EXISTENTIAL MENTAL HEALTH: AN EMPIRICAL APPROACH[1]

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Most forms of psychotherapy, recent surveys show (4), are much confused in their standards and objectives. In this respect existential analysis makes a definite contribution. Although it is doubtful whether *Daseinsanalyse*, logotherapy, or any other variety offers a distinctive form of therapy, they all propose a distinctive and potentially valuable definition of mental health as the goal for therapy: a mind is healthy when it has achieved a sufficient store of "meaning" to enable it to master suffering and to direct daily action.

Now, meaning is a broad concept; at best it merely locates a syndrome. While various existential authors favor one or more of the components of this syndrome, the following seem to cover the range of current existential writing on the norms of mental health.

1. *Uniqueness*. Not only must the individual realize that he is a unique being, but he must also be aware that each situation he encounters and his relation to it are unique. According to Viktor Frankl, "The uniqueness of every human being and the singularity of all life are vital components of the meaning of existence. This singularity, however, must be distinguished from mere numerical singleness. All numerical singleness in itself is valueless" (2, p. 82). Frankl adds that such meaningful singleness is always directed toward the community.

2. *Responsibility*. Responsibility, according to Frankl, springs from uniqueness. Sartre (7) points out that man must first become aware that he is responsible for his own existence, and that he is nothing else but what he makes of himself. Responsibility is the use of freedom; it requires a capacity to get along with destiny (that part of being which cannot be altered), but also to be superior to it. Although destiny must be endured where necessary, it must be shaped where possible.

3. *Self-affirmation*. Meaning implies not only an awareness, but also an affirmation of one's own existence. Paul Tillich (8) emphasizes that self-affirmation has two parts: self-affirmation as an individual and self-affirmation as a part of a larger world, i.e., community. Existential anxiety is due to the awareness of one's inability to affirm oneself.

4. *Courage*. Tillich defines courage as "the self-affirmation of being in spite of the fact of non-being. It is the act of the individual self in taking anxiety of non-being upon itself by affirming itself either as a part of an embracing whole or in its individual selfhood" (8, p. 155). Despair is surrender of courage and self-affirmation to the power of non-being, which makes human existence meaningless.

5. *Transcendence*. The capacity to transcend the immediate boundaries of time, writes Rollo May (6, p. 67), is an inseparable part of self-awareness. Nietz-

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sche's Zarathustra proclaims, "And this secret spake Life, herself to me. 'Behold' said she, 'I am that which must ever surpass itself' " (6, p. 71). To be rigidly confined to a specific world in time detracts from the meaningfulness of one's existence and can be the basis for various forms of mental disorder.

6. *Faith-commitment.* Gordon Allport defines faith as the belief in the validity and attainability of some goal or value set by one's intentions. "It is the inseparability of the idea of the end from the course of the striving that we call faith" (1, p. 131). But a truth or value becomes reality only as the individual produces it in action, which includes producing it in his own consciousness. According to Kierkegaard (5), a value does not exist until the individual has made some commitment to it. Although faith-commitment includes religious faith, it is not limited to religious faith alone.

7. *World view.* The individual exists in three modes of the world: the *Umwelt*, or natural biological world; the *Mitwelt*, or world of relationships among human beings; and the *Eigenwelt*, the world uniquely present for each individual and the basis for seeing the real world in its perspective. All three modes are dynamic, not static (6, p. 60). The ability to "live" in these three worlds simultaneously is at the very core of mental health, because otherwise the preceding components will not receive full expression.

These components served as the basis for the present study, the purpose of which is to examine whether the mental patient has found less meaning, as defined here, than the "normal" person. Specifically, it is the hypothesis of this paper that five groups of subjects representing five steps of mental health operationally defined (locked-ward mental patients, parole mental patients, chronic physical patients, man-in-the-street, and college students) will show the same order of mental health existentially defined.

METHOD

Questionnaire. A questionnaire (see Table 1) rather than a projective technique was used because "meaning" is presumably a conscious experience. Each item is based on and implied in a definition of one of the seven components of "meaning." The response is assumed to be a direct expression of the presence or absence of the component.

1. Items 6, 15, 20, and 30 attempt to determine the subject's conscious awareness of his *uniqueness*. Items 6 and 20 directly ask if S has this awareness, whereas item 15 asks if it is so acute that S is unwilling or unable to cope with it. Item 30 attempts to determine whether or not S's singleness has value for the community.

2. Items 1, 8, 22, and 29 deal with *responsibility*. In item 1 a negative response expresses absence of responsibility, because it suggests that man does not rule destiny, but is being ruled by it. The other items create various situations aimed at S's ability to rule his sociological and biological destiny.

3. Items 10, 13, 17, and 26 are aimed at S's *self-affirmation* as an individual and as a member of a community. Item 13 was suggested by Tillich's claim that

TABLE 1. EXISTENTIAL MENTAL HEALTH (OR "MEANING") QUESTIONNAIRE

1. Do you think a white person should work for a Negro boss? (*Yes.*)[1] R[2]

2. Is it more important to know about what a person has done in the past and is doing now, or about *what he hopes and plans to do in the future?* T

3. On what would you be willing to spend most of your time and money? (*Belief in the attainability of a goal or value, e.g., "I would help others."*) F

4. Ed lived at home until he went into the Army. He was in the Army three years and during this time didn't have a chance to return home even once. He is now through with the Army and is going home for the first time in three years. Do you think that he will find things at home pretty much the same as they were before he left, or do you think *things will be different?* W

5. Do you feel that you are a religious person? (*Yes.*) F

6. Would you say that all people are pretty much alike, or are they *different from each other?* (Preliminary question, not scored.) How about yourself? Would you say that you are pretty much like other people, or *different from them?* U

7. Should a person try to do something even if he isn't sure that he can do it? (*Yes.*) F

8. Sam is the son of a wealthy business executive. He wants very much to marry a poor girl. But his father dislikes her and will not give him any money if he marries her. If he forgets about the girl, his father assured him that he would make him a wealthy man. What do you think he should do? (*Marry her.*) R

9. If a man has been sentenced to jail where he has to spend the rest of his life in a cell, do you think he has anything to live for? (*Yes.*) C

10. Mr. Adams is a man on the jury at a murder trial. Everyone on the jury except him thinks the defendant is guilty. Should he *try to convince the other jury members* that the defendant is innocent, or should he just agree with them? S

11. Where do you think you will be, and what do you think you will be doing five years from today? (*Ability to transcend the past and present in terms of the future, e.g., "I will be holding a certain job out of the hospital."*) T

12. A newspaper reporter was given an assignment in a small uncivilized village. He would have to live there for two months to complete the assignment. This means that he would have to give up all the comforts of home to sleep in a mud hut on a straw mattress. The sun in this village is very hot. If the reporter completes the assignment, he will become an editor. If not, he will be given another assignment. What should he do? (*Take the assignment.*) C

13. Do you think that death is the worst thing that can happen to a person? (*No.*) S

14. Is it a good idea to *think about the future*, or do you think people would be better off if they just thought about each day as it came along? T

15. Would you like to be more like other people than you are? (*No.*) U

16. If you think a painting is pretty, do you think just about everyone will like it? (*No.*) W

17. Some people say life is useless. Others say it is *not useless*. What would you say? S

18. Do you believe in God? (*Yes.*) F

19. Should a person give his opinion even if he thinks everyone will laugh at him? (*Yes.*) C

20. Do you usually like to do what everybody else does? (*No.*) U

21. Some people say *every day is different* from the one before. Others say every day is pretty much the same. What would you say? T

22. After David was through with high school, he worked as a clerk in a small grocery store. After working there for 15 years, he saved enough money to own his own store. He was losing his sight, however, and the doctors told him he

would be blind in another two years. Because of this, do you think he should take on the responsibility of owning his own store? (*Yes.*) R

*23. What do you want to do when you leave the hospital? (*Belief in the attainability of a goal or value, e.g., "Make good on the outside."*) F

24. Should a person try to think only about things that are pleasant and encouraging? (*No.*) C

25. Some people feel the world is a dangerous place in which men are basically evil. Others *do not feel the world is a dangerous place.* What would you say? W

26. Joe, a patient at a hospital, was once a jet pilot but no one believes him when he tells them this. He really was a jet pilot. What should he do? (*Continue attempts to convince.*) S

*27. Do you like to *think about what you will do when you leave the hospital,* or would you rather think about what happens at the hospital each day? T

28. Which one of the following do you expect to give you the most satisfaction: *family relations, religious beliefs and activities,* recreational activities, *doing something for someone else?* F

29. Bob wanted very much to play on his high-school basketball team, but didn't know whether or not he should try out for the team because he was so short. Everyone else on the team was at least three inches taller than he. Do you think *he should try out,* or not? R

*30. Would anything at the hospital be different if you weren't here? (*Yes.*) U

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[1]Italics indicate answers scored plus, i.e., mentally healthy.

[2]The letters after each item indicate the respective meaning component:

U = uniqueness (items 6, 15, 20, 30)
R = responsibility (items 1, 8, 22, 29)
S = self-affirmation (items 10, 13, 17, 26)
C = courage (items 9, 12, 19, 24)
T = transcendence (items 2, 11, 14, 21, 27)
F = faith-commitment (items 3, 5, 7, 18, 23, 28)
W = world view (items 4, 16, 25)

*Items 23, 27, and 30 apply only to the three patient groups.

non-being threatens man's ontic self-affirmation in terms of death. A positive answer indicates a great deal of anxiety about death, which will tend to undermine the individual's ontic, spiritual self-affirmation. This can lead to emptiness and despair. Item 17 is to determine victory or defeat of such despair.

4. Items 9, 12, 19, and 24 measure *courage.* The last three aim at the capacity to take upon oneself negatives, for a fuller positivity. Item 9 creates a threatening situation which offers S the opportunity to affirm himself in spite of it.

5. Items 2, 11, 14, 21, and 27 aim at *transcendence.* Item 21 questions S's capacity to transcend the immediate situation; the other items question his capacity to transcend the past and present in terms of the future.

6. Items 3, 5, 7, 18, 23, and 28 refer to *faith-commitment.* Although religious faith is not explicitly incorporated in Allport's definition, items 5 and 18 are concerned with religion. They are largely responsible for the failure of this component to differentiate the various test groups (see below). Items 7 and 23 question the validity and attainability of a goal; items 3 and 28 are concerned with capacity to find meaning in values.

7. Items 4, 16, and 25 question *world view.* They ask whether or not S has a meaningful relationship with his *Umwelt, Mitwelt,* or *Eigenwelt.* While item 16 is directed at *Eigenwelt,* items 4 and 25 are not directed at any one world because

the individual exists in all three worlds simultaneously. Since the world is not static, any indication in item 4 that it is, expresses lack of a meaningful relationship with the world.

Evidently, there is no clear-cut distinction between the components; several items deal with more than one component. The components are not meant to be independent, however, but are primarily intended to give content to the concept of meaning and serve as guideposts for testing this concept. Although the results for each component may have a distinctive character, our chief concern is with the total score.

Each item is scored plus (mentally healthy) or minus, the number of plusses representing the total score. Separate subscores were also arrived at for each of the seven components. The positive answers are indicated in italics in Table 1. Most items being of the fixed-alternative type, scoring is objective. For the three open-end items, namely 3, 11, and 23, codes were developed, and they were scored by the author and a second person; discrepancies were negligible.

Subjects. The questionnaire was given verbally to five sample groups of 30 men each: locked-ward mental patients, parole mental patients, chronic physical patients, the man-in-the street, and college undergraduates. The first four groups were matched for age and education; they were on the average 40 years old and none had been to college. The fifth group was composed of students at Harvard Summer School (1959).

The locked-ward patients came from a single ward of a large custodial state mental hospital. Before attempting to administer the questionnaire, the author spent several hours each day for two weeks on the ward to become acquainted with the patients and win their trust. The patients would often answer only two or three questions a day. Often, however, a proposed trip to the canteen was incentive enough to complete the questionnaire.

The parole patients were from the same mental hospital, but had free access to the grounds. Like the locked-ward patients, they had been hospitalized for several years, and a few were former locked-ward patients. Although the two groups are not clearly distinct, the staff psychiatrists considered the locked-ward patients as being "sicker."

As control for the factor of hospitalization itself, a group of chronic physical patients was also tested. Theirs, like the mental hospital, was also a large custodial hospital where little personal attention is given to the patients. After prolonged hospitalization, the patient may become the victim of "hospital psychosis." The prevailing atmosphere of gloom, boredom, and despair was so striking that it seemed reasonable to hypothesize that this group would score lower than the man-in-the-street, but not as low as the parole mental patients.

The man-in-the-street group consisted of taxi drivers, bus drivers, barbers, policemen, janitors, and construction workers in Harvard Square.

Because the components of meaning were taken from the work of educated men who may be somewhat divorced from the ways in which an uneducated man gives his life meaning, a group of college undergraduates was added. The questionnaire may have an "ethnocentric" bias in favor of students, so that the peculiar insecurity and wonder of the intellectual may obtain a higher score in mental health. By adding college students it was possible to test the extent to which this assertion might be true.

RESULTS

Table 2 shows the number of plus answers obtained by each group on each item and their mean total scores. If there is a progressive increase of plus responses from locked-ward patients to undergraduates, the item can be considered to be of diagnostic value and to fit the hypothesis. Item 15 is an example of an ideal diagnostic item. Only on three items—2, 5, and 18—did the locked-ward patients score higher than the undergraduates. On items 5 and 18 mental patients were more willing to commit themselves to religion than undergraduates. On item 2 the patients were more willing to disregard the past and present in favor of the future. The mean total scores show a consistent increase from locked-ward patients to undergraduates.

TABLE 2. NUMBER OF PLUS RESPONSES ON EACH QUESTIONNAIRE ITEM, AND MEAN TOTAL SCORES, BY GROUPS

Item No.	L	P	C	M	U*	Item No.	L	P	C	M	U*
1	18	21	28	27	27	17	20	13	27	29	27
2	17	18	14	18	14	18	27	17	29	30	21
3	20	22	22	26	25	19	19	20	26	28	27
4	23	21	25	23	26	20	10	11	16	20	23
5	19	23	18	26	16	21	14	20	19	14	27
6	18	13	20	14	23	22	17	18	22	22	24
7	19	20	25	26	28	23**	24	20	19	—	—
8	21	22	24	24	22	24	8	10	11	14	25
9	18	21	20	21	22	25	8	19	24	20	17
10	20	19	23	25	28	26	14	14	13	11	17
11	14	12	5	20	27	27**	16	11	20	—	—
12	19	25	27	28	29	28	23	28	29	29	30
13	15	18	28	26	27	29	23	29	29	30	29
14	7	16	13	25	28	30**	9	5	10	—	—
15	12	13	19	23	27	M total scores	16.8	17.9	20.9	23.1	24.7
16	11	18	22	27	30						

*L = Locked-ward patients C = Chron. phys. patients U = Undergraduates
P = Parole patients M = Man-in-the-street

**Items 23, 27, and 30 apply only to the three patient groups.

Each group was compared with every other group on each component subscore and on the total score, using the Kolomogorov-Smirnov test (3). Items 23, 27, and 30, which apply only to hospital patients, were omitted from the calculations. With one exception, all differences are in the predicted direction. Table 3 lists the differences which were found to be significant. Although between adjacent groups on the hierarchy only one difference in total scores is significant (at the .05 level), all differences between groups two or more

TABLE 3. LEVELS OF SIGNIFICANCE OF GROUP DIFFERENCES ON EACH "MEANING" COMPONENT AND ON TOTAL SCORE

	L-P*	L-C	L-M	L-U	P-C*	P-M	P-U	C-M*	C-U	M-U*
Subscores										
Self-affirmation	—	.05	.05	.01	.05	.05	.05	—	—	—
World view	.01	.01	.01	.01	—	—	—	—	—	—
Responsibility	—	.01	.05	.05	—	—	—	—	—	—
Transcendence	—	—	.01	.01	—	—	.01	.05	.01	—
Courage	—	—	—	.01	—	—	.01	—	.01	—
Uniqueness	—	—	—	.01	—	—	01	—	—	—
Faith-commitment	—	—	.01	—	—	—	—	—	—	—.05
Total score	—	.01	.01	.01	.05	.01	.01	—	.01	—

L = Locked-ward patients C = Chron. phys. patients U = Undergraduates
P = Parole patients M = Man-in-the-street
*Adjacent groups

places removed from each other are at the .01 level of significance. This hierarchical arrangement substantiates our hypothesis.

The one significant difference between adjacent pairs is between parole mental patients and chronic physical patients. This indicates that "meaning" is basically a function of mental illness, not hospitalization, although hospitalization may be a contributing factor.

The two extremes of the hierarchy, locked-ward patients and undergraduates, differ significantly on the total score as well as on each subscore, except for faith-commitment. Adjacent groups differ significantly on only one subscore, a different one for each pair of groups. With a larger distance between the groups, however, the significant differences become more numerous.

Faith-commitment turns out to be the most problematic component. It significantly differentiates in the predicted direction only between man-in-the-street and locked-ward patients. The difference between man-in-the-street and undergraduates is actually significant in the reverse of the predicted direction, the only case where the results do not conform to the predicted direction of the hierarchy.

DISCUSSION

The psychiatric conception of mental health is based mainly on practical considerations. Whether an individual is able to function in society is *the* criterion for a therapist. When a mental patient is able to function within the hospital society, he is often considered ready to leave the hospital. This is an operational definition of mental health that is useful, objective, and pragmatic. But it lacks more theoretical considerations.

The suggested concept of "meaning" is an attempt to provide a theoretical setting, an inclusive background. That such a theoretical understanding and the operational definition are not divorced from each other is evident from the results of this study.

Turning to the philosophies which men hold, for a starting point in the assessment of normality and abnormality, would seem to be a logical and fruitful undertaking. Since holding a philosophy is a basic human characteristic, psychology should be sensitive to the relationship of man to his universe. Although such a concern may at first sight seem "ascientific," it actually places the "mechanical" aspects of the personality—those that can be studied objectively—into a broader scheme that does not deprive man of his humanness. This investigation, therefore, is offered as a union of "science" with existential philosophy, a union which gives science a depth based upon generations of philosophical inquiry.

SUMMARY

The relationship of the existential concept of meaning to mental health was explored. To give the concept structure, "meaning" was defined in terms of seven components derived from ideas found in existential philosophy and psychology. A questionnaire was constructed with all items derived from the seven components. It was administered to locked-ward and parole-ward mental patients and to three non-psychiatric control groups. The results supported the hypothesis of this study: the five groups of subjects responded to the questionnaire of existential mental health (total scores) in the same order into which they fell on the basis of operational-pragmatic criteria of mental health. The results thus lend empirical validity to an existential conception of mental health.

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