Ola Sigurdson, »Existential health. Philosophical and historical perspectives«

ABSTRACT

In this article I strive for a conceptual clarification and constructive elaboration of the concept of existential health. Taking my cue from the multidimensionality of health – referring to contemporary experience, the WHO definition of health as well as pre-modern conceptions of health – I compare existential health to other concepts of health – i.e. physical, mental, social and spiritual. I argue that existential health should not be seen as yet another dimension of health – not even spiritual health, the most likely candidate as Valerie DeMarinis and Cecilia Melder, two prominent Swedish psychologists of religion, has argued – but rather is a reflexive experience of health. By »reflexive« I mean an intentional relation to one's own experience of ailment and health, including a relation to these experiences as one's own. My conclusion is that existential health as a concept should be reserved for this reflexive feature of human subjectivity in relation to health, cutting across all other health dimensions, so as not to confuse the conceptuality in speaking of health.

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EXISTENTIAL HEALTH. Philosophical and historical perspectives

What is health? The answer to this question has been as elusive as it has been prominent since the beginning of human history. The answers, throughout history as well as in our own times, have been varied, to say the least. In this article, I will try to suggest what is involved, philosophically, in the use of different conceptions of health, especially contemporary definitions of existential health, and I will also make a constructive suggestion about what I think is a productive understanding of existential health. More precisely, I want to first launch a discussion of the multidimensionality of health in order to more clearly distinguish the dimension of health we could call existential. Is it one dimension among others, or is it more of an overarching concept, even including all other dimensions? In the next section, I will compare the result of this discussion to some contemporary uses of the concept of existential health. This will call for a short digression to consider the concept of health in history and especially what distinguishes modern concepts of health. Finally, I will make a suggestion concerning existential health, that it should involve a reflexive relation to our own health as a significant characteristic.

HEALTH IS MULTIDIMENSIONAL

Health has multiple dimensions. This is clear from experience; as one of my acquaintances put it: »Imagine that it is possible to be so healthy when you have so many ailments!« She has been retired for several years and her age has brought various »ailments« upon her, but nevertheless she feels healthy up to the point that she even experiences the relationship between her many ailments and her continuing health as a kind of paradox. This is an anecdotal example, of course, but I would not think it controversial to suggest that this is a common experience among many people, and not just the elderly. This experiential perspective on multidimensional health is, in a way, recognized by the World Health Organization's (WHO) definition of health from 1948: »Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.«[1] Here, the distinction is made between a biomedical definition of health as the »absence of disease or infirmity« – perhaps loosely corresponding to the ailments in my example – and a »state of … well-being« –

maybe more or less corresponding to my acquaintance's experience of health. Although the WHO definition of health does include the absence of disease or infirmity, it chooses to state that health is not »merely« this absence, and one may well draw upon this distinction to suggest that it is possible to be in a state of well-being despite the presence of disease or infirmity. To generalize this insight with regard to health, it is indeed possible to be ill and well at the same time; neither illness or disease nor health is an absolute condition.

But there is more to the definition as well as the experience of my acquaintance, namely, what is usually referred to as »negative« and »positive« definitions of health. Health as the absence of disease or infirmity is clearly a negative definition, and this definition corresponds to a negative experience of health in the sense that if I am healthy, this health is not an experience as such but rather the absence of experience. In Swedish, there is a saying, »hälsan tiger still« which, literally translated, means »health remains silent«. This saying points to the insight that if I am healthy in this sense I usually do not spend time brooding over this state but instead I am busy doing other things, getting on with my life. This is precisely what the German philosopher Hans-Georg Gadamer calls the »enigma of health«:

> Health is not a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one's fellow human beings, of active and rewarding engagement in one's everyday tasks.[2]

Health as a state of well-being, on the other hand, is a positive definition; it points to experiences that most of us (hopefully) do have sometimes, experiences that often go under different names than health. Gadamer recognizes this dimension of health too, despite his emphasis on the enigmatic dimension, as »a general feeling of well-being«.[3] Consider such experiences as peace of mind, harmony, flow, fitness and so on. Since what is »positive« about the definition is not positive feelings, but merely suggests the presence of experience rather than the absence, maybe it should be argued that experiences such as anger, striving or emancipation also belong here. Be that as it may, for now I only want to point to the multidimensionality of health both »vertically«, between negative and positive experiences or definitions, and »horizontally«, between different aspects of human existence: physical, mental and social.

I suspect that it would not work to carry the distinction between health as the absence of disease or infirmity and health as a state of well-being too far: Consider, for a moment, having the stomach flu; is that really compatible with a subjec-

tive feeling of well-being? Sure, you can consider yourself lucky, for instance, for having a home despite your flu, but I suspect that most of us feel miserable when we are ill. Moreover, there is an aspect of time involved in a bout of flu; it is transient, and the thought of its transience make it (perhaps) more bearable. Here, then, there might be a point in distinguishing between »objective« and »subjective« well-being; the person suffering stomach flu might well feel miserable »subjectively« but nevertheless be considered (even by himself) to be in a state of well-being »objectively« if he has a home and people to care for him in his time of misery. On a related note, a deep dissatisfaction with one's living conditions may well have negative consequences for one's physical health. That health has multiple dimensions does not mean, then, that these dimensions are completely independent of each other, but neither does it suggest that there is a complete correlation between them. Instead, the relationships (in plural) between different dimensions seem to be of a more complex kind. More examples from experience could be developed to show even further nuances of these relationships, and even in the definition from WHO, well-being consists of not less than three different dimensions of well-being: physical, mental and social.

This article concerns existential health, a dimension of health that I have not yet defined or even mentioned since the beginning of this article. However, to be able to talk meaningfully about existential health, I first needed to establish that health is hardly one thing and one thing only but instead has many dimensions. A first, tentative attempt at a definition of existential health might be that this is an encompassing perspective on health in that it concerns all of human existence, including the physical as well as the mental and social. I do not think this reduces the multidimensionality of health to some kind of »wholeness«, as it is still possible to recognize physical, mental and social well-being as relatively independent dimensions of health. Indeed, the talk of »holistic« health has, in my opinion, a legitimate aim of promoting a view of health as pertaining not only to biomedical aspects, but to the person as a whole. Nevertheless, any such talk runs the risk of not acknowledging the complexity of human existence, including the relative independence of these different dimensions. I prefer the concept of existential health to holistic health, mainly on grounds of connotation. Existential health should not lead our thoughts to any preconceived idea of wholeness, at least not in any straightforward sense.

MEASURING THE QUALITY OF LIFE

Let me now turn to another aspect of the multidimensionality of health, and especially existential health, namely how this has been conceptualized by the WHO definition. As I have

already mentioned, the positive aspect of this definition points out three dimensions of well-being: physical, mental and social. Recently, however, a lot of research has been done on what is called »spiritual« well-being, spiritual being a distinctive dimension alongside the other three in the WHO definition. According to Harold G. Koenig, more than 1 000 quantitative studies assessing the relation between spirituality and health had been conducted prior to the year 2000, and by the middle of 2010, a further 2000 studies had been published.[4] The reason for such research is of course that spirituality, including religious beliefs, is an important asset for many people when coping with illness and disease. One argument against including this spiritual dimension is that it is supposedly impossible to measure. But to counter this objection WHO has developed a questionnaire in order to measure, in some way, the impact of spirituality on well-being, the WHOQOL-SRPB Field-Test Instrument. WHOQOL-SRPB stands for World Health Organization Quality of Life – Spirituality, Religiousness and Personal Beliefs. The questionnaire consists of 32 questions that cover quality of life aspects related to SRPB. We might initially note that this questionnaire wants to avoid associating spirituality with any specific religious or otherwise confessional *credo* but instead is intended to measure the impact of spirituality whatever the worldview of the population measured.

For the person filling out the test, spiritual well-being is potentially characterized, according to the questions in WHOQOL-SRPB, by such facets as (1) connection to a spiritual being, (2) meaning and purpose in life, (3) a sense of awe and wonder, (4) wholeness and integration, (5) spiritual strength, (6) harmony and inner peace, (7) hope and optimism, and (8) faith as a resource.[5] As Marcelo P. Fleck and Suzanne Skevington put it, the »philosophy underpinning the WHOQOL-SRPB development is that from a QOL perspective, having a profound belief – religious or not – could give a [transcendent] meaning to life and to daily activities, working as a coping strategy to deal with human suffering and existential dilemmas«.[6] The reason for the absence of spiritual facets in earlier questionnaires as well as in the public debate on health might have several explanations, two of them being, first, the already mentioned difficulty purportedly involved in measuring spiritual well-being, and second, a more general bias against religion, with which spirituality has been associated, in the once seemingly self-evident but now more or less outdated secularization theory.[7] The last few decades, however, have seen an increasing recognition of the importance of spirituality for health. WHO has hosted a discussion about whether »spiritual« should be added to the other three dimensions of well-being and developed the WHOQOL-SRPB Field-Test as a way of measuring quality of life in relation to spiritual issues.

I will say more on the question of what spirituality could mean soon, but let me just mention that there have been objections to the very idea of putting spiritual well-being alongside physical, mental and social well-being, as some have argued that there is nothing distinctive about spiritual well-being that is not covered by the other three dimensions. Therefore, adding it to these three would be redundant. Another related objection is that spirituality, rather than being one dimension alongside others, really encompasses them all, and that therefore it would be a category mistake to put it alongside physical, mental and social health, since this would be akin to counting apples, pears, bananas and fruit. However, according to Kathryn A. O'Connell and Suzanne M. Skevington at the WHO Centre for the Study of Quality of Life, it can be shown that spiritual well-being is relatively independent of each of the other dimensions.[8] This means that it is not an overarching concept, encompassing all other dimensions, but rather is an integral and distinctive part of well-being. Of course, there are overlaps between different dimensions, such as, for instance, between spiritual and psychological dimensions in relation to hope and optimism as well as inner peace, but that does not mean that a spiritual dimension of well-being cannot be distinctive. On the contrary, the results show, according to O'Connell and Skevington, that participants in the study conducted by them in the UK considered the spiritual dimension both distinctive and important to the quality of life. According to research conducted in Sweden by the psychologist of religion Cecilia Melder, however, what she calls »existential health« (which, in effect, for her equals »spiritual health«) is a dimension that is both distinctive from other dimensions of health and at the same time is closely interrelated with other such dimensions.[9]

What such a spiritual life might look like varies, of course, not only between cultures and traditions but also, given that we now live in a pluralistic world, within certain geographical areas, such as a Scandinavian nation-state. Research has shown, for instance, that the meaning of happiness (which I take is commonly understood as close to, if not equal to well-being) and ideas about how to achieve it differ between cultures. Just to choose one illustrative example, Yukiko Uchida and Shinobu Kitayama suggest that between Americans and Japanese, the Americans place more emphasis on independence whereas the Japanese place a higher value on interdependence.[10] Such different notions of happiness are rooted in differing cultural models of the self, models that have a historical genealogy. If American history and culture in recent centuries have emphasized the autonomous self that is the agent of its own happiness, in Japan the stress on the importance of acting in attunement with one's significant others has resulted in a conception of happiness as a more interpersonal

ideal. Whereas the American way of life encourages people to act against a background of optimism, believing in the achievability of their personal goals, from a Japanese perspective, happiness is more ambivalent since its negative dimensions are incorporated in the horizon of expectation. The cultural differences between America and Japan should not be overestimated, nor should they be expected to be part of every single individual's emotional and pragmatic repertoire, but nevertheless these differences do result in distinctive strategies for coping: »[A]sserting the independent self and blaming external circumstances for the unhappiness« for Americans, and »restoring harmony and interdependence with the surrounding situation« for the Japanese.[11] Uchida and Kitayama's discussion points out for us that the meaning of spiritual life and consequently also spiritual health will look different in different cultural, historical and social settings. This does not, I think, undercut the usefulness of cross-cultural questionnaires such as the WHOQOL-SRPB, but highlights the need to situate their answers contextually.

Two things should be noted with regard to the WHOQOL-SRPB and the question of the place of spirituality in it. First, it is, as Gadamer puts it, »extremely significant that in today's highly developed technical civilization it has proved necessary to invent an expression like the 'quality of life', which serves only to describe what has been lost in the meantime«.[12] The expression »quality of life« denotes the fact that we are actively involved in our own lives and that we have to decide how to lead them. This is, of course, not only a fact in scientific cultures like Western modernity, but more or less in all cultures, and Gadamer suggests that we should ask what insight might be found in tradition that we might want to retrieve. I will say something more about that soon. Second, it should also be noted that it is indeed a characteristic of our late modern world that we want to measure the »quality of life« through instruments such as the WHOQOL-SRPB. In part, this wish is probably motivated by the aspiration to live up to certain scientific standards and thereby to legitimize the very idea of spiritual health. I would not deny that this can be a fruitful approach in some ways, but I still wish to keep in mind the need for a critical vigilance even in the face of science; what aspects of health are highlighted in this way, and what aspects fall out of focus? If health is enigmatic, as Gadamer proposes, in that it withdraws itself from our conscious awareness, do we really do the matter justice through a questionnaire? I shall return to these questions, but let me now move on to the question of the relationship between spiritual and existential health.

EXISTENTIAL HEALTH VS SPIRITUAL HEALTH

The term »existential health« has been used for a while, at least in scholarly works in Sweden. The concept is used most extensively in the psychology of religion, especially by the professor of psychology of religion at Uppsala University, Valerie DeMarinis, at least since 2003 in a book titled *Pastoral Care, Existential Health, and Existential Epidemiology* and in several later articles discussing existential dysfunction as a cultural epidemic.[13] In the book she defines the existential dimension as concerned with how meaning is construed for the individual, and it is therefore consequently quite wide-ranging, encompassing »worldview conception, life approach, decision-making structure, way of relating, and way of understanding. It also includes the activities or expressions of symbolic significance, such as rituals and other ways of [making] meaning.«[14] In a later article on the same theme, DeMarinis develops the concept of existential public health, suggesting that existential dysfunction is the lack of any »operational narratives, value structures, and decisional pathways as well as the ritualized expressions of such«.[15] It is quite clear that for DeMarinis, the choice of the concept »existential health« is, at least in part, motivated by her wish not to prescribe a certain tradition of existential meaning, for instance some particular religious tradition, but instead to use it as a functional concept including many different worldviews and traditions, both religious and non-religious, both traditional and non-traditional. Further, according to DeMarinis, existential health is close to WHO's description of the third public health revolution. Whereas the first focused on communicable diseases and the second on incommunicable diseases, the focus of the third is quality of life. Identifying a lack of viable existential traditions for a significant section of the population in a certain region or state, psychology of religion can, while still being existentially neutral, contribute policy recommendations with regard to »wellbeing, prevention, and intervention« or, in other words, empowerment for the individual.[16]

DeMarinis's perspective is developed further by one of her doctoral students, the already mentioned psychologist of religion Cecilia Melder, in her dissertation with the telling title (in translation) *The Epidemiology of Lost Meaning. A Study in Psychology of Religion and Existential Public Health*, published in 2011.[17] Melder considers »existential health« to be the same as »spiritual health«, except that, for her too, »existential« is a term that in a Swedish context does not carry connotations associating it with any particular confessional tradition.[18] She distinguishes content from function, claiming to be neutral in regard to the former, and also suggests that »existential« refers to »an inner dimension« that nevertheless interacts with »the

outer world in the form of, for example, one's own body and other human beings«.[19] The desire for neutrality is not only motivated by her academic standards, but also, and perhaps foremost, by a perceived difficulty, especially in a Swedish context, in developing »value neutral« definitions of SRPB or spirituality, religion and personal beliefs. According to Melder, this is why, in Sweden, questions concerning existential health have not been very high on the public health agenda, despite its quite obvious importance for questions of public health.[20] It is interesting to note, however, that her informants nevertheless use the term »spiritual« rather than »existential«. This tells us something about one use of existential health, which in DeMarinis and Melder is strategic; the choice of terminology finds its ultimate reason in »existential« being a less loaded and more neutral term than »spiritual«, at least in Sweden. I have some doubts about whether the change of terminology from »spiritual« to »existential« really does help to solve these problems, especially since both Melder and DeMarinis are interested in suggesting policy recommendations for the maximization of existential function. Be that as it may, for now, the important contribution of their joint perspective is the stress on the importance of existential health for public health issues, and as a part of these issues in itself. Concluding on Melder, it is clear that her use of the term »existential« is more or less synonymous with the use of »spiritual« in discussions of the relationship between quality of life and health conducted in English; here, »existential health« means the same thing as »spiritual health«.

Let me mention two things that might complicate the accounts of DeMarinis and Melder. First, through Melder's choice of terminology, and contrary to her claimed intention, she actually repeats a kind of Cartesian dualism with regard to the relationship between mind and body in suggesting that existential refers to an »inner« dimension that can be complemented by input from the »outer« world. That such a distinction shows up here is not surprising, however, as the effective history of the concept of spirituality, at least in modern times, has often put this concept in a bipolar dualism with embodiment, setting spirit over against body, as was done for example in some of René Descartes' writings and their effective history. Obviously, despite Melder's and DeMarinis's wish to avoid the value-laden connotations of spirituality by using »existential health«, the modern dualism seems to linger still. Thus my second point of contention would be that the choice of »existential« over against »spiritual« does not achieve what it seeks to in the substitution of terminology. Even the very concept of spirit is a multifaceted one with a long and winding history, and when questionnaires such as the WHOQOL-SRPB make use of it, it is indeed already used in an inclusive way so as to

avoid the impression that only religious believers would have a »spiritual life«. Once upon a time, »spiritual« was not understood as a contrast to »bodily« or as an aspect of human existence, but more as an all-encompassing concept describing the intentional direction of the entire human existence.[21] All of this may have changed, but whether we choose to talk of spiritual or existential health, it seems to me that it would be premature to define any of these as just another dimension alongside the other three, physical, mental and social. I do recognize the need for the psychology of religion in defining »spiritual« or »existential health« in a way that makes it possible to measure somehow, but nevertheless we should be aware that we don't forget this broader use of the terminology »spiritual« or »existential«. I would suggest following the praxis of WHO in naming the hitherto neglected dimension »spiritual health« but reserving the use of »existential health« for the more encompassing perspective. To explain in more detail what I mean by this, I need to make a historical detour.

PRE-MODERN AND MODERN CONCEPTIONS OF HEALTH

Let me return to the distinction between health as the »absence of disease or infirmity« and health as a »state of … well-being«; this was central to my initial claim that health has many dimensions. But what is the reason behind the interest in this multidimensional health in recent decades? What does it signify, and why do we need to distinguish between different dimensions in the first place? I think one of the main reasons for the interest in dimensions of health other than just the biomedical is the sense that something vital to our understanding of health is lost if we do not attend to these other dimensions, whether they are called physical, mental, social, spiritual or existential well-being. Our current understanding of health, at least in Western or Western-influenced parts of the world, is in large part a result of the biomedical revolution that has been a central part of the modernization process. The physician and philosopher Jeffrey P. Bishop reminds us in his book *The Anticipatory Corpse* that in pre-modern medicine, cure and care were not as separate as they have become in modernity.[22] Even if one distinguished, in medieval society, between *cura animae*, the care of the soul, which was the responsibility of the priest or the church, and *cura corporis*, the cure of the body, which belonged to the doctor or the hospital, these two forms of *cura* were taken together in the monastic houses. Indeed, it was not until the advent of modernity that they came to be regarded as different species altogether, and not just different responsibilities for the same human being.

Please note that I do not claim that health as an absence of disease or infirmity and as a state of well-being historically

used to be one and the same thing. If that were the case, then it would be in principle impossible to distinguish between, say, a physical infirmity and a spiritual state. This would mean that physical infirmity would always run the risk of being »moralized«, so that the infirmity in question would be interpreted as having its cause in some moral deficiency of the patient. The French historian of science Georges Canguilhem calls this an »ontological theory of disease«.[23] It is quite clear for us in late modernity, I think, that disease or infirmity might well have a cause that lies outside of anything for which I could be held personally responsible. It is quite clear, however, that even before modernity one was aware that there are diseases that are simply diseases in the sense that they are outside of our moral or spiritual responsibility. Consider, just briefly, the well-known story about the healing of a man born blind from the Gospel of John, chapter 9, where Jesus denies to his disciples that the reason for the man's blindness would be that he or his parents had sinned (v. 1–3).[24] This is an illustrative story for my purposes here, first in that it denies any necessary relationship between the man's infirmity and his spiritual state. Second, however, the disciples, although mistaken, refer to a larger picture of health than merely the absence of disease or infirmity, and in this they were indeed acting from their previous experience of Jesus. In the story of the healing at Bethesda, chapter 5, Jesus asks a sick man »Do you wish to get well?« (v. 6) – a question that implies that the wish to get well concerned not only the physical aspects of the man's existence, but spiritual too. The Greek word for »well« here is *hygies*, and the connotations of this word are much wider than just health in a biomedical sense. As the German historian Klaus Bergdolt points out, it »is significant that the Greek language has no word to describe health in a purely 'clinical sense'« but includes »[h]ealth, healing and religious faith«.[25] *Hygies*, to the author of the Gospel of John, includes, among other things, health as the absence of disease or infirmity, as it extends to spiritual salvation as well as social recognition and personal empowerment. In other words, then, in these well-known pre-modern stories we find an example both of a concept of health that is significantly broader than the modern concept of health as the absence of disease or infirmity, and also a realization that there is a need to distinguish between different dimensions of health instead of thinking of these different dimensions as one and the same. Even in the pre-modern stories from the Gospel of John, there is a recognition of the multidimensionality of health without collapsing these different dimensions into each other.

The Gospels were not the only sources of such recognition of the multidimensionality of health as well as a more holistic understanding of the person. As Bergdolt points out, in the

Corpus Hippocraticum, which has been very influential in Western medicine, the focus was not on illness as such but on the sick individual.[26] In this approach to medicine, curing diseases was not distinguished from caring for one's own health by living right. Dietetics, for example, was a prominent part of medicine, among other things. Today, dietetics is the science of what and when to eat and drink, but in antiquity it also included other dimensions of healthy comportment, such as »climatic factors, the environment, sleeping and waking, sexual intercourse, rest and activity, as well as optical and acoustic factors«.[27] Physical and spiritual well-being were seen as harmoniously dependent upon each other. It might be worth mentioning that music was also considered to be a part of the healing process of medicine in ancient Greece, as it could be used to restore or moderate the harmony of the patient.[28] Even to Galen, the most influential physician of our era, who practised in Rome in the second century, health is a holistic affair; it is »classified as a *habitus*, which was not only oriented towards an optimal physical regime, but also aspired to the harmonization of all aspects of human life«.[29] Similar »holistic« doctrines of health, if we may call them that, could be found not only in Greek, Roman, Biblical or monastic traditions but also in Islam, which drew heavily on the Hippocratic tradition.

Undoubtedly, these traditions would need to be discussed at much greater length to really understand how they conceived of health. My only point here, however, is that these traditions had a »personalistic« understanding of health, by which I mean that they held together, in the understanding of the human person, different dimensions of health. To be sure, it was well known that these dimensions that we call physical, mental, social and spiritual really could be distinguished from each other, so even though most of these traditions worked within an »ontological health« framework, it was understood that there were non-causal relations between these dimensions. What most of all separates us from the pre-modern in terms of health is that we no longer regard health as a whole. Health has become, in modernity, defined as the »absence of disease or infirmity« and the reason that the definition by WHO also mentions well-being as an aspect of health is primarily that the relation between these two aspects is no longer self-evident, as it would have been for anyone living before modernity. I do not only mean that these two aspects of negative and positive health definitions are distinguished from each other but, more emphatically, that they are not even associated with each other. »Cure« and »care« today are regarded as separate activities, catering to the »body« and the »soul« respectively, in a dichotomy that characterizes a lot of contemporary medicine.

The development of a modern conception of health will not be dealt with specifically here.[30] My digression on the pre-

modern conception of health just serves as a contrast to the modern dichotomy between different dimensions of health that the WHO definition tries to amend; the aim is not to return to a pre-modern concept of health but to search for an adequate understanding of health today in the light of past conceptions. According to Bergdolt, once again, it is in the nineteenth century »that the concept of health comes down to a matter of what is *measurable*. For most doctors, healing became a technical process, while sickness meant a deviation from the *norm*«.[31] In essence, then, doctors measure bodies or tissues or cells or molecules to establish whether the object in question deviates from the established norm or not. This means that the modern negative definition of health relates to what is considered normal. As Canguilhem puts it, »every conception of pathology must be based on prior knowledge of the corresponding normal state«.[32] Disease is no longer a disturbance of the harmony of human beings but rather deviation from the statistically established norm. Medicine, consequently, is no longer considered to be an art but a natural science. Cartesian dualism separated the body from the soul, and whereas the body could be studied by scientific methods, the soul was understood as the agent of this study in a bifurcation of subject and object and is thus itself not available for study.
A further consequence of this conception of health as the absence of disease is that it is no longer within the patient's power to ascertain whether he or she is healthy or not; instead, that power is held by the medical specialist. In a strict definition of disease and health from the perspective of medical science, well-being, whether physical, mental, social or spiritual, comes into play as far as it is measurable and thus within the scope of medicine to study or to cure. It is a third-person perspective on health as something measurable, not a first- or second-person experience of health.

CONCLUSION

Let me now draw this discussion to a close by returning to what my acquaintance said: »Imagine that it is possible to be so healthy when you have so many ailments!« What this assertion expresses is, among other things, that she has a relation to her own health or illness. She never specified to me what her ailments consisted of, and so we cannot draw any conclusions about the nature of these ailments from her assertion about her own health. It is not unlikely, given her age, that some physical ailments might be involved, but nevertheless, what is important is that she gives expression to a first-person reflexive experience of health. By »reflexive« I mean that she intentionally relates to her own experience of ailment and health, and relates to that experience as her own. To put it another way: It is not only I who experience health or illness, but it is

me who is the subject of that experience so that I could call that experience mine. This might sound like a play on words, but as far as it is possible for us to relate to our own experiences, thereby appropriating them, it is in fact one of the foundational forms of our subjectivity. I would suggest that »existential health« would be a term that is fitting for this reflexive relation to our experience of health and illness. This is something that I have already suggested throughout this article, for instance in proposing that existential health might be understood in a productive way as an encompassing aspect of health, rather than just one dimension of it alongside all others. Indeed, I think there is good reason to talk about spiritual health alongside physical, mental, and social (and perhaps even ecological) health, but spiritual health does not, or does not yet, in the way the concept is used in contemporary research, do full justice to this reflexive dimension of health. I think, further, that questionnaires such as the WHOQOL-SRPB could be helpful in measuring spiritual health as well as arguing for its place alongside other dimensions of health. Nevertheless, there is reason to think that measuring the quality of life will not ever do justice to that enigmatic dimension of health that Gadamer mentions, that health, in a way, withdraws from our experience so that, according to this understanding, health is characterized by the absence of experience rather than by some positive attribute. Even if I hesitate to use the term »holistic health«, existential health according to my suggested definition of it may well include experiences of brokenness as well as a certain discrepancy between different horizontal dimensions of health: physical, mental, social or spiritual.

The reason I want to advocate this encompassing definition of health as existential health is because I worry that, through its incorporation alongside other dimensions of health, spiritual health could be instrumentalized in a way that would be detrimental to our understanding of health (and maybe even to our health itself). The Canadian philosopher Charles Taylor has claimed that in our contemporary Western world, knowledge about health and the experience of health have become two completely different things: »The expert may be leading the most 'unhealthy' life, without ceasing to be an expert; whereas the dutiful patient, who (we hope) is brimming with health, understands very little why his regime is a good one.«[33] To bridge the gap – but not to close it – between a third-person »objective« view on health and a first-person »subjective« experience of health, we need to again understand how intertwined these two perspectives are. My health is never just a matter of how my measures are on a scale between health and disease, whether it concerns physical, mental, social or spiritual health, but always also how I relate to these measures.

A sharp distinction between observation and experience or object and subject tends to understand health as an object or a condition intrinsically unconnected to my plans, longings or hopes as a person other than as an asset to these plans, longings or hopes; it does not understand health or disease as a part of who I am and in relation to and from within which I plan, long or hope. It does not ask what health is good for, but posits it as a value independent of me as a person, or rather as an asset, hopefully, ready to be used by me.

Yet another way of putting it is to claim that measurable dimensions of health and disease or illness only make human sense in a context, and that context is our lives understood not as objects but as histories. As the Dutch philosopher Annemarie Mol puts it in her book on the logic of care, the world »is not something we may look at and judge from the outside. Instead, we are caught up and participate in it, body and all. Chronically, until the day we die.«[34] What the concept of existential health can remind us of, I think, is that health is not a possession. We must not lose sight of the fact that it is we who are healthy or not, and that our health is a concern to us just because it is such an important aspect, in all its dimensions, of how we go about doing things. Existential health is, I would suggest, a non-instrumentalizable aspect of our subjectivity or personhood; it is not something I need to get along with my life, it is rather the very act of living this life as I am living it. Despite all its flaws and shortcomings and diseases, I am healthy, existentially, when this life is mine.

ENDNOTES

1 Preamble to the *Constitution of the World Health Organization* as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (*Official Records of the World Health Organization*, no. 2, p. 100) and entered into force on 7 April 1948.

2 Hans-Georg Gadamer: *The Enigma of Health. The Art of Healing in a Scientific Age* (transl.: Jason Gaiger & Nicholas Walker. Cambridge/Malden, Mass., 1996), 113.

3 Gadamer: *The Enigma of Health*, 112.

4 Harold G. Koenig: »Commentary. Why do research on spirituality and health, and what do the results mean?« in *Journal of Religion and Health* 51:2 (2012), 460.

5 *WHOQOL-SRPB Field-Test Instrument* (Geneva, s. a.), electronic resource [internet]: www.who.int/mental_health/media/en/622.pdf [2015-12-11].

6 Marcelo P. Fleck & Suzanne Skevington: »Explaining the meaning of the WHOQOL-SRPB« in *Revista de Psiquiatria Clínica* 34, suppl. 1 (2007), 68.

7 Cf. John-Paul Vader: »Spiritual health. The next frontier«

in *European Journal of Public Health* 16:5 (2006), 457. On the last point, see Grace Davie: *Europe. The Exceptional Case. Parameters of Faith in the Modern World* (London, 2002); José Casanova: *Europas Angst vor der Religion* (Berlin, 2009).

8 Kathryn A. O'Connell & Suzanne M. Skevington: »Spiritual, religious, and personal beliefs are important and distinctive to assessing quality of life in health. A comparison of theoretical models« in *British Journal of Health Psychology* 15:4 (2010), 729–748.

9 Cecilia Melder: *Vilsenhetens Epidemiologi. En religionspsykologisk studie i existentiell hälsa* (*Acta Universitatis Upsaliensis. Psychologia et sociologia religionum* 25. Uppsala, 2011), 231.

10 Yukiko Uchida & Shinobu Kitayama: »Happiness and unhappiness in East and West. Themes and variations« in *Emotion* 9:4 (2009), 441–456.

11 Uchida & Kitayama: »Happiness and unhappiness«, 452.

12 Gadamer: *The Enigma of Health*, 104.

13 Valerie DeMarinis: *Pastoral Care, Existential Health, and Existential Epidemiology. A Swedish Postmodern Case Study* (Stockholm, 2003); idem: »Existential dysfunction – as a public mental health issue for post-modern Sweden. A cultural challenge and a challenge to culture« in *Tro på teatret. Essays om religion og teater* (*Religion i det 21. Århundrede* 3. København, 2006); idem, »The impact of post-modernization on existential health in Sweden. Psychology of religion's function in existential public health analysis« in *Archive for the Psychology of Religion* 30 (2008).

14 DeMarinis: *Pastoral Care*, 45.

15 DeMarinis: »The impact of post-modernization«, 59.

16 DeMarinis: »The impact of post-modernization«, 71.

17 Melder: *Vilsenhetens Epidemiologi*. Melder's dissertation has a very informative account of the third public health revolution on pp. 35–47.

18 Melder: *Vilsenhetens Epidemiologi*, 20, 25f.

19 Melder: *Vilsenhetens Epidemiologi*, 26.

20 Melder: *Vilsenhetens Epidemiologi*, 59.

21 For an account of this in the Christian traditions, see my book *Heavenly Bodies. Incarnation, the Gaze and Embodiment in Christian Theology* (Grand Rapids, forthcoming 2016), chapter 9.

22 Jeffrey P. Bishop: *The Anticipatory Corpse. Medicine, Power, and the Care of the Dying* (Notre Dame, 2011), 256.

23 Georges Canguilhem: *The Normal and the Pathological* (transl.: Carolyn R. Fawcett & Robert S. Cohen. New York, 1991), 1.

24 We need not concern ourselves here with the question whether the portrait of Jesus in the Gospel of John is historically accurate or not; even if it isn't, the Gospel of John is a

historical document showing some of the prevalent opinions at the time.

25 Klaus Bergdolt: *Wellbeing. A Cultural History of Healthy Living* (transl.: Jane Dewhurst. Cambridge/ Malden, Mass., 2008), 14.

26 Bergdolt: *Wellbeing*, 25.

27 Bergdolt: *Wellbeing*, 33.

28 Bergdolt: *Wellbeing*, 53.

29 Bergdolt: *Wellbeing*, 91.

30 See, rather, my article »Religious embodiment between medicine and modernity« in *ARC. The Journal of the Faculty of Religious Studies* 40 (2012), 1–24.

31 Bergdolt: *Wellbeing*, 287.

32 Canguilhem: *The Normal*, 51.

33 Charles Taylor: *A Secular Age* (Cambridge, Mass./London, 2007), 501.

34 Annemarie Mol: *The Logic of Care. Health and the Problem of Patient Choice* (London/New York, 2008), 108.