MARIA LEPPÄKARI

Contesting spiritual dimensions of health

Salutogenic approaches to post-secular quests for quality of life[1]

Introduction

This article dwells on three key concepts: *spirituality* (religion, meaning making), *health* (being well, wellness) and the *contemporary post-secular individual search for significance*. Within a classic salutogenic and health promotional frame of reference, dimensions of health are usually referred to in terms of the physical, mental, social and spiritual. Following development of the classical approaches, cultural, ecological and existential subcategories have been added to the concepts in order to clarify the contents. Scholars in the field of health promotion argue that these dimensions of health and well-being are, in a general way, closely interrelated (Lindström & Eriksson 2006, 2010). This article explores the ways in which spirituality and well-being interact. It is influenced by the author's previous research in religious studies and current experiences of health promotion work. This article is divided into five sections: salutogenesis and health promotion; quality of life and spirituality; previous research on religion and health; indifference and fundamentalism, and some final remarks.

Quests for obtaining a good quality of life and strivings towards meaningfulness in everyday life could perhaps be considered to be a reflection of a contemporary and perhaps, a rediscovered, popularity of meaning-searching and spirituality in Finnish society. My aim here is to clarify some perspectives on the spiritual dimensions of health, as it is understood to be the fourth dimension of health within salutogenic settings and how this in turn stands in relation to the phenomenon we call religion. This article is an invitation to join me in my academic adventure. It is an attempt to make use of health

1 Special thanks to Folkhälsan Research Centre and the Programme for Health Promotion for their generous financial support and belief in the importance of the 'spiritual dimensions of health'.

promotional definitions, and simultaneously shed light on aspects of contemporary spirituality; that is, to study the way spirituality is perceived in expression and practice; the ways people refer to spirituality when they talk about and refer to 'meaning' or 'significance' in life. Since this project is at its port of embarkation, this article dwells purely on theoretical aspects, and no empirical studies are yet being included.

Contemporary life management is affected by stressful environments, unlimited awareness, constant inputs and tiredness that very often contributes to an increased sense of emptiness and lost meaning. The responses to societal stress factors are, naturally, managed by individuals in several different ways. Some individuals choose to downshift at work, some seek help in pharmacies or healthier food, some practice body-shaping, while others engage in environmental and political activities and still others search for guidance and significance from life coaches and management gurus. Yet, some tend to turn towards traditional religiosity, or towards alternatives to it such as alternative religious movements and spiritual trends, mindfulness or yoga. Some, perhaps, feel better when simply redecorating their house and garden according to the principles of *feng shui*.

Here theoretical bridges are constructed in order to broaden an interdisciplinary understanding of the subject of the relationship between health, well-being, quality of life and religion, an old and well-known symbiosis of religion and health. Challenges here are met by emphasising the *salutogenic* understanding of some of the processes taking place when people in their own life contexts create meaning while 'making sense of a sense of coherence'.

The search for physical and mental well-being is but one example of how health and spirituality may interact. In this article I attempt to outline some theoretical parameters for rediscovering the fourth dimension of health, as defined by Aaron Antonovsky in light of Kenneth Pargament's understanding of religion, and Antoon Geels's perspectives on contemporary spirituality. Health, or well-being refers here particularly to how people today construct significance and how they define a good quality being achieved in their personal lives. It is worth noting that when I refer to 'quality of life' it is not simply a matter of glamour, monetary success and happiness; rather it is to be understood as a concept which describes the efforts made by individuals in their searches for personal significance, enabling themselves to see the bright sides of life, even when dwelling in an ostensibly miserable life condition and sickness. And that is the key to *salutogenesis*.

Salutogenesis and health promotion

Salutogenesis was the first model systematically to explore health in terms of development towards the health end of the health continuum, also known as the unhealth continuum (Antonovsky 1979, 1987). *Salus* comes from the Latin word 'health', and *genesis* from the Greek for 'origin', meaning nothing more than the *origin of health*. Conceptually, salutogenesis is defined as 'the process of movement toward the health end of a health-ease/disease continuum' (Antonovsky 1993, quoted in Lindström & Eriksson 2010: 18). This theoretical model, focusing on resources for health and processes for health promotion, later came to be connected with global health promotion work. The revolutionary idea was presented in Aaron Antonovsky's book entitled the *Mystery of Health*, where he turned his medical research on pathogenic diseases upside down, and started emphasising strength in wellness.

Aaron Antonovsky was an American-Israeli medical sociologist especially interested in stress and coping theory in the 1960s. When looking at some of the outcomes of his statistical data on epidemiological research into the female menopause in the 1970s, he posed the question: 'What creates health?' The origin of Antonovsky's ideas on salutogenesis derived from interviews he conducted with Israeli women who had experienced the concentration camps of the Second World War, and who in spite of their harsh life experiences managed to stay healthy.

To get a grasp of salutogenic perspectives, one needs to look back in history and understand the context of modern public health. Health promotion has its roots in the period right after the Second World War, at the time of the foundation of the United Nations and the Declaration of Human Rights. The World Health Organization (WHO) was assigned a mission to defend human rights, from the perspective of health. Perhaps the most well known definition of health is included in the WHO (World Health Organization) constitution, and still valid: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity' (Lindström 1994: 8). This original WHO definition of health is embedded in its own time and place, hence reflecting the outcomes of the post-World War II era and has since, of course, been developed. Nowadays the definitions of health also take into account more complex social and cultural perspectives. But the quote above is still the official definition being used.

Between the years 1948 and 1977 the WHO moved from a healthcare and health system approach towards a contextual population approach, which marked a huge shift in perspective. The first moves towards health promotion

were to be seen in the WHO global strategy *'Health for All' by the year 2000* (WHO 1981; Lindström & Eriksson 2010: 26; and for more recent development, see Vader 2006: 457).

The WHO vision to reduce inequity and foster sustainability with the aid of interdisciplinary and intersectoral approaches not only aimed towards 'adding years to life', but also 'adding life to years' with humans being 'active participating subjects in our own lives', according to the WHO Ottawa Charter (1986). This was a set of principles and values that inspired the global *health promotion movement*. The main objective of the overall process of health, according to the health promotion movement is to enable humans to live an active and productive life in terms of the Ottawa Charter.

Hence, good health came to be seen as a process through which people can learn to develop health through the control of health determinants, thereby giving all humans an equal opportunity to live an active and productive life. Grand-scale community approaches and health policies in order to achieve *a healthy society* became central to the WHO's global work while simultaneously striving for equity for all humans.

In the 1980s Antonovsky set out forming his new theoretical framework for health, known as *salutogenesis* and within this framework lies its key concept, known as a 'sense of coherence', simply shortened as SOC. Later on he constructed an instrument to measure the phenomenon; the 'orientation to life questionnaire'. Here I will, however, due to limited scope, not go into the details of that. It can shortly be stated that Antonovsky's legacy to health promotion is not only limited to empirical questionnaires; as Antonovsky himself points out, using the SOC scale is not the same as being guided by the SOC vision (Kickbush 1996: 6). According to Bengt Lindström and Monica Eriksson, the SOC theory emphasises the fact that humans have the capacity to cope with and even to improve their health through their own choices, depending on the way they interpret and view their lives.

> Antonovsky introduced his salutogenic theory of a 'sense of coherence' as a global orientation to view the world, claiming that the way people view their lives has a positive influence on their health. A sense of coherence explains why people in stressful situations stay well and even are able to improve their health. (Lindström & Eriksson 2006: 238.)

The central key concept of the salutogenic theory then is this 'sense of coherence' (SOC), defined according to Antonovsky (1987: 19) in the following way:

> . . .a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement. (Antonovsky 1987: 19; cf. Lindström & Eriksson 2006: 241.)

Usually the salutogenic theory is referred to in a slightly more compact way. It is sub-categorised into three themes (or dimensions) in life: a) *comprehensibility*, b) *manageability,* and c) *meaningfulness*. Within these dimensions humans manage to view their lives as coherent, comprehensible, manageable and meaningful. A person's health assets enable him or her to achieve inner personal reassurance, trust and the confidence to identify one's own resources within oneself and in one's immediate environment. We could call it a capability of emotional recycling of health determinants, to be able to reuse one's own abilities and assets, and to create new ones as life goes on. Especially, meaningfulness, the third dimension of SOC, includes a perspective that can be called a life orientation; *a meaningful way of life*. Though SOC has mostly been used as an evidence-based measurement instrument, it has become a philosophy. It stands for a salutogenic way of thinking, a way of being, and it involves a dimension of action (at least to some degree).

Another important concept within the salutogenic framework is the 'generalised resistance resources' (GRRs), which provide the prerequisites for the development of SOC. These resources are found within people as resources bound to person and capacity, but also in both immediate and more removed environments, with both material and non-material qualities. According to measurement, at least four of the GRRs have to be at one's disposal in order to facilitate the development of a strong SOC. These would be for example, meaningful activities, existential thoughts, contact with one's inner feelings and social relations. The key issue of connectedness here is not only to have these abilities at one's disposal but to actually make use of them. (Antonovsky 1979, 1987; cf. Lindstöm & Eriksson 2010: 20 and 2006: 241).

As mentioned earlier, in the WHO constitution a new declaration of health was introduced: 'health is not only the absence of disease and infirmity but a state of complete well-being in a physical, mental and social meaning' (United Nations Department of Public Information, 1948 in Lindström & Eriksson 2006: 239). A shift of focus from a strict medical orientation on health towards the subjective well-being of the population resulted in a holis-

tic perspective on health, thus including *physical, mental* and *social* perspectives. Idealistically, it did so much in concordance with the general optimism during that time period. In 1987 a fourth dimension was introduced; *spiritual* well-being (Lindström & Eriksson 2006: 239; cf. Vader 2006: 457), perfect in its timing, and in accordance with Antonovsky's original set of the four dimensions of health.

Research on health promotion (HP) can be essayed from several academic angles. According to Lindström and Eriksson (2010: 28) these might include a philosophical point of view; a biomedical or a pathogenic approach, focusing on the elimination of risks associated with diseases, or when given a salutogenic perspective, health promotion can be studied and achieved through specific processes that become outcomes when focusing on the resources for health as suggested within the salutogenic framework. Antonovsky perhaps did not originally intend SOC as a philosophical reference. Nowadays, however, in the practical interpretations and implementations of HP, where Antonovsky's theoretical research frames are being applied as a reference, the salutogenic setting has become an operational platform for Scandinavian Health Promotion (HP) work.

Health promotion is to be understood then as a continuous or ongoing long-term process throughout life, with a focus on the resources for health (i.e. assets or health determinants) enabling humans to gain control and make use of their resources in order to improve (empower) their well-being, to enable them to live an active and productive life. And when all this is placed within the *salutogenic context* it sums up what is meant by the aspiration to 'enjoy a good quality of life' (cf. Lindström & Eriksson 2010: 28–9; Lindström 1994: 11). At a first glance HP may give the reader an impression of utopian expectations for some futuristic perfect world, but when taken into praxis it can actually—with small efforts—generate well-being on a social communal level, and on an individual level.

The relationship between spirituality and health promotion is complicated. Jean-Paul Vader, for example, has noticed the absence of the *spiritual dimension* in the public discourse of HP in Europe, and writes that

> . . .with the exception of end-of-life interventions, this dimension [spiritual] is almost totally absent from discussions of public health and health promotion in Europe, whether it be in the discourse of public health professionals or policy-makers (Vader 2006: 457; cf. Melder 2011: 18).

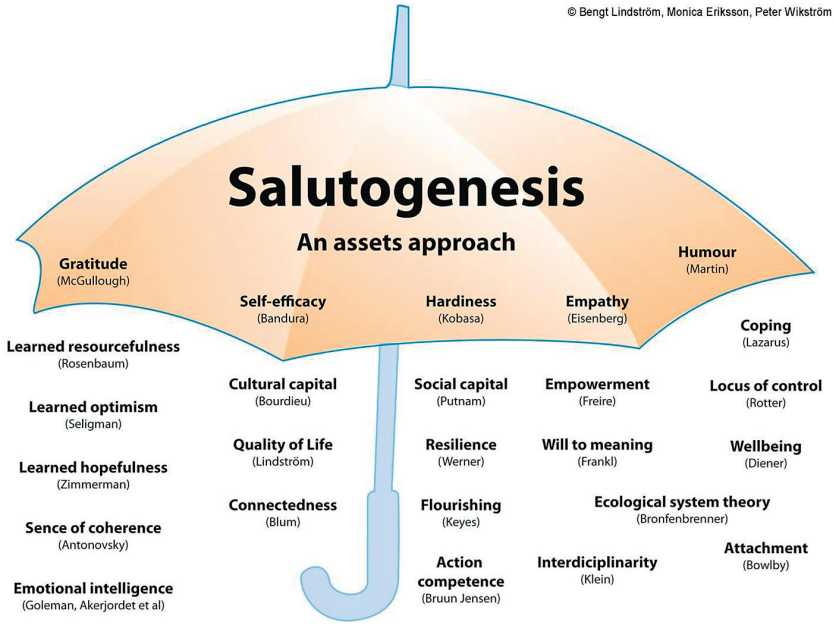

Figure 1. This image shows different theoretical models for achieving salutogenic perspectives (Lindström & Eriksson 2010: 55).

When SOC is being contextualised and reformulated, for example, into social working environments, team-building efforts and specific work tasks at community levels, it plays a significant role in relation to strict motivational factors. Therefore, from my own working experiences of HP in community fostering projects I find that perhaps the theory of salutogenesis still in a way falls within some thin shred of mystery. Perhaps its 'mystery' lies in its success in creating a bridge between humanistic and more philosophical values and the world of evidence focused medical and health paradigms. The question still remains, what is meant by spirituality within health promotion?

To summarise, *salutogenesis* represents a globally orientated view of the world, and it claims that the way people view their lives has a positive influence on their health. Aaron Antonovsky's theory of a *sense of coherence* (SOC) represents comprehensibility, manageability and meaningfulness. It is an explanation as to why people in stressful situations can manage to stay well and even be able to improve their health, and they do so because they feel that they live a meaningful life. *Health promotion* is a process that enables people to increase control over, and to improve their health. It thereby enables people

to live an active and productive life, with well-being and quality of life as their ultimate goals.

Quality of life and spirituality

People seek to fill what is perceived as emptiness in life with more content. Rephrased, people are searching for quality in their lives. 'Quality of life' (QoL) then, is understood to be the implicit outcome of the health process itself. And quality, as such, is always related to a value judgment. The concept, *quality of life* (QoL) is generally associated with positive values such as happiness, success, wealth, health and satisfaction. It signifies a characteristic, that of an exquisite standard (Lindström 1994: 19). Whether we speak of a capacity that can be perceived through collective or individual senses of values, or simply progress of welfare or wealth, it all adds up within the central values of our lives. *Life*, according to Bengt Lindström, as we perceive it through our five senses, is defined as the period of time between birth and death. In its most reduced form, life is only the passage between these two end points. A minimum of life would then provide only survival (Lindström 1994: 20). Everything that is added to survival might then be considered as a bonus in life.

Scholars are trained in critical thinking and just love to analyse things into their constituent parts, re-construct them and ultimately construct defini-

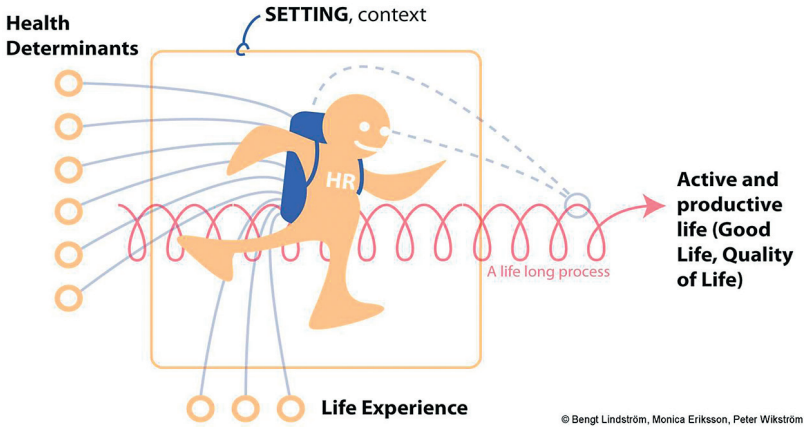

Figure 2. An illustration of how quality of life is the outcome of the health process (Lindström & Eriksson 2010: 27).

tions. We need to do this in order to create our own working tools when analysing what we see and what we think is happening around us. A traditional way of looking at things is to systematise things, and for that we need to create the categories in which to place information. The same applies with religion. The word 'religion' originated from the Latin word *religio* and it is much debated whether it originally meant reverence towards the gods or *re-ligare;* to reconnect, or some ancient monastic order. It naturally depends on who you ask; Cicero, St Augustine or Lactantius.

Social scientists tend to avoid dealing with substantial parts of religion (Hood 2003: 242–3), while psychologists of religion tend to be more interested in the question 'what makes religion tick?' Kenneth Pargament, a psychologist of religion among many others, has chosen to define religion as 'a process, a search for significance in ways related to the sacred' (Pargament 1997a: 32). What makes this complicated is that both the categories 'religion' and 'sacred' fall into problematic ontological discourses. Pargament's argument goes, on one hand, as follows:

> The religious world wraps its *search for significance* in higher powers: deities; ultimacy; and the beliefs, experiences, rituals and institutions associated [by humans] with these transcendent forces. People are called religious when the sacred is part of their deepest values and when the sacred is involved in the way they build, maintain and change these values. (Pargament 1996: 216, my italics; cf. Leppäkari 2006: 15.)

Or to put it more simply: 'significance includes life's ultimate concerns—death, tragedy, inequity' (Pargament 1997: 31). We may consider the term 'religion' to be complicated and complex as it gathers people and provides meaning for individuals, groups, and nations. Throughout the ages, culture intertwined with religion has shaped our ways of thought and still continues to do so. 'Religion' does not fit into a simple scheme; it gives even the scholar the impression that it is like an organism sometimes living its own life within a group or person. Naturally, we find organised systems of thought and practices within religion, but religious life does not always fit into our predesigned schemes and norms. Religion is subject to change. We can witness how 'worldviews' and 'spiritualities' tend towards something which is considered to be existential thinking.

How should we then define 'spirituality' in the present context? Does spirituality matter, and if it matters, what is it good for? Being successful, happy and healthy in our society are typically characterised as the standards for

quality of life. Perhaps it is descriptive of a utopian dream of success. The sum of a happy and meaningful life is always individual. Very often it equals the values that we attribute to the fruits that we have collected during a lifetime. These values are naturally personal and embedded in our historical contexts; families, upbringings, education and so forth. But they are also personal narratives of success in life, work and emotional efforts, property, family, a sense of happiness and contentment, ease, and so forth. If life's fruits do not appeal to us, we consequently feel unhappy, unsuccessful and perhaps lack the energy to deal with our feelings of inadequacy. The individual experience of inadequacy may, as we know from various studies, during hard times lead to sorrow. In situations such as this we humans long for significance, a sense of happiness, a situation where we may be confident and at ease.

The various means by which people confront dis-ease (the word does not necessary mean sickness, but includes discontentment) in life is, as previously pointed out, individual and context-bound. Yet, simultaneously there are of course various options to choose from in handling such situations: medications, therapies, existential meaning seeking, turning towards institutionalised or new religions, simply by changing lifestyle, cognitive behaviour, or priorities in life, just to mention a few possibilities. They all offer ways of resolving the situation at hand for humans seeking ease and meaning to life.

In his critical analysis of contemporary society Antoon Geels (2007) describes how postmodern pluralism has contributed to a sense of 'existential uncertainty', something that many of our contemporaries seem to suffer from. We humans have, according to Geels, more or less lost our ability to make and ask meaning-creating questions. This in turn, has led to a deficiency of meaning-creating symbols and is accompanied by enclosed norm superficiality.

Some reflections on previous research into religion and health

Religion and spirituality are multifaceted, overlapping constructs whose specific definitions remain a subject of debate. However, there is some agreement about the general outlines and boundaries of these terms (Palante & Sherman 2001: 7). Both religiousness and spirituality can be seen as reflecting 'the feelings, thoughts, experiences, and behaviours that arise from a search for the sacred' (cf. Palante & Sherman 2001: 7–8). Perhaps some people would prefer to use the word 'transcendence' here instead.

Among the innumerable challenges of studying religion and health, one of the most fundamental problems concerns definitions. Religiousness and

spirituality are, according to Thomas G. Palante and Allen C. Sherman, complex, multidimensional constructs. 'Despite more than a century of research and theoretical work devoted to religion, there is no simple single or widely accepted definition' (Palante & Sherman 2001: 5).

Palante and Sherman use the word 'spirituality' to refer to personal concerns with the transcendent—with something sacred, ultimate, or beyond superficial appearance. Spirituality, then, may or may not be embedded in a formal, established religious tradition. 'Religious', 'religiousness', 'religious orientation' and 'religious involvement' are concepts being used synonymously to refer to both the personal and social (including institutional) aspects of engagement with an established faith tradition. Relative to these broad terms, Palante and Sherman use 'religious' or 'spiritual coping' more specifically to designate particular effort when, for example, managing the demands of a specific challenging situation (e.g. a diagnosis of heart disease, coronary artery bypass surgery; Palante & Sherman 2001: 8).

Concerning the future challenges of research on faith and health, Palante and Sherman do actually point towards the potential of salutogenic approaches, arguing that traditional 'pathogenic' approaches to research on religion and health, which emphasise risk reduction, should be complemented by a salutogenic perspective. The interface between religion, spirituality, and health is an extraordinarily rich area for academic investigation. For many, a concern with the sacred or transcendent goes to the heart of what it means to be human. Health professionals also indicate that research results show that a spiritual or religious life may have implications for mental and physical well-being. To explore the meanings, magnitudes and mechanisms for these connections is still a major challenge.

While pointing towards the potentials of salutogenic approaches, Palante and Sherman underline Jeffrey S. Levin's argument in his article 'How religion influences morbidity and mortality and health: Reflections on natural history, salutogenesis, and host resistance':

> . . .that traditional 'pathogenic' approaches to research on religion and health, which emphasizs risk reduction, should be complemented by a 'salutogenic' perspective, which focuses on health promotion and wellness. The factors involved in promoting health and wellness are not necessarily the same as those involved in reducing risk (e.g., Antonovsky 1987; Benyamini Idler, Leventhal & Leventhal 2000). (Palante & Sherman 2001: 393.)

Jeffrey S. Levin's call for greater sensitivity to the salutary effects of faith is consistent with the growing emphasis on 'positive psychology' (e.g. optimism, wisdom, creativity) that is emerging in other fields of research (Palante & Sherman 2001: 393).

It does not come as a surprise that most academics do not feel comfortable using the word 'spiritual health'. Speaking of 'spiritual health' does not fit in well. There are, however, several studies that indicate the relevance of an existential meaning-creating dimension, but there is no space for going into detail here. John-Paul Vader, for example, writes in the *European Journal of Public Health* that belief in and a commitment to the transcendental and the metaphysical (due to their intimate connection to the very sense and purpose of existence) is probably the most powerful motivator of human behaviour and behaviour change known today (Vader 2006: 457). This intimacy with the transcendent may come with positive and constructive benefits, but it may also have negative and destructive qualities with unsettling consequences (Leppäkari 2008: 106–12). David Greenberg and Eliezer Witztum, for example, in their book *Sanity & Sanctity: Mental Health Work Among the Ultra-Orthodox in Jerusalem* (2001) have highlighted the role of psychiatric care and mental illness when understanding and dealing with religious points of view.

And yet further John-Paul Vader manages to formulate what for many is felt as an uncomfortable challenge, while simultaneously pointing out the risk of depriving empowering assets:

> By ignoring the spiritual dimension of health, for whatever reason, we may be depriving ourselves of the leverage we need to help empower individuals and populations to achieve improved physical, social, and mental health. Indeed, unless and until we do seriously address the question – however difficult or uncomfortable it may be – substantial and sustainable improvements in physical, social, and mental health, and reductions in the health gradient within and between societies, may well continue to elude us. (Vader 2006: 457; cf. Melder 2011: 18.)

In the Scandinavian context during the last decade the existential dimension in healthcare has gained importance. Two of the most recent contributions to the topic are, first, the doctoral dissertation by Cecilia Melder, who has studied how the existential dimension of health, understood as the ability to create and maintain a functional meaning-makins system, affects the person's self-related health and quality of life (Melder 2011). Her study showd a posi-

tive outcome (see Melder, in this volume). Health dimensions are, according to Melder, referred to as the physical, mental, social, ecological and existential (Melder 2011). The second example is Maria Liljas Stålhandske's study of women's existential experiences within Swedish abortion care (Stålhandske *et al*. 2011: 1–7). Based on her research, Stålhandske makes a call for including existential dimensions in the healthcare sector. She has indicated that the existential dimension bears significant relation to health assets and is connected to an individual's meaning-searching processes and well-being.

To summarise, *spirituality* then can refer to personal concerns with the transcendent—with something 'sacred', ultimate or beyond superficial appearance. It may, or it may not be embedded in a formal, established religious tradition (cf. Palante & Sherman 2001: 8). Yet at the same time it points towards matters that are closely connected with humans' search for meaning—which we have always done—in order to achieve a sense of meaningfulness in life. For this there is no need for 'religiosity', in terms of the words' connotations of a transcendent agency, or forces of ultimate concerns.

Somewhere in-between indifference and fundamentalism

In my previous research within the field of religious studies I have traced and accounted for the dissemination, reinvention and mutation of religious ideas and representations (Leppäkari 2006, 2008), with particular focus on popular, present-day fundamentalism, which might be rephrased more exactly as non-holistic and exclusive interpretations of religious settings (and agencies) with a specific interess in Jerusalem as an apocalyptic-millenarian symbol. The outcome of my research outlines that things are not simply created in a vacuum. Images of a religious individual playing an active part in apocalyptic settings are constructed through a network of engagement and dialogue with others.

The myth of the apocalypse contributes to a holistic image of the world where the individual end-of-time adherent is convinced that she or he has an active role and plays an important part in the working out of the world's destiny and mankind's redemption. Those who are not embedded in religious dualism do perhaps live in a fragmented world. At least, when viewed by an 'insider' of a religious uncompromising fundamentalist community, most 'others' may seem to lack a common value system of meaning (cf. Geels 2007). A decline in commonly held cultural values, if seen as a decline in the value monopoly, would open up markets and opportunities for new values. In 2011,

when writing this, there is a market, including both supply and demand, for products meant to cure peoples' sense of meaninglessness and emptiness. It is here that we get into specific questions related to spirituality and well-being.

Indifference has an antithesis, and it is called fundamentalism. Fundamentalism, which is popularly in the news media attributed with naive and simplistic values, can also be described as a meaningful system that makes it possible for individuals and groups to endure, to feel able to create meaning, significance, and a sense of belonging in a world that is perceived as hostile. Existence between these two extreme poles between indifference and fundamentalism marks the gray zone of reality, the world that we currently live in.

A fundamentalist literalist stance usually creates order in a chaotic environment. But it may also cause anxiety. It is not uncommon that the thought of going astray from what is perceived as the 'right religious track' becomes unbearable and a situation loaded with fear. Dystopias and religious images of the end of the world can raise existential fear. Representations of the end-times, destruction of the world and eternal condemnation can unleash emotionally charged both intra- and interpersonal conflicts that give rise to anxiety (Leppäkari 2008: 109). Therefore, with religious fundamentalism, as with religion in general, there are at least two perspectives to take into consideration—empowering functions and anxiety factors. Furthermore, as religion can be understood as having an emancipatory power, it also has its limits (Dillon 2010: 153).

When the market for products that generate meaning and significance is strong, there is also a lot to pick and choose between. Alternatives exist, and many of these alternatives have come to be seen somewhat as substitutes for traditional, institutionalised religiosity. There is an open market and a need for spirituality. If you got it, there are several others ready and waiting to get it too. Nowadays it is housebroken (*rumsrent*) to talk about 'spirituality' in existential contexts, without feeling it to be an obligation or necessary to associate the word predominantly with a Christian—specifically Protestant—presetting. Scholars of religion and theologians have, I would dare to argue, come over the word's connotations to its Christian heritage that most of the older generation of scholars in religious and cultural studies very much objected to. The concept of *spirituality* can then be used in order to describe an attitude of individuals who express a sense of longing, striving for an inner sense of peace. Spirituality stands for a holistic life orientation within the lifelong learning process of fabricating one's own significances.

With all this spiritual stuff in mind we need also to take a closer look at the word 'secular', originating from the Latin word *saeculum* meaning a cen-

tury or age. Hypothetically, therefore, people who are in the *saeculum*, can be seen as being embedded in ordinary time as in opposition to a religious time (Taylor 2007: 54–5). When the word 'secular' is being used as it commonly is in opposition or antithesis to religion, it is in order to make a clear standpoint more or less saying: 'this is not connected to (institutionalised) religious practices or systems of belies'. This is a discussion that is embedded in a macro-social discussion of the Western religious landscape, which currently is the subject of much debate (cf. Habermas 2008, Dillon 2010) and referring to an increasing public visibility of religion and religious actors while being central to the recently developed concept of the 'post-secular'. Scholars argue that the concept itself remains in need of further clarification. To keep things simple here, 'post-secular' is an academic construction, which from my perspective simply describes the way I am here referring to world-views in between the above-mentioned two poles of the extremes marking the grey area somewhere between indifference and fundamentalism.

The present-day relationship between religion and consumer culture can, according to Moberg and Granholm, be seen as contributing to an increased general visibility of religion throughout Western social and cultural life in general. Their critical remarks on scholarly talk and theorising about the 'post-secular' as 'discourses critical of earlier hegemonic secularist discourses that present religion as a negative social force' (Moberg & Granholm 2012) definitely adds some fuel to further study of that specific topic.

Contesting spirituality in post-secular settings

What has been referred to here as spiritual health is, in other words, attached to lifelong learning processes and humans' search for significance, well-being, and quality of life. This is nothing new; it is something people have done through the ages. My critique of the 'secularity and post-secularity discourse' is simple: 'religion' did not disappear anywhere. It has been alive and kicking from its earliest days. Perhaps religion in its institutionalised forms in a postmodern secular European context has faced some criticism while its members take note of 'exhaustion' and search for significances in some alternative ways. But that does not really concern a scholar of religion, and it is not, I would dare to argue, any very upsetting news for the Scandinavian Lutheran or Orthodox clergy either. As Michele Dillon describes it, religion is not just about rational ideas; it also entails embodied experiences and emotions which need to be recognized as highly contested within and beyond

religious interpretive communities by recognizing the fluidity between religious and secular identities, worldviews and motivations (Dillon 2010: 153). An integration of religiously derived arguments and insights into the 'secular' public sphere is possible if we focus on 'alleviating the pathologies of our era' (Dillon 2010: 153).

There are quite numerous ways of looking at spirituality. I feel tempted, at least for my own use of the word, to distinguish between two ways of describing spirituality. The first 'type' could be called *spirituality as a religious experience*—that is to say the way it has become described in traditional western and/or *institutionalized forms of religion*. The second description would offer a perspective on *spirituality as an individual expression of an inner sense of significance and peace*. The latter is attached to what I have here tried to outline with the aid of salutogenic perspectives.

Spirituality needs not to be characterised as a 'religious experience' in the traditional (perhaps I would benefit from using the word 'popular' or 'secular' here) use of the word, but rather represents the perspective of an attitude towards how our contemporaries express their longing for an inner peace, spiced with a clear meaning creating function and motivation in their lives. Contentment in the moment and longing for inner peace can also be seen as the outcome of an exploration of one's inner feelings, attitudes, and the norms to be accounted for when searching for meaning and motives for actions. Contemporary spirituality should not be understood as a form of self-centred individuality. It is, rather, to be understood as an *attitude* towards, or an expression to which the individual reflects his or her self-image in the mirror that we call life.

Life is certainly unpredictable. As uncertainties and changes cross our life paths, seen from the salutogenic perspective, remaining in good spirits when facing all these challenges and illnesses that life comes with, the important thing is to be able to maintain making use of one's abilities and finding direction in life (Lindström & Eriksson 2010: 12). This means to be able to deal with chaos and uncertainty, whether it is perceived to be taking place on an individual, communal, or on a global scale.

When people talk about a search for personal significance that goes beyond our immediate senses (spiritual), and when a sense of stability appears (well-being) in what is felt to be a moment of chaos, when identified and felt as something worthwhile achieving (health), perhaps, then we come close to what could be meant by the 'spiritual dimension of health'. But due to our cultural heritage, even though use of the word 'spirituality' has become more and more widely accepted within the field of religious studies, I still would

perhaps prefer to replace the word 'spiritual health' with the more modern and to the general public more appealing 'existential health' simply because the word's positive connotation and accessibility in post-secular settings. The word 'spiritual' has, though, a more fashionable edge to it.

This perspective is new, at least for me, while being used to focus on end-of-the-world speculations, apocalyptic violence, death and strong dualistic prejudices. One way to shed new light on an old subject is simply to turn one's perspectives upside down: that is, not to focus on crisis and death, but rather to place one's academic focus on the positive side of life, and point out the positive health effects and assets that are created in the processes where our contemporary fellow humans search for significance. In such a way we can open up perspectives and find new ways to integrate existential dimensions as part of meaning-creating processes in both theory and in practical health promotion work. That is, if you are not fully prepared or convinced yet—to use the words 'spiritual health'.

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