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Original Paper

Psychiatry and Religion: A Stance

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Abstract

A dialogue between psychiatry and religion is still not easy to conduct despite the awareness that religion (and spirituality) can play an important role in the way patients cope with their mental disorder. In this contribution the goal is to pave the path in the hope that it will promote dialogue. To achieve this goal, we take three steps. We will start with describing science and religion as social practices characterized by epistemic, practical, collective and individual goals. The next step is some analysis of what we mean by commitment. Based on what we have found we will be able to describe what we mean by a stance, followed by what in our view characterizes mostly the stance "psychiatry and religion". Holism, values, a certain conception of the professional role, and inclusiveness are the essential issues.

Keywords

psychiatry, religion, science, social practices, certainties, stance

1. Introduction

This contribution is about developing a position or a stance with regard to one of the most intriguing and much debated issues of human nature: religion and mental functioning. To a certain extent this theme is as old as human thinking on the human condition. In a sense this fascination is not surprising, nor is the religious viewpoint from which ordinary people and philosophers viewed and reasoned. What kinds of explanations were available in premodern and prescientific eras other than religious belief and philosophical ways of reasoning? This pertains not only the issue of human nature and her functioning but also mental health and illness. From the beginning the inexplicable in its mystery had been something tremendum et fascinans (Otto, 1917/1947), obviously strongly connected with gods and demons. However, intrigued and even annoyed by this "atopon" ("ατοπον"; something not at its understandable place, Aristotle) philosophical and theological thinking sought understanding (Note 1) (Jüngel, 2003, pp. 274-275).

At first understanding was sought under the umbrella of faith ("fides quaerens intellectum", Anselm [1011-1109]), but since the Enlightenment humankind has got the courage to think for themselves (Kant, 1783/1983). Science has taken a huge flight. It enables us to understand, to control, to predict and to adjust in almost every domain of daily life in various and successful ways. And still there are issues or needs that science cannot or only very limitedly address, issues we usually call spiritual, religious or existential. Issues that arise when life becomes questionable. Therefore, both religion and science search for intelligibility; science aims at technological and predictive intelligibility, religion at existential intelligibility (Stenmark, 2004, p. 29). Extension of science, medical discourse became a successful alternative for religious explications of mental health issues not earlier than at the beginning of the nineteenth century. However, from its very beginning psychiatry was at odds with religious authority and its discourse. And, surprisingly or not, it still is.

1.1 Religion and Psychiatry

"Psychiatry was Religion before it was Psychiatry" (Stone, 1998, p. XI). This sentence is the first line of the prologue of Stone's history of psychiatry. It is about the function religion used to have, addressing our needs on an individual and social group level, especially with regard to ethics and morals, but also to raising children. He illustrates his idea behind this statement by telling a few anecdotes, which make his point clear. Each anecdote highlights a specific aspect out of different religious traditions. Healing speech in Christianity, healing encounter in Buddhism, anagogy in Zen, freedom from anger, greed, and lust in Hinduism. Stone does not deny the resemblances between the traditions he points at, his point is that psychiatry's "taxonomy has changed considerably (…) since the time of Buddha, our ways of healing the deluded through verbal means, while different perhaps in outward form, have *in their essence changed very little over the past three millennia*" (Stone, 1998, p. XIX). Perhaps the scientifically educated reader is frowning upon such a view, however to quote Stone once again: "And there are no chemicals (…) that will replace a healing speech, a mother's soothing word, a father's reassurance, a religious leader's wisdom, or a psychiatrist's warmly supportive comment or life-unifying interpretation" (Stone, 1998, XIII). Therefore, the coherence, interface, interaction, or complicated relationship (whichever word one wants to use for proper typology) between religion, mental illness and treatment is of all times and all places, and still is.

1.2 Taking a Position

This article is about developing, and taking a position in this ongoing debate. What is meant by the noun position? We do not mean making a choice, pro or contra this or that opinion, although that is an element of it. It is about more than that. It is not merely my or somebody's personal position either, so purely subjective. However, a personal element—it is my belief—is always present in whatever discussion, especially in controversial issues such as religion in psychiatry (Sims, 2009). Therefore, it is a strange argument from the opposite to say not only that religion is just a personal matter, but also that the topic of religion in psychiatry is just an esoteric activity of certain psychiatrists with a special

inclination to or bias towards religious issues based on their personal history and religious socialization. That might be a risk, but the same holds true for the counterparts and their opinions in connection with their life history. However, there is far more to it. Yes, a position means a commitment, but a commitment, even a religious or spiritual commitment, cannot be dismissed as a subjective disadvantage or defensive attitude.

2. Science and Religion as Social Practices with Differentiated Goals

As Stenmark, Swedish philosopher of religion, (and many others) made clear, religion and science are "both not merely sets of statements, theories, linguistic discourses" (2004, p. 42). Individual practitioners and practitioners together may acknowledge individually or together what the goals of religion or science are. They are both social practices, and therefore can be looked at on an individual and a social level. So individual scientists or professionals or groups of scientists or professionals may decide what their goals of religion and science are. Stenmark postulates that there are not only epistemic (intelligibility) and practical goals (shaping epistemic goals), but also personal and collective goals. Collective goals refer to the goals that are shared by the members of a certain community. Personal goals refer to the goals of the individual scientist or religious believer in science or religion (e.g., finishing a paper on religion and psychiatry/science; Stenmark, 2004, p. 32, p. 35, p. 42).

Religion and science, religion and psychiatry as a field of inquiry, have their communities of practitioners. These communities have their epistemic, practical, collective, and individual goals, their social contexts, and their traditions. The epistemic and practical goals, although important and indispensable, are not my first interest here. It means that when I am interested in developing and assuming a position, I am not only interested or developing a personal involvement based on a personal commitment, even though the personal aspect is not excluded from the outset. From the very start I am working towards a collective position based on collective goals and a commitment in the psychiatric community worldwide. That seems quite ambitious. It is, and, as we will see, not in vain!

2.1 A case: The WPA Section on Religion, Spirituality and Psychiatry

Imagine a group of professionals who put their heads together and conclude to set up a working group. Then this group acquires the status of scientific section by a worldwide professional organisation of psychiatrists, the World Psychiatric Association (WPA). Subsequently, this section expands to a worldwide network. This is in short the history of the WPA Section on religion, spirituality, and psychiatry, founded in 2003 (Verhagen, 2017). And the section formulated its epistemic, practical, collective, and personal goals. Briefly summarized, as a group of professionals we aimed to contribute to what could be called the long-term project of understanding a certain aspect of human nature, especially the aspect of mental health and illness in connection with religion and spirituality. The section aimed at stimulating research and developing knowledge and knowhow. Formulated this way, it indicates the epistemological and practical goals. However, there is a problem, here. Even at the time of

the founding of the section a lot of knowledge and knowhow was already available. Nonetheless, that availability did not mean that use was made of it, at least not in mainstream psychiatry. Take for instance guidelines. Religion and spirituality are rarely mentioned. Even in the run-up to DSM 5, well documented proposals to expand the DSM text on specific features and differential diagnosis to include the impact of religion and spirituality were not integrated in the final text (Peteet et al., 2011).

So, the section not only aimed at epistemological, but even more strongly at practical goals. How to make the available knowledge and knowhow work? Besides, that practical goal served both collective and personal goals. Therefore, in the view of the section, advancing–awareness and promoting knowledge, skills and change of attitude among professionals was an extremely important goal on all four (epistemic, practical, collective, and individual) levels. The goals, of course, are closely related.

This is only one side of the functioning of a professional working group like a scientific section of the WPA. Professional members of this specific group, at least a lot of them, are committed to religion and spirituality in various ways. That means that there might be goals not just from the scientific point of view but also from the religious/spiritual realm. Perhaps these goals are more or less explicit but are not forbidden in advance. The religious or spiritually committed professional could be interested in the epistemic aspects of religion and spirituality in psychiatry from a religious point of view as well. Health (mental) and illness are most certainly important issues in religious traditions, and in the way people describe their spirituality. Could the religious and spiritually committed professional also contribute to these issues? It might not be the main challenge, but nevertheless. They certainly can and they actually do. In that way these committed professionals could contribute to the welfare of religious and spiritual communities and their members. And that is not the only point. It might be that this contribution from the religious or spiritual realm could have positive significance for the scientific knowledge and practice of the profession as well. That is what interests us here mostly. Again, stated this way, we become aware of personal and collective, epistemic, and practical goals, but from a religious point of view. Besides, this is of course not only valid for religion and spirituality, it applies equally to other views of life.

2.2 Differences between Science and Religion too Objectionable?

Surely, this approach is not without difficulties. One could point at the differences between the epistemic goals of science and of religion, as Stenmark explains (2004, p. 43). He points at the fact that religion is about being religious, about living religiously. Religious epistemology is more complex, “not purely” epistemic as in science. This might be true, but it is confusing and evokes possible misunderstandings. Being religious and living religiously is certainly not without epistemic claims, as Stenmark admits (2004, p. 43). Just like scientific knowledge has to fulfil certain external criteria, religious knowledge or view of life has to fulfil these criteria as well. Otherwise, that knowledge would be nonsense instead of science, or superstition instead of religious knowledge (Drees, 2010) (Note 2).

Stenmark points at another difference. According to him the epistemological collective goal of science

is to increase the general body of knowledge, whereas in religion "it is to increase the knowledge of its practitioners personally to such an extent that they can live a religious life successfully" (2004, p. 44). That might be true if one compares pure science and religious practice, but it is not entirely true in applied science like medicine, especially psychiatry. It is common practice to disseminate knowledge to each of the practitioners to such an extent that they can fulfil their professional role in accordance with the prevailing standards. It is important to nuance this issue, as Stenmark does (2004, p. 44). In fact, we need to differentiate between religion and theology. The aim of theology is similar to the aim of science. Compared to that, I actually make a comparison between applied or practice-oriented science (e.g., psychiatry) and applied or practice-oriented theology (religious life and spiritual life).

Something similar can be said about the personal and collective practical goals of the religiously committed professional. Such a professional might be interested in contributing to the welfare of patients including their religious or spiritual health as part of their personal welfare. Such a professional might be motivated to develop his or her skills and attitude according to the professional's personal view of live, be it religious or non-religious.

With this I have depicted the climate and the ambitions of the group. This depiction serves as background for the development of the position or stance, which is the personal (what is the author's position with regard to psychiatry and religion) practical (how is the available knowledge useful in practice and what knowledge does practice need) and collective goal (promoting [awareness of] knowledge in the psychiatric community) of this thesis. That is to say, this stance should ultimately serve a collective goal.

3. Being Committed

There is, however, another aspect that deserves attention. What is the meaning of being "committed" to science and/or religion or spirituality? A position or stance is also but not solely about commitment. I will propose to look at this "being committed" in a certain way.

According to Mühling, a German theologian, there is an important difference between the Anglophone approach of the dialogue between theology and science and the German approach (Mühling, 2014, p. 14). The Anglophone approach, illustrated by the typology proposed by Barbour (2000), suggests that "theology and science are different poles of a spectrum", that they share certain characteristics despite the differences that are certainly there. The German approach is more one of contrast or distinction. The natural sciences stand opposite the humanities. Of course, the difference between the two approaches is not so black and white. However, Mühling proposes a creative third way, which is very helpful in our goal to clarify what could be meant by being committed.

Whatever the goals scientists and theologians have, and a derivate of these professionals in applied science and religion, they do something. Mühling focuses on the concept of action, of doing something, paving the way for his approach. His claim is that doing something presupposes among other things a

specific set of what he calls certainties (Mühling, 2014, p. 14; 2012). What are certainties? Certainties are a specific kind of pragmatic knowledge. Mühling gives the example of drafting a book (2012). If I want to author a book, I have to know what the book is about, how to write, how to use facilities, and that it is meaningful to write this book. Probably some of these beliefs are not very explicit, but nevertheless, one thinks about it, one becomes aware of these and probably other beliefs or certainties. Certainties like these are always there. They are not securities, they are not infallible, and one can question them. Secondly, according to Mühling, certainties are no hypotheses. The practice of science and theology may aim at the development of and search on hypotheses, the practice itself presupposes certainties. "Therefore, where hypotheses provide the advantage that potential actions only imply potential consequences no one is actually responsible for (because they are only potential, not actual), actual actions imply certainties that do imply real consequences – they alter the state of the world we live in – and are therefore my responsibility" (Mühling, 2014, p. 15). "Certainties are always a serious matter, whereas hypotheses only stand to become serious" (Mühling, 2014, p. 15).

Certainties have an action-guiding meaning. Most of the time, we are probably not aware of our certainties since they are undisputed or self-evident. Nevertheless, it can be useful to make them explicit, for instance in the dialogue between science and theology, and between psychiatry and religion. Of course, as Mühling explains, certainties are bound to persons, hypotheses are less bound in that sense. Does that mean that certainties are merely subjective? No, it does not. Certainties are particular and belong to a common narrative tradition (Mühling, 2014, p. 16). Nobody is without tradition, which could be dubbed the objective aspect of certainties (Markus, 2004, p. 149). These certainties, therefore, have three aspects: guiding, subjective and objective.

One further important distinction is necessary. There are two kinds of certainties. Some of them are empirically testable, others are not. Each action presupposes both. Take the example of writing a book. How to write is empirically testable. Whether it is meaningful to write the book is not empirically testable and of a different level. One could decide to interview readers of the book about its meaningfulness after it has been published, which would give some empirical information afterwards. However, we are not talking about the meaningfulness for readers but for the author. At the same time, it does not mean that we do not have reasons for our certainty about the meaningfulness of book. We have reasons, no proof. And if we did not have such reasons, it would probably not be very reasonable to write the book.

Empirical certainties concern natural and social circumstances, and facts. It is about certain knowledge contents which we can trust and which we actually do trust. Of course, these certainties can always be revised. The non-empirically testable certainties concern meaningfulness of certain actions, views of life, views on human being, views on reality, religious beliefs, and spiritual views. In other words, it is reasonable to expect that certainties of this second type have religious or spiritual content. There is another aspect to it. Non-empirically testable certainties are value-laden. We already pointed at the

action-guiding meaning of certainties. With regard to the non-empirically testable certainties it means that there is a normative element to this action-guiding aspect. That normativity is of course important because it holds the professional to certain convictions and rules based on his or her religious or non-religious worldview. Surely that may influence the professional's view on science as well. In other words, certainties like these can have a regulatory meaning.

A final important element needs to be mentioned. We started this paragraph with Mühling's third way of focusing on action. What does that mean for the dialogue between science and religion? It can only mean that certainties always influence the work of the scientist and the professional. in two directions. Implicitly non-empirical certainties will shape the attitude, the work, and the goals of the scientist and professional. As Mühling states, it will happen all the time (Mühling, 2014, p. 25). On the other hand, scientific findings and discoveries will always shape the certainties and commitments of the scientist and the professional (Mühling, 2014, p. 25). In fact, they can have huge effects, not just minor changes, but ground-breaking changes as well. Take for instance the impact of the evolution theory and psychoanalysis on religious thinking. This bidirectional impact brings Mühling to the conclusion that "every interdisciplinary dialogue always implies an inter-religious dialogue" (Mühling, 2014, p. 26).

To conclude this paragraph: The concept of certainties illuminates what we mean by commitment and it gives more content to the base on which professionals in science/ psychiatry and religion act as they do.

4. Intermezzo: Motives

Let us draw up an interim balance. This contribution is about developing a position, a stance with regard to religion and spiritualty in psychiatry. Thus far I have outlined a context: a group of professionals in mental health care, especially psychiatrists, connected in a worldwide network under auspices of the WPA. I clarified that parallel to a scientific and religious community, whose group is focused on certain epistemic and practical, personal, and collective aims. We also realized that members of the group personally and collectively do hold to certainties that at least partly typify their commitment and guide their actions. These two elements are indispensable for the next step of our endeavour. However, before going into that, another question arises.

One might still be suspicious of the motives behind our aim. Quite often, attempts to ask for awareness of religion and spirituality in psychiatry are met with scepticism. Is it not a religiously inspired old missionary drive, and is it not in fact a violation of professional boundaries? So let me try to explain my motives and give a disclosure on this (Sims, 2009). First of all, wonder. Wonder is an interesting emotion. It is usually elicited when something powerful or beautiful strikes us (Fuller, 2006, 1-15; Schreurs, 2006). Fuller quotes Descartes stating that wonder has the function of being aware of what appears only rarely, and that it "originates in response to novel or unexpected stimuli" (2006, p. 10, p. 14). In that sense wonder can stimulate new commitments (see also James, 1902/2002). This wonder is, secondly, a source of curiosity. There is this intellectual and practical curiosity to explore what it could

mean to look at religion and spirituality from a psychiatric point of view, and vice versa. If we intend to take a whole person approach as the most appropriate and respectful approach toward psychiatric patients, then there can be no ban on this curiosity. If, for the sake of the discussion, we would assume that there is no missionary drive at stake, the effect of our investigation could quite go into an opposite direction. Psychiatry does not need to submit to whatever religious claim, but psychiatry could be enriched. Its approach of the patient could become more differentiated and more tailored. And patients might profit from it. Last but not least, our plea might help to remove all kinds of misunderstandings. Again, the topic "religion and psychiatry" is much debated on. However, misunderstandings persist, despite the progress that has been achieved. It is therefore important to eliminate these misunderstandings, wherever possible.

5. A Stance

In order to achieve my goal, I will propose to consider "religion and spirituality in psychiatry" as a particular stance within the field of mental health care, especially in psychiatry. What is meant by a stance? The American philosopher Van Fraassen coined the concept, "A philosophical position can consist in a stance (attitude, commitment, approach, a cluster of such—possibly including some propositional attitudes such as beliefs as well). Such a stance can of course be expressed, and may involve or presuppose some beliefs as well, but cannot simply equated with beliefs or making assertions about what there is" (Van Fraassen, 2002, pp. 47-48). In other words, a stance is not just a belief or opinion, although beliefs and opinions are part of it. It is a certain way of reasoning, and of doing research, and of acting.

It would take too long to go into the background or history of the concept here. In short, Daniel Dennett introduced the term, but unlike Van Fraassen, he used the term for strategies for dealing with any system, as tactics of interpretation (Bennett & Hacker, 2003, pp. 419-427); Van Fraassen, 2004). He stipulated three tactics: the physical, the design and the intentional stance to explain or predict behaviour of a system. Bolton and Hill used his approach, especially the intentional stance, in their philosophy of psychiatry (Bolton & Hill, 1996; see also Fulford et al., 2006). Rashed elaborated the intentional stance and added a "spirit stance" as an intentional stance which subverts the person's agency, and at the same time maintains a form of intentionality (Rashed, 2020). Here we follow Van Fraassen's use of the concept as a policy or strategy, that guides ways of action, based on choices, decisions and goals (Van Fraassen, 2004).

The link to Dennett is not the only possible one. Van Fraassen also points to the German philosopher Wilhelm Dilthey (1833-1911), who introduced the (German) term *Weltanschauung* (Worldview, emphasis added by Van Fraassen, 2004, p. 177). This is an interesting connection, because Dilthey linked the term not just to the intellectual capacity of the human mind but also to the emotional, volitional, and behavioral capacities (Loonstra, 2016). In other words, he sees a worldview as cluster of

beliefs, values, attitudes “required to be in alignment with the holder’s modes of representation, volition, and values” (Van Fraassen, 2004, p. 177). Worldviews, according to Dilthey (and later on to Karl Jaspers) arise from the need to integrate experiences that come from our being related to life.

In accordance with Van Fraassen’s description I would like to formulate the case of psychiatry and religion as such a stance (Note 3). That is as a set of related commitments, certainties, goals, attitudes, and concerns, that are guiding and unified in a coherent whole, involving “*a self-regarding commitment for its own preservation*” (emphasis added by Van Fraassen, 2004, p. 177). I remind the reader that we used these keywords in the description of science and religion as social practices and in our analysis of commitment. Using the concept in that way is not tried out here for the first time. Others have applied it to complex lines of thought as well, for example Van den Brink and Smits (2015), who coined a Reformed Stance. In our case the concept of a stance might help us to bring together the elements with which our argument is structured. That might bring us a set of advantages, which would help us beyond the controversial status quo we are in.

What would these advantages look like? In the first place, psychiatry and religion as a stance is in a formal sense not fundamentally different from any other stances in psychiatry. A stance is a conglomerate of professional knowledge, attitudes, certainties, and goals. In that way, one stance does not fail for the other, unless the stance does not meet the characteristics as postulated by Van Fraassen. It does not signify that disagreement in the sphere of professional knowledge, attitudes, certainties forecloses criticism; on the contrary. Van Fraassen wishes to emphasize this. Otherwise, our approach would become a license for whatever nonsense or superstition. However, psychiatry without the psychiatry and religion stance would be incomplete. On the other hand, a psychiatry and religion stance does not intend to claim a special position as if the issue of religion and spirituality is a more favourable or more meaningful position than any other one, leaving the others behind. As if it would be possible to develop a religious (read Christian) psychiatry or religious (read Christian) psychotherapy. As a matter of fact, this has been done, and most recently by Johnson (2017; e.g., Hyder, 1971; Minirth, 1977). That would be a mistake as well. “Religion and psychiatry” is a valuable stance, no more and no less than any other position.

So, what would then be the special contribution of a psychiatry and religion stance? It is a matter of accentuation, of importance attributed to human functioning and welfare, and of intensity and urgency attributed to certain aspects of illness and health, which would otherwise be neglected (Note 4).

6. The “psychiatry and religion” stance

When we look closely at the question of a special contribution, we will be able to distinguish some elements that can be considered specific, if not exclusively, for a psychiatry and religion stance towards psychiatry and mental health. In the first place I think of a holistic approach to the patient as a person. This, of course, is not an exclusive input of a psychiatry and religion stance. Take for instance the

biopsychosocial model, which suggests a holistic approach. However, grosso modo it does not function that way, and religion, spirituality or worldview are not included (Lewis, 2008; De Haan, 2017). Therefore, a biopsychosocial-spiritual model has been suggested, especially for this reason: the holistic approach of the patient as a person (Culliford & Eagger, 2009). The interesting corollary is that it opened and opens research to other issues than the usual ones. This is not insignificant, because it is not only what has happened and happens in research, but it happens in clinical practice as well, an opening up of other aspects related to mental illness and health.

Closely related to this holistic approach is the issue of culture and values, which is also a typical element from the perspective of a psychiatry and religion stance. And again, this is not the exclusive input of our stance. Values-based medicine and values-based psychiatry, values-based care have made an enormous contribution to this aspect of clinical practice. Cultural psychiatry has made a major effort in this domain of psychiatry and care. However, the religious and spiritual aspects are subordinated to values and culture, and not sufficiently estimated at its own value.

Thirdly, the psychiatry and religion stance refers strongly to the professional and his or her personal worldview. That seems to be a predictable and obvious issue, but it is not. For a long time, the person of the professional, the worldview of the professional and how this relates to the professional role had not been accounted for, because it simply did not matter in that way (Glas, 2017, 2019; Schreurs, 2020). This idea and approach were a formidable mistake. It turns out that religious, spiritual, existential or worldview issues inevitably belong to the centre of professional role fulfilment, and that they do not just fulfil a subordinated, if not negligible, role. Such professional performance requires general virtues such as integrity, reliability, compassion, respect, altruism, which find their natural resources and inspiration in one's worldview (Glas, 2019).

Fourthly, we are not using the word religion exclusively here. On the contrary, that would only undermine the psychiatry and religion stance, as if we only had religious and spiritual traditions in mind. By religion and spirituality we mean the entire domain characterized by beliefs, values, and attitudes that people have about themselves, about the world around them (immanent and transcendent) and what people can know, say, and do about it. And that takes place within a religious or spiritual tradition, on the edge of it or (far) beyond it. It is not unusual to describe "worldview" in this or similar way as a more comprehensive term (Stenmark, 2022). A term such as "lived religion" has also come into circulation in recent years and is about this inclusiveness (Verhagen, 2022). All these terms are intended to be maximally inclusive in order to do maximum justice to the diversity in the religious and spiritual realm and beyond. The psychiatry and religion stance is intended to maximize this diversity.

7. Conclusion

Our aim was to develop a stance with regard to religion and spirituality in psychiatry. In order to do so we needed several concepts from philosophy of religion, philosophy of science and theology.

Everything was considered with a view to an interdisciplinary dialogue between scientists and practitioners on science and religion, but also between clinicians and patients on psychiatry and religion. The efforts of the group, the WPA Section on religion, spirituality and psychiatry succeeded in the acceptance of a Position Statement on Spirituality and Religion in Psychiatry by the Executive committee of the WPA (Moreira-Almeida et al., 2016)! In this contribution I reflected about what has become indispensable and necessarily developed and formed over time as the basis of the entire trajectory. The result is a well-founded so-called psychiatry and religion stance.

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Notes

Note 1. Theological thinking starts with wonder as well, however, there is a difference compared with science. In theology its wonder is evoked by that which has no "topos", that which comes to the world. In that sense understanding leads deeper and deeper into wonder (Jüngel, 2003, p. 275; see also Fuller, 2006).

Note 2. Markus (2004) developed a set of criteria of formal and practical adequacy for assessing views of life. Views of life demand internal and external consistency and internal and external coherence, and practical adequacy (existential suitability, universalisability, integrity, inspirational quality), otherwise the processes of ascribing meaning and religious coping would fail (see also Pargament, 1997).

Note 3. To avoid misunderstandings, I do not mean an individual stance but the stance of the group. As Rowbottom puts it, the psychiatry and religion stance is a set of individual stances "{s1, s2, s3, …sN}" (Rowbottom, 2005, p. 214).

Note 4. Van den Brink & Smits (2015) introduced the notion of intensification in the debate of what a stance is.