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Quality of life: A megaconcept of coming époque

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Summary

In implicit psychology, Western culture primarly equates the quality of life with good health, a well-functioning family and then with the possession of material goods or mammon – money. According to the political élite in advanced countries, the quality of life is mainly ensured by economy-height of the GDP, symbolized mainly by costs of the shopping basket. But what about the sick, handicapped and elderly? The non-quality of their life was first noticed by medical experts in the early 30s of the 20th century. They primarily underlined a relief from pain-discomfort, independence from medicaments, medical aids and the milieu. More or less in parallel with this, the psychologists also became interested in researches on the quality of life. Their principal criteria for it came to be experience of satisfaction, well-being and happiness. Gradually, the phenomenon of quality of life became a subject of scrutiny by sociologists, environmentalists and political scientists; their numerous criteria for the quality of life are selectively dealt with here.

The present study understandably lays stress on the psychological concepts of the quality of life. The principal terms are delimitated in confrontation with the views of various authors, methodical procedures are dealt with as problematic issues and certain methodologies (WHOQOL, LSS, ComQuol, SEIQUoL), as also some international comparative studies (HDI, HLE) are illustrated.

The present study gives an outline of the author's model of the quality of life which, in comparison to existing concepts, especially focuses the basal (universal) plane, from the individual-specific (civilizing) and meta (cultural-spiritual) level. It furthermore includes a definition of at least six components on the basal level which, along with others, become transformed into higher levels. Nonetheless, decisive for the quality of life on any level is the meaning of life as a universal psychological regulator of human behaviour. It is a spirituality that most abundantly satiates the meaning of life.

Quality of life represents a mega-problem for the oncoming époque of mankind, bringing along paradigmatic changes in psychology, both on the theoretical plane and in application: from psycho-correction, psychotherapy, to optimisation and prevention.

Key words: Quality of life, satisfaction, well-being, happiness, meaning of life, spirituality

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„Der König ist tot, es lebe der König“ – „The King is dead. Long Live the King” - that is how I reacted to the first invitation to the Regensburg Conference of Psychologists. As some of you may know, I am preparing a historical review of the previous ten Meetings of Psychologists from the Danubian Countries. We, i. e. myself and my friends, consider them as a closed chapter of history in Middle European psychology over the last four decades of the 20th century, i. e. during the time of the cold war in the world. Despite this, I repeat: Long live the King.

I would like to make you remember the fact that each of these meetings reflected, as a “Leitmotiv”, one of the mainstream problems of basic or free research in the so called Eastern and Western parts of the Middle European region; about this, however, elsewhere.

Now, I would like to stress that the topic of my opening lecture – “Quality of life”- reflects not only relevant “regional” needs for investigation after the fall of the “Iron Courtain”, but - I dare saying - it is also undoubtedly one of the main, interdisciplinary problems of psychology at the time of the ongoing globalization of our world.

At first, about the meaning of terms

In contrast to quantity, i. e. the amount, number, size etc., quality is linguistically understood as value, attribute or the essential nature of objects or phenomena. Hence, it is a certain definiteness, particularity by which a given phenomenon or object as a whole differs from another whole.

We can say, the quality of soil, water, air, foodstuffs, products, but also: the quality of school (education?), a film, a law, etc. However, could such an approach also be applied in the case of people and their lives?

Certainly, one may also be approached from the quantitative and the qualitative aspect. Quantity here, that is in fact longevity – length of an individual’s life spelt in years. And as to quality?

I shall first attempt to answer to this crucial question through etymology. As you know, the word quality derives from the Latin term *qualis*, i. e. what kind, sort, size, color etc.; therefore, *what is* this or that life and *what it may be*. But the adjective *qualis*, has its origin in the pronoun *qui*; hence, we might also formulate our question as: Who has what sort of life? Or else how does someone’s life differ from that of others (cf. Křivohlavý, 2001); and let us add, how does it differ here and there, now and formerly.

But right now it should be observed that, in accordance with the current implicit theory, there is no sense in dealing with the question formulated like this, for an evaluation of the quality of life differs extremely from one individual to another; allegedly, it is a vain effort to strive and trace certain generalities – as even some scientifically oriented colleagues affirm. This notwithstanding, in surveys of this type, the quality of life of our contemporaries in our civilized countries is most often characterized by the following values: good health and an orderly family life, already referred to above. Further, material possessions, eating standards, dressing, social standing, owning the gains of civilization, leisure and, in general, the universal “deities” of this world – money.

Naturally, scientific approaches to the quality of life do not reject the common sense. According to G. L.Engel and J. Bergsma (1998), we should distinguish between a macro-, a mezzo- and a personality level in the quality of life. The first one deals with countries or large communities, mezzo-personality refers to smaller groupings (workplace, school, social

organizations etc.,). However, in my view, the personality level is not exhausted by the individual himself, as it also includes the world of the next kin – usually the family.

One of the most common wishes among people is to wish someone good health.

It is true, however, that health is – as its self-evident – only one of the preconditions of a good life, which is, in fact, a concealed one: those who are so-to-speak healthy do not perceive health as a great value. They might be frustrated that they do not have enough financial means to buy a modern house, a new car, an expensive vacation abroad, etc. This and other things, unlike health, are historical and social phenomenon of the living-standard of people from civilized countries in the 20th century. Whatever! Along this, to the shame of the wealthy and the well-to-do alike, there is a billion of hungry people on this earth.

With this introduction, I have touched upon several implicit (lay) opinions about quality of life. In our Middle European conditions, a functional family – a good family background – is considered to be included among these opinions. It would be incomplete, within the framework of a rich, more accurately, materially wealthy society which, moreover, promotes individualistic philosophy, not to mention new forms of the old hedonism: seeking the so-called top experiences using psychotrophic substances, the so-called sex-tourism, mass states of ecstasy by young people, etc.

But do the above mentioned implicit opinions and beliefs exhaust the quality of life concept to the extent it has been developed in individual areas of scientific knowledge?

Medical approaches

Historically, pioneering can be considered as quality of life. It appeared in the 30s of the 20th century in connection with chronic patients with phtiseological, oncological, internal medical and psychiatric diagnoses (Spilker, 1990). Soon thereafter, the quality of life issue shifted from the geriatric treatment facilities to quasi normal life in association with the sharp population increase of older and old people in developed countries (Steinhagen-Thiesen, 1992).

The medical approaches to the quality of life could be divided into clinical and research ones. Without claiming to present a representative view, we can list the criteria recently presented in the clinical context e. g. by my colleague, Vl. Zikmund (1997). To paraphrase, we can state that quality of life is manifested by the following indicators:

1. Diminishing (abolishing) suffering (physical as well as psychological), mainly pain.
2. Reaching a level, where the individual is not dependent on others in everyday life.
3. Ability to cope with demanding situations, with load and stress.
4. Ability to live in suitable social relationships, participate in social activities.
5. Achieving one's own security in life by satisfying specific, mainly, material needs.
6. Satisfaction with one's own life, joy of life, feeling of happiness.

Perhaps, the medical approach to quality of life is most completely represented by the World Health Organization Project – WHOQOL (1997). It assumes six domains with various indicators forming quality of life in the following structure:

Domain	Facets incorporated within domains
1. PHYSICAL HEALTH	Energy and fatigue Pain and discomfort Sleep and rest
2. PSYCHOLOGICAL	Bodily image and appearance Negative feelings Positive feelings Self-esteem Thinking, learning, memory and concentration
3. LEVEL OF INDEPENDENCE	Mobility Activities of daily living Dependence on medicinal substances and medical aids Work Capacity
4. SOCIAL RELATIONSHIPS	Personal relationships Social support Sexual activity
5. ENVIRONMENT	Financial resources Freedom, physical safety and security Health and social care: accessibility and quality Home environment Opportunities for acquiring new information and skills Participation in and opportunities for recreation/ leisure Physical environment (pollution/noise/traffic/ climate) Transport
6. SPIRITUALITY/RELIGION/ PERSONAL BELIEFS	

The WHOQOL project structure clearly indicates that health as a basic precondition of quality of life does not stand alone. It is, to a great extent, the result of man's interaction with his environment. In order to better understand these relationships it is necessary to focus in more detail than it has been done in the 5th domain of the WHOQOL project – on

Ecological-environmental criteria.

The German ecological-environmental lexicon (Katalyse, 1990) lists as many as 13 areas which determine or affect the health of people and thereby the quality of life living predominantly in civilized countries. I present them here in an alphabetical order:

AGRICULTURE
AIR
CHEMICALS
DWELLING
EARTH
ENERGY
FREE-TIME
INDUSTRY
HEALTH
NOISE
RADIATION
TRANSPORTATION
WASTE
WOOD
WORK

To these complex determinants of or effects on people's health, actually on the quality of life, we could add dozens of partial factors. Allow us to just randomly list the following: sharp fluctuations in the weather, hurricanes, floods, snow storms, frequent smog, size of greenery in a location, high-rise living vs. family housing, traffic density, emissions from factories and vehicles, harmful chemicals in water, earth and food, cleanliness of locations, potential industrial accidents in the vicinity, playgrounds and recreation centers, sewage system, water purification and waste management, approximation of airports, etc.

As we can see, some of the above and a whole number of other ecological-environmental factors affecting health as a precondition for quality of life, surpass its semantic space. After all, this is in full compliance with the WHO's definition of illness. You see, not the absence of illness or a physical or psychological disorder but an optimal physical, mental and social well-being is the complex criterion of health. The truth of this is proven, among other things, by the ever-increasing proportion of illnesses, the etiology which is based on social and psychological factors (Rosival-Zikmund et al., 1992). These have been called civilization illnesses or, more accurately, illnesses caused by civilization (heart attacks, strokes, cancer, stomach ulcers, etc.). A special spot is occupied by psychosomatic illnesses, the pathogenesis which is dominated by emotional states or, better, by emotional conflicts (high blood pressure, gastrointestinal disorders, allergies, etc.). Thus, as we can see, many stimuli and situations are coming together here which we could call

Social or socio-psychological agents of quality of life.

Again, as in the case of ecological/environmental determinants, I will first present the areas as they are analyzed e. g. by the Dutch sociologist R. Veenhoven (1997):

1. MATERIAL WEALTH
2. LIVING STANDARD
3. PROTECTION OF INDIVIDUALS
4. FREEDOM
5. SOCIAL EQUALITY

6. CULTURAL CLIMATE
7. SOCIAL CLIMATE
8. POPULATION PRESSURE
9. MODERNIZATION

I will try to make these more accurate by presenting partly different versions than in the study by author, just referred to the following:

1. it is not just the Gross National Product per capita but the buying power of certain currency compared to those of other countries
2. it is above all nutrition (at least 2500 cal/person/day), in broader terms this includes enough safe drinking water, the size of living space, employment structure, etc.
3. this includes the protection of individuals by the society, the incidence of suicides and fatal accidents, the extent of corruption, violence, vandalism, etc.
4. besides political freedom and respecting of civil rights this also includes, according to R. Veenhoven, individual personal freedom as postulated by liberal-exhemists (abortion, homosexuality, euthanasia, etc.)
5. the indicators are statistical dispersion of income, social inequality of genders, discrimination of minorities, etc.
6. education (mainly percentage of people striving for higher education), information access, value orientation, cultural and spiritual life, etc.
7. in addition to the ever-needed tolerance toward others, this concerns trust towards institutions, élites, social participation as well as armament costs, etc.
8. along with the general trend of increasing population density in the cities there is a sharply advancing 2nd population revolution characterized by an ever-increasing proportion of seniors in the population, called unproductive by „economists“
9. modernization is represented mainly by urbanization, industrialization, informatization.

After all that has been said here about quality of life in this or that relation to health, we may have a feeling that this is such an extensive phenomenon that it can be considered more a cliché than a scientific category. And we have as yet said nothing of the higher levels of quality of life, above all

individual/psychological concepts.

The long-term hegemony of behaviorist methodology in psychology is probably the reason for why the quality of the life phenomenon has, for decades, been kept on the periphery of interest by the majority of psychological researchers. Only classic psychoanalysts included, directly or indirectly, quality of life in their concepts.

A certain turnabout occurred in the first decade after WW II, when variously specialized psychologists began to study manifestations of load, stress, discomfort and other things, i. e. phenomena contraindicating the quality of life. Researches on satisfaction played a special role, be it with work, family or life in general.

Finally, by chance, the third source of the discovery of the quality of the life phenomenon as a psychological problem were those researchers who established the so-called third wave in the development of psychology, the so-called humanistic psychology. True, even here, in addition to self-realization, self-actualization and self-fulfillment the anti-indicators of quality of life, e. g. life traumas, crises and depressions, intervened.

It would be incomplete to write about quality of life without mentioning oriental psychological teachings and techniques. Although they were not created in the arms of sciences, they did have a lively response in technological – consumer societies.

According to North American sources, the beginnings of serious empirical studies on quality of life go back to the 1970's when OECD needed to measure in individual countries the so-called „social well-being". Unlike this research, N.N. Brandburn's (1969) studies using numerous population samples in the USA dealt with the structure of psychological well-being. Moreover, the work of A. Campbell et al. in 1976, also based on numerous population samples in the USA, was titled „The Quality of American Life".

In 1992, proceedings, published in Germany from a symposium, had a fitting title „Lebensqualität in unserer Zeit – Modebegriff oder neues Denken?" (Today's Quality of Life – a Fashionable Term or a New Way of Thinking? Seifert, Hg., 1992). The quality of life problem was discussed here not only intensively but extensively as well: at first as an ethical aspect of medicine, then in connection with new techniques and technologies and finally, as a socio-economic and environmental problem ("gebaute Umwelt"). Naturally, much attention was paid to the old and the sick, but by the same token, to the media as a multi-meaning factor, as well. Unfortunately, the psychological approaches such as to the quality of life were here very modestly represented. The publication reveals, among other things, that SPD (the Social Democratic Party in Germany) as early as in 1972, had quality of life as their "Leitmotiv" in their successful election campaign.

Also, this problem was an issue in the former Czechoslovakia in the 70's, as is evident from the later-date symposium titled "Psychological and Medical Aspects of Quality of Life" organized at the Institute of Experimental Psychology S.Ac.Sc. in 1994 (M. Stríženec, Ed., 1994).

These psychological concepts of quality of life are focused mainly on the English expression „well-being". In general, well-being is considered to be an important psychological indicator of good health or illness (mainly chronic), in other words, aging. The structure of well-being is created mainly by: the occurrence of positive or negative emotions over a longer period of time, the absence of unpleasant physical "feelings" such as slight headaches, tiredness, positive self-esteem, continuous meaningful activities, optimistic attitudes towards life, people and the world, etc. It is necessary to add, that the concept of well-being is interwined with the definition of satisfaction (Pavlík, 1997) on the one hand, and with the concept of happiness, on the other hand (Veenhoven, 1999).

However, the understanding of well-being as well as experiencing physical and mental bliss, i. e. happiness, must be differentiated from the concept and methodological approach of the Chicago psychologist M. Czikszentmihaly (1992). He introduced the term "flow" to name

the continuous joy of life. It is loaded by several components such as experiencing almost ecstasy in total concentration on some activity, experiencing (feeling) coping with demanding situations, thorough engagement in focusing on clear goals, almost self-forgetting, changed perception of time, etc.

A problem, probably most closely associated with the psychological approaches to the quality of life, is that of a methodological grasp of this phenomenon. Its core resides in the discovery of indicators. Should these include only those that constitute the content of an individuals' experiencing, or the so-called objective measures of behaviour?! And further: should the quality of life be estimated solely through internal criteria (statements by the subject himself), or also those by outsiders, i. e. evaluation by another person (e. g. the physician?!). And further: is it really a question of quality of life when we confine ourselves to the *status quo* - the momentary condition of a given individual and refrain from searching after past experiences and uncovering the designs and goals for future life?

I have to admit that thus far, I have not succeeded in finding a method that would correspond to the regulatory concept in psychology, so to say, an integrating one. Dominant in the rich mosaics are questionnaires. They are legion, even though all similar in their main topics. As an illustration, I have selected three of the latest forms: LSS, ComQuoL, SEIQUoL.

The LSS – Life Satisfaction Scale – (Priebe, Huxley, Stone, Knight, 1988) rates a subject's satisfaction with the aid of 11 life dimensions:

ONE'S HEALTH STATUS
SELF-CONCEPT
SOCIAL RELATIONS
FAMILY RELATIONS
SECURITY SITUATION
LEGAL STATUS
HUMAN ENVIRONMENT
FINANCIAL STANDING
RELIGION (BELIEF)
PARTICIPATION IN LEISURE ACTIVITIES
EMPLOYMENT – WORK (SCHOOL)

The satisfaction scale has 7 intervals, starting with "it could not be worse", through various shades of dissatisfaction – satisfaction, up to "it could not be better".

The method is used as a basis for carrying out health and social policy in a definite population, a definite region, etc.

Another questionnaire, intensively propagated at present, ComQuoL – Comprehensive Quality of Life – is of Australian provenance (Cummins, 1997). The author starts from a concept according to which quality of life manifests itself objectively and subjectively, although only a low measure of mutual relationship exists between these two approaches. Both of these components become manifest in the following seven domains:

MATERIAL CONDITIONS
HEALTH STATUS
PRODUCTIVITY
INTIMATE RELATIONSHIPS
SECURITY
STANDING IN A GROUP
EMOTIONAL WELL-BEING

The objective aspects of the above domains comprise the relevant measures of the presumed "objective well-being", the subjective aspect being expressed by the degree of satisfaction in relation to the importance a subject ascribes to the various domains.

The starting point of the method SEIQoL – The Schedule for the Evaluation of Individual Quality of Life (O'Boyle, McGee, Joyce, 1994) is a concept in which the respondent himself first defines, and then evaluates the quality of life. Into a prepared form, he has to enter five topics – areas of his basic life interests.

What is your goal (aim, intention) in life? What is your primary, utmost goal (aim, intention) in life? Hence, this is an individual-subjective delimitation of the quality of life.

The second step consists in evaluating the relevant cues given by S ("State of how successful you are in implementing this life goal, i. e. how satisfied are you with it? "). To meet this task, the subject enters the percentage of satisfaction with the relevant cue from 0 to 100%. Finally, as previously, S is asked to allot a degree of importance to each of the cues – again in percentages. However, this time he has to divide 100% among the five topics he had written down, which gives rise to a certain hierarchy of the relevant components of the quality of life. To this is added – third step – a so-called "thermometer of life satisfaction", i. e. a horizontal line where, on one edge it is "as bad as it can be" and on the other "as good as it can be"; S has to mark the selected spot with an x. A simple calculation then yields the overall measure of the quality of life expressed by the number from any value to 100 and similarly also the overall measure of satisfaction with it. Naturally, a deeper judgment analysis may likewise be applied here.

Past studies show that just one S out of some twenty enters the same five cues – which most frequently include health status, family, work, religion, finances, education, etc. Understandably, components of the quality of life are strikingly subject to a life-long development. While the trio of them – family, health, independence – remains relatively constant within the broader age bracket, the authors (from Dublin), on the basis of records on elderly people, set up the following hierarchy of importance of the various dimensions, with data on their frequency:

Social activity	95
Health	91
Family	89
Life conditions	80
Religion	75
Finances	25
Relations	18
Independence	16
Work	5
Happiness	5

This brief introduction of psychological concepts of quality of life, after we have mentioned the medical, environmental and sociological ones, should leave nobody in doubt about quality of life being a multi-level, multi-dimensional phenomenon. So it is extremely important to welcome

less or more integrative approaches to quality of life

In 1990, the so-called "Human Development Report" was made available by the appropriate UN "Office". Until 1999 (UN, 2000) was written on the bases of a method in which as a criterion of the appropriate index, several indicators were used: life expectancy at birth in this or that country (separately for men and women), percentage of people who are not expected to live after the age of 40 (in developing countries) and after the age of 60 (industrialized countries); furthermore, basic literacy of adults and higher education possibilities (again separately for men and women), and in developing countries functional literacy of adults. Finally, data were gathered on living standards expressed by per capita income in USD (separately for men and women). This indicator includes different criteria for developing and industrialized countries: in the case of the former, it involves the percentage of people with no access to drinking water, health care and a percentage of underweight children under age 5; in the case of the latter the criterion is as follows: percentage of people living under 50% of the mean income per personal needs. Finally, there is a criterion applied in different ways concerning the long-term unemployment rate (more than 12 months).

There is a more recent effort to grasp the quality of life concept in a more integrative way (even though this concept is transposed to a different level here) done by the already mentioned Dutch sociologist R. Veenhoven. At the University of Rotterdam, he set up a „World Database of Happiness". R. Veenhoven has carried out several research projects to date one of which is particularly interesting to us: a project focused on the phenomenon of expecting a happy life, in 48 countries (1996). What does it involve?

Unlike the previously relatively sophisticated methodological approaches UN HDI, R. Veenhoven took a risk when he chose as the integrative measure only two indicators of the mean life expectancy in this or that country multiplied by the coefficient of experiencing happiness, measured empirically on the scale of 0.1-1.0. He came up with several findings: which he may not have even been aware of, considering the extent of our comparison.

I compared two integrating indicators of the quality of life, viz. the "Human Development Index" (HDI), made available every year by the UN and the "Happy Life Expectancy" (HLE) Index, being a measure utilized by the same Dutch sociologist R. Veenhoven in a cross-cultural study in 1996. I repeat, HDI is calculated from a number of variously weighted indicators within four domains, i. e. longevity, education, decent standard of living, unemployment. HLE, on the other hand, is an indicator providing two data only: attained age and experiencing of happiness.

Figure 1:

HUMAN DEVELOPMENT INDEX IN NATIONS
(Human Develop. Rep. Office, 2000)

HIGH		**MEDIUM**		**LOW**	
1. Canada	0.964	46. Trinidad	0.797	140. Lao pdr	0.491
2. Norway	0.932	47. Hungary	0.795	141. Congo, d.r.	0.479
3. USA	0.927	48. Venezuela	0.792	142. Sudan	0.475
4. Japan		49. Panama		143. Togo	
5. Belgium		50. Mexico		144. Nepal	
6. Sweden		51. St. Kitts		145. Bhutan	
7. Australia		52. Grenada		146. Nigeria	
8. Netherands		53. Dominica		147. Madagascar	
9. Iceland		54. Estonia			
10. United Kingdom		55. Croatia		151. Zambia	
11. France		56. Malaysia		152. Haiti	0.430
12. Switzerland		57. Colombia		153. Senegal	0.426
14. Germany		58. Cuba	0.765	154. Ivory C.	0.422
		59. Mauritius	0.764		
20. Ireland		60. Belarus	0.763		
21. Spain				160. Angola	0.398
22. Singapore				161. Guinea	0.398
23. Israel		125. Irak	0.586	162. Chad	0.393
24. Hong-Kong	0.880	126. Morocco	0.582	163. Gambia	
25. Brunei	0.878	127. Leshoto	0.580	164. Rwanda	
26. Cyprus	0.878	128. Myanmar			
		129. Papua			
				198. Guinea-B.	
36. Czech R.	0.833			169. Mozambique	
		135. Congo		170. Burundi	
		136. Kenya		171. Burina f.	0.304
42. Slovakia	0.813	137. Cambodya	0.514	172. Ethiopia	0.228
		138. Pakistan	0.508	173. Niger	0.228
45. Costarica	0.801	139. Cosmoros	0.506	174. Sierra Leone	0.254

Figure 2:

HAPPY LIFE EXPECTANCY
IN 48 NATIONS
(R. Veenhoven, 1996)

Country	**HLE-index**	**Country**	**HLE-index**
Bulgaria	31.57	Chile	47.37
Nigeria	32.42	Israel	47.94
Belarus	33.87	Argentina	48.96
Russia	34.48	Italy	51.15
Latvia	35.01	West Germany	51.68
Lithuania	35.90	Finland	52.74
India	36.44	Spain	52.77
Estonia	36.50	Canada	52.89
Romania	37.08	Japan	53.00
South Africa	38.16	New Zeeland	54.86
Slovenia	38.34	Luxemburg	55.01
Hungary	39.56	France	55.37
Czechoslovakia	39.89	Australia	55.88
Brazil	42.87	Nothern Ireland	56.49
China	43.84	Norway	57.76
South Korea	44.04	USA	58.83
Portugal	45.51	United Kingdom	59.24
Greece	45.78	Belgium	59.24
Philippines	45.87	Denmark	59.49
Mexico	46.02	Switzerland	59.80
Turkey	46.11	Sweden	61.52
Poland	46.88	Netherlands	61.64
East Germany	47.04	Iceland	62.04

The placement of the various countries of the world offers no surprise: the first places in the one and the other lists are occupied by developed larger and smaller countries, the countries on the way of development and those of the former socialist block being at the tail-end.

Nonetheless, a remarkable feature, especially from the methodological approach, is the correlation coefficient we have calculated between HDL and HLE: .788 with a high mathematico-statistical significance. Without intending to go into a detailed analysis, we may state at least this: not „extrinsic“ indicators (standard of living), but „intrinsic“ contents go to satiate the phenomenon of the quality of life.

Glancing at the standing of the various countries on the HDI and HLE lists, I was struck by the simple statistics of the numbers of psychologists in the various countries associated in the „International Union of Scientific Psychology“ (Zimbardo et al., 1995).

Figure 3:

PREVALENCE OF PSYCHOLOGISTS AROUND THE WORLD
(Zimbardo et al., 1995)

Country	Psychologists per million of population	Country	Psychologists per million of population
The Netherlands	884	Cuba	186
Belgium	606	Austria	178
Israel	568	Poland	159
Finland	540	Ireland	157
Switzerland	531	German Democratic Rep.	151
Spain	528	Colombia	143
USA	521	Dominican Republic	134
Norway	514	Hungary	113
Federal Rep. of Germany	490	South Africa	83
Brazil	433	Greece	60
Uruguay	387	Hong Kong	36
Italy	348	Japan	36
Australia	342	Romania	32
Argentina	323	Armenia	29
France	322	Union Soviet Soc. Rep.	18
Canada	313	Turkey	14
New Zealand	247	Philippines	9
Great Britain	244	India	7
Czechoslovakia	226	Korea	7
Venezuela	202	Pakistan	6
Yugoslavia	192	Zimbabwe	6

However, a mathematico-statistical calculation of Pearson‘s correlations proved a big surprise: the number of psychologists in the various countries shows a high correlation with the quality of life, as followed by the UN Human Development Index .632^{++} and the indicator of a Happy Life Expectancy amounts to .600^{++}! What then does it mean, overlooking a certain methodical error in data comparison?

„Tell me, how many psychologists are there in your country and I can tell you much about its quality of life“.

It would certainly be a totally false interpretation if we considered psychologists as such to be the artificers of the quality of life in this or that country. But closer to the truth is the hypothesis, that where there is a higher quality of life, there is also a higher number of psychologists and the other way round. However, I have no intention to set out along this interpretational line, either.

I lay stress on the hypothesis that not only clinical psychologists or health psychologists, but in our modern times also further psychologists – specialists are those who by their engagement contribute to an improvement of the quality of life. Here, not only their considerable share,

but also a new order of the globalizing world goes to the account of psychologists of work and organization, educational, community, ... political psychologists as advisors for managers.

In our opinion the quality of life is a phenomenon which by its complexity surpasses the previously described integrative approaches, which we became aware of after publishing our

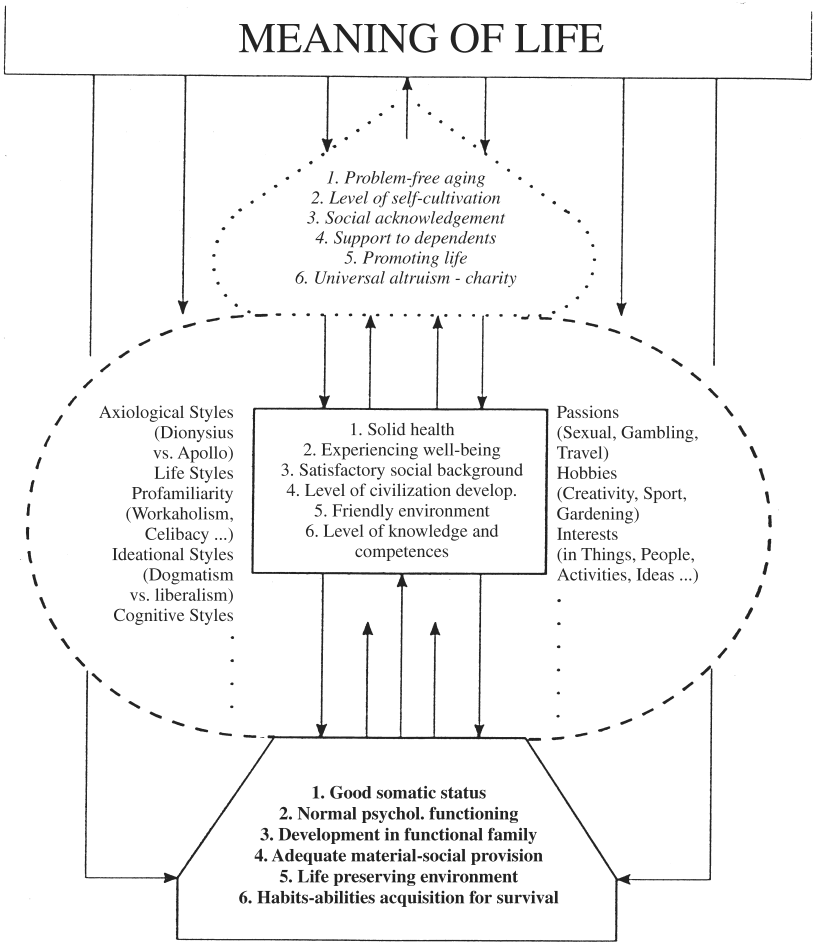
Hypothetical model

of quality of life. It differs from all others known to date by five characteristics:

1. Above all, it is a three-level model. We differentiate between a basal, i. e. existential (all human) level, mezzo- i. e. individually specific (civilization) level and a meta-, i. e. elite (cultural/spiritual) level of quality of life. Naturally, this qualitative differentiation reveals various scores for individual, partial indicators they contain.
2. The basal level consists of at least six areas of life, which satiate good or bad quality of life of any person in this world. They are: normal somatic state, mental functioning in the norm, functional family, material/social security, life-giving environment and acquisition of basic skills necessary for survival. With each item, there should be the accompanying adjectives optimal, adequate and relative, because with such a diversity of human kind, no absolute norms can be valid for all members of Homo Sapiens living at the beginning of the third millennium.
3. Our model implies that each area in the basal level of quality of life has its qualitatively higher representation at the mezzo- and/or meta- levels. For example, normal somatic state represents good health at the mezzo-level and problem-free aging ending in natural death at the meta-level. Similarly, normal mental functioning expands at the mezzo-level to experiencing satisfaction and well-being; and both of these are at the meta-level of quality of life, basically a spiritual welfare from man's self-cultivation through cultural and spiritual values accepted by the individual, a group or a society. However, this does not mean that higher levels of quality of life are exhausted only by phenomena transformed from the basal level. This is especially true of the individual civilization level, where, in addition to the indicators layered from below, quality of life can be loaded by a whole number of others such as: artistic activities, sports, hobbies, etc (see the model).
4. Our model only touches upon, but does not specify relationships between individual components of quality of life, be it at the horizontal or vertical level. We do expect, however, that these will be variously multi-factorial which can only be detected by systematic research. At the same time, I would like to clarify the above mentioned hypothesis by stating that the deterministic effect of lower level indicators on the higher ones is manifested only in case of borderline dimensions. Let me illustrate this on an extreme example: a physically handicapped person (basal level) with an additional serious progressive illness (mezzo-level), can experience intense mental happiness not only during meditation. In general, the existence of psychological reality in man is that a particular substance which can regulate, i. e. change itself according to accepted values. That means that it can, naturally only to the point of the limit values, dampen the instinctive needs (determinants), select from the physical, social and cultural environment (effects) and usually freely decide according to accepted values, intentions and goals.
5. Finally, in our three-level multidimensional model the king, so to speak, is the all-around factor:

Meaning of life

Figure 4:



Model of quality of life (D. Kováč, 2003)

Not that it is a totally unknown component of quality of life; the new aspect lies in the fact that we do not consider meaning of life – discovering or enhancing it – to be a mere component but a universal principle of quality of life (for more details see figure 4).

However, is this individually highly differentiated phenomenon accessible to the general scientific understanding?

I assume that the professional cultural community here is more or less familiar with the bestseller by V.E. Frankl about the will to meaning of life (1997). This humanist considers the

revelation, discovery and development of the meaning of life to be the principal motivation force behind human behavior. On the other hand: the absence or lack of this – we think one of the psychological system regulators of behavior – causes the so-called existential neurosis, according to V.E. Frankl. That is why we can find meaning of life in hardship and suffering which is a privilege of the developed psychological reality in man. It allows self-transcendence. The author confirmed his concept of meaning of life by his own life – he survived a Nazi concentration camp.

Based on accessible literature and mainly on P. Halama's study (2000), I tried to define meaning of life in the following way: it is an individually created system's regulator of human behavior intra-psychologically composed through which one ascribes a substantial, existential importance to one's own being, to others and to the world at large in accordance with accepted values.

Here, the word „intra-psychological" means, that meaning of life is created by an integration of cognitive, emotional and motivational components, in other words the one's will potential. This involves the following: ability to know oneself, to understand others, to seek optimal solutions; well-being, self-control, efficacy; planning of events, searching for aims, coping with demanding life situations, etc.

Empirical researches revealed that, in addition to the development of value orientation, which develops, more or less, simultaneously with the maturing of personality (one's own happiness, family, professional career, love for nature, hobbies, evangelization, etc.), the various important life events (e. g. serious illness, marriage, birth of a child, loss of a loved one, bankruptcy) are also effective sources of meaning of life. Furthermore, it also involves attitude toward death in general and one's own in particular (banalizing it, making it a taboo subject, the so-called acceptable death, death as a cultural value, etc.). Naturally, a huge source of meaning of life is internalized in religious faith: not only in selfless acts of goodness in this world but the faith in the life continuing in transcendence.

To summarize, we can state that the discovered and developed meaning of life is such a prime regulator of individual components of quality of life that it is also the most effective source of man's permanent satisfaction with life, a source of continuous well-being, a forum where moments of happiness can briefly appear.

In the past, much criticism was expressed regarding the lack of interest on the part of psychologists in dealing with quality of life. But nowadays, we must wonder that it is still possible that the meaning of life phenomenon does not appear in any of the better-known psychological personality theories! (see, for example, Ananyev, 1969; Magnuson – Endler, 1977; Nakonečný, 1965; Hampden-Turner, 1991; Hall-Lindzey, 1997). The only exception is Antonovsky's „Sense of Coherence" (1988), even though the author considers himself to be a medical sociologist.

Be the explanation of this drawback of psychology in the past as it may, the present is different, more hopeful. The multidiscipline conference recently organized in Vancouver, Canada July 13-16, 2000, titled „Searching for Meaning in the New Millennium" testifies to this. In the introductory speech, the main organizer, Paul T. P. Wong proclaimed: „This is a

conference on positive psychology, positive psychotherapy, positive health, positive aging, positive dying, positive management, positive education, positive spirituality and everything else ready for a infusion of the positive spirit. In sum, this is the first conference on the positive revolution for the new millennium“ (Wong, 2001). To complete the picture of all the above, I would like to add that one of the key presentations of a researcher working in this area – D.G. Myers was titled just like his new book: „American Paradox – Spiritual Hunger in the Age of Plenty“ (Myers, 2000).

This information has brought us to the final concept of our study on quality of life, i. e.

Spirituality

In various places in my presentation I have stated, that the best way to delimitate spirituality is most lapidary to quote an episode of an unknown origin from ancient times. A certain pharaoh's scribe allegedly asked the workers building a pyramid: „What are you doing?“ „I'm cutting stone“, one said. Another one said: „I'm feeding my family“. But one said: „I am building a temple“. The interpretation of these three different descriptions of the same activity is relatively unequivocal: the first case represents an orientation to concrete activity. The second statement accentuates the social focus of this activity and the third one can be understood as an idea which goes beyond the practical needs of people, since it is focused on human spirit, it is transcendental.

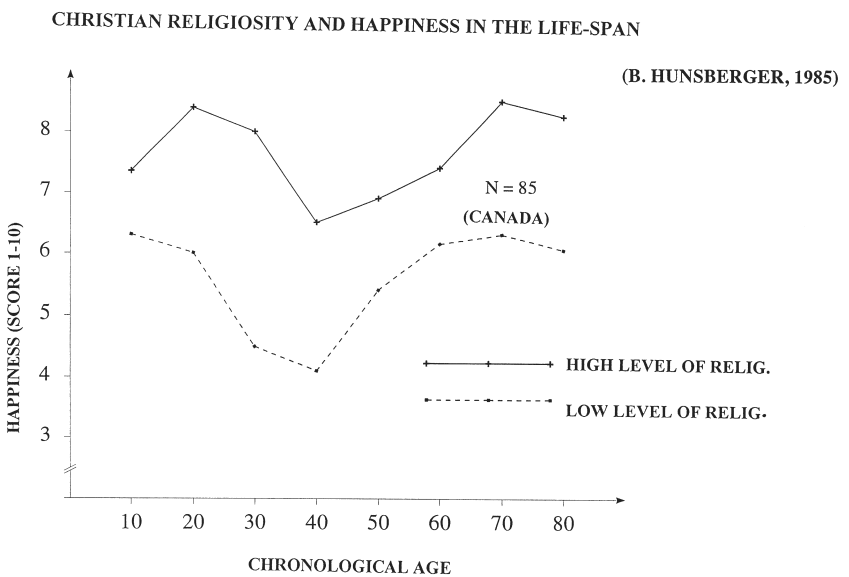
Faith in transcendence is, as proven by anthropological data, a historical development of mankind, as well as the presence (then and there), it has always been existing in the majority of past and present populations. However, religiosity and spirituality are not identical potentials of personality; but I leave this to be clarified by experts (e. g., E. J. Cuscelly, 1994; Grün – Dufner, M., 1997; Zimmer, 1995) who differentiate between spirituality from above, spirituality from below (in other words spirituality of creation) and spirituality of redemption. Within this framework, religiosity (to paraphrase M. Stríženec's characteristics, 1996) is a personal positive approach to transcendence – to God, involving the following triad: cognition (religious beliefs), experiencing (religious feelings) and action (religious rituals and cults). All this is pronouncedly reflected in the value orientation, in other words, it should be incorporated in everyday behavior of religiously „oriented“ individuals.

It is not my intention to go any deeper into this subject but – according to many empirical findings – I do dare to claim that religiosity and spirituality are at the core of meaning of life. Reasons for this: for the individual personality they bring equilibrium in life (i. e., satisfaction with life – the so-called „contentment in the soul“), enriching oneself with wisdom (generally valid experience in human kind), permanent joy from giving selfless love (greater joy from giving than from receiving), possibilities and improvements of personality (even at the level of metanoia), etc. (see V. Smékal, 2000). And finally, there is the promise of eternal bliss, i. e. the solution to the question of what happens after death, which strongly touches not only religious people but, as research has found, indifferent ones and agnostics as well, summa summarum all of us.

In western cultures, where over centuries, religiosity and psychology have had the chance to develop freely, there are many empirical studies proving the positive effects of religiosity on health in a broad sense (WHO). I say that it is not, however, the so-called miraculous sudden

cures, nor curing through so-called faith, which have recently flourished under the name of alternative medicine (David, 1998). Of course, this is not a matter of „religiosity" represented by sects. However, scientific research cannot identify a positive effect of religiosity on maintenance and development of health by the intervention of supernatural forces, even if we are totally convinced of their existence. In our opinion, the positive relationship between religiosity (naturally not of any kind) and health lies in the fact that religious individuals and groups live a healthier lifestyle in many areas of life: they are modest in eating, they regulate their drinking of alcohol, live in a functional family, are in harmonious relationships and can cope with demanding life situations in a satisfactory way. In other words, they are satisfied with life and usually experience well-being and happiness, i. e. shortly they have an appropriate quality of life.

Figure 5:



Conclusion

The turn of the millennium has provoked many to think about their visions, balancing the good and bad in their lives. Experts of the Heidelberg society for innovative market research have written a dubious study for the next years of the third millennium. Right at the beginning it says: as early as in the 1970s, social researchers were aware that under the surface of economic prosperity a great change has occurred. A victorious progress of post-materialistic values began in the form of a quiet revolution: large portions of the population in western industrialized states discovered that besides a standard of living, there is also quality of life as a decisive value (according to H. Barz, 2000). Everything is pointing to the fact that this prognosis will have a broad paradigmatic impact, unfortunately not on us living in the so-called transforming countries; here evidently the material civilization wealth leading to

Figure 6:

limitless consumerism is the dominating feature. But let us hope that the „small islands" of meaningful search for quality of life filled by spiritual culture will, sooner or later, become, even in our countries, „greater land masses". After all, we have a historically verified potential in our Christian tradition, but it must be effectively developed.

As a matter of fact, the quality of life is not any fashionable expression, but a mega-concept of the coming époque.

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