2. Concerning Psychological and Existential Health

Peter la Cour, Research Center on Existential Health, Innlandet Hospital Trust, Norway

The Old Testament refers to a distinction between body and soul. The New Testament unfolds a threefold division of body, soul, and spirit, imported from Greek thought. What is meant by the words? There are no definitions anywhere. Most people can probably agree on what the body is, but what about soul and spirit?

In the newly published "History of the Soul" (Høystad, 2021), the countless understandings of the soul in Western cultural history are dissected. Høystad begins his book: "Most people think they have one – very few can explain what it is." I am not certain he is right. It might be the term "soul" is nowadays so problematic a term that far from everyone will claim to have one, as it is associated with old times Christianity, immortality, and transcendence. At the end of the reading of Høystad's book, one is left very informed about the highly changeable character of the definitions of the soul, and it is even more difficult to confirm to have one. Nevertheless, I guess everyone will testify immediately to have a *consciousness* – which might or might not be the same.

Historically, the universe has been assumed to be well described and understood by different leading cultures. The intellectuals of the specific time meant to know of humans and nature and human nature as such, but in reality, they only spoke about their own time and place. Newer or revised understandings are always held high, sometimes even as universal. The history of science is the history of revised mistakes.

We are maybe a little more aware that things change with context at present time. We do more seldom hear about "the human" as a universal construct, as we are more aware of social, cultural, psychological, environmental, narrative, religious, and even biological contexts. We are not able to talk about any reality outside our culturally created language, our shared understanding of physics and logic, and our shared assumptions and definitions about what is up and down (Hendricks, 2021).

Likewise, we cannot talk about our psyche without talking about the reality of context, our language, our schooling, our actual and possible interactions, our learned behavior. As existent persons, we testify to each other's psyche to be psychologically existent ourselves. On the one hand, the interior of humans is 100% culturally and socially built, contextual, and therefore collective. There is no individual psyche.

On the other hand, we cannot talk about the psyche at all without already have acknowledged individual consciousness in ourselves and others: the fact that we all experience to exist. There is a "something" that wakes up in the morning, looks out through the eyes, and can hear the thoughts. This experience of the experiencer is 100% private, it can in no way be shared with others. Individual bodily sensations and feelings, e.g. waking up in the morning can be told of, but never experienced by another person. The psyche seems to have two very distinct dimensions that cannot be put on the same line. It is 100 % collective and 100 % private.

This chapter will consider some of our very basic concepts about the building stones which are creating the health of our psychological lives – and the relations to the body and the social and environmental outside world.

Vertical orientations: Principles of layers in the psyche

When cognitive psychotherapy theory hit mainstream psychology in the 1980s, the understanding of the psyche fell very deep from the high pedestals, in which older psychology and theology formerly had placed it. Deeply rooted in behaviorism and the principles of only working with observable data, cognitive/behavioral psychologists have always argued that the human psyche is basically a product of our learning processes. They divided our psyche into two main parts: the cognitive and the emotional, both of which can learn lessons and act appropriately based on the learned.

Extremist cognitive theorists and researchers now claim they have abolished the gap between body and psyche (Bolton &Gillett, 2019). They find the psyche to be an information processing machine and as such just part of our biology, since all biology, unlike physical and chemical processes, is characterized by interpretation of information. In physics and chemistry "A causes B". In biology, "A causes B in the most observed cases", as they write. Life interprets information and gives room for alterations and mistakes, and evolution is possible. Psyche is nothing but biology.

Few academics go that far in reductionism, but by claiming the psyche to be made of cognition and emotion, cognitive psychotherapy theory also washed away psychological essentials with the bathwater. One such essential was the conscience or what we wish to call it. The conscience had been a cornerstone in the understanding of human nature in nearly all theology for thousands of years, and it was a cornerstone in Freud's three-department human being (id/ego/superego). Most of our Christian religious culture is built on awareness of it, and it leans closely to one other essential left out: the consciousness as phenomena, as it escapes any possibility for being observable, even to be properly defined.

However, cognitive psychotherapy models are not flat. There are layers of learning built in. On the surface, there are *traits* and tendencies observable, and they build on habits and

automatic thoughts. The automatic thoughts are based on core assumptions or *schemata* and beneath them are *rules of living,* which can be helpful or not. The rules are products of cognitive and emotional learning through life. Learning biology and learning principles are at the bottom and thinking about thinking – called *meta-cognition* – is at the top of the cognitive vertical model.

The older psychoanalytic three department model was also layered. The near-to-biology needs and emotions are placed at the bottom, then comes the unconscious psychic life, then the conscious ego, and above the ego, the superego is created by significant relations during childhood. Cognition, emotion, consciousness, body, and society are somehow blended and mixed in this model, which makes it very hard to consider the respective single elements and to separate single psychic processes within the model.

Cognitive psychology had two basic elements in psychic life, cognition and emotion, and psychoanalysis counts three. The third model mentioned here comprises four hierarchical ordered elements. It is the model of modern esoteric psychology (Hauge, 2008). Here, humans are clearly layered and consist of what is named body, emotion, intellect, and spirit (more layers are claimed to exist in the transcendent but are not relevant here). The ranked four-tier system is depicted in Figure 1.

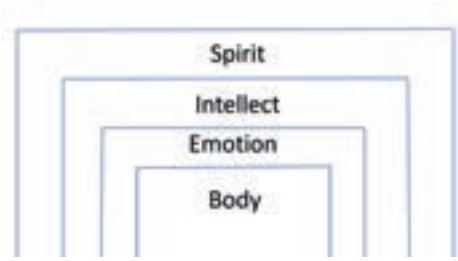

Figure 1. Modern esoteric psychology model of the human

The model has principles connected: it is an up-going system characterized by the fact that the higher layer can relate to the lower, it can "see" it, but the lower layer is not able to "see" and relate to the higher. The body cannot relate to anything – it is just there and by that, it is innocent by nature. The body is always innocent, even when it comes to disease and death.

The emotions are in the body, and they can relate actively to the body. Some of the emotions can be regarded as pure body sensations such as pain and some desires, while other emotions are more complex, but still experienced as emotions within the body. Similarly, the intellect can see and relate to both body and emotions, while the emotions cannot see and relate to the intellect. On top comes the spirit, and it can relate to all layers,

body, emotions, and intellect. Because a higher layer can relate to a lower, personal choice and guilt can be possible. Regarding health, the spirit can be guilty in all relations downwards: body, emotion, and intellect for example by choosing unhealthy food, denying certain emotional expressions, or lying to another human.

An encompassing model of humans in (a materialistic) context is the so-called hierarchy of natural systems, proposed among others by medical internalist Georg Engel (Engel, 1977). He places the human in the middle between the atoms and the biosphere (Figure 2).

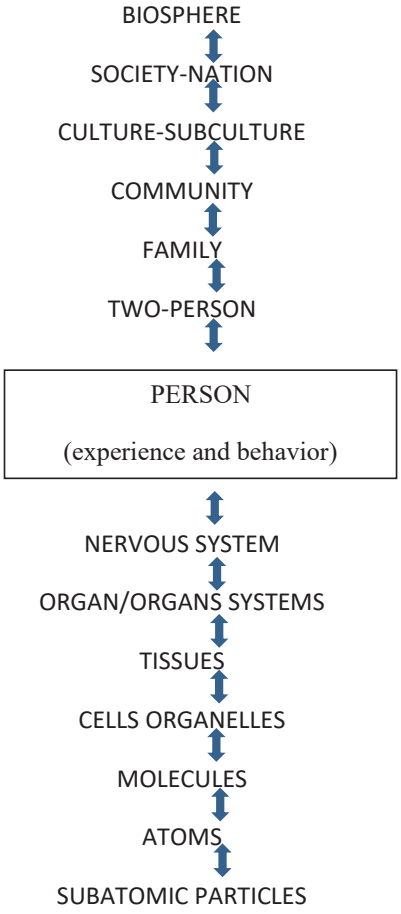

Figure 2. The original “Hierarchy of Natural Systems” model of G. Engel (1980)

The model is a model of *emergence.* The higher level is constituted by the lower level but comprises characteristics and abilities not represented or present at the lower level. Tissues are made of cells but have gained qualities and functions not present at the cell levels alone. The logic of emergence goes very well for the two main parts over and under the middlebox

named “person” in the figure. However, the logic cannot be applied to the levels under and over the box named “person”, as we have no idea of the relation between the nerves and the experience (and behavior). We do not know what experience is made of – it is somehow related to nerves, but it is not built of nerves. Neither do we know anything about the logical bonds between experience and a two-person unit. The two-persons unit is certainly not built of experiences as it is material and observable.

The model suggested a completely new idea related to health, however. It claimed that illness is not fixed to a special organ or level but is present everywhere through the hierarchy of natural systems. A heart failure is not just a failure of the heart but is represented at every level, disturbances can be found in the molecules, the blood, the person, as well as society. This original idea somehow disappeared in the following years, where the model became largely misinterpreted as classic psychosomatic thinking (Ghaemi, 2009, 2010).

Concerning psychological health, the model had nothing to offer at all. Later critique has focused on the wrong understanding of modern system theory (complexity theory) and the missing element of subjectivity in the model (la Cour, 2021). Attempts to define psychological health will be the focus of the following.

Horizontal orientations: Attempts to define psychological health

The disciplines of psychiatry and clinical psychology have dealt with psychological *bad* health in western culture for 150 years. Psychic illnesses are now listed in diagnostic manuals (as ICD11); a continuously updated number of officially labeled psychiatric diseases. Some of these are seen caused and closely related to body or nerve abnormalities for example dementia or abuse-related hallucinations, while others are seen almost independent of body and nerve functions, for example, social disabling pessimism or antisocial personality disorder.

Much less is written about being psychological *good* health. What does it mean to be psychologically healthy? There is certainly no single answer, but American psychologists Batson, Schonrade, and Ventis have listed the following seven different kinds of definitions nearly 30 years ago (Batson et al., 1993):

1. Absence of mental illness: The psychiatric thinking that if no mental disease is present, we are healthy (negative definition).

2. Appropriate social behavior: The cognitive psychology view of social adjustment as the best sign of psychological health (culture relative).

3. Freedom from worry and guilt: The psychoanalytic ideal of a ceasefire in the inner constant battle between conflicting inner forces.

4. Personal competence and control: The more power-oriented ideals of self-mastery (e.g. Adler)

5. Self-acceptance or self-actualization: The American humanistic psychology ideals of full personal growth into some sort of completion

6. Personality unification and organization: The ideal of a unique mature balance between personality and environment

7. Open-mindedness and flexibility: The ideology that close-minded and rigid persons live a less attractive life

As seen, the list ends with old school American values - as expected when developed in America in the late 1980s. It would not be too hard to bring such a list up to date by adding the buzzwords of the contemporary and modern psychotherapeutic movements. Concepts as “mindful”, “resilience”, “acceptance” and “commitment” might capture the dominant psychotherapeutic ideals in contemporary western psychology.

The kind of list could be expanded in multiple ways, and it highlights that psychological health can be seen and has been seen in an ideological and cultural malleable way, deeply related to societal context and contemporary cultural values.

Anyhow, something other is noteworthy. Some of the mentioned definitions see psychological health from the outside, as observable (e.g. social adaptation), while others see psychological health from the inside (e.g. self-acceptance).

The existence of two kinds of psychology

Let us consider the “inside” and “outside” kinds of psychology further. In the context of academic psychology, psychology as a discipline has developed along two different lines, sometimes called the ideographic and the nomothetic orientations to address the psyche. Historically, this division of psychology originated in the two schools of Wilhelm Wundt and William James (Hergenhahn, 1997), but it mirrored older dichotomies in theology, philosophy, and theory of science in general.

The two dimensions differ in what is considered as valid ways to get information about the psyche. The ideographic orientation and perspective take the subject seriously and see the conscious experience as the basis of knowledge of psychology. It can embrace things such as art perception, dream analysis, and existential concerns and attitudes. Its focus is on the *private* inner life and is less observant of what is given by context, biology, conditions, or building stones for psychology The nomothetic perspective on the other hand sees the building blocks of psychological life in focus as valid knowledge of the psyche. It focuses on what is observable and common, shared between subjects, *collective*. It views the psyche as

learning biology, brain and brain functions are central knowledge. What is learned are the biological, cultural, and social givens: language, norms, social life, socio-ecology, and socio-economy. It does not take in the conscious experience or personal attitude and by that, it is less observant of the sides of inner life that cannot be objectified and shared.

Instead of trying to join the two incommensurable types of psychology, we could hold the idea of splitting them properly. That means to make a split between private and collective psychology. That is done by the contemporary psychologist and philosopher Ken Wilber (Wilber, 2007) among others. Wilber is known for combining the division of the inner and outer world with a division of the private and collective, giving a holistic picture of the human world seen as a "quadrant" (Watanabe, 2010). With a few modifications, the basic pluralistic picture can be presented as a "circumplex" model showing the two crossing continua, resulting in four dimensions, as seen in Figure 3.

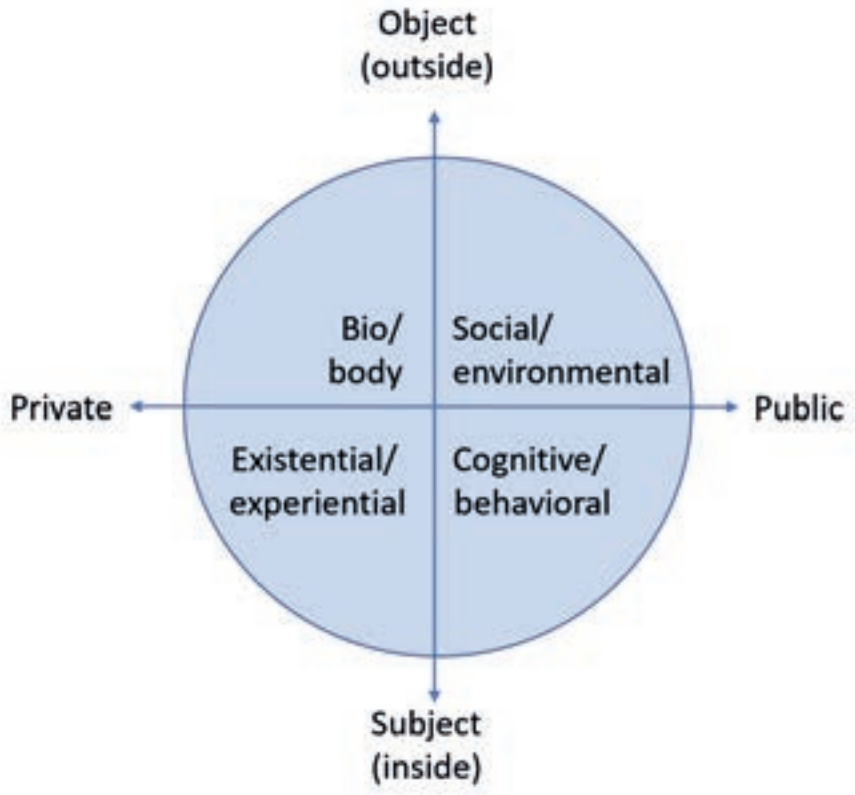

Figure 3. A circumplex model of human dimensions

Four dimensions of human life

These dimensions have previously also been considered as possible dimensions of health and illness, combining them with a symbol of complexity (la Cour, 2021, 2022). Here, let us short recapture the former description of the two upper dimensions before going further into what is important in this context, the distinction, and definitions of the "psycho" and the "existential", here named as cognitive and existential.

The dimensions must be seen as all interrelated, but somehow segregated for and by humans, as we have no common concepts, language, or understanding of phenomena covering all four dimensions as one.

The first dimension (upper left) is "bio" (biological) represents the natural science perspective of a specific human. Bio represents the private, material body and comprises the body as an object, the body as "it". Bio can be described positively in biological and medical terms. Bio links the concrete individual to basic biological matter and principles, such as the principles of regulation and homeostasis in the body (e.g. digestion, immune system, hormones).

Concerning health, taking a blood sample and analyzing it for specific antibodies can be an example of the biological dimension.

The second dimension, (upper right) "social", represents individuals in relation to objectifiable surroundings, structures, and environment shared with others. It is the environmental and social science perspective. The social field comprises the physical, material environment, and the political characteristics (the social context) in the environment such as structures of groups and society, networks, workplaces, and the sociodemographic facts connected to this, standards of education, economy, social segregation, housing conditions, etc.

Concerning health, development, and communication of better nutritional advice can be an example of the social dimension.

The collective and private side of psychology (dividing the "inner side")

The third dimension, (lower right) "cognitive", represents those dimensions of the inner world that are common, connected to, and shared with others; our learning interactions with and within the collective, observable interpersonal reality. It is the inner side of the intersubjective world, all the abilities, and qualities of a person such as intelligence and personality, which others know or can know of, the trait personality as such. It is the psychological functioning when psychologically described (not the brain functions, which are bio). Psycho concerns all the intersubjective, cultural, and cognitive elements; the language learned and spoken, the schooling and education, the learned common knowledge of the

world. It comprises the behavior, cognitions and emotions learned and shared with others as interpersonal, the observable characteristics of relations to e.g. children, family, friends, and colleagues: the cognitive and social perspectives of psychology. Psycho concerns the daily automatic administration of psychological needs, traits, habits, and behavior of the person, e.g. the person's lifestyle, role-playing, dispositions, tendencies and learned social adjustment, the person's cognitive style, talents, and impairments, the personality in its exchange with social reality and groups. This includes subconscious patterns as well as conscious psychological patterns. Psycho comprises all observable psychology based on learning principles, along with observable or shared moods and problems. Mental health and psychiatric illness are included in this dimension when they are intersubjective, observable, and can be registered, described, and treated by others as signs of unusual mental functioning. Psychiatry and cognitive psychology are typical disciplines involved.

A health routine in this dimension could be diagnosis and treatment of depression or stress when these psychological dysfunctions are treated with cognitive style (learning-based) psychotherapy or behavioral regulation as working principles. For the patients/clients, the impact and changes resulting from such personal contact and learning are part of this third dimension.

The fourth dimension, (lower left) "existential", represents all experiences and orientations a human has on one's own, the "I" perspective. It is the thinker. It includes the experienced body, when it is seen as "me", the bodily sensations, perceptions, joys, and pains; experiences of wellbeing and suffering. The experienced body is constantly scanned for sensations and feelings, and it can feel well or sick.

The existential dimension embraces the subjective orientations, i.e. the personal reflections and choices made by the individual. It is a truly subjective, experiential dimension grounded in the basic experience of being alive and participating in the world, to be existent. The existential dimension comprises the inner life where the "I" makes its considerations over the world and its events, not mirroring, but valuing things. It comprises concepts as meaning, hope, will, purpose, life satisfaction, the joy of life, and all genuine choices in life, as well as the opposites: crisis, meaninglessness, hopelessness, agony, suffering, lack of engagement, and living without direction. Existential encompasses the personal narratives and includes experiences such as dreams, fantasies, and perception of art. The field covers the sources of meaning in life, personal values, ethics, world views, beliefs, convictions, religious orientations, ultimate concerns, political views and commitment, and the motivations and choices based on these orientations.

This dimension is the least objectifiable of all. Humanistic sciences are involved with disciplines like humanistic-oriented psychology, theology, anthropology, philosophy; disciplines that hold what is subjectively experienced as a reality, including the medical profession when understood as a humanistic discipline ("the good doctor" (Bailey, 1993)).

Some health-related examples: Some feel sick but are well in laboratory tests, others feel well but have abnormal lab tests. Some are very careful of keeping up good health, others do not care much about their body and are not cautious about it. Some can accept illness and thoughts of death, others cannot. Some engage, others capitulate during illness. Some experience loneliness even when surrounded by others. Some die from meaninglessness and sorrow. Some choose to commit suicide.

Limitations and strengths of the four dimensions

The four-dimensional model represents a reduction of reality like any model. Some aspects of reality will not fit anywhere in the model, and many other aspects will cross or be present in multiple or any of the fields. The lines between the fields are not intended to reflect reality as such but represent our cultural, social, and historical understanding at the present time. On the practical level, the borders may be set mainly by the language, routines, research, self-understanding, and practical handling of the perspectives in the dimensions.

Most important is the acknowledgment that all four fields are fully present all the time; none can be left out, but one or another can be in focus in specific contexts**.**

"Culture" is not placed anywhere specific. Culture is a concept extremely hard to define as it is all-pervading (Hatala, 2012). Culture is not a "thing" or a "process" that can be placed in any specific dimension as it is everywhere. Culture is in biology (e.g. the body develops and shapes under cultural conditions such as food traditions and fashions); culture is cognitive (e.g. in the cultural language learned); culture is social (e.g. work hours), and culture is existential (e.g. worldviews, ethics, and religion). Culture is convincingly also suggested to be understood in a 2 x 2 factorial design, very much like the four dimensions suggested here (Carriere, 2014).

A model is always a balance of what is captured for the ease of understanding and what is left out for the ease of understanding.

Health and illness

The model suggests the idea to hold a holistic concept of health and at the same time to specify health in all four dimensions: Physical health, social health, mental health, and existential health. Each dimension has possibilities for unfolding and development in linguistic and scientific concepts and expressions. The pathways of causations between the dimensions are also explorable. They are themselves very interesting, and Karunamuni et al (Karunamuni et al., 2021) have mapped these cross-discipline borderlands with central research areas such as psychoimmunology, stress/HPA axis, placebo, stigmatization, and life events research. These are indeed promising and upcoming research fields which have to

cope with the challenges of combining two or more languages and common scientific understandings.

A suggestion for defining health through the dimensions

When combining the initial part of this paper regarding the hierarchical nature of our human existence with the four-dimensional model, it could be tempting to end up coining some structural thoughts as a raw draft of definitions of what is healthy in the different dimensions.

In a sort of slogan-like manner, WHO has defined health as "more than the absence of illness". But what is the content of the "more than the absence"? The interesting part is what *constitutes* the "more". How is it defined? Can it be further elaborated?

I will briefly take my chance.

If we think of the four dimensions in a hierarchical structure, we can follow the principles of downward inclusion and upward blindness from Figure 1 and depict the four dimensions in hierarchical order as done in Figure 4.

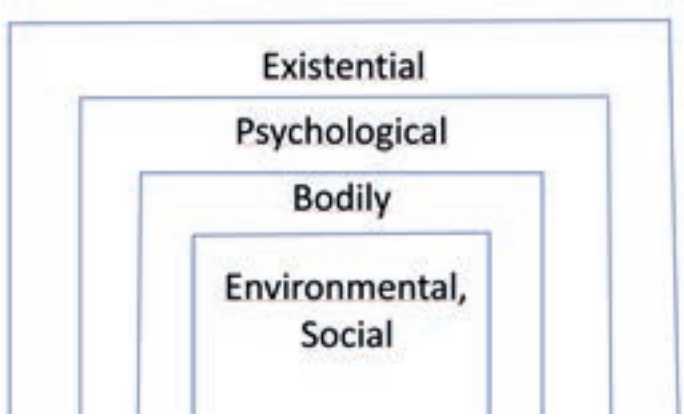

Figure 4. The four dimensions in a hierarchical structure

With this figure in mind, the health defining principle could now be suggested in this way: A specific layer of health is most healthy when it is able to serve the layer above well. This means making possibilities for nature of creating something more advanced, more evolved, and higher organized. Health may structurally be defined as *well-functioning in relation to making it possible to serve the dimension above.*

With this kind of definition, we will define health elements in every dimension by their function and *resources*. The idea of health seen as a resource was originally formulated by WHO in 1986 (World Health Organization, 1986). In this paper, it was also stated that health as a resource regards health as *a means* and not as *an end*. The concept has later been discussed and developed further (Williamson & Carr, 2009).

With these thoughts, we might even begin to define health in the dimensions.

Environmental/social health.

Resources for biological life are of course the basic building stones. Resources can be viewed as for example functional and reliable atmosphere, temperature, nutrition, environmental variations, and reproduction possibilities. Recycling processes must also be present, which paradoxically involves biological death as an environmental health resource. For more advanced mammal life, a healthy environment includes social resources for keeping up social bonding. For humans, healthy environment resources also include supplies of cultural, political, and organizational structures. In modern human civilization, all structures of a health care organization are healthy environmental resources, such as availability of health knowledge, healing professions education, functioning hospitals, high tech bio equipment, and common access to health care.

Physical health

Physical health is defined as resources for well-functioning of the layer above, the psychological/cognitive level. This implies biological resources for the creation and maintenance of emotions, attention, memory, and all learning processes. Cognitive functions are possible and served by well-developed and well-functioning body parts and processes, organs, homeostasis principles, including all brain functions. Physical injury or biological functional error is defined as unhealthy or ill if it disturbs or disrupts psychological/cognitive functioning.

This kind of definition might offer a solution to several endless health discussions, for example, whether well-medicated asthma or the absence of a little finger on the left hand can be regarded as an illness. Likewise, it can bring new light to the long-lasting discussions about health viewed as “apparatus-failure”, where any malfunction in the body-machine ideally must be corrected. The apparatus-failure viewpoint has made death the ultimate enemy in all medical history. But biologically seen, the body has its own biological project: it develops, reproduces, and dies. Death is as natural and healthy as reproduction; death is the holistic biological purpose of the body. Death is not the enemy, it is part of biological health to decay and die (la Cour, 2016), (and it might be a provoking thought that death might serve the higher levels also…)

Psychological/cognitive health

Psychological/cognitive health is present when the cognitive/emotional resources, psychological well-functioning, and development make subjective existential life possible. By

this, mental dysfunction is still an illness as defined in psychiatry. However, psychiatry has faced the problem of relativism, what is sick in one context might not be sick in another context. Psychiatry has been accused to be a completely constructivist activity, as there are no "objective" sick thoughts or measurements of such. The definition suggested here might offer something new to this discussion. The idea that psychology/cognition is healthy when serving the existential level might be a kind of steppingstone of the relativism of psychiatry. Dementia, depression, anxiety, stress, psychosis, etc. do not serve the existential dimension well.

Existential health

Existential health might be defined as the resources for the experience of living a fulfilling life. A fulfilling life might be seen as a preparation for even a higher level of existence, which includes transcendent life orientations such as religion, but it can also be fully seen as immanent as in the existential lines of thought with concepts such as meaning, hope, will, purpose, life satisfaction, the joy of life, and the ability to grow or derive meaning from crisis and life contradictions. Existential health is not the question of being alive, as in biology, but living a life valued as worth living, connected to an experienced life continuity of past, present, and future. Existential health also includes the experience of being "full of days", then embracing personal death, death on time.

The open end will be the questions of what defines "fulfilling". It could be something inherent in biology or the universe, or it could include dimensions of transcendence that go beyond ordinary time and space. These questions may be the upper ceiling for psychology, and where other disciplines take over.

Perspectives…

These lines of thought are certainly unfinished and complex, the intentions for writing them are to contribute and inspire further elaboration and rethinking, whether it be of medical, psychological, theological, or philosophical nature. It is the endless puzzle of the relation between subject and object; "what is me and what is not me" as William James has formulated the basic mystery.

References

Bailey, I. (1993). Sir William Osler (1849–1919): Physician, Teacher, Historian, Biographer, Bibliophile. Journal of Medical Biography, 1(1), 2–10. https://doi.org/10.1177/096777209300100102

Batson, C. D., Schonrade, P., & Ventis, W. L. (1993). Religion and the individual. A social-psychological perspective. Oxford University Press.

Carriere, K. R. (2014). Culture Cultivating Culture: The Four Products of the Meaning-Made World. Integrative Psychological and Behavioral Science, 48(3), 270–282. https://doi.org/10.1007/s12124-013-9252-0

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. Science, 196(4286), 129–136. http://www.ncbi.nlm.nih.gov/pubmed/847460

Ghaemi, S. N. (2009). The rise and fall of the biopsychosocial model. The British Journal of Psychiatry : The Journal of Mental Science, 195(1), 3–4. https://doi.org/10.1192/bjp.bp.109.063859

Ghaemi, S. Nassir. (2010). The rise and fall of the biopsychosocial model: reconciling art and science in psychiatry. Johns Hopkins University Press.

Hatala, A. R. (2012). The Status of the "Biopsychosocial" Model in Health Psychology: Towards an Integrated Approach and a Critique of Cultural Conceptions. Open Journal of Medical Psychology, 01(04), 51–62. https://doi.org/10.4236/ojmp.2012.14009

Hendricks, S. (2021). You don't see objective reality objectively: neuroscience catches up to philosophy - Big Think. Thinking. https://bigthink.com/thinking/objective-reality-2/?utm_medium=Social&utm_source=Facebook&fbclid=IwAR0UGGOP_c0XjWErDKC7pwtG4JShQ9QVlEbl5MKVmRuS1ub-Bc06-Co_BHg#Echobox=1641395392-1

Hergenhahn, B. R. (1997). An Introduction to the History of Psychology. Third Edition. Brooks/Cole Publishing Company.

Karunamuni, N., Imayama, I., & Goonetilleke, D. (2021). Pathways to well-being: Untangling the causal relationships among biopsychosocial variables. Social Science & Medicine, 272, 112846. https://doi.org/10.1016/J.SOCSCIMED.2020.112846

la Cour, P. (2016). Sundhed og det hele menneske. In J. Holten-Andersen, M. H. Richter, A. G. C. Jensen, S. Melgaard, R. Wolff, J. Eskildsen, & K. Holten-Hansen (Eds.), Livet efter væksten - samfundsvisioner i en omstillingstid (pp. 17–29). Hovedland.

la Cour, P. (2021). Hvad er vedvarende uforklarede fysiske symptmer? FADLs Forlag.

la Cour, P. (2022). The four-dimensional model of health and illness. Submitted to Journal.

Watanabe, T. (2010). Metascientific foundations for pluralism in psychology. New Ideas in Psychology, 28(2), 253–262. https://doi.org/10.1016/J.NEWIDEAPSYCH.2009.09.019

Wilber, Ken. (2007). A brief history of everything. Shambhala.

Williamson, D. L., & Carr, J. (2009). Health as a resource for everyday life: advancing the conceptualization. Http://Dx.Doi.Org/10.1080/09581590802376234, 19(1), 107–122. https://doi.org/10.1080/09581590802376234

World Health Organization. (1986). Ottawa charter for health promotion, 1986. https://apps.who.int/iris/bitstream/handle/10665/349652/WHO-EURO-1986-4044-43803-61677-eng.pdf?sequence=1