

English Summary

The epidemiology of lost meaning. A study in psychology of religion and existential public health in a Swedish context

Introduction

The existential dimension of spirituality has proven to be of great importance during the last two decades when it comes to studies of self-rated-health and quality of live (DeMarinis, 2008; Moreira-Almeida & Koenig, 2006; O'Connell & Skevington, 2010; Sawatzky, Ratner & Chiu, 2005). In the public health sector, it is interesting to note that this existential/spiritual dimension had been present in the early years when the term public health first occurred in the Swedish dictionary. In the year 1926 it was defined as a people's physical and spiritual health (Svenska akademien, 1926, p. 1070). During the intervening years of great medical- and scientific technical improvements in the field, the existential/spiritual perspective had been put aside and now once again this dimension has come into focus (Vader, 2006; Rutz, 2006).

The World Health Organization [WHO] began its "Health for all people"-strategy in 1977. At its conferences in Ottawa 1986 and Sundsvall 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 way of including the existential/spiritual dimension in the overall health perspective has been to develop theories and methods that can be used for research studies and therapeutic interventions 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, p. 77). Also, Professor Harold

Koenig, Director of the Center for Spirituality, Theology and Health at Duke University, North Carolina notes the following 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, p. 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, p. 1652). Professor Jean-Paul Vader claims that we need to address the spiritual dimension. In his Editorial in 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, p. 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. This is done through three theoretical perspectives: health related to an existential dimension; public health out of a perspective of psychology of religion; and, object-relations theory. Sweden is a country with a very developed privatization of the meaning-making arena related to spirituality, religion, and personal beliefs. In many studies, Sweden stands out as a country with a very high number of members in the Church of Sweden and with many turning to the church for the baptizing of children, 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 lives. With that in mind when we examine public health reports from Sweden we see that there is a very healthy population considering ratings of: infant death, smoking, exercising, 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 normally are not in the health-risk groups. We can see this profile in groups of young men and especially women with mental illnesses such as depression and anxiety, the increasing statistics connecting overweight and stress, and an increase in the experiencing of

pain (Sveriges Kommuner och Landsting [SKL], Socialstyrelsen & Statens folkhälsoinstitut [FHI], 2009). Rutz notes, “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, p. 1652). He 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, p. 99).

This thesis is based on an explorative study in the psychology of religion, through the perspective of existential public health, on an ethnic Swedish adult population’s existential needs.

Central research question:

- How does the existential dimension of health, understood as a person’s ability to create and maintain functional meaning-makings 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 to create and maintain 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 new pilot program “VVV” (adult growth in Vällingby parish) for adult persons in a suburb of Stockholm, Sweden, organized by a parish within the Church of Sweden. The purpose of the program has been to create a locally-based program for men and women of working ages, offering them the opportunity to develop a functional lifeview of themselves and their environment with the opportunity for developing their existential/spiritual dimension, in a program based on different life issues. These issues have included but were not limited to: Health and Stress, Life and Work, and Close Relationships. The program has included five different elements every semester. It has started with a lecture on the life issues for the season followed by four different activities in which

each participant could 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 Holy Bible and its context. All activities during the season have been centered on the chosen life issues. The program has given each participant the opportunity to take part in as many of the activities that the person has wanted. Over the first five semesters of this new pilot project, when the material for this study was conducted, a total of 756 participants have taken part in the program's cumulative activities, representing 246 individuals who participated in different program activities.

Theory

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

Health with an existential dimension

In the last couple of decades there has been an increasing interest in the existential/spiritual dimension in relation to self-rated health. Different definitions and methods have been used in these studies, for example: participation in religious activities' impact 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. WHO has, from the beginning, pointed to the importance of a holistic perspective on health (WHO, 2006, p. 1). In the work of "Health for all people"-strategy WHO developed the concept of supportive environment which includes different 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). WHO has also presented models for developing Public Health programs for increasing supportive environments. Supportive Environments Action Model [SESAME] is one of them, which can be used for planning and evaluating programs (Haglund, 1996, p. 98). With inspiration from the third international WHO-conference within the "Health For All"-strategy in Sundsvall, SWEDEN, 1991 and the Supportive Environments Action Model [SESAME] that was presented in the conference book *We Can Do It!*, SESAME has been used in this study for presentation of the VVV-program and for identifying important aspects in developing 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 instrument was developed in a pilot study conducted in 18 different countries around the world. Some scientists have criticized the 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 a time period of the last two weeks and measures the spiritual, religious, and personal beliefs [SRPB] through eight different aspects: spiritual connection, meaning and purpose in life, experience of awe and wonder, wholeness and integration, spiritual strength, inner peace, hope and optimism, and faith. In the worldwide pilot study with 5,087 persons, a significant relation 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 with medical personal statistical significance was found between self-rated health and the existential/spiritual dimension (WHOQOL-SRPB Group, 2006, p. 1486). O'Connell and Skevington who conducted the WHOQOL-SRPB pilot study in the UK have also analyzed 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, p. 744). They have also reviewed and evaluated seven quality-of-life assessments (O'Connell & Skevington, 2007, p. 77). 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 wellbeing" (O'Connell & Skevington, 2007, p. 85). Their conclusion is that WHOQOL-SRPB "represents a new assessment frontier for investigations of positive health" (O'Connell & Skevington, 2010, p. 744).

Public Health from the perspective of psychology of religion

In the field of psychology of religion there is a long history of investigating perspectives related to health on individual, group, and community levels. There are many researchers today who define the time we are living in as being post-modern. This concept is not completely clear as to what it relates to and what it stands for (Ekedahl & Wiedel, 2004, p. 9; Liljas Stålhandske, 2005, p. 91). To some extent it can be related to the concept of secularism, which also is a complex phenomenon. However, a post-modern usage does include, for some researchers, two trends that partly work in opposite direc-

tions. 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, for example decreasing participation in local church services (Pettersson, 2006). These trends have been observed both in Sweden and internationally as reported in results from the World Values Survey [WVS] (Inglehart & Baker, 2000; Pettersson, 2006).

A post-modern situation, with too many choices, can lead to mental dysfunction if a person is unable to make a choice, unable to make meaning and thereby affecting the person's ability to make life decisions (DeMarinis, 2003, p. 29). Professor Valerie DeMarinis has shown that this could lead to chaos do to the loss of cultural and existential tools that could assist persons or groups in there 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, p. 236). In her study she has developed a cultural analysis model, an adaptation of Kleinman's model of the dimensions of culture, and has used it for analyzing the existential health dimension in Sweden. The existential dimension is one dimension among the physical, psychological, social and ecological dimensions, but also plays a special role for understanding perceptions of health and illness in its interaction with the other dimensions (DeMarinis, 2003, p. 44f.).

Through a second model DeMarinis has, inspired by David Wulff's categories for psychology of religion, constructed a worldview typology model for how different approaches to meaning-making systems can be understood, including both literal and symbolic worldview constructions of systems with or without a transcendent belief foundation (DeMarinis, 2004, p. 163f). 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 is for people that lack the capacity for constructing meaning, thus indicating a dysfunctional worldview function (DeMarinis, 2008, p. 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 advocates the important role of play and its contributions

to health and development. The child's play transforms in adulthood into forms of cultural and religious expressions (Winnicott, 1997, p. 77, 91). Human growth is an ongoing process for Winnicott, which starts with birth, if not earlier, and continues until death (Winnicott, 1991, p. 19). Physical and psychological developments are two parts of the same developing process and not separate entities (Winnicott, 1991, p. 33f., 65ff.). 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 will lead to problems and disappointments (Winnicott, 1998a, p. 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 common side takes place in a third area, a potential room for negotiation, the transitional space.

This transitional space is created through the relation a baby has to the person that has primary parenting responsibilities, called the mothering function for the baby. Through that person the baby creates an 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, p. 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 room whereby play can contribute to processing the outer- and inner worlds so that good enough-health and growth can develop (Winnicott, 1991, p. 156f.). For the adult person different activities can work for promoting the transitional space, it could be religion, culture, and all kinds of different activities that have the same standard and safety frames that play has as long as its purpose is to integrate the inner and outer realities (Winnicott, 1998a, p. 148).

Method

Sample

A mixed-methods design, including two quantitative surveys and a qualitative semi-structured deep interview, has been used for this study. The 87 persons that took part in the study were selected out of the total VVV-group. The group itself was not a group of marginalized persons and they could in 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 post-secondary education. Most of the participants in VVV, about 80%, were women and so also in the sample for this study.

The 61 persons that answered the VVV instrument were people that went for the lecture that began the semester focused on the theme: “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 persons were asked to participate in the survey and all answered the questionnaire. This group consisted of all participants in 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 persons were strategically selected for the interviews. The strategic selection criteria were: 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 in the beginning of the interview with the instruction to: “paint a lifeline/life journey”. The person then told her/his life story from the drawing and follow-up questions for clarifications were posed. An interview-area guideline was used for the rest of the interview. At three selection points in the life journey: retrospectively for childhood and “three years ago,” and currently 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 daily life function.

In the analysis of the results from WHOQOL-SRPB the whole group was divided into smaller groups: three groups 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 analyzed in the Statistical Package for the Social Sciences (SPSS, Inc. Chicago, IL, USA, Version 12.0), for quantitative data-analysis.

The interviews were analyzed first by the themes derived from the physical, mental, social, environmental, and existential health dimensions. Further analysis of the existential dimension was done through DeMarinis’ six categories of meaning-making systems. In the next step I categorized the interviews out of the eight existential dimensions from WHOQOL-SRPB as dimensions of spirituality, religiousness, and personal belief with attention to the function of and meeting of existential needs. The interviews were ana-

lyzed in the OpenCode 3.4 data-analysis program (Umeå universitet, 2010), a system developed for coding Grounded Theory-based data, but which worked well even for other forms of qualitative data that were more theory driven.

Results

The VVV survey

In the VVV survey 71% of participants were between the ages of 36 and 55, and 81% were women. A total of 74% were working or studying and 12% were on sick leave. Concerning the existential dimension, 72% believed that spirituality was important or very important. There was a great variety concerning how people were making meaning in their lives. A slight majority, 51% included a higher dimension, 33% excluded it and 11% 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%, responded that they used a Christian ground but excluding any higher power, 62% included a higher power using a combination of different systems to make meaning in their lives. Only 19% reported a single-tradition way of making meaning: that they had a non-spiritual/non-religious ground and didn't count on any higher power; or that they counted on a higher power and had a spiritual/religious ground. The rest, 81%, made their own combinations in a mix of different meaning-making systems that sometimes were in direct contradiction to each other. Many of the responding persons, 70%, created some kind of meaning-making activity on their own and 61% did so in conjunction with others. Among the answers to the open-ended question about private-based activities, the four most frequent activities included: meditating, pray, conversations with friends, and being in the 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 persons. The age range was 31-73, the median age was 43. Of the responding persons 20 were female. The results showed no statistical significance between "How do you feel?"³⁰ 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

³⁰ The original question G1.5, "How is your health?" is in the Swedish context translated to "How do you feel?".

the existential health dimension ($p = .001$)³¹. 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 to also be a tendency towards a link to environmental health but it is not statistically significant ($p = .051$). The results do not reveal any mayor significance when the SRPB dimensions were 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 analyzed 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 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 persons in the interviews 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 to 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 if 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 on more conscious intellectual level.

³¹ All correlations presented here are positive.

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 feels a serious threat to her/his life.

2) Health dimension of existential significance related to the 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. At 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 wavy” 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 a 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 exam-

ple, "I realized 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, like 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 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 of "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) 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 with this population concerns the infrequency of a conscious level of reflection where the informants combined their own health situation with the feeling of existential need (related to a spiritual, religious and/or personal need), that also had some kind of interpretation on an intellectual level to 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 handle the new situation with its needs. For all persons in the interviews there had been experiences of a mixing of meaning-making systems, and also experiences of lacking a functional meaning-making system, in terms of DeMarinis' typology. One reason why the potential introjection between existential needs and existential interpretation is just partly working as a functional existential meaning-making health dimension could be that cultural differences exist between the Swedish context and 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 to a greater extent interacting with the emotional experience of the situation. This pilot study naturally has its limitations, not in the least its small size as well as other methodological issues. Its results cannot be generalized, nor is this the aim of such studies. However, the results provide a way of thinking about these issues and their challenges within the Swedish cultural context.

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 WHO's health perspective, in DeMarinis' health dimensions and 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 the 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.

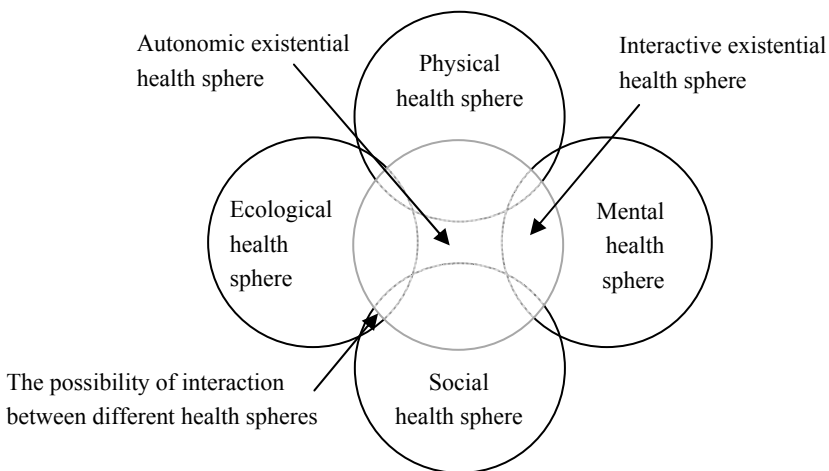


Figure 12. The different spheres of health

Furthermore, I found in the material that there is a clear difference in the emotional- and the 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 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.

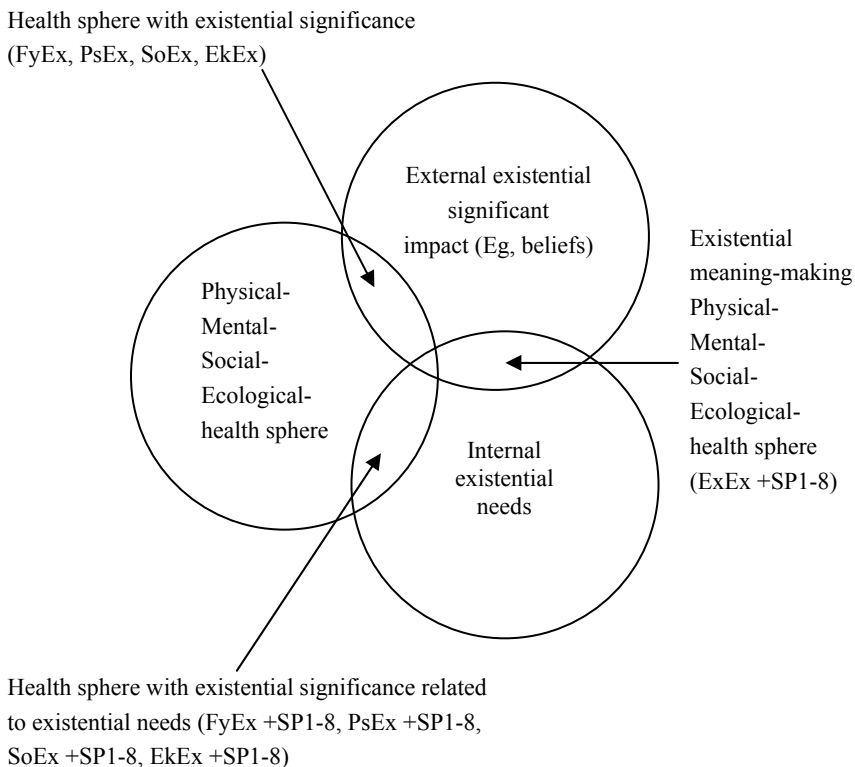


Figure 13. Meaning-making processes related to health spheres and existential needs

Discussion

Related to Theory

To go further in scientific studies exploring the existential dimension of health, to analyze 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 the 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,
- 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 healthful development and life quality.

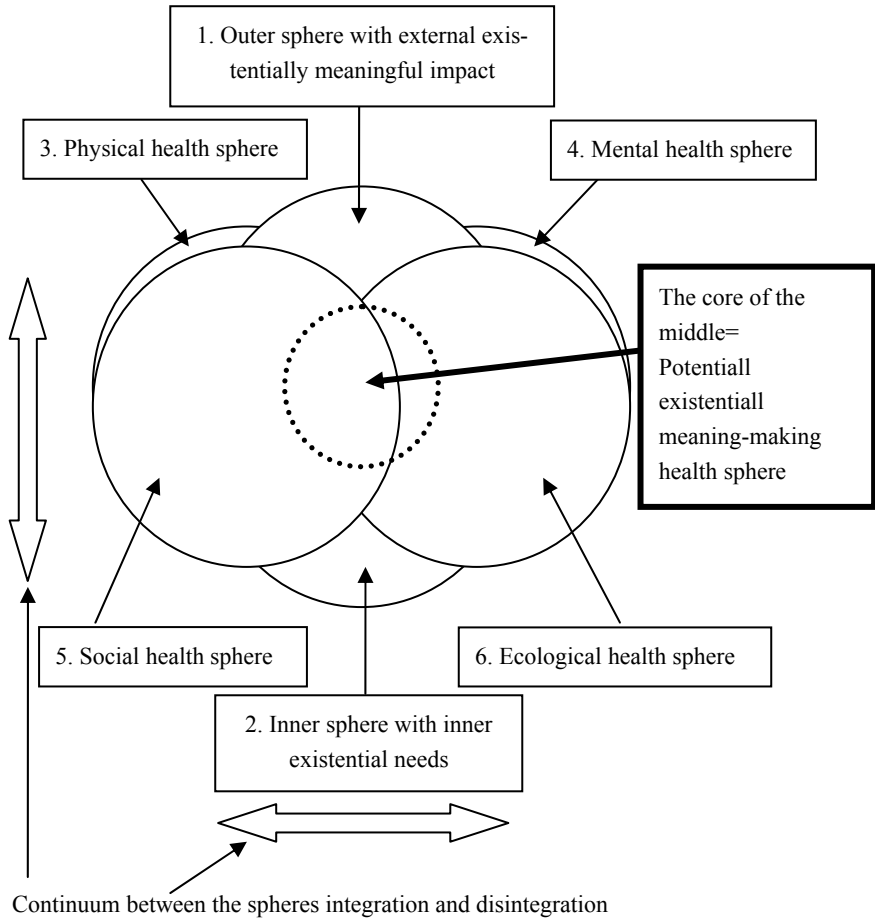


Figure 14. The existential health model

The study has generated two hypotheses:

- 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.
- The existential health sphere, which in itself is the result of the introjection between the existential interpretations and internal existential needs, has an essential position.

Related to Practice

Some implications for the development of public health program interventions could be drawn from these results.

Identify needs and problems

An intervention should be based on efforts to strengthen the three active components of the meaning-making process. Efforts must therefore be based on: a realistic assessment of situations in life with external existential meaningful relevance; internal existential needs; and, with attention to the introjection process to develop and maintain functional existential meaning-making structures.

Building alliances

A key aspect for developing an effective intervention is to identify who is going to be in charge of an existential public health program intervention and finding the appropriate partners in this endeavor. I can conclude from this study that it is possible to develop an existential public health intervention, but the question remains, who is going to take the responsibility in the societal context? Health in Sweden belongs traditionally to the secular sector and existential and spiritual issues to the religious sector. Medical care in our cultural context is not focused on existential issues and our churches and faith communities are not focused on health. The consequences of this tend to be that the issue falls in the gap between different organizations. Maybe it is time to create a new authority that could be in charge of existential public health work, with other organizations as supportive partners.

Develop strategies

An existential public health intervention in Sweden needs to be constructed from our Swedish socio-cultural context. Efforts should be made through various types of interventions to reach different dimensions (with reference to Figure 14) to reinforce the process of introjection of the existential meaning making systems. It is important that there are a variety of activities in the intervention including: discussion, intellectual reflection, creative work, and playful experiences. There have to be aspects in the program for supporting the introjection process by impacting both inner existential needs and external existentially-meaningful expressions.

Design implementation

The interventions should be done in groups, with a format that permits each individual member to understand and work with her /his relevant information. In my material there are a number of informants mentioning the importance of the social context for issues relating to the meaning-making dimension. The processes must find legitimacy for the individual, which is clear in our postmodern context. Therefore, this change in meaning-making cannot be achieved by an authoritarian regulatory format as it needs to emerge in dialogue with others. In this way individuals may take part in and through many people's ways of creating meaning in everyday life and also of getting the opportunity to formulate their own thoughts and to test them. Another

factor that is of importance in conducting the intervention on a group level is of course economic. Even if one could achieve the same results with individual interventions, group interventions must be considered as a much more cost-effective alternative. This is important not in the least because the intervention must be prepared for a large number of people, as we might have an increasing number of people with health problems relating to the existential dimension. There is a risk that we are facing the threat of an existential crisis due to the increasing number of people that are living without a functional meaning-making system.

"Nothing is as good for your health as feeling that life is meaningful and that every day means something new"

Professor emeritus Arvid Carlsson, awarded The Nobel Prize in Medicine, 2000.

Källförteckning

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