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The epidemiology of lost meaning

A study in the psychology of religion and existential public health

Introduction

I would like to present the studies I carried out and results I gained as I completed my doctoral thesis on existential health, which is entitled 'The epidemiology of lost meaning: a study in the psychology of religion and existential public health in a Swedish context' (*Vilsenhetens epidemiologi. En religionspsykologisk studie i existentiell folkhälsa*, Melder 2011). I will also give a brief presentation of the interventions for people with psychiatric diseases that we conducted in Spring 2011.

The existential dimension of spirituality has proven to be of great importance over the last two decades when it comes to studies of self-rated health and quality of life. We see the positive effects it has on blood pressure, depression and life expectancy for chemotherapy and HIV patients, to mention just a few examples (DeMarinis 2008, Moreira-Almeida & Koenig 2006, O'Connell & Skevington 2010, Sawatzky *et al.* 2005). In the public health sector, it is interesting to note that this existential/spiritual dimension had already been present in the early years when the term public health first came into the Swedish language. In the year 1926 public health was defined as 'a people's physical and spiritual health' (*Svenska akademien* 1926: 1070). During the intervening years of major medical and scientific technical improvements in the field, the existential/spiritual perspective had been put aside, but now once again this dimension has come into focus (Vader 2006, Rutz 2006).

The World Health Organization (WHO) began its 'Health for All' strategy in 1977. At its conferences in Ottawa in 1986 and Sundsvall in 1991 attention was given to the need for supportive environments, including a spiritual dimension, as a key aspect of the third public health revolution (WHO 1986, 1991). One of the main factors in the work of creating an effective means of including the existential/spiritual dimension in the overall perspective on health has been to develop theories and methods that can be used for research

studies and therapeutic interventions which are aimed at developing an understanding of the conditions of existential/spiritual public health, and the potential for existential/spiritual epidemiology.

Professors Kathryn O'Connell and Suzann Skevington from the WHO Centre for the Study of Quality of Life at the University of Bath write, 'Although spirituality has been seen as irrelevant, or difficult to measure, a growing body of peer reviewed articles point to a positive and important relationship between spiritual beliefs and other domains of quality of life in health' (O'Connell & Skevington 2007: 77). Also, Professor Harold Koenig, Director of the Centre for Spirituality, Theology and Health at Duke University, North Carolina makes the following observations in an interview for the *Journal of Religion and Health*:

We need to design better studies. There is already a lot of evidence accumulating that religion is somehow related to personal and public health, but we're still left with a number of questions about how and why it works (if it indeed does positively affect health). We need more studies, better-designed studies, and we need more research funding in this area so we can conduct these studies. (Aten & Schenck 2007: 187.)

In *The Lancet* Professor Wolfgang Rutz describes the current public health status in Europe in this way, 'During this period of European transition, societal stress and loss of social cohesion and spiritual values directly affect patterns of morbidity and mortality' (Rutz 2004: 1652). Professor Jean-Paul Vader claims that we need to address the spiritual dimension. In his editorial for the *European Journal of Public Health* 2006 Vader writes:

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 and 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: 467.)

It is against this background that it is of importance to study the existential/spiritual dimension in relation to self-rated health and life quality in Sweden. Sweden is known as a country with a highly developed privatisation of the

meaning-making arena related to spirituality, religion, and personal beliefs. Sweden is a country with a very high number of members in the Church of Sweden and with many turning to the Church for their children's baptisms, for marriage, and for funerals. Yet at the same time many of these people do not believe that the Church's theology can be of use in creating meaning in their everyday lives. In many studies, for example the World Values Survey (WVS), Sweden stands out (Inglehart & Baker 2000, Pettersson 2006). With that in mind when we examine public health reports from Sweden, we see that there is a very healthy population in terms of infant mortality, smoking, rates of exercise, and longevity, but at the same time we have studies indicating that a high percentage of people report that they do not feel well. These results are partly from groups that do not normally fall into the health-risk category. We can see this profile in groups of young men and especially women with mental illnesses such as depression and anxiety. The statistics for these groups increasingly connect overweight and stress as well as an increase in the levels of pain being experienced (SKL: 2009). Rutz writes that:

If we look at the described community syndrome consisting of depression and aggression, addiction and violence, self-destruction and suicide, cardio and cerebrovascular diseases, accidents, risk-taking lifestyles, anomy and 'moral insanity', we can see how this is related to the factors we know today as the most important determinants of mental health, namely existential cohesion and ethical values, social interaction and capacity, helplessness and control, identity and dignity. (Rutz 2006: 99.)

The context of the secular situation is the way in which I prefer to talk about existential dimensions of health, rather than religious or spiritual dimensions. Existentialism is a wider concept that includes the religious and spiritual dimensions. It could also include a profane meaning-making system (excluding a supernatural power)—for example a political or philosophical perspective. This is my background, and in one way we could talk about a secular situation from which we could draw outlines for post-secular practice in relation to health-promoting dimensions. Not as a reconstruction, but rather as a construction of something new in developing definitions, methods and models for developing existential public health.

This thesis is based on three theoretical perspectives: 1) health related to an existential dimension as developed by the WHO and especially its 'Health for All' programme, 2) public health from the perspective of the psychology of religion, and 3) object-relations theory as presented by Donald Winnicott,

claiming that personal development is fundamental to the entire life cycle, and that religious and cultural activities could play a role in that development. It is an explorative study of the psychology of religion, through the perspective of existential public health, on an ethnic Swedish adult population's existential needs. I used a mixed-methods design, including semi-structured interviews ($N=5$), and surveys: 1) on meaning-making ($N=61$), and 2) a Swedish pilot translation of WHOQOL-SRPB (self-rated health and quality of life including spirituality, religiousness and personal beliefs), ($N=21$).

Central research question

How does the existential dimension of health, understood as a person's ability to create and maintain functional meaning-making systems, affect the person's self-rated health and quality of life?

Sub-questions

- What factors affect the existential dimension of health, self-rated health and self-rated quality of life?
- How do these factors interact with each other?
- Which of these factors have a supportive and which have a debilitating effect on the possibility of creating and maintaining the existential dimensions of health?
- Can these supportive and debilitating factors contribute to an existential public health intervention that can increase self-rated health and self-rated quality of life?

The study has been conducted in conjunction with a pilot programme, 'VVV', which has been investigating adult development in the parish of Vällingby, a suburb of Stockholm in Sweden. The programme was organised by the Church of Sweden. The purpose of the programme has been to create a locally-based programme for men and women of working ages, offering them the opportunity to develop a functional life-view of themselves and their environment, with the opportunity for developing their existential/spiritual dimension, in a programme which is based on a number of different life issues. These issues have included, but were not limited to; health and stress, life and work, and intimate relationships. The programme has included five different elements every semester. It has started with a lecture on the life issues to be covered for the season, followed by four different activities, in which each participant can choose to take part. These activities have included a day in silence for rest and recreation; a weekend with creative activities; a group for

existential/spiritual discussion with a focus on everyday life; and, a seminar about life issues viewed from the perspective of the Holy Bible and its context. All the activities have been focussed on the chosen life issues. The programme has given each participant the opportunity to take part in as many of the activities that they have wished. Over the first five semesters of this pilot project, when the material for this study was collected, participants had taken part in one the programme's activities a total of 756 times cumulatively, representing 246 individuals who had participated in the range of activities available.

Theory

The working theories and basic perspectives in this thesis are drawn from three areas: 1) health research with attention to the existential dimension, 2) public health from the perspective of the psychology of religion, and 3) object-relations theory.

Health with an existential dimension

Over the last couple of decades there has been an increasing interest in the existential/spiritual dimension in relation to self-rated health. A variety of definitions and methods have been used in these studies, for example, a consideration of the impact that participation in religious activities has on the health dimension; faith content and its impact on health; and, a third perspective, which I use here, the function of the existential/spiritual dimension's impact on health. The WHO has, from the beginning, pointed to the importance of a holistic perspective on health (WHO 2006: 1). In the work of 'Health for All' strategy the WHO developed the concept of a supportive environment which includes a variety of aspects, including the spiritual dimension, to increase health and life quality, 'Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction.' (WHO 1991.) The WHO has also presented models for developing public health programmes for increasing the supportiveness of environments. The supportive environments action model (SESAME), which is presented in the publication of the proceedings from the third international WHO conference held at Sundsvall in 1991 and can be used for planning and evaluating programmes, is one of them (Haglund 1996: 98). Along with other sources of inspiration from the third international WHO conference within the 'Health For All' programme, SESAME has been used in this study for a presentation

of the VVV programme and as a way of identifying important aspects to be developed in designing further existential health interventions.

WHO has developed a trans-cultural field-test instrument for measuring the function of the existential/spiritual dimension related to health and life quality: the WHOQOL-SRPB survey. This was a survey which originally included 100 items, relating to physical, mental, social and environmental health, carried out in 2002. It was supplemented, after a pilot study in 18 different countries and cultures around the world, with 32 items relating to the existential dimension (WHO 2002). Some scientists have criticised this instrument for measuring mental health instead of the religious/spiritual dimension. Others have pointed to the importance of developing a trans-cultural instrument, which could work in different religious cultures and environments. The instrument focuses on a person's health and life quality during the time period of the last two weeks and measures their spiritual, religious, and personal beliefs (SRPB) through eight different aspects: spiritual connection, meaning and purpose in life, the experience of awe and wonder, wholeness and integration, spiritual strength, inner peace, hope and optimism, and faith. In the worldwide pilot study which took in 5,087 persons, a significant relationship was found between the SRPB items and the overall self-rated health items, and also between the SRPB items and each of the different aspects of health. The greatest significance was found in the relation to the mental health dimension and the social health dimension. In a study of personal medical statistics, significance was found between self-rated health and the existential/spiritual dimension (WHOQOL-SRPB Group 2006: 1486). O'Connell and Skevington who conducted the WHOQOL-SRPB pilot study in the United Kingdom have also analysed the results in relation to belief characteristics including the strength of personal beliefs, practice, and religion. They found that, 'The importance ratings showed that all SRPB facets were important or very important to QoL overall, despite expected variations between beliefs groups' (O'Connell & Skevington 2010: 744). They have also reviewed and evaluated seven quality-of-life assessments. They found that apart from the WHOQOL-100, none of these instruments was designed for cross-cultural use in contexts where religion and spirituality may be particularly salient to health and well-being (O'Connell & Skevington 2007: 77, 85). Their conclusion is that WHOQOL-SRPB 'represents a new assessment frontier for investigations of positive health' (O'Connell & Skevington 2010: 744).

Public health from the perspective of the psychology of religion

In the field of the psychology of religion there is a long history of investigating perspectives related to health at individual, group, and community levels. There are many researchers today who define the time we are living in as being postmodern. It is not completely clear as to what the concept relates to and what it stands for (Ekedahl & Wiedel 2004: 9; Stålhandske 2005: 91). To some extent it can be related to the concept of secularism, which is also a complex phenomenon. However, the concept of postmodernism does include, for some researchers, two trends that to some extent work in opposing directions. One trend is that people tend to be more and more interested in aspects concerning the spiritual dimension of life, and another trend is that people tend to be less involved in traditional ways of expressing their religiosity, as, for example is evidenced in a decreasing participation in local church services (Pettersson 2006). These trends have been observed both in Sweden and internationally and have been reported in results from the World Values Survey (WVS) (Inglehart & Baker 2000, Pettersson 2006).

A postmodern situation, which presents the individual with too many choices, can lead to mental dysfunction if a person is unable to make a choice, unable to make meaning, affecting their ability to make life decisions (DeMarinis 2003: 29). Professor Valerie DeMarinis has shown that this could lead to chaos due to the loss of cultural and existential tools that could assist persons or groups in their meaning-making processes and, depending upon the extent of this phenomenon in a given cultural context, can constitute a threat to society: 'It is time for an alarm to sound that signals the start of an epidemiological warning: that of existential epidemiology' (DeMarinis 2006: 236). She has developed a cultural analysis model, an adaptation of Arthur Kleinman's model of the dimensions of culture, and has used it for analysing the existential health dimension in Sweden. The existential dimension is one among the physical, psychological, social and ecological dimensions, but also plays a special role for understanding perceptions of health in the way it interacts with the other dimensions (DeMarinis 2003: 44 f.).

Through a second model DeMarinis has, inspired by David Wulff's categories for the psychology of religion, constructed a world-view typology model for how different approaches to meaning-making systems can be understood, including both literal and symbolic world-view constructions of systems, with or without a foundation in transcendent belief (DeMarinis 2004: 163 f.). In the Swedish context she found it necessary to add two additional categories to the original model. One new category includes a mix of different systems for meaning making; for example being a Christian and

also attending Wicca ceremonies; and a second category for people lacking the capacity for constructing meaning, thus indicating a dysfunctional worldview function (DeMarinis 2008: 66).

Object-relations theory

My understanding of how the existential dimension is developed and maintained as a resource for health and life quality is related to one of the early psychoanalysts, Donald W. Winnicott. Winnicott focuses on a health perspective that includes both the psychological and somatic aspects of a person's growth. He emphasises the importance of play and its contribution to health and development. A child's play transforms in adulthood into forms of cultural and religious expression (Winnicott 1997: 77, 91). Human growth is an ongoing process for Winnicott, which starts at birth, if not earlier, and continues until death. Physical and psychological developments are two parts of the same process of development and are not separate entities (Winnicott 1991: 19, 33 f., 65 ff.). Life is complicated and the big issue is to handle the fact that the outer world and the inner world, with its fantasies, dreams, and wishes, will not be in harmony and that this will lead to problems and disappointments (Winnicott 1998: 132). The child's ability to play is crucial to the ability to develop and negotiate between these worlds. The negotiation between the inner, personal, psychological side and the outer, shared side takes place in a third area, a potential space for negotiation, the transitional space.

This transitional space is created through the relation a baby has to the person that has primary parenting responsibilities for the baby, called the mothering function. Through that person the baby creates the illusion that he/she is the same unit as the parenting function. The baby thinks he/she controls the world. The development of this illusion is based on a feeling so strong that it can be introjected into the small child's world. (Winnicott 1997: 36.) For Winnicott introjection—incorporating an attribute from the outer world and making it one's own—is an important process in creating the potential space in which play can contribute to processing the outer and inner worlds so that good-enough-health and growth can develop (Winnicott 1991: 156 f.). For the adult person different activities can work in promoting the transitional space; it could be religion, culture, and all kinds of different activities that have the same standards and safety frames that play has, as long as its purpose is to integrate inner and outer realities (Winnicott 1998: 148).

Method

Sample

A mixed-methods design, including two quantitative surveys and a qualitative, semi-structured, in-depth interview, has been used for this study. The 87 people that took part in the study were selected out of the entire VVV group. The group itself was not a group of marginalized persons and they could, from an overall perspective, be seen as representatives of a group of ethnic Swedish people of working age, from one of the older suburbs of Stockholm. Most of the participants had some type of secondary education and some also tertiary education. Most of the participants in VVV—about 80 per cent—were women and so also in the sample for this study.

The 61 people that answered the VVV instrument were people that attended the lecture that began the semester and which focussed on the theme of 'A Place of Respite'. A total of 89 people were asked to participate in the VVV survey and 61 returned the questionnaire. In the WHOQOL-SRPB Field-Test Instrument, 21 people were asked to participate in the survey and they all answered the questionnaire. This group consisted of all the participants of a weekend activity where creative activities such as painting, arts and crafts lectures, and discussions were included. The purpose of these activities was to help participants to develop a functional life view. Five people were strategically selected for the interviews. The strategic selection criteria were that they represented different spiritual/existential approaches to the VVV activity; they had different life situations and religious backgrounds; and they were representative of the age and gender of the overall VVV population.

Survey instrument and data analysis

The VVV surveys were designed for doing an inventory of demographic factors, factors about meaning-making in life and meaning-making rituals. The WHOQOL-SRPB was a Swedish translation of WHO's international instrument (presented above). The semi-structured interview was partially based on a drawing that the person did at the beginning of the interview with the instruction to: 'paint a lifeline/life journey'. The person then told her/his life story using the drawing and follow-up questions for clarification were posed. An interview area guideline was used for the rest of the interview. At three selection points in the life journey, retrospectively from childhood, 'three years ago', and at the time of the interview, the person marked on a scale provided if he/she included a higher (transcendent) dimension in the life journey, if it was a literal or symbolic interpretation, and if it was important or not for functioning in daily life.

In the analysis of the results from WHOQOL-SRPB the whole group was divided into smaller groups: three groups were formed out of the health and quality of life items, and three groups out of the SRPB items. The analyses were then conducted for these sub-groups. The data from the WHOQOL-SRPB and VVV instruments were analysed in the Statistical Package for the Social Sciences software (SPSS, Inc. Chicago, IL, USA, Version 12.0), for quantitative data-analysis.

The interviews were analysed first according to the themes derived from the physical, mental, social, environmental, and existential health dimensions. Further analysis of the existential dimension was done through DeMarini's six categories of meaning-making systems. In the next step I categorised the interviews out of the eight existential dimensions from WHOQOL-SRPB as dimensions of spirituality, religiousness, and personal belief, with attention to the function and meeting of existential needs. The interviews were analysed by means of the OpenCode 3.4 data-analysis programme (Umeå University 2010), a system developed for coding grounded theory-based data, but which worked well even for this form of more theory-driven qualitative data.

Results

The VVV survey

In the VVV survey 71 per cent of participants were between the ages of 36 and 55, and 81 per cent were women. A total of 74 per cent were working or studying and 12 per cent were on sick leave. Concerning the existential dimension, 72 per cent believed that spirituality was important or very important. There was a great variety of strategies employed in making meaning in their lives. A slight majority, 51 per cent, included a higher dimension, 33 per cent excluded it and 11 per cent didn't know. When people responded to what they use as a grounding system for their meaning-making, they combined a lot of different systems. Almost half, 47 per cent, responded that they used a Christian basis, but excluded any idea of a higher power, 62 per cent included a higher power, using a combination of different systems to make meaning in their lives. Only 19 per cent reported a single-tradition way of making meaning: these either had a non-spiritual/non-religious ground and didn't count on any higher power; or they counted on a higher power and had a spiritual/religious ground. The rest, 81 per cent, made their own combinations from a number of different meaning-making systems that sometimes were in direct contradiction with each other. Many of the responding persons

—70 per cent—created some kind of meaning-making activity on their own and 61 per cent did so in conjunction with others. Among the answers to the open-ended question about private-based activities, the four most frequent activities included meditation, prayer, conversations with friends, and being in nature. Among the examples of group-based activities, the four most frequent answers included meditation, worship, conversations with friends, and VVV-activities.

The WHOQOL-SRPB Field-Test Instrument

The Swedish pilot translation of the WHOQOL-SRPB Field-Test Instrument was completed by 21 people. The age range was 31–73, the median age being 43. Out of those who responded, 20 were female. The results showed no statistically significant relationship between ‘How do you feel?’¹ and ‘Are you currently ill?’ But when focusing on the health items ‘How do you feel?’ and ‘How satisfied are you with your health?’, the results showed a significant relation to the existential health dimension ($p = .001$)². The results also showed a significance between the overall ratings of physical, mental, social, and environmental health and the existential health dimension ($p = .008$). In relation to the different dimensions, the results showed that there is significance between the overall existential health dimension, and mental health ($p = .008$), and social health ($p = .046$). There seems also to be a tendency towards a link to environmental health, but it is not statistically significant ($p = .051$). The results do not reveal any major significance when the SRPB dimensions are divided into the different components, the eight clusters, of the existential dimension. A significant relation was found only between a few of the eight different aspects of the existential, SRPB, dimensions when analysed in relation to the two overall items about health: ‘How do you feel?’ and ‘How satisfied are you with your health?’ ‘How do you feel?’ had a significant relation to ‘spiritual connection’ ($p = .037$) and ‘inner peace’ ($p = .029$). When that question was combined with ‘How satisfied are you with your health?’ there was a significant correlation to ‘inner peace’ ($p = .023$) and to ‘hope and optimism’ ($p = .046$). The SRPB dimensions as a whole showed significance in relation to how people feel and the function of the existential dimension for handling and interpreting difficulties. The respondents’ answers to two of the four original SRPB items in the WHOQOL-100, the ones that included health—‘To

1 The original question, G1.5, ‘How is your health?’ is in the Swedish context translated as ‘how do you feel?’

2 All correlations presented here are positive.

what extent do your personal beliefs give you the strength to face difficulties?’ and ‘To what extent do your personal beliefs help you to understand difficulties in life?’— had in combination a significant correlation to the item ‘How do you feel?’ ($p = .008$).

The interviews

The results showed that all five of the interviewees had experienced times of good and poor health, and good and poor life quality. All of them had also experienced changes in their meaning-making systems, related to intensity, form, and importance, in close connection with self-perceived health and life quality. In the coding of the interview material, nearly no statement related to health was unrelated to an existential dimension of life, regardless of whether it was physical, mental, social or environmental. Of a total of 430 statements in the interviews, only 12 that related to physical, mental, social and environmental health dimensions did not relate to an existential dimension, compared to 418 statements related to any of those health dimensions that had existential relevance. In addition to these, there were 593 statements related to the existential dimension with explicit connection to an autonomous existential health dimension, or related to an existential meaning-making dimension at a more intellectual level.

Analysis of the interviews revealed that to be sick is not the same as feeling unwell and the other way around. There is a continuum between being sick and being healthy, and another between feeling well and feeling unwell. One of the most important results was that the existential dimension needs to be divided into three different aspects as noted below:

1) *Physical, mental, social and environmental health dimensions of existential significance and the autonomous existential dimension.* Almost all statements in the interviews concerning any of the health dimensions show that there is an existential significance—418 statements, compared with 12 that did not show this. Different health dimensions have existential relevance as construed by the person in relation to her/himself, her/his surroundings, and/or in relation to a transcendent or immanent force, for example, ‘Also when I had blisters the last time I ate penicillin, and it truly felt generally chaotic’ and ‘I’ve suppressed a lot as I have no energy whatsoever to deal with it.’

There are also 160 statements that appear to make the case that the existential health dimension in itself could constitute an autonomic health dimension of importance for self-rated health. This health dimension can be separated out and can function independently from the other health dimensions, for example when the person experiences a serious threat to her/his life.

2) *The health dimension of existential significance related to existential needs.* In relation to the large number of statements in this study where informants talked about their physical, mental, social, and environmental health aspects as having existential relevance there was relatively little connection to or in common with the eight categories in WHO's perspective for spirituality, religiousness, and personal beliefs in the WHOQOL-SRPB Field-Test Instrument. On 545 occasions, during the interviews, information was coded as 'health dimensions with existential significance' and of those 139 were related to existential needs. The strongest connection was found in the mental health dimension relation to existential need and more specifically to the need for 'inner peace' (SR 6) and 'hope and optimism' (SR7). For example, 'I do not really know where my life is going and it is a bit turbulent and rocky' and, 'I'm longing for someone. . .and was feeling a bit disorientated.'

The second strongest connection to existential need was in relation to the social health dimension, which was related to the need for 'meaning and purpose in life' (SP2). For example, 'to be part of a community is to find meaning in life.' In relation to the physical health dimension with existential relevance there was the need for 'wholeness and integration' (SR4), with a focus on 'body, mind and soul' and 'feeling, thought and action' for example, 'I realised that if I continue like this, it is going to be a serious thing, it will be placed in the body and in the soul.' And also the need for 'hope and optimism' (SP7) was conveyed, as in this memory from childhood: "God please help me so I don't have cramps", I remember that I added this at the end [of the evening prayer]. Not many statements connected the environmental health dimension with any existential needs. Of a total number of eight statements, six related this dimension to the need for 'experiences of awe and wonder' (SP3), for example; 'perhaps there is some force, I can feel some sort of religious feeling when I go out into the wilderness.' In the autonomic existential health dimension there are also statements that connect this dimension to existential needs, but not to the extent that might be expected. Only 56 of 160 statements related to the autonomic existential health dimension are linked to existential needs and once again the most common needs are those for 'inner peace' (SR 6) and 'hope and optimism' (SR7), for example; 'still I think I have a core of myself that is worth preserving', and 'to move forward so I have to take it easy, but it is still slippery'.

3) *The meaning-making, existential dimension of health, related to the existential needs in relation to the other health dimensions.* The third aspect of the existential health dimension in this population concerns the infrequency of a conscious level of reflection where the informants combined their own health

situation with the feeling of spiritual, religious and/or personal need, which also had some kind of interpretation on an intellectual level in terms of religion, philosophy or other ideology. This aspect is quite rare in my material. Some of the informants related to this kind of interpretation when they talked about experiences of physical illness in childhood, and some about experiences of a strong need for security and inner peace associated with psychological vulnerability. Besides these experiences, most of the meaning-making is more related to an intellectual level without being conscious about the existing existential needs. The interviews showed that in times of life changes there often is a lack of a functioning existential, meaning-making health dimension that could interact between the new situation with its existential relevance, the feelings related to existential needs, and the existential interpretation.

When there is a discrepancy between these dimensions, the informants often seek new forms of existential interpretation when the old one is not enough to deal with the needs associated with the new situation. For all of the interviewees there had been experiences of a mixing of meaning-making systems, and also experiences of a lack of a functional meaning-making system, in terms of DeMarinis's typology. One reason why the potential introjection between existential needs and existential interpretation is only partly working as a functional existential meaning-making health dimension could be that cultural differences exist between the Swedish context and the WHO's definition and approach to understanding spiritual health, as found in the items in the WHOQOL-SRPB Field-Test Instrument.

However, this can only partly explain why the sense of existential need is not more pronounced when the informants relate to situations in life relevant to their existential situation. Nor does it explain why the existential interpretation is not interacting with the emotional experience of the situation to a greater extent. This pilot study naturally has its limitations, not least due to its small size, as well as other methodological issues. Its results cannot be generalised, nor is this the aim of such a study. However, the results offer a way of thinking about these issues and their challenges within the Swedish cultural context.

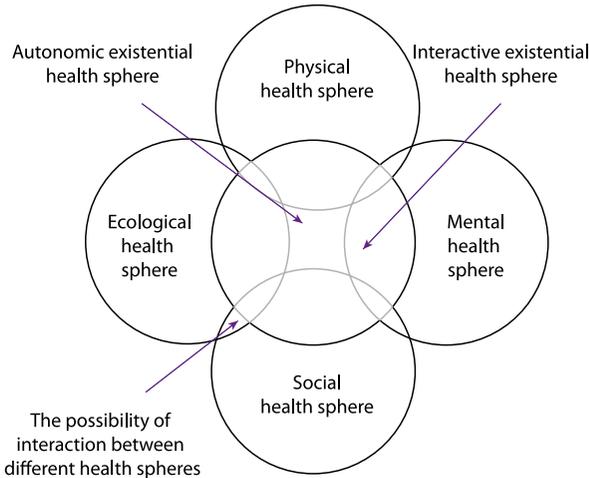


Figure 1. The different spheres of health

Analysis

As an answer to the research question, I found that there is a relation between self-rated health and a person’s existential dimension in life. The relation is strong and complex. This relation finds support in the WHO’s health perspective and in DeMarinis’s health dimensions, and it is linked to Winnicott’s understanding about the function of potential space. I found that the various health spheres in the form of physical, mental, social, ecological, and existential health are closely interlinked (see Figure 1). The existential health sphere plays a key role, both in its interaction with the other spheres of health, and through its capacity to function as an autonomous sphere of health. Almost no experience of the other health spheres is unaffected by the existential dimension.

Furthermore, I found in the material that there is a clear difference in the emotional and intellectual connections to the meaning-making processes. This has prompted me to identify as a separate sphere (see Figure 2) existential meaning-making systems which have an emotional connection to the existential needs of each individual and an existential interpretation linked to a religious, philosophical and/or ideological reflection. A higher degree of introjection between these dimensions, of an internal/autistic sphere related to the existential needs and wishes and an external/realistic sphere consisting of the existential interpretation, could provide an existential meaning-making

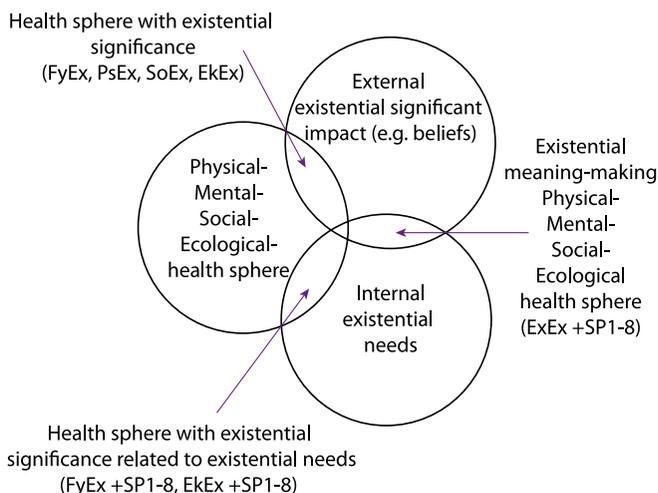


Figure 2. Meaning-making processes related to health spheres and existential needs

health sphere that could work as a resource in a person’s life and experienced health. That introjection process is possible to reinforce by interventions based on creating supportive environments.

An existential health model

To go further in scientific studies exploring the existential dimension of health, to analyse the impact of this health dimension, and in the end to use the knowledge as a resource in public health work, we need to develop theories, models, and methods. To contribute to the development, I wish to present a model based on the theoretical conclusions of the study and how the model can contribute to knowledge to develop an existential health intervention.

The model is based on the six spheres and a potential existential health sphere (see Figure 3). The interrelationship between the different spheres is dependent upon varying degrees of integration. Well-integrated spheres give a higher level of self-rated health. The model consists of

- Four spheres of health: the physical, mental, social and ecological;
- An internal sphere related to existential needs;
- An external sphere, consisting of the individual’s existential interpretation related to factors outside the inner world, factors relating to a religious, philosophical and/or ideological reflection; and,

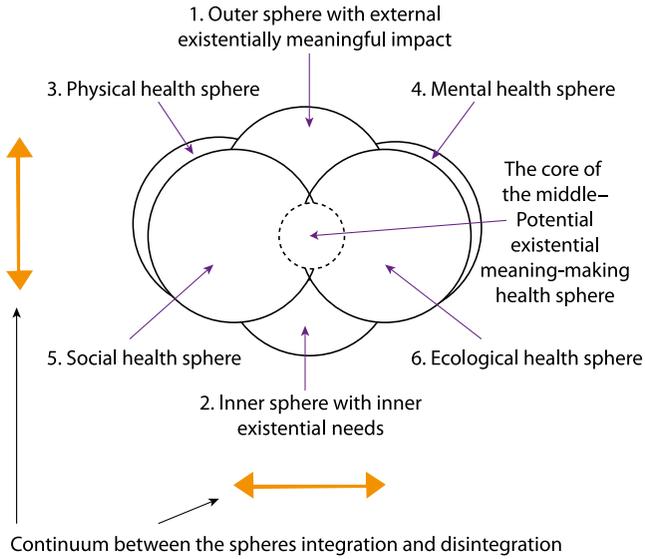


Figure 3. The existential health model

- A potential existential health sphere, which is the sum of the existential meaning-making processes, which is based on the degree of introjection between the internal sphere and the outer sphere.

This gives rise to a model in which all the various health spheres are included with their mutual relationships, and the existential health developed out of a potential dimension created by the introjection between the external, subjectively perceived world and the inner world. In this potential dimension the functionality of the individual's existential meaning-making structure forms the basis for healthy development and life quality.

The study has generated two hypotheses:

1. Perceived health and life quality are based on the five spheres of health: the physical, mental, social, ecological, and existential. All spheres of health may interact and influence each other, and;
2. The existential health sphere, which in itself is the result of the introjection between the existential interpretations and internal existential needs, and has an essential position.

Post-secular practice: an existential public health intervention

During the spring of 2011 we conducted a seven-week programme with the aim of developing an existential health intervention. We met a small group of ten people on long-term sick leave due to psychiatric diseases twice a week for three hours each time. Before and after the intervention, these people and a control group, which was matched in terms of age and gender from the same centre, complemented the Swedish pilot translation of the WHOQOL-SRPB survey. The intervention was based on the eight perspectives of the WHO's SRPB dimensions. We had two half days focusing on each of the perspectives: hope, meaning, personal beliefs, wonder and so on. One session was spent on each of the perspectives of spiritual connection and strength; hence the total of seven weeks instead of eight. The sessions were structured in a similar manner around six components. Each session started with an introduction, usually with music and some event or ritual and a poem saying something about the existential perspective of the day. For example, the first time we met, the theme was hope. The participants came into a dark room where only a small candle was burning. Some peaceful music was played and a short poem was read, saying that a person should never believe that he/she is so lonely, poor or sad that they will never have a friend, never have something to give or never smile again, because the sun will rise when the night is over. Each person had a candle at his/her side, which was then lit, and everyone went up to a large table with black and white photographs on it. They put their candles on the table and selected three different photographs: one for hope, one for hopelessness and one for themselves. After the introduction came the four main sections: one part with intellectual inputs from different religious, philosophical, political systems or outer structures, for example from modern psychosocial findings. After that, we held discussions, which were often inspired by the SRPB perspectives in the survey; for example, 'how often do you feel awe?' or 'what makes you feel wonder, for example in art or nature?' Every session included a creative component. For example, when dealing with the theme of awe, we discussed being in awe of nature and I was given input from creation myths from different religious systems. Then the participants painted a large painting together—using spoons, to reduce performance anxiety. The participants took turns every five minutes and began painting where someone else had just stopped. The next time we met we continued to discuss awe. During this session, every person made a small frame and cut out a small piece from the large painting, which became their own picture of creation.

Every session had a final component of relaxation. For example, this could involve trying a breathing technique, or meditation. During the intervention,

the participants added things to their own rosary, such as a pearl to represent harmony, a symbol they created themselves to represent their personal beliefs, a seashell to represent awe, and so on. We did this to develop the method, to create an existential public health intervention and to test the WHOQOL-SRPB survey in a 'before and after' study.

The aim of this intervention was to develop the foundation for an evidence-based intervention that could increase existential health and thereby increase self-rated health. It turned out that the participants belonged to different religions. Some of them were active in their personal beliefs, but most of them were not. The group included members from various Christian churches, but also from the Jewish community, The International Society for Krishna Consciousness and from The Swedish Humanist Association.

Final insight

Although the study is very limited, a preliminary analysis shows that the intervention had a positive impact on the participants in the intervention group, in contrast to the control group. The control group did attend other activities like singing, guitar playing, cooking and so on. In the intervention group, eight people completed the survey before and after the intervention and attended more than half the sessions. Of these eight people, six reported a higher level of existential health and a higher overall level of self-rated health. In the control group, which consisted of ten people, only one reported a higher level of existential health and two reported a higher overall level of self-rated health. In the intervention, one person scored lower on the existential and self-rated health scales after the intervention, while in the control group nearly half scored lower when they completed survey for the second time (after eight weeks).

The next step, and my wish, would be to study this intervention on a wider scale in order to design an evidence-based, existential health intervention. This could be a complement to other forms of therapy and rehabilitation, both in the form of more specialised rehabilitation such as for people undergoing probation, suicide prevention, physical and mental rehabilitation programs, and also as a means of ill-health prevention.

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