištena je **Skala zadovoljstva životom** (*Satisfaction With Life Scale*, Pavot i Diener, 1993). Sastoji se od pet tvrdnji koje opisuju različite aspekte zadovoljstva životom (npr. "Sve važne stvari koje sam želio u životu, već sam ostvario"), uz koje su građani trebali označiti koliko se na njih odnose, koristeći ljestvicu slaganja od 1 do 7 (1- u potpunosti se ne slažem; 2 – ne slažem se; 3 – donekle se ne slažem; 4 – niti se slažem niti se ne slažem; 5 – donekle se slažem; 6 – slažem se; 7 – u potpunosti se slažem).

Osjećaj dobrobiti

Građani Rijeke izrazili su iznadprosječan osjećaj subjektivne dobrobiti, odnosno on iznosi 7, pri čemu je minimalni mogući rezultat 0 (ima ga 0,2% građana), a maksimalni 10 (ima ga 2,7% građana).

Žene i muškarci imaju podjednako izražen osjećaj dobrobiti. Isto tako, gotovo sve dobne skupine imaju podjednako izražen osjećaj dobrobiti, osim dobne skupine od 75 i više godina kod koje je osjećaj vlastite dobrobiti nešto niži nego kod ostalih.

Osjećaj dobrobiti i dob



ing and civil responsibility, emotional and material support to others, better intergenerational communication (skills and resources transfer between generations), higher involvement in the local community and volunteering.

Subjective well-being in this research is measured using the **Affect Balance Scale** (Bradburn, 1969). The scale consists of ten questions regarding specific feelings (e.g. "Have you felt satisfied because of something that you achieved in the last few months?") to which citizens had to answer whether they felt this way in the last few months.

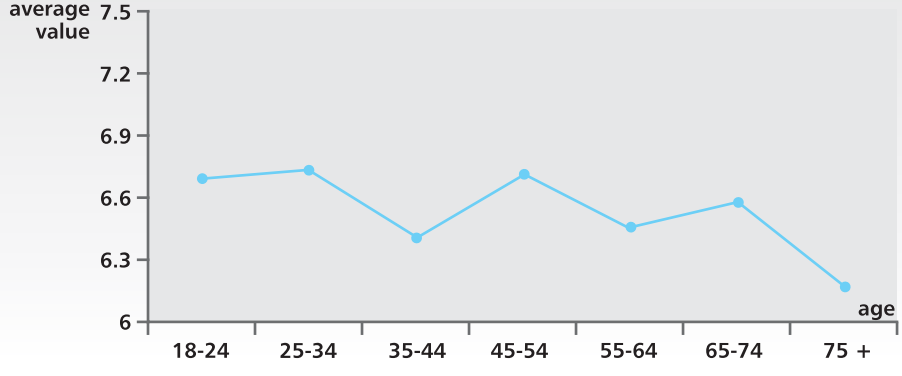
For measuring life satisfaction, in this research we used **Satisfaction With Life Scale** (Pavot and Diener, 1993). It consists of five statements describing different aspects of life satisfaction (e.g. "I have already achieved all the important things that I wanted in life."), next to which the citizens had to mark to what extent it refers to them, using the scale from 1 to 7 (1 – I agree completely; 2 – I disagree; 3 – I partly disagree; 4 – I neither agree nor disagree; 5 – I somewhat agree; 6 – I agree; 7 – I completely agree).

Subjective well-being

The citizens of Rijeka have above average subjective well-being (i.e. 7), where the minimum possible score is 0 (in 0.2% of citizens), and maximum 10 (in 2.7% of citizens).

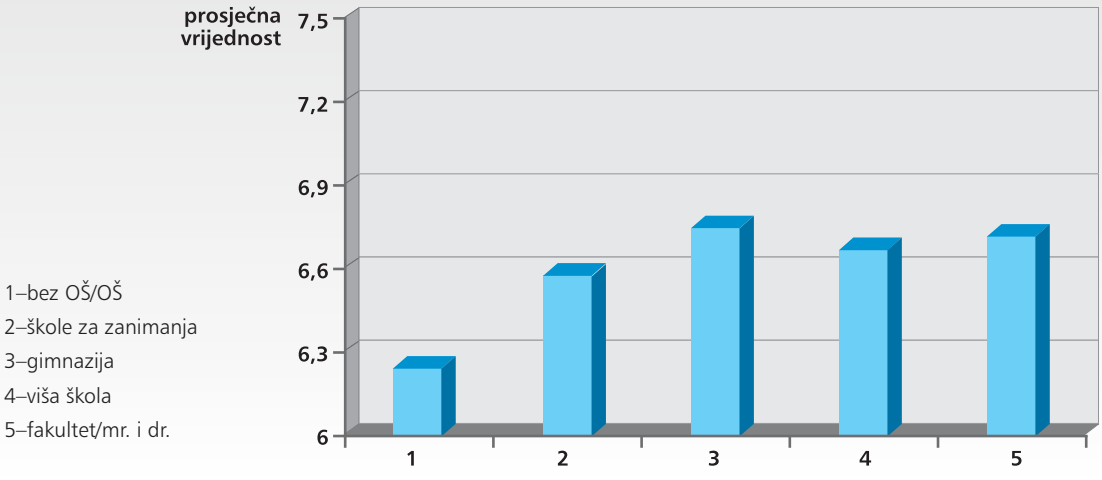
Women and men have equal subjective well-being. Furthermore, almost all age groups have equally expressed subjective well-being, except the 75 + age group, which has slightly lower subjective well-being than the others.

Subjective well-being and age



S obzirom na obrazovanje, najniži osjećaj dobrobiti imaju osobe koje su bez škole ili su završile samo osnovnu školu, dok ostali imaju podjednaku percepciju osjećaja vlastite dobrobiti.

Osjećaj dobrobiti i obrazovanje

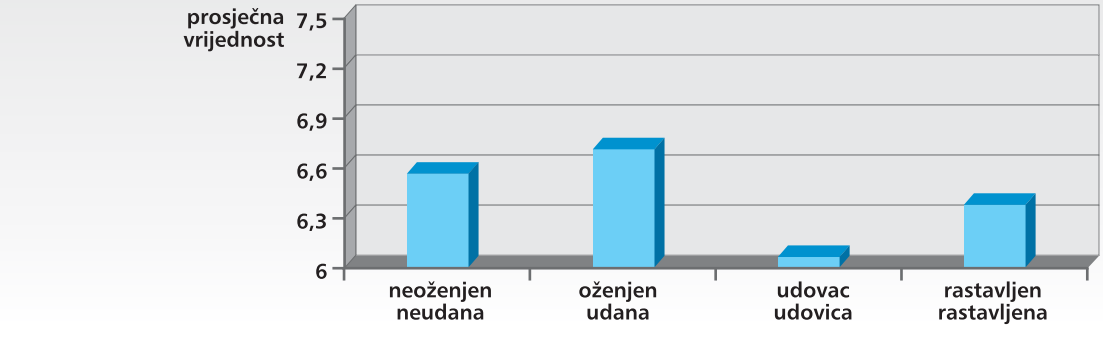


1–bez OŠ/OŠ
2–škole za zanimanja
3–gimnazija
4–viša škola
5–fakultet/mr. i dr.

Između zaposlenih, nezaposlenih i radno neaktivnih nema značajne razlike u osjećaju dobrobiti.

S obzirom na bračno stanje, najniži osjećaj dobrobiti imaju udovci i udovice, dok osobe ostalih kategorija bračnog stanja imaju podjednak osjećaj dobrobiti.

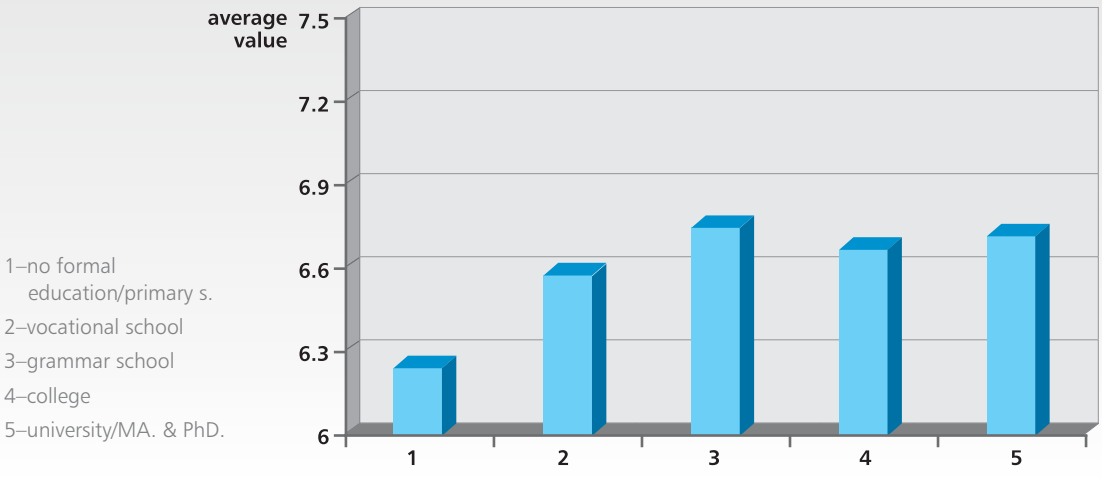
Osjećaj dobrobiti i bračno stanje



Među osobama različita obiteljskog stanja, nešto niži osjećaj dobrobiti imaju samci u odnosu na osobe koje žive u višečlanim obiteljima.

Considering educational background, persons without any formal education or with having finished only primary school have the lowest subjective well-being, while others have an even perception of subjective well-being.

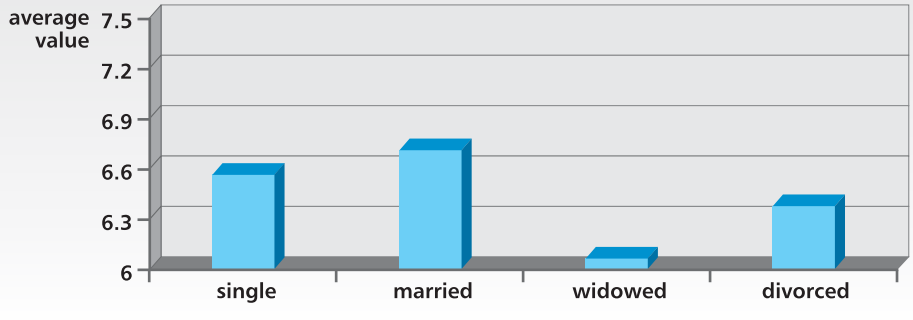
Subjective well-being and education



Between employed, the unemployed and the economically inactive persons, there are no significant differences in subjective well-being.

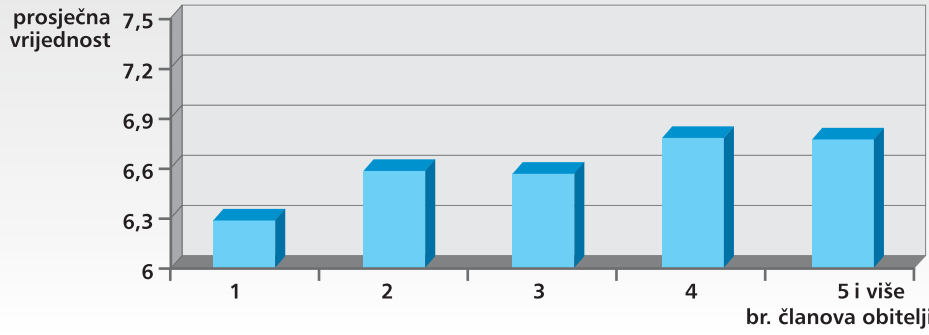
Considering marital status, widowers and widows have the lowest subjective well-being, while persons in all other categories of marital status have an equal perception of subjective well-being.

Subjective well-being and marital status



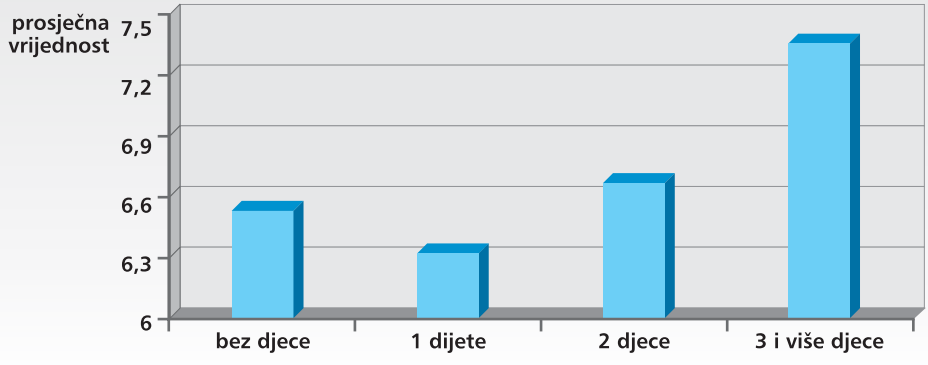
Between persons of a different family status, single persons have a somewhat lower perception of subjective well-being compared to persons who live in numerous families.

Osjećaj dobrobiti i broj članova obitelji

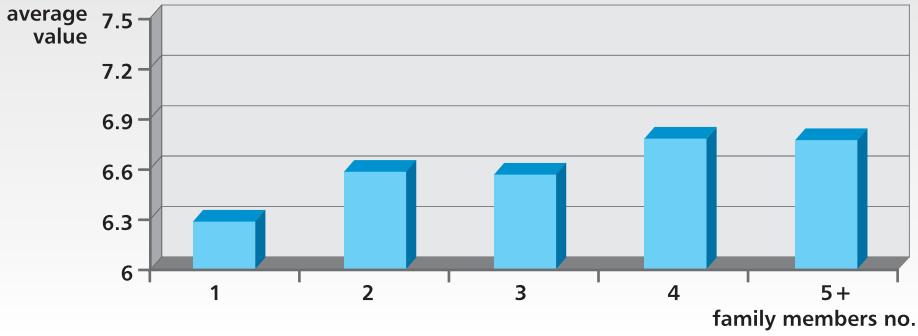


S obzirom na broj djece koju imaju, najizraženiji osjećaj dobrobiti imaju osobe s troje i više djece, dok najniži osjećaj dobrobiti, niži čak i od onih koji nemaju djecu, imaju osobe koje imaju jedno dijete.

Osjećaj dobrobiti i broj djece

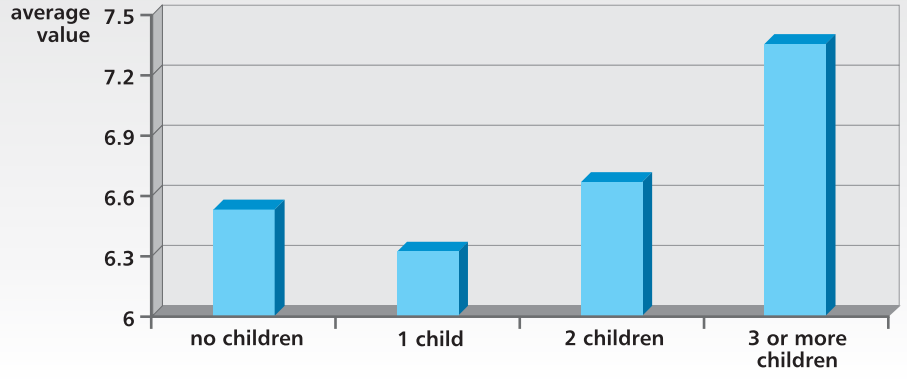


Subjective well-being and the number of family members



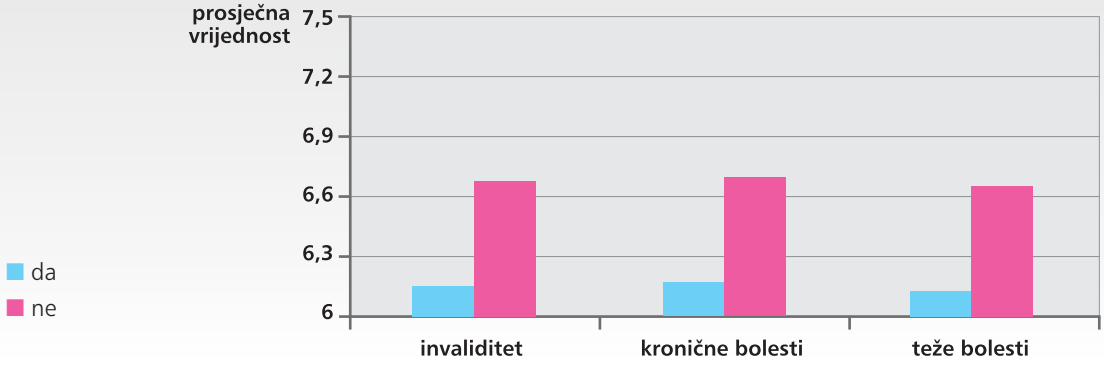
Considering the number of children, people with three or more children have the highest perception of subjective well-being, while the lowest perception of subjective well-being, even lower than people without children, are those with one child.

Subjective well-being and the number of children



Osjećaj dobrobiti značajno je niži kod osoba s invaliditetom, kod onih koji boluju od kroničnih bolesti ili su preboljeli neku težu bolest nego kod onih bez invaliditeta, koji ne boluju od kroničnih bolesti ili nisu preboljeli teže bolesti.

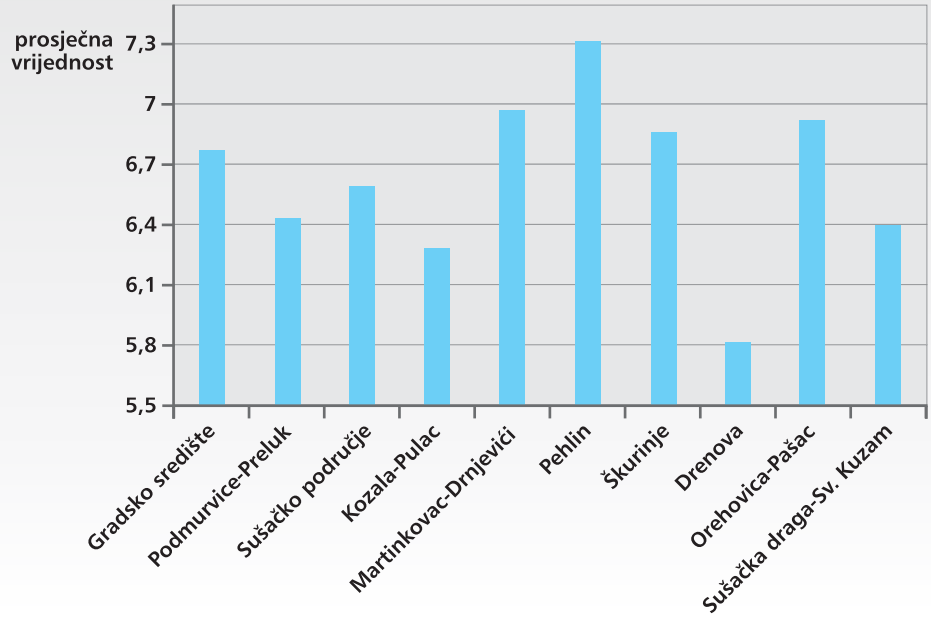
Osjećaj dobrobiti i invaliditet/bolest



Što netko ima viši osjećaj dobrobiti, manje intenzivno doživljava tjelesne simptome.

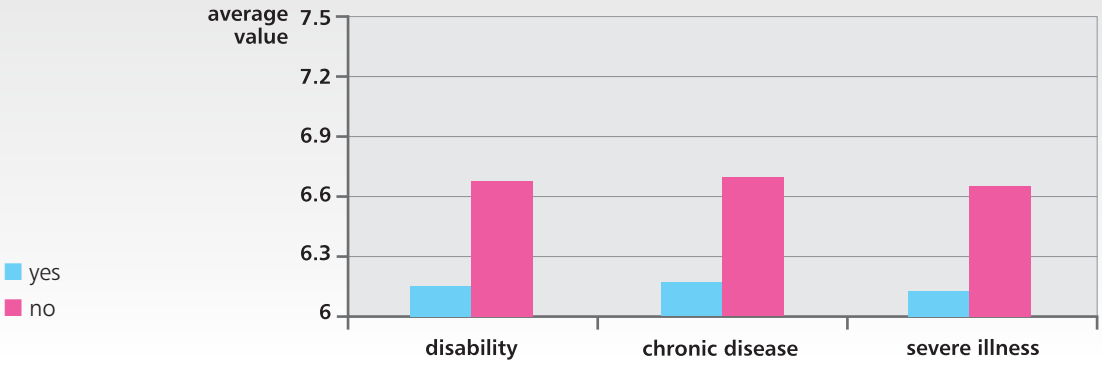
Najvišu razinu osjećaja dobrobiti imaju građani koji žive na području prostornih cjelina Pehlin, Martinkovac-Drnjevići i Škurinje, a najnižu građani koji žive na području prostornih cjelina Drenova i Kozala-Pulac.

Osjećaj dobrobiti i mjesto stanovanja



Disabled people, persons with chronic diseases or those who have suffered from a severe illness have a considerably lower subjective well-being, than those without disability, those who do not suffer from a chronic disease or have not suffered from a severe illness.

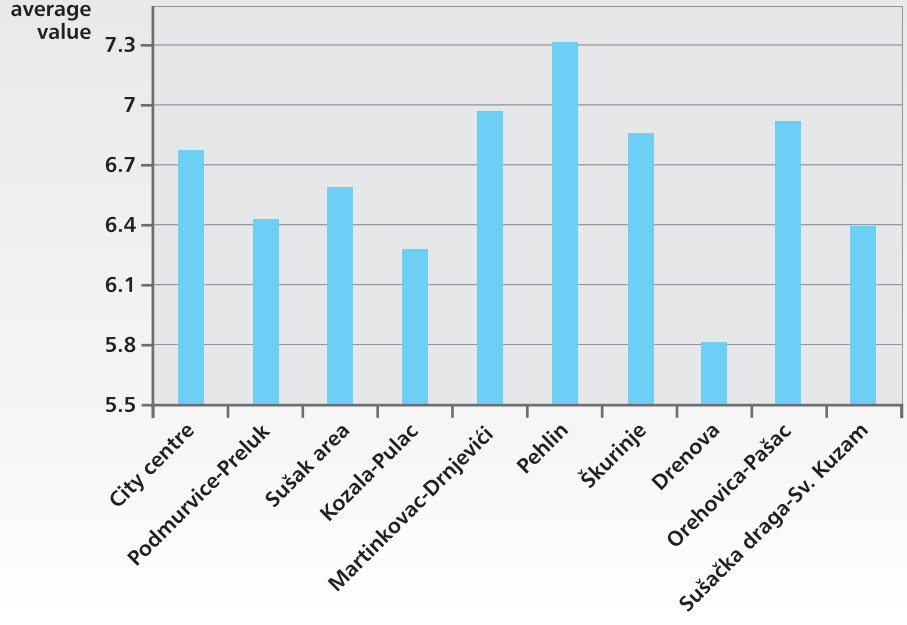
Subjective well-being and disability/illness



The higher the subjective well–being, the less intensely are physical symptoms perceived.

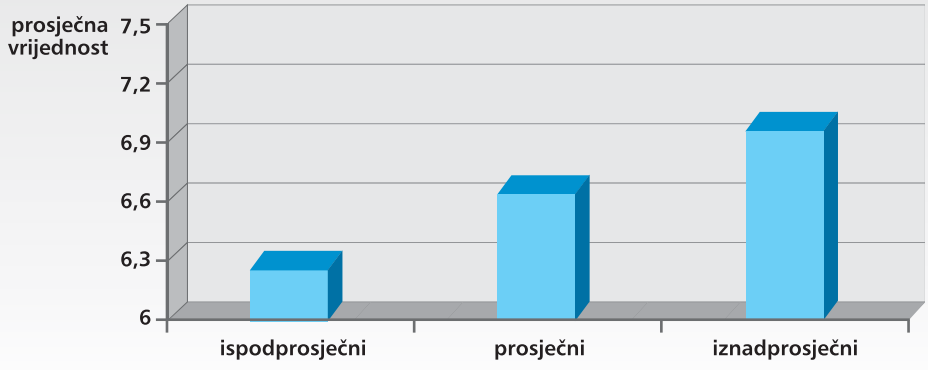
The highest perception of subjective well-being are those living in the areas of Pehlin, Martinkovac-Drnjevići and Škurinje, while the lowest are those living in the areas of Drenova and Kozala-Pulac.

Subjective well–being and place of residence



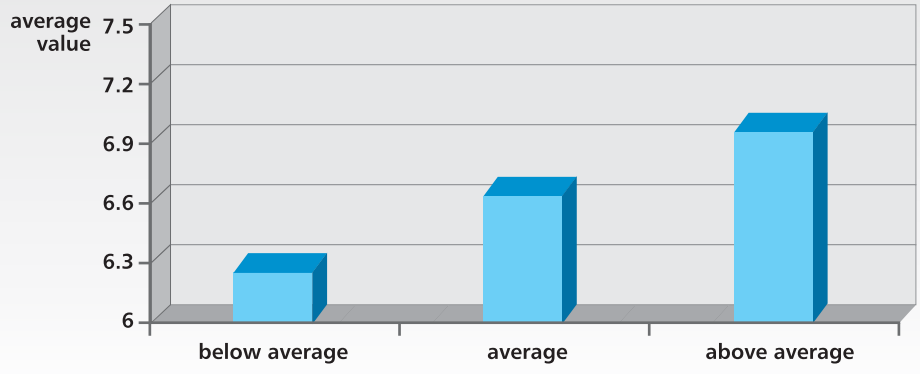
Osjećaj dobrobiti raste s povećanjem iznosa ukupnih mjesečnih prihoda kućanstva.

Osjećaj dobrobiti i prihodi kućanstva



The perception of subjective well-being follows the growth of the total amount of monthly household income.

Subjective well-being and household income

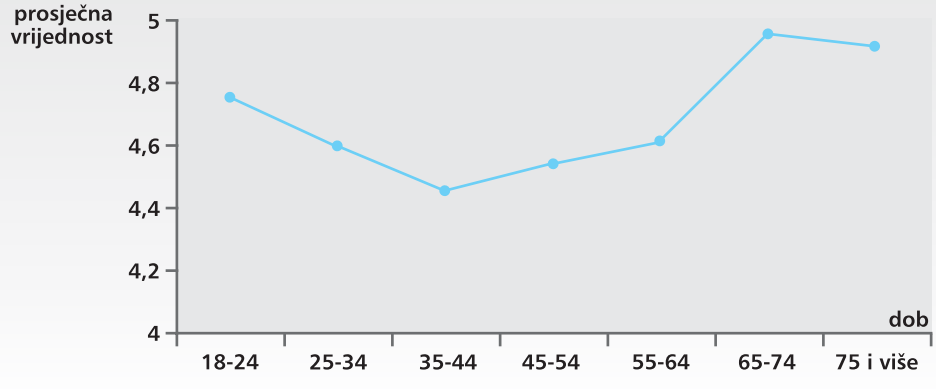


Zadovoljstvo životom

Minimalni mogući rezultat na ljestvici zadovoljstva životom korištenoj u ovom istraživanju iznosi 1 (ima ga 0,9% građana), a maksimalni 7 (ima ga 1,9% građana). Kod građana Rijeke zadovoljstvo životom u prosjeku je visoko (iznosi 4,8). Dobiveni rezultat pokazuje da se Riječanima sviđa njihov život i da imaju osjećaj da je sve na svome mjestu. Riječani ne misle da je njihov život savršen, ali osjećaju da je većina toga u njihovu životu u redu. Zadovoljni su svojim životom, ali ga ne shvaćaju olako. Za većinu građana život je ugodan, mnogi su dijelovi njihova života zadovoljavajući – posao, škola, obitelj, prijatelji, slobodno vrijeme i osobni razvoj.

Zadovoljstvo životom podjednako je kod Riječanki i Riječana. S obzirom na dob najzadovoljnije su životom osobe od 65 godina naviše, a najnezadovoljniji životom su oni u dobi od 35 do 44 godine.

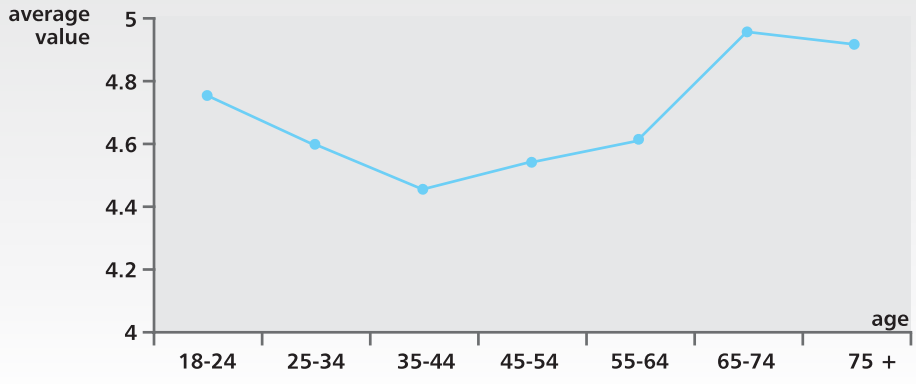
Zadovoljstvo životom i dob



The minimal possible score on the life satisfaction scale used in this research is 1 (i.e. in 0.9% citizens), and maximum 7 (i.e. in 1.9% of citizens). The citizens of Rijeka express on average a high life satisfaction (i.e. the average of 4.8). The findings obtained show that the citizens of Rijeka like their life and have a feeling that everything is as it should be. They do not perceive their life as perfect, but feel that most things in their life have fallen into place. They are satisfied with their life, but do not take it for granted. The majority perceive their life as pleasant, and many domains of their life satisfactory – work, school, family, friends, free time and personal development.

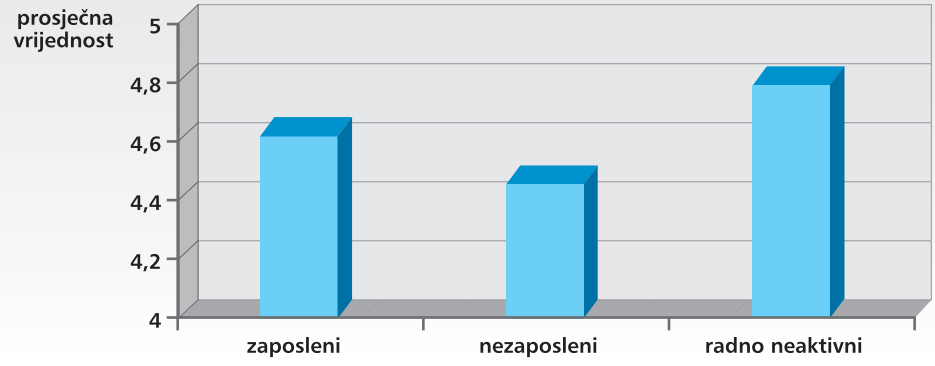
Life satisfaction is equal in female and male populations of Rijeka. Considering age, the most satisfied with their life are persons aged 65 and over, and the least satisfied with their life are those in the 35 – 44 age group.

Life satisfaction and age



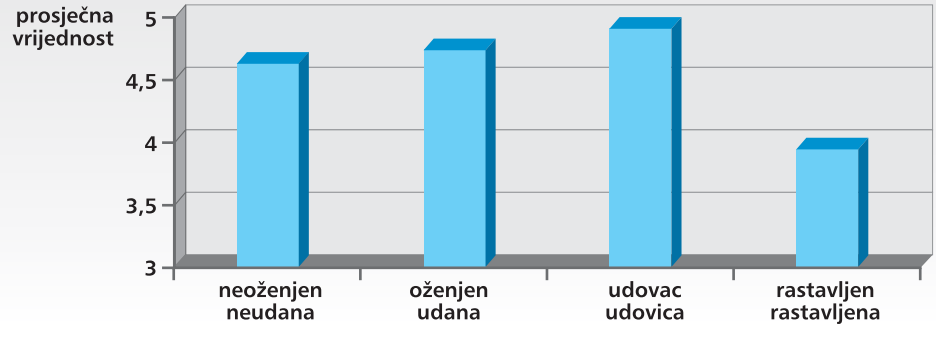
Osobe različita obrazovanja podjednako su zadovoljne životom, dok su među osobama različite radne aktivnosti najzadovoljnije životom radno neaktivne osobe.

Zadovoljstvo životom i radna aktivnost



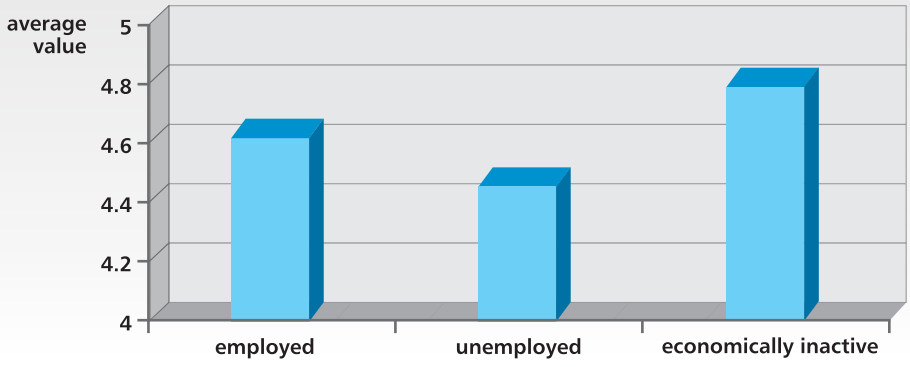
Rastavljene osobe značajno su manje zadovoljne životom od neoženjenih/neudanih, oženjenih/udanih i udovaca/udovica.

Zadovoljstvo životom i bračno stanje



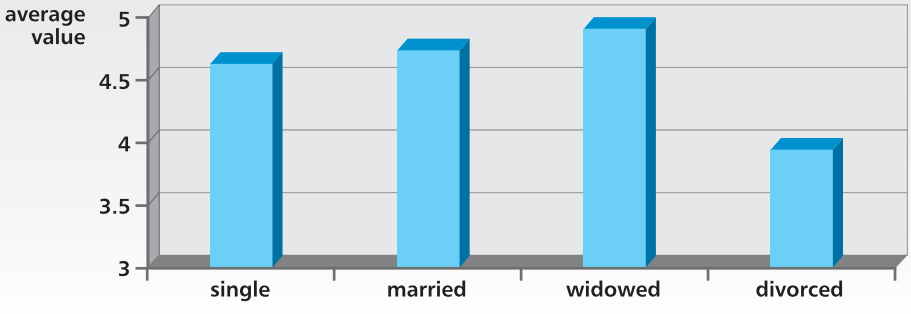
Persons with different educational backgrounds are equally satisfied with their lives, while among persons who have a different work status, the most satisfied are those who are economically inactive.

Life satisfaction and economic activity



Divorced persons are considerably less satisfied with their life than persons with different marital status.

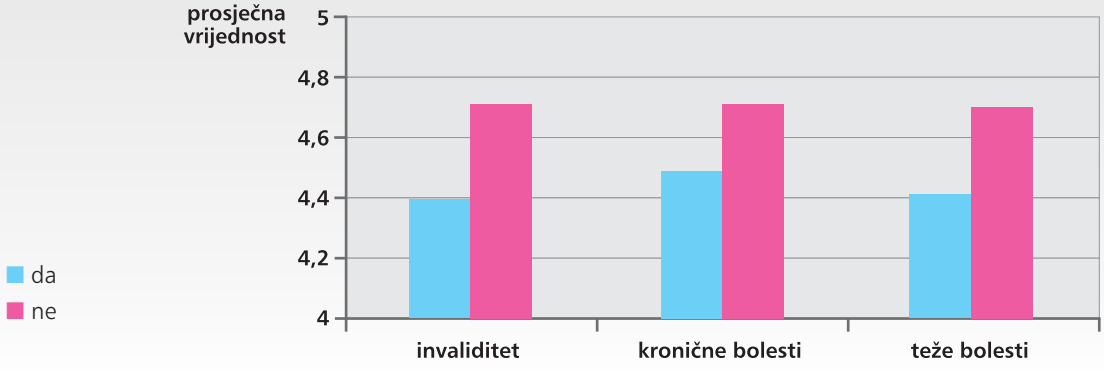
Life satisfaction and marital status



Broj članova kućanstva i broj djece koje netko ima nisu povezani sa zadovoljstvom životom.

Zadovoljstvo životom više je kod osoba bez invaliditeta, onih koji ne boluju od neke kronične bolesti i nisu preboljeli neku težu bolest nego kod osoba s invaliditetom, onih koji boluju od kroničnih bolesti i koji su preboljeli težu bolest.

Zadovoljstvo životom i invaliditet/bolest

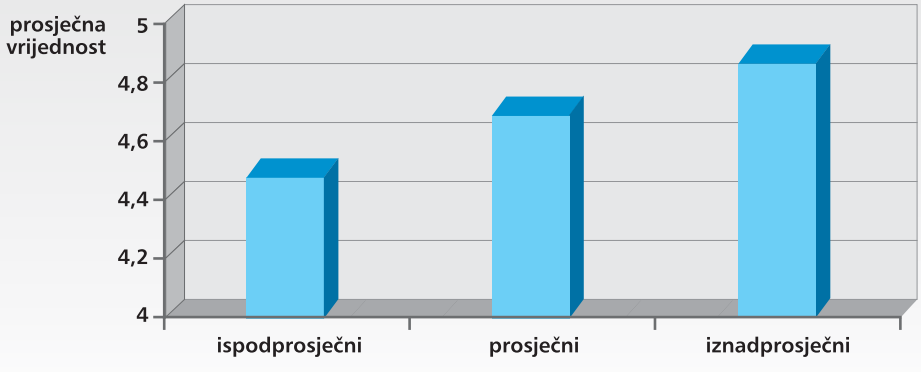


Riječani koji osjećaju višu razinu zadovoljstva životom manje intenzivno doživljavaju razne tjelesne simptome.

Bez obzira na području koje prostorne cjeline žive, građani Rijeke podjednako su zadovoljni životom.

Međutim što imaju veća ukupna mjesečna primanja kućanstva građani su zadovoljniji životom.

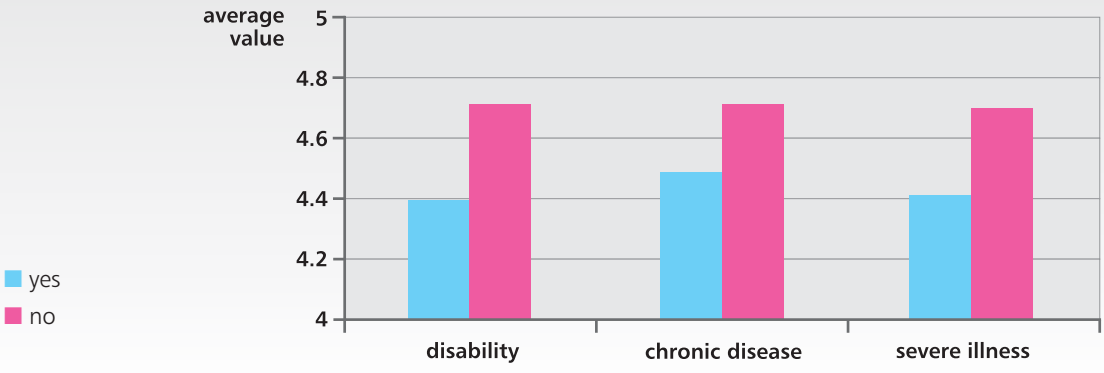
Zadovoljstvo životom i prihodi kućanstva



The number of family members and the number of children do not influence life satisfaction.

Life satisfaction is higher in persons without disability, persons who do not suffer from a chronic disease or who have not suffered from a severe illness than for disabled persons, persons who suffer from a chronic disease or those who have not suffered from a severe illness.

Life satisfaction and disability/illness

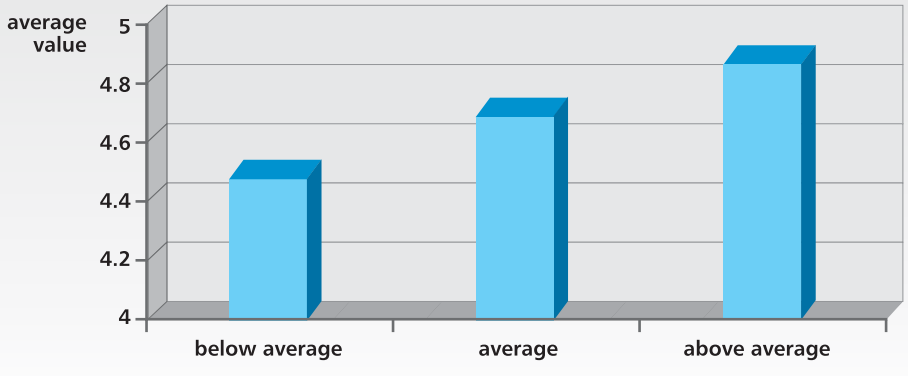


The citizens of Rijeka who have a higher life satisfaction experience different physical symptoms less intensely.

Regardless of the area of residence, the citizens of Rijeka are equally satisfied with their life.

However, the higher the total amount of the monthly household income, the higher life satisfaction is.

Life satisfaction and household income



Zaključak

Na osnovi provedenog istraživanja o **indikatorima mentalnih poremećaja i mentalnog zdravlja**, može se reći da je mentalno zdravlje građana Rijeke u cjelini zadovoljavajuće.

Depresivnost je kod građana Rijeke u prosjeku relativno niska. Međutim treba istaknuti da se 11,3% građana osjeća umjereno ili jako depresivno.

Anksioznost se općenito doživljava relativno rijetko, ali treba napomenuti da je 4,7% Riječana često anksiozno.

Građani Rijeke u prosjeku su rijetko usamljeni, međutim s usamljenošću ponekad ima problema 11,9% građana.

U prosjeku su u zadnjih godinu dana Riječani doživjeli četiri stresna životna događaja. Najčešće su doživljavali stresne događaje slabijeg intenziteta, kao što su odlazak na godišnji odmor, božićni blagdani, manja financijska zaduženost i slično. Od najintenzivnijih stresnih događaja relativno velik broj građana Rijeke doživio je odvojenost od bračnog partnera (8,8% građana), smrt bliskog člana obitelji (12,5% građana) i teže ozljede ili bolest (11,2% građana).

Iako je doživljaj stresnosti kod građana Rijeke u prosjeku umjeren, stres često doživljava 6,4% građana.

Nasreću, građani Rijeke imaju relativno visoku percepciju socijalne podrške od svojih prijatelja, obitelji i kolega, što je jedan od najvažnijih zaštitnih faktora protiv štetnog djelovanja stresa.

Nadalje, samopoštovanje Riječana također je iznadprosječno visoko, kao i njihov optimizam.

Nakraju, treba istaknuti da su Riječani iznadprosječno zadovoljni svojim životom te da je njihov osjećaj dobrobiti prilično visok.

Ispitujući različite sociodemografske pokazatelje, identificirane su **skupine građana koje imaju povećan rizik** od nastanka problema vezanih uz mentalno zdravlje.

Najrizičnije skupine građana Rijeke su osobe s trajnim oštećenjem zdravlja (osobe s invaliditetom), osobe s izraženijim tjelesnim simptomima i senzacijama, te osobe s ispodprosječnim mjesečnim prihodima kućanstva.

Conclusion

Based on the research conducted on the **indicators of mental disorders and mental health,** it is safe to say that the mental health of the citizens of Rijeka is generally satisfactory.

On average, depression among the citizens of Rijeka is relatively low. However, it should be pointed out that 11.3% of citizens feel moderately or very depressed.

Anxiety is generally experienced relatively rarely, but it is important to say that 4.7% of the citizens of Rijeka often feel anxious.

The citizens of Rijeka rarely feel lonely, but 11.9% of the citizens sometimes experience problems of loneliness.

Over the past twelve months the citizens of Rijeka experienced on average four stressful life events. The most common were stressful events of lower intensity, such as going on holiday, Christmas, a minor mortgage or loan, and similar. Among the most intensive stressful events, a relatively large number of the citizens of Rijeka experienced a separation from their spouse (i.e. 8.8% of citizens), a death of a close family member (i.e. 12.5% of citizens) and major injuries or illness (i.e. 11.2% of citizens).

Although the experience of stress among the citizens of Rijeka is moderate, it is frequently experienced by 6.4% of citizens.

Fortunately, the citizens have a relatively high perception of social support from their friends, family and colleagues, which is one of the most significant protective factors against the detrimental effects of stress.

Furthermore, the self-esteem of our citizens is also above average, as is their optimism.

In conclusion, it is important to point out that the life satisfaction among the citizens of Rijeka is above average, and their feeling of well-being is quite high.

The risk groups of citizens who are more prone to problems related to mental health have been identified while examining various socio-demographic indicators.

The most endangered groups of citizens are persons with permanent health damage (i.e. disabled persons), persons with more prominent

Također, rizične su skupine građana koje žive na pojednim gradskim područjima i to posebno na području prostornih cjelina Sušačkoga područja i Sušačke drage-Sv.Kuzma, a kao samo nešto manje rizični oni koji žive na području prostorne cjeline Podmurvice-Preluk.

Rizičnu skupinu predstavljaju i rastavljene osobe, a u nešto manjoj mjeri i udovci, odnosno udovice.

Kad se radi o dobi, općenito su najrizičnija dobna skupina najstarije osobe (75 godina i više), a ovisno o različitim indikatorima mentalnog zdravlja rizične su i neke druge dobne skupine. Tako npr. kada se radi o stresu, najrizičnije su osobe mlađe i srednje životne dobi. Srednju životnu dob karakteriziraju i povećana usamljenost i niže zadovoljstvo životom. Za depresivnost je uz najstariju životnu dob rizična i najmlađa životna dob (18-24 godine).

Žene su također rizična skupina za razvijanje nekih psihičkih problema, kao što su depresivnost i anksioznost.

Dosadašnje znanstvene spoznaje, kao i rezultati ovog istraživanja sugeriraju sljedeće **intervencije** za zaštitu i poboljšanje mentalnog zdravlja i prevenciju mentalnih poremećaja u gradu Rijeci:

1. Podići razinu pružanja usluga zaštite mentalnog zdravlja na području grada Rijeke i u kvantitativnom i kvalitativnom smislu (zdravstvene ustanove, savjetovališta, krizni telefoni, mobilni tim stručnjaka, itd.).
2. Poticati raznolike programe (npr. treninzi asertivnosti, grupe samopomoći, rekreativne aktivnosti – posebno brzo hodanje i trčanje, psihoedukacija i slično) kojima je cilj razvijanje i osnaživanje čimbenika koji štite mentalno zdravlje građana (npr. vještine suočavanja sa stresom, vještine pridobivanja socijalne podrške, razvijanje samopoštovanja itd.).
3. Zbog učestalosti i intenziteta doživljavanja, kao i prevencije ozbiljnih posljedica kojima mogu rezultirati (npr. samoubojstvo, zloporaba sredstava ovisnosti), Riječanima bi posebno trebalo omogućiti veću dostupnost različitim tretmanima i programima za redukciju anksioznosti, depresivnosti i usamljenosti te njihovih simptoma (psihološko savjetovanje, psihoterapijski tretmani, farmakoterapija, socijalizacijske aktivnosti, aerobne fizičke aktivnosti itd.).

physical symptoms and sensations, and those with below average household monthly income.

In addition, risk groups are also those living in certain areas of the city, in the area of Sušak and Sušačka draga-Sv.Kuzam in particular, and a just slightly less risky group are those living in the area of Podmurvice-Preluk. The divorcees are also a risk group, as are widowers and widows to an extent.

Concerning age, the most endangered group generally are the elderly (i.e. aged 75 and more), and depending on various mental health indicators, other age groups are at risk. For example, when it comes to stress, younger and middle aged persons are the most vulnerable. Middle-aged people experience more feelings of anxiety and less life satisfaction. Depression places the elderly, along with the youngest (i.e. 18 – 24 age group) among risk groups.

Women are also a risk group for developing some psychological problems, such as depression and anxiety.

The current scientific findings, as well as the findings of this research, suggest the following **interventions** for protecting and improving mental health and preventing of mental disorders in the city of Rijeka:

1. To improve the level of mental care service in the area of Rijeka, both quantitatively and qualitatively (e.g. health institutions, counselling centres, help lines, expert mobile team etc).
2. To support various programmes (e.g. assertiveness trainings, self-help groups, recreational activities – brisk walking and jogging in particular, psychoeducation etc) that aim at developing and reinforcing the factors that protect the mental health of citizens (e.g. stress coping skills, skills of attracting social support, developing self-esteem etc).
3. Due to the frequency and intensity of an experience, as well as the prevention of adverse consequences they can result in (e.g. suicide, abuse of addictive substances), the citizens of Rijeka should be provided with access to various treatments and programmes for anxiety, depression and loneliness reduction as well as their symptoms (e.g. psychological counselling, psychotherapeutic treatments, pharmacotherapy, social interaction activities, aerobic physical activities etc).

4. Pojedine rizične skupine građana Rijeke (npr. osobe s invaliditetom, starije osobe itd.) trebalo bi motivirati za uključivanje u specifične programe prevencije mentalnog zdravlja i tretmane mentalnih poremećaja.
5. Informirati građanstvo koji su im programi i usluge za zaštitu mentalnog zdravlja trenutno dostupni u gradu Rijeci.
6. Nastojati ukloniti barijere za traženje i nalaženje pomoći u slučaju psiholoških problema (npr. neznanje, nepovjerenje, strah, predrasude, financijski razlozi, nedostupnost zdravstvenih ustanova i programa za zaštitu mentalnog zdravlja, stigma psihički bolesne osobe i slično).
7. Podići svijest nositelja lokalne političke vlasti o rizičnim faktorima za mentalno zdravlje na koje lokalna zajednica može djelovati i upoznati ih s važnošću mentalnog zdravlja građana za cjelokupnu zajednicu i važnošću njegova sustavnog praćenja.
8. Političkim, ekonomskim i drugim mjerama umanjiti rizične socijalne faktore (npr. niski prihodi, loše obrazovanje, nemogućnost rada, određeni stresni životni događaji itd.) na koje lokalna zajednica može djelovati, a koji su povezani s mentalnim zdravljem.
9. Omogućiti zapošljavanje stručnjaka za mentalno zdravlje i mentalne poremećaje (posebice u odgojno-obrazovne ustanove i ustanove na razini primarne zdravstvene zaštite).
10. Trajno pružati pomoć u stručnom usavršavanju stručnjacima koji se bave mentalnim zdravljem.

Istraživanjem je stvorena i početna **baza podataka** kao osnova za buduća istraživanja s ciljem **sustavnog praćenja mentalnog zdravlja** građana grada Rijeke i evaluacije mjera koje bi Grad Rijeka, posebice Odjel gradske uprave za zdravstvo i socijalnu skrb trebao poduzeti radi njegove zaštite i poboljšanja.

Neke od mogućih implikacija rezultata ovoga istraživanja mogle bi biti u području kreiranja političkih kampanja, praćenja efikasnosti pojedinih političkih opcija u unapređenju kvalitete života građana, te kod stvaranja i održavanja percepcije o gradu Rijeci kao mjestu poželjnom za život.

4. Certain risk groups of the citizens of Rijeka (e.g. disabled persons, the elderly etc) should be motivated to take part in specific programmes of mental health and prevention of mental disorders.
5. To inform the public of programmes and services for mental health protection currently available in the city of Rijeka.
6. To make an effort in removing all obstacles for finding and receiving help in the case of a psychological problem (i.e. lack of awareness, mistrust, fear, prejudice, financial reasons, the inaccessibility of health institutions and programmes for mental health protection, the stigma of a mentally ill person, and similar).
7. To raise awareness of the local government to the risk factors of mental health which the local community can affect and of the importance the mental health of the citizens has for the entire community, as well as the need for its regular monitoring.
8. To use political, economic and other measures to reduce risk social factors (e.g. low income, poor education, inability to work, certain stressful life events etc) which the local community can affect, and are connected to mental health.
9. To enable hiring experts in the mental health and mental disorders field (i.e. especially in educational institutions and the institutions of primary health care).
10. To permanently promote professional education of the experts in mental health.

This research has created a preliminary **database**, as starting point for future research in order to **continuously monitor the mental health** of the citizens of Rijeka and evaluate the measures that the City of Rijeka, the Department of Health and Social Welfare in particular, should undertake in order to protect it and improve it further.

The findings of this research could have possible implications for creating political campaigns, as monitoring the efficiency of certain political options for promoting the quality of lifestyle the citizens enjoy, and for creating and maintaining an image of Rijeka as a city that is appealing to live in.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