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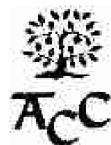

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Religious Systems as Sources of Control and Support

Robert B. Tapp and June L. Tapp

"Religion" and "community mental health" share conceptual ambiguity, but for different reasons. Western religions are ancient, varied, and in great flux. Empirical studies of religion, whether individually or institutionally focused, are surprisingly scarce (cf. Berkowitz & Johnson, 1967). The concept of community mental health, on the other hand, is too new and broad to be plagued with serious or disruptive divisions. Nevertheless, its status in relation to earlier mental health and ~sychotherapeutic movements is a matter of corltention. Any discussion of present and potential relationships between religion and community mental health starts with these ambiguities and proceeds by analytic and historical means.

Social movements as pervasive as mental health or religion are bound to produce coexisting partisans reflecting many historical changes and developments. When we find many "true believers," each with conflicting claims, the best way to proceed is by a careful ground mapping. We will then at least know who belongs where, and where we are ourselves. While this in itself will not give us any sense of direction, it will nevertheless prove essential to anyone who has decided where he wants to go.

Traditional Western religion and traditional interpretations of mental health afford a number of intriguing structural similarities. Both have been highly individualistic, focusing upon the person. Each begins with diagnosis (sin/neurosis), proffers a therapy, and promises a remisssion (salvation/mental health). Each has its experts, its texts, its institutions, its devoted laity. Each has its enemies. Each has a clearly discernible past and a likely future.

The thesis here is that this future will be one of increasing convergence. For quite different reasons, the role of expertise in the two areas is lessening. A mixture of democratization and secularization affects both, fostered in part by growing doubts about the efficacies of their respective diagnoses, therapies and remissions. If religion has been strong on goals, it has been weak in techniques. And if mental health has been strong in techniques, it has been vague on goals-better able to define "illness" than "health." The present shared mood of uneasiness and lost dogmatisms is reminiscent of "actors.. in search of a play."

In what follows, we will generally use the broader term "psychology" as including psychotherapy and psychiatry, and "community mental health" as synonymous with community psychology or community psychiatry. When the more specific terms are used, the reasons will be obvious. In speaking of "mental health," we have in mind the various movements aimed at promoting "mental hygiene," or "psychotherapeutic orientation"-movements which have given rise to the relatively recent efforts toward "community mental health." Our references to religion will concentrate on the American scene but will make occasional reference to comparative religious phenomena.

RELIGION AND MENTAL HEALTH

Parallels. Focusing on the last half-century, religion and mental health can be viewed as

distinct *weltanschauungen,* exhibiting parallels and differences. Both are *totalistic* rather than adjunct. They presume to cover the whole range of human life, from basic needs to highest satisfactions. In this totalism they differ from, for instance, medicine, which typically has been concerned with physical health and not the more philosophical issue of "health for what." Put another way, the physician does not follow his client out of the consulting room and into his job, family life, recreation, creativity or solitude. Such pervasive human activities only concern an adjunct orientation when they produce painful symptomology. No human activity, however, can be alien to a totalistic orientation. This parallelism of concern has brought religion and mental health into both confrontation and accommodation.

Both orientations are also *expertistic.* Western religions especially have relied heavily on prophets, priests, theologians, and teachers who have "correctly" interpreted their beliefs. In the West, this has been an ongoing interpretation of some "revelation" -an intrusion upon the human scene from a supernatural realm of divine person whose basic authority cannot be questioned. The religious expert or theologian has been seen as a guardian, interpreter, and channel of the supernaturals. In certain non-Western religions and some modernized versions of Western religions, the functional supernaturals have been "highly unusual" persons or events (the *man* Buddha or Confucius, a *human* Jesus, creations, holocausts) but the function of the expert has remained. A similar expertism can be found in the mental health movement in relation to the issues of who is competent to make a diagnosis or evaluate a therapy. Illustrative of this would be Heinz Hartmann's contention that only another psychoanalyst could correctly interpret or evaluate the transcript of a psychoanalysis (1959).

Differences. If totalism and expertism are the main parallels between religion and mental health, there are also differences which must be noted. In both these parallels and differences, there are often gaps between pretense and practice-between what a field would like to do and what it in fact does. At this point, we are primarily concerned with the pretenses, and necessary qualifiers will be added as we proceed.

The mental health movement has been typically naturalistic in the philosophical sense of that term. It has concerned itself with events and processes in the ordinary world of human experience. While there are assuredly difficult problems surrounding the concept of "mental event" or allegations: concerning "other minds," these problem areas are in the ordinary, natural world and not in the supernatural time and space which occupy part of religions' concern. The "time" in which psychological processes unfold is ordinary time, or what philosophers would call "public time." This naturalism makes the mental health orientation both scientistic and temporalistic-stances that have never characterized religion. Religious events, and subsequent human experiences recapturing and recapitulating those events, occur in what Mircea Eliade calls "sacred space" and "sacred' time" (1958). These terms are a helpful explication of a supernaturalistic orientation.

Flowing from this naturalism of the mental health orientation is a kind of pragmatism which' differs from the religious orientation. The results of psychotherapy transpire in some foreseeable future, some point in time at which verification procedures become appropriate. Indefinite or endless psychotherapy is conceptually impossible. The verification of religious assertions turns ouUo be quite another matter. Recent attempts to clarify religious language have led one religious philosopher to speak of "eschatological verifica. tion" -a verification that takes place only in some end.of.time or after-history (Hick, 1957). Quite apart from the logical difficulties in conceiving of "time" when there is no more "time," such a category illustrates well the nonpragmatic nature of religious thinking.

The third major difference we see between the religions and a mental health orientation is in the universalism of *outlook* (in psychological terminology, generality of construct). Because of its scientistic stance, mental health speaks typically of "the human condition" and describes particular behaviors within the context of assumptions about general behavior. Recent concerns with genetic determinants of behavior may qualify this somewhat, but the basic proposition still seems to be valid. Religion, on the other hand, is primarily concerned with particular groups. While it may generalize about "the human condition," its focus is on the "true believers," the "members of the church," the "born Jews" (or Hindus, or Shintos, or Navahos). As we will argue later, this religious

nonuniversalism (particularism) poses serious barriersto the assimilation of mental health values.

ACCOMMODATIONS OF CONTEMPORARY AMERICAN RELIGION TO MENTAL HEALTH

We have thus far been regarding religion as a set of orientations occurring within all human cultures. In order to assess the reciprocal relationships of religion and community mental health, we must now examine American forms of religion since 1900. One dominant process, highly significant for our purposes, has been that of accommodation-the religious adoption of the mental health orientation without basic modification or critique. This has, in religious circles, been a selective situation. Along with accommodation, there has been intransigeant rejection as well as critical assimilation. All three processes must be borne in mind, but we will first look at accommodation.

Determining the valence of religious institutions and ideas in American life is a complex matter. Religious statistics are notoriously uneven in reliability. Nevertheless, they give some picture of the institutional structuring of religion. The most recent *Yearbook of American Churches (1968)* listsa total membership of 105,000,000. This total probably reflects 80-90 percent of church membership, and includes Roman Catholics (45 percent) and Jews (5 percent). The clergy total is 264,000, of whom 138,000 have "charges" (meaning they are related to a parish or congregation). Granting that many of those listed are not engaged in full-time religious professions, the community mental health movement can still count on a sizable personnel reservoir from the alliedhelping-field of religion.

If we try to understand American religions in less denominational terms, we must distinguish Catholics, Jews, "cooperative" Protestants, and "other" Protestants. This distinction between Protestants notes that the members of the National Council of Churches as well as most state and local councils are drawn from those Protestant groups committed to cooperative or common action despite ideological diversity. The fact remains, however, that the "other" Protestants are increasingly cooperating in their own common causes. Furthermore, National Council membership does not have the same ideological implications as does nonmembership. We can safely assert that most of the 27 million nonmembers share a common "evangelical" ideology. If one.third of the 39 million National Council members are also conservative-fundamentalist in outlook (cf. *Time,* 1969), this gives the right wing of Protestantism a 60 percent plurality. This membership base inflates the totals of the *Yearbook,* but the proportions are probably correct.

Americans are more "religious" than other Western nations on a number of indices-frequency of church membership and attendance, frequency of financial support, and donated time. Between 60 and 70 percent belong to churches and synagogues (this is very near an all-time historical high). An unknown additional percentage are nonmember attenders. Polls consistently find that 97 percent "believe in God." Clergymen are ranked high on occupational scales and as sources of help in crisis. What this all means is that any assessment of the role of religion in community mental health must necessarily come to terms with the "meaning" of religion for a very large segment of the population.

Even if we had more accurate institutional data, however, this kind of analysis would become complex. For instance, one must distinguish between institution, bureaucracy, and value structure. In the case of Roman Catholicism, the institution and the bureaucracy are most readily visible, but this should not allow us to overlook the nominal member who is barely touched by the institution or bureaucracy and yet has assumed no other aff1l.iation. We should not stop short of asking people which church they "stay away from," since this will help define the meaning of religion for them and help us discover the various noninstitutional, nonbureaucratic modulations of religious values and aspirations.

In the case of American Jews, the complications stem from whether Jewishness is an ethnicity or a community, largely of birth, which must somehow be voluntarily affirmed and maintained. The traditional position is that one is Jewish if he had a Jewish mother. Among some Reform spokesmen one finds the polar position that Judaism should be a voluntary faith (like Methodism) and that unless one chooses to be Jewish he is not. Further confusion is fostered by the fact that most non-Jews probably concur with the Orthodox position that persons from "Jewish" families

remain "Jewish" unless they convert. Some fundamentalist Protestant groups and their converts even refer to "Hebrew Christians." In any *event, some sizable number of Americans* regard Judaism as the religion they "stay away from." They differ from the nominal Catholics in that the label of their birth is urged upon them not only by their former coreligionists but by many in the community at large.

When we turn to the majority Protestant group, the situation is highly ambiguous. Recently, historians have argued that the Weber-Troeltsch typology of church/sect has little relevance to the American scene where the key institution is the "denomination" -characterized by relative openness of membership and diffuseness of belief (Mead, 1963). Denominations are far more significantly correlated to social class than to specific beliefs or behaviors.

The least diffusion, institutionally, occurs at the conservative right end of the Protestant spectrum. This is, perhaps, the unique American aspect of Protestant development and will be, we contend, of great significance as the community mental health movement expands. Professionalized groups have tended to overlook this fundamentalism since it lies outside their class experience, but it is a major religious phenomenon. Fundamentalism is characterized by two features: a simple, direct approach to the Bible (rather than a concern for some historical tradition of interpretation) and a stress upon "spiritual experience" rather than intellectualized belief. For these reasons, the bureaucracy of fundamentalism reflects a nonuniversity, nonseminary type of training. Six out of ten American Protestant ministers have had neither college nor seminary education (Nichols, 1952). This represents a very real departure from the mainstream European Protestant tradition of a "learned ministry." It also explains why more Americans would view Billy Graham and Oral Roberts as great theologians than they would so regard Reinhold Niebuhr or Paul Tillich. And it points up the difficulties that community mental health personnel will experience when involving the clergy. Since this dichotomy in class, education, and outlook pervades the Protestant ministry, it is hard to find a city where clergy are able to effect serious cooperation with one another, let alone with other professional groups.

Since acceptance, status, and power are interrelated, present processes of democratization seem likely to increase the influence of fundamentalism and fundamentalist leadership. One of the real effects of court decisions and social policies aimed at "separation of church and state" is to weaken the "established" religions and therefore increase the relative strength of the less-known religions. Perhaps this will also be the net outcome of the various ecumenical movements aimed at bringing religious groups into closer cooperation. If so, the present hegemony of university and seminary trained religious professionals will attenuate.

Religious accommodation to a mental health orientation is most readily observed on bureaucratic rather than institutional levels. That is to say, we must look to the behavior of individual clergymen and the seminaries that train them. The roster of the American Academy of Religion and Mental Health, founded in 1954, provides illustrative data, as do the affiliations of those who write for its organ, the *Journal of Religion and Mental Health.* A number of overlaps will be found here and in the Council for Clinical Training, founded in 1930. In the main, such clergymen, professors, and hospital chaplains come from those denominations serving the middle class, educated, white American Protestant and Jew (Klausner, 1964). In other words, there has been a close relationship between bureaucratic concern for a mental health orientation and parishioners open to, and able to afford, psychotherapy. Most of the mainstream Protestant seminaries now offer instruction in "pastoral psychology" or "pastoral counseling." Two journals reflect this development and are valuable as descriptions of ideology and practice: *Pastoral Psychology* and the *Journal of Pastoral Care.* Many seminaries-Protestant, Catholic, and Jewish-now require a supervised hospital internship (usually lasting for one summer).

One cannot, however, explain the rapid spread of mental health ideas among the mainstream Protestant bureaucracy simply in terms of the acceptability of these values to the general membership. Unpopular social values (antiwar, prointegration) have spread as rapidly without similar lay acceptance. We must, therefore, examine some of the factors within the bureaucracy-especially if we are concerned to estimate

the continuance of support for the mental health movement.

The mainstream Protestant bureaucracy is today characterized by an urge to "relevance." This is seen in the considerable clerical involvement in various phases of civil rights activity and in opposition to the Vietnam war. In these cases, as we have suggested, clerics hav~ often paid a high price in being ahead of their members. Yet this very increase in marginality creates its own kind of opennesses. In earlier decades psychotherapeutic themes were more dominant in intellectual circles and this same urge to relevance impelled clergymen into mental hygiene, mental health orientations, and organizations.

This very salience of the mental health movement affected the members of many mainstream Protestant churches, and some of the bureaucratic accommodation may be attributed to a "normal" motivation of holding members. O. Hobart Mowrer has in fact argued that some clergymen were too zealous in referring parishioners to psychotherapists (1961). A parallel response was the creation of church sponsored and housed counseling centers (e.g., Fritz Kunkel in Los Angeles, Smiley Blanton in New York). Certainly there has been a reciprocal relationship between Protestant acceptance of psychotherapy and the increase in "Protestant" psychotherapists. More recently, Roman Catholic openness has led to an increase of "Catholic" psychotherapists. We take it for granted that the hostility of classical psychoanalysis toward religion needs no documentation here. Interested readers may find an historical explication of this in the semipublic discussions of Sigmund Freud and Oskar Pfister, a Swisspastor (Freud, 1964).

A more ideological factor helping accommodation was the popularity of "neoorthodox" theology during the 1930s and '40s, reviving an Augustinian view of man which stressed the limitations of rationality in personal and social life (cf. especially Reinhold Niebuhr). Man was instead to be viewed as "sinner," prone to self-deception, pride, and continuing distortion of outlook. Mowrer (1961) has tellingly delineated the parallels of this stance to an orthodox Freudian position. Libido provides a kind of biological determinism just as sin provides it religiously. Faith relaxes anxiety just as insight relaxes superego. Perhaps less apparent outside theological circles is the devastating critique the neoorthodox position leveled against "pietism" and "Christian liberalism" which had stressed inward growth and human self-perfectability.

More recently, the ideas of Paul Tillich have promoted accommodation. Tillich fused German romanticism and existentialism with a number of psychoanalytic concepts. Tillich's memorial ser. mon for Karen Horney is an interesting example of this ideological blend (1953). Perhaps more importantly, his own dialectical treatment of such key theological problems as the God-concept (equating it with "the ground of being") not only made religious thought palatable to many skeptical outsiders but led some followers to proclaim "Christian atheism" or assert that "God is dead." Insofar as a naturalistic outlook is troubled by theistic allegations and God-talk, this new climate of opinion reduces many barriers to accommodation.

As a final factor, we must note the ecumenical movement. The Protestant ecumenical movement, beginning in the early twentieth century, brought together spokesmen from different traditions in an atmosphere of mutual respect to discuss theological as well as social concerns. Such cooperative experiences have fostered a kind of federationism, coupled with a will to compromise. Since Vatican II, Roman Catholicism has fostered its own ecumenism, reflecting an eagerness to enter into dialogue with other positions. In differing ways, both ecumenical movements have fostered an increasing openness to accommodation. Interestingly, most clinical pastoral training programs in hospitals have been ecumenical in the sense of being interfaith. There the focus upon the problems of patients inevitably creates an awareness of the relativity of particular and traditional theological solutions.

BARRIERS AND LIMITATIONS TO ACCOMMODATION

Accommodation, as used here, describes those who have essentially incorporated mental health ideas into their overall religious framework. If our initial characterization of the contrasts and parallels of religion and mental health is correct,

accommodation can only occur when certain religious ideas are either lacking or abandoned. This is another way of stating Samuel Klausner's conclusion, after analyzing years of religion and psychology literature, that the "marginals" on either side are most likely to adopt the terminology and ideas of the other camp (1964). This is an instance of the openness we have described.

Theologically, psychotherapeutic ideas have most directly challenged certain "doctrines of man." (We would favor "humankind" as a less gender-biased term, but classical and contemporary theological formulations not only use "man" but often treat "woman" as a separate "order.") At the risk of oversimplification, we will characterize these as the "pilgrim" doctrine and the "citizen of two worlds" doctrine. The monastic system obviously embodies the pilgrim doctrine, but modified versions of it are found throughout Christian history, especially in what has been called "ascetic Protestantism." Man is understood as a kind of horizontal duality, with upper and lower parts. The upper, spiritual part is higher and its needs and demands should be heeded, whereas the needs of the lower part must be suppressed. Plato had described the body as "the prison of the soul" and this theme is the basis of the pilgrim doctrine. Man's real home is not on earth but in some postmortem, heavenly abode and this life should be treated only as a journey. A Muslim version of this runs, "This world is a bridge; build not a house thereon." Any human activity must be legitimated by its contribution to the welfare of the soul; and the "soul" is viewed as nonmaterial and therefore not subject to empirical description or assessment. Clearly, the pilgrim doctrine leads to excessive denial and suppression from a mental health standpoint. Equally clearly, the pilgrim doctrine must view mental health ideology as naturalistic and unspiritual.

The "citizen of two worlds" doctrine, on the other hand, views man as a kind of vertical duality. One "side" is religious allegiance and responsibility; the other side is responsible to the world. The "world" is necessary, real, and not inherently bad (although, of course, it cannot rival or reach the "heavenly city"). This doctrine of man has the advantage of granting a quasi-legitimacy to many human activities. Sex, for example, is to the pilgrim doctrine an unfortunate necessity at best, and a thing to be shunned at worst. For the citizen of two worlds, however, it can be seen as a legitimate activity of pleasure and fulfillment insofar as it is always subordinated to a spiritual doctrine of cosmic love. In most versions of this doctrine, there are many dimensions on the, "secular" side that have no spiritual counterparts and therefore no ecclesiastical inhibitors. For most modern treatments of this kind of dualism, this would apply to areas of power, pleasure, politics justice, and the like. Here there is no overarching spiritual wisdom, and secular wisdom is neither inhibited nor challenged.

In other words, if we view various religious doctrines of man from the mental health *weltanschauung,* they can be arranged along a continuum. The pilgrim doctrine at the far right demands rejection of all "secular" wisdom, including psychotherapy. The citizen of two worlds doctrine would fall somewhat right of center. On the far left, we hypothesize a naturalistic doctrine of man, indistinguishable from the mental health, naturalistic position. This represents complete accommodation. Between the extreme and the center of our spectrum is space for a number of stances that we shall call "critical assimilation" doctrines.

Earlier, we outlined a number of cultural and historical presses that had encouraged doctrines of accommodation. Now we will suggest three types of theological press that limit acc<;>mmodation and therefore result in some sort of critical assimila. tion. One is the result of viewing psychotherapy as a "method" rather than a *weltanschauung.* Albert Outler suggests that the Freudian "wisdom about life" can be rejected while the "wisdom about therapy" is adopted (1954). While this approach leads into philosophical problems such as the actual independence of alleged ends and methodol. ogies, it clearly recognizes that full accommoda. tion would indeed involve crucial ideological shifts.

The second type of theological limitation is somewhat harder to state but represents the most prevalent and serious form of reservation held by theologians. Cyprian, a 2nd century church father, contended: *Extra ecclesiam nulla salus* ("Outside the church there is no salvation"). That doctrine has always been troublesome in its arrogance and has typically been hedged with footnotes about an "invisible" or "latent" church. The initial dilemma

that forced these qualifications was the need to ascribe postmortem status to pre- or extra-Christian worthies such as Plato and Moses. To consign them to Hell might have made "logical-theological" sense, but it grated upon common human decencies and left the Deity who wrote such a script in the position of being more arbitrary and less humane than ordinary humans. Thus the footnotes.

This same dilemma persists in relation to modern mental health. If we regard this as the highest human good, it approximates what religion has called "salvation." Can it exist *extra-ecclesiam;* is it possible for non-Christians? If so, what becomes of the basic rationale for the church? Those theologians who grant extra-ecclesiastical salvation have one set of problems while those who deny it must either rely upon some arbitrary definitional basis, or show, by some empirical procedures, that non-Christian mental health still leaves something to be desired.

A third theological limitation upon accommodation stems from the conflict between certain modern values and what could be termed "historical integrity." This can be illustrated by reference to anti-Semitism. Men of good will, Christian and otherwise, are now agreed that anti-Semitism is a disvalue. Nevertheless, early Christianity was shaped in an anti-Jewish environment. Its literature both reflects this and also sustains a more broad-gauged and complicated anti-Semitism. While there may well be a number of causal determinants for anti-Semitism, recent empirical studies consistently show its close relationship to mainstream forms of Christian and New Testament instruction. Should modern Christians therefore purge their basic book? liberal democratic ideology might argue "Yes," while historical integrity might demur. Numerous American communities have been torn apart by arguments over the "Passion Play," which focuses on this issue. Such controversies are better indicators of conflicted feelings than are discus sions of the evils of prejudice or the inevitably desirable results of religiousness.

In assessing the degree to which American religion has accommodated to, or assimilated, mental health concepts, we must not be misled by trends and tendencies which, although widely publicized, have actually a very limited and stratified appeal. For the great majority of American Protestants and Catholics, there has been little exposure to mental health ideology through religious channels-due to the concomi. tance of limited educational exposure of both parishioners and clergy. Milton Rokeach observed (1968) that religious persons do not seem to be significantly freer from anxiety or prejudice than their non-church-going neighbors. In part, this may simply indicate that these mental health values have not been effectively assimilated. More likely, it points to the c'onfounding of such values with inhibiting values-"double messages." In many religions, for instance, teachings about the brotherhood of man exist along with exhortation to convert others to one's own faith. Such confounding of values is probably the explanation of numerous findings on the correlation of orthodoxy and prejudice.

A further explanation of the ideological nonaccommodation of religion to mental health is semantic. Similar words often carry dissimilar meanings in religious and psychological contexts. The controversial papal encyclical on contracep. tion *Humanae vitae* speaks continually of "love" and "duty" but uses these words with connotations strange to most non-Catholics. The controversy created by this pronouncement indicates that these older connotations are also unfamiliar or no longer acceptable to many Catholics as well.

Sexuality as a Test Case of Accommodation

It will be clear that we have been regarding the mental health movement and the several religious traditions of our culture as embodying different, and often conflicting, outlooks. A number of terms could be used to describe the interaction processes at work here: accommodation, assimilation, rejection, rapprochement, competition, conflict. The traditional religious term for the desirable outcome in such confrontations is "conversion" -a fundamental shift in basic outlook which makes the erstwhile outsider an insider. There is no reason to think that this is a one-way process. In fact, one of the most intriguing conversions of the present century has occurred in relation to Western religions and sexuality. The history of this conversion is worth reviewing as an extreme illustration of religious accommodation to the mental health movement.

One of Freud's greatest contributions was a delineation of psychosexual development, culmi. nating in mature genital sexuality. Freud's focus was upon the price paid for "civilization" in terms of repression and pain. To recognize and alleviate repression became a major goal of mental health, along with the minimization of pain. This pain-pleasure balance is acutely centered in man's attitude toward his sexuality. More precisely, the problem is one of human sexuality, since Freud's vision insisted upon the sexuality of children and women.

A gross, but nonetheless significant, measure of attitudes toward sexuality is found in attitudes toward birth control and family planning. Here the ecclesiastical record is both available and instructive. At the turn of the century, religious groups were almost unanimous in condemning contraception as a negation of the fundamentally "procreative" function of sexuality. One by one, the churches have come to accept and then endorse birth control. It would, of course, be too simple to regard this as the ready acceptance of a mental health movement value. We have to reckon with urbanization, education, democratization, feminism, class mobility, and a number of other cultural forces. But the acceptance was essentially completed even before the advent of "the Pill" and the women's liberation movement. Even more significant than the endorsement of contraception was the religious reformulation of values toward human sexuality. *Towards a Quaker View of Sex* (1964) is perhaps the most revolutionary restate. ment, but the search for new values may also be seen in the more moderate treatments of Seward Hiltner (1953) and Joseph Fletcher (1954). Also instructive is the historical reconstructionism of William Cole (1955). Sex, for these modern Cmistians, becomes recreation as well as procreation, and the emphasis broadens toward almost total theories of human fulfillment through sexuality (Bailey, 1952).

What this sexuality paradigm shows is the inevitability of religious-cultural rapprochement. We have chosen it not because it is isolated but precisely because we regard it as prototypical of accommodation. If this assumption is correct, similar processes will become patent in regard to pleasure generally, to leisure, to social freedom, and other preoccupations of postindustrial society.

CRITICAL ASSIMILATORS AND INTRANSIGEANT REJECTORS

The almost uncritical religious adoption of a mental health attitude of sexuality, just described, represents a nearly unparalleled situation. Almost no other aspect of mental helath emphasis has been as freely adopted. The much more normal religious reaction, where there is not total rejection, is one of "critical assimilation." By this we mean a reassessment of present religious practices and traditional ideas in the light of mental health ideology, guided by the basic assumption that there is something sound in these practices and that the critical assimilation of the challenging ideology will build upon and improve existing religious practices. A great majority of theologically trained writers who have confronted the mental health movement have fallen in this camp, as has been the case with psychotherapeutically trained workers with personal religious involvement. What follows is simply a pointing to a few of the major contemporary figures in this area. It is illustrative rather than exhaustive.

Jesse McNeill's *History of the Cure of Souls* (1951) is a useful survey of religious traditions, including some materials from the non-Western world, and provides a helpful context in which to assess contemporary efforts at critical assimilation. Where parallels of theory or practice. between existing religions and particular aspects of the mental health movement can be found, a reenforcing assimilation can occur. Some specific instances of this occur in the treatment of alcoholism as described by Howard Clinebell (1966), Richard McCann's treatment of religious leadership (1962), and Hans Hofmann's discussion of attitudes toward sexuality (1967). Useful examples from the standpoint of counseling practice are Paul Tournier (1957) and O. Pfister (1923). From the psychological side, the personality theories of Gordon Allport (1950) and of Rollo May (1953) have explicit religious components.

Somewhat further removed from the religious mainstream, a number of Jungians have explored religious and mental health parallelisms. Ira Progoff (1959) and F. Kunkel (1943) are representative of this orientation.

Mowrer's writings (1961, 1964), while sharply critical of the Freudian component in mental health, are very concerned to find prototypical religious theories. Erich Fromm's interests, while well to the left of the religious mainstream, reflect a continuing reassessment of past religious contributions (1950, 1966). Operating from a somewhat similar humanist orientation, Rudolf Oreikurs reflects a parallelism in the Adlerian tradition (1968). Henry Murray's later writings also blend a humanist orientation with a concern for preparallelisms in the religious traditions (1960). Gardner Murphy also shares a similar orientation (1958). "Peak experiences," according to Abraham Maslow's typology, are a widespread human phenomenon, and some of them occur in religious contexts (1964).

There has also been an interest in discovering parallelisms between mental health and non-Western religions. These parallels are, of course, more useful in building critical models than in assimilating social structures, but they reflect yet another approach to the problem of the inner relations of religion and psychotherapy. Alan Watts (1961) and Gerald Heard (1964) are good introductions to this interest. We can also note Charles Morris' assumption that - the personality structures typically associated with varied religions are quite universally distributed, and his several attempts to build empirical models to assess this (1942,1956).

Consistent rejection of a mental health orientation by religious persons has been a somewhat different process than accommodation or critical assimilation. For one thing, persons may not know or care to know a different ideological position if they are sufficiently satisfied with their present one. In a culture where -the mental health orientation is widespread, ignorance of it becomes de facto rejection. But this is a process without a rationale.

In some cases this rejection becomes conscious and takes on polemical qualities. Most of these polemics, however, have been addressed to the faithful and have not been intended primarily as academic treatments. A brief survey of some of these positions may be found in Klausner .(1964).

Since it is the thesis here that religious perspectives will have an increasing voice in policy determination regarding community mental health, and since a sizable proportion of American religious affiliation is sympathetic to intransigeant rejection, it is important to sketch certain recurring themes found along the religious "right." Academic psychology and psychotherapy have been faulted for their naturalistic view of man which ignores his spiritual, transcendent dimensions. Without such a dualistic perspective, it is held, sin and evil lose their cosmic definition and succumb to cultural relativism. The most serious issue for conservative religions, however, has already been noted-the prospect of salvation apart from "Christ and/or the Church" (for conservative Judaism, substitute "the People"). While critical assimilators might be willing to view psychotherapy as a preface or restorative to "religious" living, the intransigeant rejectors view it as a subversive competitor.

WHEN MODELS FAIL

An abundant literature has grown, from within and without, detailing the "failures" of the mental health movement. This is relevant in explaining the emergence of the community mental health movement and also because of its significance in assessing religious reactions to mental health in its various forms. It was inevitable that the slow and lengthy processes of psychoanalytic therapy would be criticized as economically discriminatory and class bound. It was probably equally inevitable that various forms of group therapy would. emerge, whereby individual therapists could carry larger loads. It was probably also predictable that as psychotherapy came to be defined as a "helping" process, the necessity for having highly trained helpers would be questioned. Part of this same process may be seen in the rise of client-centered therapies where the diagnostic skill of the therapist is less important than the potentials for self-cure of the patient so far as this can be properly facilitated.

An interesting challenge to the traditional model of "illness" came from the studies of Hans Eysenck and his followers (1965). Logically, of course, there must be something like a "spontaneous remission rate." Insofar as it can be estimated, this provides a base rate for assessing the effectiveness of various psychotherapies. Thus

far, empirical research in this area has not provided a decisive verdict in favor of various therapies.

The central aspect of the mental health crisis, however, has been the direct attack upon the "illness model" itself. If "mental illness" is essentially a euphemism for behavior that some particular culture or subculture does not like (Szasz, 1961), then of course the mental health practitioner is in no sense analogous to the medical practitioner who has a reasonably specific cure for a reasonably specific malady. Mental illness is not so much a "real" thing as a form of behaving that is "labeled" as undesirable by the society. The psychotherapist has lost that authority that was his when his role was viewed as analogous to the medical therapist.

It may be reassuring to know from the history of science that the breakdown of a model is typically the symptom that some larger, more effective synthesis is on the horizon. Nevertheless, as workers lose faith in the old model a clear demoralization results until its better replacement is in being.

This breakdown of model has intriguing parallels with a similar breakdown of the religious model of "sin" and its "cure." The mainstream of Western religiousness has also diagnosed the human ailment and prescribed a cure for that illness. The same secular mentality, however, that has insisted that psychotherapy produce its "results" has done the same thing for religion, with the same disquieting outcome. In the past, religion has been able to deal with the call for verification by suggesting that it may not occur "in this world" but rather may only appear in some *eschaton,* some "other world" or some "new epoch." As the metaphysical basis for such dualism attenuates, the attractiveness of the solution disappears. Similarly, religion has often argued that the cure will be more evident to God than to man or that even if it is apparent to man, it is apparent to man in his individual subjectivity and is not a matter for public appraisal or verification.

These solutions, needless to say, have lost much of their attractiveness in the current critical climate. Thus the background for our discussion of the emergence of community mental health and the relationship of religious institutions and ideas to this emerging movement is set by the somewhat parallel breakdown in the traditional patterns of dealing with mental illness on the one hand and religious illness on the other. When traditional models break down, it is both easier and more necessary to try new solutions. The old ways may or may not "work" -whatever that means. The patent fact is that they are surrounded by a large-scale loss of confidence and an intense impatience.

COMMUNITY MENTAL HEALTH AS A RESPONSE TO THE CRISIS

The community mental health movement is a major response to this internal crisis within psychotherapeutic circles. The history of the community psychology movement is detailed elsewhere within this volume, and our purpose here is simply to highlight certain aspects of the development that are relevant in the assessment of the interactions with religious institutions and ideas. The development is intriguing in that funds have preceded theories, perhaps more so than in any other aspect of psychotherapy. As a result, those who controlled the funding were in a position to give some clear direction to development of the field; at the present time, however, there is little evidence that such direction has occurred. M. Brewster Smith has openly voiced the fear that this "third revolution in mental health" may have misfired into an urbanized version of the state mental hospital (1968).

Certainly there is a built-in conflict between those who see the greatest mental health needs among the poor and those who are willing to fund a kind of necessary activity and let geographical allocations be determined by normal political processes. Whatever their needs, the poor do not lobby effectively in city councils and state legislatures. Since the enabling legislation and funding for community mental health centers preceded any serious national concern for "the poor," it is not surprising that the outcomes have proved less than ideal or that middle class areas have found these centers a way to augment their own supply of mental health services.

If we view traditional psychotherapy as a response to the demand for services in a middle class market, then the community mental health center is a potential experiment in mass-marketing of a comparable product. The outcome may well hinge upon the social power that those now

deprived of treatment are able to bring to bear. Insofar as education, health, and police services as presently distributed are examples of what will be achieved by democratic political mechanisms, it seems unlikely that major benefits of community mental health will be directed to the poor.

Equally interesting will be the response to various community powers within local community mental health centers. Given the traditional tensions between psychiatric and psychological professionals, the addition of religious and other professionals may lead to some interesting alliances. Quite possibly, persons who pose the least threat to existing interests may be drawn into this balance of power. The threat posed by clergymen may well be a function of their own psychological sophistication and the amount of community power they represent. In theory, their interests will ultimately be harnessed and balanced by a board drawn from the community.

Most interesting of all will be the situation when it is realized that the center's "catchment area" and the clergymen's "parish" are coterminous, and that this single space inadvertently is now served by de facto co-"ministers." Neither profession has a notable record of willingness to share power.

Since the early stages of the community mental health movement, attempts have been made to explore the epidemiological model developed in public health. This model is considerably more sophisticated than the earlier illness or sin models, and may prove quite fruitful. For one thing, it shifts attention to prevention rather than cure. It also posits an ecology of pathogens rather than simply the breakdown of individual defenses.

Notwithstanding, this alternative model carries some of the same disabilities as the earlier illness model. The very construct is much more feasible if the patient is a subsection of society and not society itself. This would also seem to be true with the concept of a "catchment area." The original illness model provided a rationale and a legitimation of the intervention by one group of people in the lives of other groups. With the loss of this model, however, such intervention becomes a more politically sensitive thing and is more likely to succeed when an upper class intervenes in the lives of an under class. The poor represent such an under class group and, to a very large extent, the same can be said of intervention with children. There may be perfectly valid theoretical reasons for intervention on these levels of society, but the fact remains that such intervention is also considerably easier and more expedient. This is a basic polarity between need and demand that characterizes any allocation of social resources. Very often those who most need some particular service are not those who actually have the means to command that service. The literature of community mental health reflects this polarity which in turn reflects basic philosophical issues about obligations and rights within the social order.

If we are really to speak of *community* mental health, our referent must be not just the poor, some manageable group, or even some particular city. It is even doubtful if we can settle for a particular country or society. In the final analysis, nothing less than the whole community of humankind will do. The logic of such an extension of the concept is flawless. But it brings into immediate relief the crucial need to redefine both the pleaning of "community" and of "health."

Some sharp redefinitions of normalcy and deviancy will emerge as the connotation of community expands: "*ours* is the desirable pattern" to "the desirable pattern is either *ours* or *theirs*" to "the desired patterns include *ours* and *theirs* and *theirs*. . . ." At the present time, most of our mental health criteria revolve around adequacy, coping, mastery, control, identity. Imagine the shift in scoring standardizations when Hindus, for instance, are given "the franchise." How acceptable to Westerners will be their acceptance, con tem plativity, aestheticism, familialism?

As an illustration of the controversies that may lie ahead, Brock Chisholm may be regarded as one of the significant public pioneers of community mental health on a global scale. His writings concerned the application of psychiatric wisdom to the role of illusory systems in human life, such as religion or belief in Santa Claus (1947), and also explorations along the lines of a nonmedically-derived model for community well-being. The latter he termed a "people's psychiatry" (1955). The controversial reception of many of Chisholm's ideas affords an indication of what lies in store for the community mental health movement as it broadens its focus to include more diverse as well as larger and larger communities.

A serious problem of authority will inevitably emerge. As the community psychotherapist views himself less as an expert and more as a catalyst, and as calls for community definition of well-being are heeded, we can foresee the rehabilitation and relegitimation of a number of alternative religious (and, for that matter, political) alternatives in defining community well-being. On a global scale, the possibilities are almost endless. With the democratization of authority, a "white Southern way of life," a "Muslim way of life," a "Maoist way of life" a "liberal, scientistic, democratic way of life" will compete with a variety of other options for public acceptance. Note that each of these ways of life fulfills our initial definition of both religious and psychotherapeutic systems as being "totalistic."

It should also be noted that despite the loss of the illness model, the behavioral sciences will enrich this process of democratization of standards of well-being. For any totalistic perspective, the selection of ends is only the beginning of the problem. The evaluation of alternative means to these ends, the training of persons who can facilitate these means, the supply of a continuing flow of research and feedback, and the continuing determination of unexpected results are all part of the psychological armamentum. Since neither the tradition nor the techniques of this kind of hard-headed analysis have been part of religious practice in the past, it would seem that psychology and psychiatry will continue to playa dominant role in the determination of the means of community well.being, even though the determination of ends comes to be more widely shared.

THE INTERVENTION DILEMMA

With the loss of the medical model, the problem of intervention has become intensified. In the traditional practice of psychotherapy, the functions of diagnosis and therapy were separated. Persons might be diagnosed as ill but until they somehow adopted a patient role, therapy was not possible. In the ideal circumstance, this patient role was voluntarily adopted. In more extreme cases it was involuntary as a result of a commitment to institutionalization by third parties. Outside of these circumstances, however clear the diagnosis might have been, it would have been unethical to intervene into the life of another person.

For purposes of analysis, let us pursue somewhat in more detail this problem of intervention, using the traditional model of pathology and considering the case of an individual. The most obvious level is that of "felt pathology." In this case, the patient comes to the doctor, showing his symptom and asking relief. The doctor, in turn, shows his expertise in the ways of diagnosis and therapy. The situation became more complicated even in the traditional situation, when "unfelt pathology" was present. Incipient alcoholism or unknown cancer would be examples of this. In this case, the therapist had to make a decision concerning his right to answer questions that had not been asked. A yet more ambiguous level appeared in the case of what might be called "unacknowledged pathology." From the standpoint of traditional mental health values, this would occur in the case of the well-adjusted "authoritarian," whether of the right or of the left. Here, above all, the diagnosis might be quite clear but the possibility or procedures of therapy received little illumination from the traditional wisdom.

The diagnosis, on which intervention might be based, was itself grounded in a consensus of an elite. This would seem to have been true even on the first level of felt pathology, where in certain extreme cases the therapist, on the basis of this consensus, might proceed to alleviate the symptom by altering the pain threshold of a hypersensitive patient. On the unfelt and unacknowledged levels of pathology, the role of this elite consensus becomes increasingly clearer.

Applying the traditional pathological model to the diagnosis of illness in a social group, the therapist had even more difficulty justifying both his diagnosis and his possible application of therapy. The epidemiological model improved the situation only insofar as it could be shown that some pathogen in an individual or subgroup had a demonstrably deleterious effect upon the surrounding group. It was considerably easier to show this in the case of smallpox than it has been in the case of, for instance, racism. Yet any realistic use of epidemiology must consider carriers as well as pathogens.

What we have been saying about the dilemmas of social intervention clearly points up the

problems that will face the mental health movement as it both gives up its original medical model and shifts its focus from the individual to society as a whole. As it makes this shift, the mental health movement will come to resemble the religious movements within our culture. That is to say, its authority and legitimacy will no longer stem from an external guarantor ("science") but will have to be societally based and democratically determined. If "illness" is defined by the community, it follows that the community is willing to support therapeutic interventions to correct such deviances and probably unwilling to tolerate unrequested interventions. This process has interesting parallels to the earlier development of religious toleration where impermissible heresies became fewer in-number as experience with freedom expanded.

We might also note the precedents from religious history where differing derivations have been made from a common term. "God" has been the authoritative term to denote a set of perceptions and evaluations taken to be true by a particular community. In 1914, for instance, most Germans and English were agreed that their nations should follow "the will of God." In practice, the derivations each side made from this "will" were in obvious conflict, but few on either side seriously argued that both derivations could not be simultaneously correct. Is it reasonable to expect "mental health" to fare any better?

THE RELIGIOUS RESPONSE TO COMMUNITY MENTAL HEALTH

In terms of our description of the significant religious accommodation to the traditional mental health movement, 1968 is surely too early to assess any response to the nascent community health movement. Religious institutions had incorporated many aspects of the earlier mental health movement into their practice of counseling and pastoral psychology. Granger Westberg and Edgar Draper's *Community Psychiatry and the Qergyman* (1966) is really the first book in the field, and it is worth noting that its actual concern, despite its title, is the traditional one: How can clergymen more effectively enter a cooperative role with physicians and psychiatrists in a hospital setting? Their study is also highly significant in that it shows the degree to which clergymen have a sense of playing a secondary role in matters of health. We predict that the religious response to community mental health will primarily be the loss of this inferiority complex.

As the community mental health professional loses his defmitive expertise (by his loss of the medical model), he will simply become one professional among the many concerned with the problems of community and society. The contemporary university-trained clergyman and the community health worker will play comple. mentary roles in the diagnosis and therapy of society, each having moved away from the traditional concerns of his own past. On the other hand, those clergymen whose concerns have not basically been with the direct rebuilding of society, but who have nevertheless yielded to some forms of accommodation to mental health, will lose their own inferiority complexes in relation to the new community mental health professional. They will also much more vocally reassert the alternative life styles of their particular religious traditions.

Putting this another way, we are predicting that there will be a rapid drop in the accommodation rate of religious professionals and institutions to a traditional psychotherapeutic orientation when the current rethinking in relation to community mental health becomes more widely known. Not only will accommodation, which primarily affected the religious professional's dealings with individual members of his congregation, decline, but an actual competitive situation regarding alternative life styles will come into being.

Historically, the variety of Western religions have been deeply concerned for the quality of the community. After the breakdown of the medieval Christendom, where to a considerable degree the church was able to set the style for the total society, religious values were effected by a pervasive moralism. From certain religious perspectives modern history can be read as the struggle of this moralism with an encroaching secularization process which successively removed from religious control the economic, educational, and sexual sectors. In those religious perspectives usually labeled "modernist," secularization has been encouraged on the assumption that it could be informed by religious values. This was the real meaning of the "social gospel" movement. Only in

very recent times have religious thinkers argued that secularization, as such, might be a good thing. There is a sense, then, in which the psychotherapeutic workers' retreating from the quasi-absolutism afforded them by a now-difficult illness model will cross paths with religious thinkers retreating from the hyperindividualism of either a traditional, pietistic orientation which is concerned only with the private and spiritual side of man or retreating from a highly psychotherapeutically accommodated version of religion which legitimated primarily a counseling function.

We predict that this crossing of paths will occur epicentric to the urban trouble spots of American cities. Specifically, the problems of long-range community mental health will be faced neither in ghetto nor suburb but in "interurbia" -where the basic deprivations have been reduced and where psychic escapism is less. Assuming that effective coping is central to the mental health of individuals and that the coping arena cannot be geographically confined, the place where concerned cosmopolitan man lives can be termed interurbia. There the unsolved problems will be both the by-products and the opportunities of an advanced technological society-and how persons in the community come to define and improve the quality of their lives.

Putting this another way, a major push for both community mental health professionals and for many religious professionals is to be "relevant." As they explore together the issues of "relevant to whom" and "relevant for when," we are suggesting that they will find a common challenge in the problem of "tomorrow." They may also discover a common lack of ready, assured, or dogmatic solutions.

THE CONTRIBUTIONS OF RELIGION TO COMMUNITY MENTAL HEALTH

The overall contention here is that we can expect a greater confluence of the psychotherapeutic pioneers of community mental health and those whose primary base is within religious institutions. If an increasing sense of equality and partnership emerges in this situation, a number of specific contributions can be made by religion to community mental health. The most obvious has to do with personnel. Recently, it has become quite clear that many professional clergymen serving local churches have been able to bring their professional skills and to devote a considerable portion of their work time to community concems which traditionally have fallen outside the justifiable scope of pastoral activity. In the past few years, the civil rights and peace arenas have been illustrative of this. Somewhat less visible are the increasing numbers of ex-ministers and members of religious orders who have been able to transfer their professional skills to community causes. In some cases this has been funded by religious denominations, but in a large number of cases it has been funded by private and governmental agencies. While no figures are available, it is clear from the number of defections from the ministry that many are now engaged in education, the Peace Corps, Vista, poverty programs, and social work. While this vocational shifting no doubt indicates an alienation from religion in some cases, it is more likely to reflect a disenchantment with the particular possibilities of the parish ministry and traditional religious structures (e.g., parochial schools, monastic orders). We make this reference because of the increasing discussions going on within religious institutions of the viability of the present form of the local church and because of the increasing number of ex-ministers who are shifting into the college teaching of religion. In this latter case, it would seem clear that there is not a total disenchantment with the religious enterprise but only with the forms of a traditional parish ministry .

In addition to this supply of fully professional contributors to community mental health, religious institutions have provided a supply of semi- and paraprofessionals in a. number of community activities and have also stimulated a flow of volunteers into organizations. Beyond this, religious institutions have provided both physical facilities and often sources of funds to the work of the larger community.

On an ideological level, religion has been a source and transmission belt of what might be called "trans cultural" concerns. The most dramatic illustration of this in recent years has been the religious opposition to the war in Vietnam. Almost every denomination has gone on record against this war, and polls have indicated a significant opposition of clergymen to the war.

The degree to which this concern reflects or is communicated to the ordinary church member is more problematic, but the concern is nevertheless indicative of the potential of religion to generate an outlook that transcends nationalism or chauvinism.

A somewhat less obvious contribution of r~ligion may be its experience and experiments with what could be called "transgenerational" community. The survival of a religious institution almost inevitably depends upon the degree to which it can communicate its values to the children who are born to its members. At an early age, the children are initiated into a symbolic community that attempts to comprehend persons of all age levels. While it would be difficult to generate criteria for success in trans generational communication, it is clear that it is a basic value for both religion and the community mental health movement.

Within local congregations, there often emerge genuine examples of the helping network, where sensitivity to human need draws persons to hospitals, families, and persons in crises. The traditions of giving to "charity" reflect a less personal version of this same religious commitment.

Finally, there have been a number of experiments throughout religious history with small group techniques. These have occurred in religious orders, in "intentional communities," and in a number of sectarian and utopian community experiments. They are also seen historically in pietistic-lay movements and in such lay groups as the Franciscan Tertiaries. A number of contemporary "underground churches" are reviving these traditions of a small, close, sharing community, and religious communes have been multiplying. As the community mental health movement tran. scends a one-to-one conception of psychotherapy, these experiences will become increasingly valuable.

THE PROBLEM OF RELIGIOUS SURVIVAL

While an analysis of human history thus far would seem to indicate the persistence of religious institutions of some form in every culture, it is less clear that there is any kind of inevitability to the centrality of influence within a culture. It is conceivable that religion might become the kind of quaint, vestigial survival that we see in astrology today.

Nothing is clearer than that Western religion in its traditional forms is threatened by the major trends of modern society. If religion is defined as fidelity to some set of beliefs, as has been done in most empirical studies, then loss of faith correlates positively with increasing education, increasing urbanization, and increasing affluence. It seems more likely, however, that just such trends will generate their own correctives. Such a process seems to us the most obvious explanation for the intellectual ferment found within churches today. Assertions that "God is dead" are not new, but it is a novelty to have such assertions made by any significant number of ministers and theologians. Such rethinking is indeed eroding the traditional dualism and supernaturalism of past religious traditions. But the new naturalism, if successful, will have the effect of providing an intellectual survival-base for future religions.

In this process, the focus of religious attention will shift sharply from metaphysical assertions to concerns with human values and their achievement. That shift will provide a basis for rapprochement between many forms of religious thinking and the more positivistic scientific thinking characteristic of university-educated persons. It will also shift the focus of religious thought from traditional beliefs to matters of life style and concern with the general quality of life.

Philosophically, there is great concern among religious thinkers with the problems of "religious language." Increasingly, one is told that it has a symbolic rather than literal function. This shift provides not only openness to a functional analysis of religion, bringing religion and the behavioral sciences closer together, but it. also may lead to a general rehabilitation of religious symbolism within the culture. In the past, such symbols have proved to be both communicatively powerful and widely understood. If the present intellectual dilemmas can be overcome, we may again see religious language play such a community function.

Finally, it would seem that the survival of Western religion depends upon a rapid attenuation of its missionary complex. The orientation of the psychotherapeutic movement is clearly pluralistic, and the philosophical situation we have been describing has eroded the certainties and

absolutism that are essential to a conversionist-missionary stance. If religion is increasingly a matter of human values, it is patently impossible to contend that any particular religion has a monopoly upon desirable values. Its beliefs might be unique, but values are a much more generalized product of human creativity.

If our analysis is correct, there are intellectual as well as sociological reasons for expecting an increase in the influence of religious institutions within Western communities. Religious ideas and personnel will therefore play an increasing role in the future of the community mental health movement, precisely because the two will have converged.

LESSONS FROM RELIGIOUS HISTORY FOR COMMUNITY MENTAL HEALTH

We have been arguing that both the psychotherapeutic and the religious orientations are totalistic. When the parallelism between the two is further extended by the development of an institutional structure around the psychotherapeutic, as is the case in the community mental health movement, the parallelism becomes quite striking. This is the case today. For quite different reasons, we have argued, both movements are in transitional stages reflecting considerable lack of clarity regarding methods, directions, and evaluative criteria. While institutional parallelism might serve to generate two competing movements, this inner condition makes it much more likely that the next few years will see cooperation rather than competition. In either case, however, an examination of religious history would prove quite valuable. To the extent that the institutional structures and ideological thrusts of religion and of community mental health are parallel, one could expect to find similar problems and patterns emerging.

Sometimes religious history is read as the resultant created by innovative "heresies" against an orthodox establishment. From the point of view of orthodoxy, heresy is always a partial, limited position. This latter position is probably correct, but various heresies have nevertheless probably provided the necessary dynamism to remind establishments of their implicit possibilities. The usefulness of dialectical interpretation should not, however, screen out the high psychic price often paid by the heretics and innovators.

One of the oldest polarities in Western religious history has been that of priest versus prophet-of the man who attempts to preserve the established order as against him who would transform it. On balance, even the most partisan historian of religion tends to recognize that there is an appropriate degree of ambivalence in viewing this polarity. Certainly this is the situation with psychotherapy, where the dilemma is whether to support the ego in its present functioning or find ways of strengthening motivation toward change. Certainly this dilemma appears on the social level, where decisions are continually required between the need for stability and the need for innovation and renewal.

At the moment, the community mental health movement is clearly on the side of innovation. Kenneth Keniston's chilling satire (1968), in which the mental health workers of the future become the enforcers of social order, suggests the ease with which innovation can shift into stabilization. If religious institutions, in their thus.far successful evolution of survival techniques, have any lessons to offer, it is precisely at this point of institutionalizing both the prophet and the priest into some kind of competitive coexistence. This is a problem of building in dissent without ever permitting it to dominate and of building in stability without permitting it to suffocate; a delicate balance, but one perhaps more easily achieved when its necessity is recognized. Parenthetically, the last two centuries of history afford a distressing series of secular revolutionary regimes that have become repressive and reactionary when in power.

A second instructive phase of religious history would be the development of the social gospel movement from the latter decades of the 19th century into our time. Here is a clear example of certain religious thinkers developing a rationale for social intervention. Early spokesmen for this movement tended to find direct religious authority for certain social stances. One could find arguments that Jesus was really a socialist, that Christianity demanded a clear commitment to the working classes rather than the owning classes. As the movement developed, it generated its own quite intense opposition. In the polemic period that ensued, the rationale for the intervention evolved. Rather than debating the issue of whether religion was concerned with the individual or with the society, contemporary defenders of inter-

vention argue that certain social situations (e.g., poverty, racism, or sexism) so corrupt certain individuals that they are unable to hear the basic religious message. Since presumably all believers have a concern to have their message heard by unbelievers, it appears somewhat easier to defend social intervention on the grounds of its furtherance of the traditional individual religious goals of the institution. This argument would seem to have its parallels in the defense of community mental health as a way of bringing nonparticipants into fuller social participation. This might prove more successful than basing intervention upon appeal to some moral imperative that the successful ought to feel in relation to the less successful. Opponents of intervention have found it considerably harder to argue against this basically instrumentalist version of ethics.

The process of democratization provides yet another instructive model. Within religious institutions, it has inevitably meant a dilution of the initial purity of the structure when it had been controlled by an elite. The experience of the Calvinist congregations of colonial New England illustrate this. Initially, voting membership was restricted to those who not only were baptized and believing Christians, but who also had personally had the experience of "regeneration." From the outset, of course, there was a certain problem relating to the membership status of the children of such persons. But the real pressures came when a majority of those who lived in the parish were viewed, and viewed themselves, as believers but nevertheless had not had the intense personal experience required for membership. This led to the development of a "half-way covenant" providing status for such persons. Quite obviously, the direction that an institution will take is a f1.Wctionof the sjze of its power base, and the ease with which consensus can be reached is similarly a function of the size of the group. In the development of Protestantism, where development of democratization has typically been found, each extension of the franchise has led to a blurring of the distinctiveness between the group and general culture surrounding it.

The other side of this coin, however, is that the extension of democratization is an extension of participation and thereby of morale. As members become involved In decisions, they become willing to commit more of their time and money. It would be hard to find a sharper contrast illustrating this than the participation levels of American and European Christians. The percentage of church attenders in America is near an all-time high, whereas European churches tend to be quite empty. In this connection it is also worth noting that the frequent prediction that democratization and high participation will lead to trivialization is not borne out. Churchgoers continue to resemble their cultural neighbors in most respects, whether they are living in churchgoing America or in non-church-going Europe. Apart from the smaller sects, church participation supports neither trivialization nor salience.

It would also be instructive to range outside of Western culture for examples from religious history which will illuminate some of the future problems of community mental health. Hinduism probably reflects the most pluralistic religion ever evolved. Intellectual atheism and intellectual theism coexist, sometimes even praying together. This variety on the level of intellectual formulation has not, however, reduced in any visible way the intensity of the religious affect and experience for the individual believer. Most interestingly, the roots of the basic ideology of toleration that has emerged in India go back into early times and are in no small measure the product of Buddhist as well as Muslim influence. It may well be that the actual encouragement of a variety of life styles, providing some kind of self-acceptance for a wide range of personality types, is most likely to flower in a culture where a variety of countervailing ideological powers exist. Pluralism in regard to religion can provide this, and probably democratization in terms of the criteria and goals of community mental health will do the same.

It may also be noted that the real impact of democratization will emerge only when genuine cultural and psychological freedom emerge. American society is only beginning to transcend its Puritan work-ethos. As alternative life styles become real options, that is, as they acquire followers and "votes," real democratization will appear. It will then become much more difficu,lt to define deviant or aberrant behavior, and much less possible to defend restraints upon it.

It may also be that in a more direct way the development of a community mental health orientation will encourage persons of our society to scan other societies in terms of their traditionally fulfIlling ways of life. One can

imagine an intensification of current interest in Japanese religion to a full-blown assessment and assimilation of the aestheticism associated with Shinto and with Japanese Buddhism. One can also imagine a reassessment of the pragmatism associated with Chinese Confucianism and the building of a society on basically nontheistic grounds. And certainly one can expect a reassessment of the ability of Hinduism to preserve a good deal of the religious tradition of its past without violation of intellect.

This kind of scrutiny of "ways of being healthily human" that have been tested in the evolutionary survival arena of the major world's religions will have a slow and indirect effect upon the pluralization of community norms. Much more intense and direct will be the impact of what could be termed religious "sector-imports." When parts of some exotic tradition are taken over (rather than full conversion) and when these parts are differentiated from their traditionally intrinsic goals, sector importation occurs. Yoga is a good example. Differentiated from the total context of Hinduism, it is being advocated as a means to physical improvement, mental focus, and even sexual prowess. Books have been published on "Christian Yoga." Certain features of Zen Buddhism lend themselves to sector import, and the same has been true ofVedantic Hinduism. The point here is that sector importation, because of existentialism involvement, facilitates an intensive pluralization.

Finally we must note the role of Western parareligions in this process of expanding the spectrum of life styles. Among the communal experiments, many consciously derive from religious "intentional communities." Certain aspects of the hippie-youth-drug subculture have adopted an explicitly religious stance. Esalenlike small group techniques are used more widely, and again the parareligious element is present. If one element of those experiences termed religious in the past is idiosyncracy, we are well into a religious revival. Nor is the literature of psychedelic experimentation devoid of religious referents and claims.

IN SUM

This chapter has delineated a variety of religious responses to the traditional ideas and values of the mental health movement, and has suggested a number of parallel aspects in both movements which have created the uncertainties and fluidities of the present. Both the rise of community psychology and the current democratization of Western religions have been interpreted as reflecting a pluralization of life styles. As a result, an increasing convergence of religious and community mental health workers is foreseen, partly as the result of the abandonment of sharply antagonistic goals firmly held by each side.

EPILOGUE-1972

During the Dalmatian summer of 1968 when we wrote this chapter, religious identifications seemed less vital, and therefore less potentially divisive, than political identifications. Soviet tanks were rolling into Prague and the Arab-Israeli war had only been tangentially religious. Since then, we have witnessed the explosiveness of religious allegiances in northern Ireland and East Pakistan-Bangladesh.Most recently, the China doors have begun to open on the world's largest project in religious transformation. To what extent can Maoism carry out its commitment to replace the traditional faiths (which include Confucianism, Taoism, Buddhism, Islam, Christianity)?

Our description of the American religious scene had focused mainly upon institutions and their visible elites, while noting a scattered individual interest in adaptation of Oriental religions. Not only has this latter development burgeoned but a more domesticated version of religious individualism has appeared within Christian circles. Among the young, "Jesus freaks" have lifted fingers. A number of their elders, especially surprising in the Roman Catholic circles, have been cultivating glossolalic experiences ("speaking in tongues"). While neither of these are new phenomena, their emergence in unexpected places reflects growing dissatisfaction with elite-defined patterns of establishment religiosities. This demo. cratization of religious institutions has been called a rise of "demotheology" (R. Tapp, 1971).

The surfacing of demotheology is also concomitant with the liberation movements among both women and blacks. In quite different ways, it has been made manifest that American religious establishments, and much of their ideologies, have been consistently, if covertly, "white" and

"male." For the foreseeable future, this pluralization and democratization seems both necessary and desirable, although some will experience it as painful and disruptive. If anyone is sanguine that ideological intergration will appear soon, we again revert to examples from religious history. In the early decades of this century, a kind of children's liberation occurred in some Protestant. circ1es-although it was accomplished *for* children and not *by* them-and the resultant religious education movement brought deep fissures into doctrines of "original sin" and "human nature." Somewhat similarly, one could interpret the rise of the social gospel in late 19th century Protestantism as a consequence of workers' liberation. A strong insistence that religion should deal with more than "souls" or "spiritual matters" was in large part the result of consciousness raising within lower class denominations and individuals. A third historical example would be the family liberation that took place in 16th century Europe. Protestants raised the banner against a monastic Catholicism, and counterattacking Catholicism made explicit place for "Christian family life."

The significant point of these historical examples is not that liberation movements have appeared before, but that their predictable long-range impact is ideological pluralization. Catholicism can hardly be said to have surmounted the cloister/hearth tensions. Nor have Protestants moved beyond recurrent cleavages over social activism. Nor have either Protestants or Catholics ceased to debate whether children are "naturally" good or evil. The liberation, within religious circles, of the consciousnesses of blacks and women may produce an even wider and longer lasting pluralization-given the percentages involved, the extent of the historical oppression, and the combined contemporary catalysts of education and communication.

Turning from religious circles to psychological circles, the implications of the medical model breakdown that we noted have also become more patent. Whatever consensus might have existed in the mid-'60s regarding mental health or illth has dissipated. As with religious ideologies, the defections and innovations have come via insiders as well as outsiders. The proliferation of models and therapies is perhaps now sufficiently widespread to be labeled "demopsychology." How else should we characterize the gravitation to such phrases as humanistic psychology, self-actualization, human potential, consciousness expansion? The common element is the continuing assertion of individually validated life styles and values.

In short, it now seems clearer that the predicted convergence of religious and psychological forces into the community mental health movement is occurring. On the religious side, an increasing diversity of practices will also be coupled with a more self-conscious and less apologetic stance. The psychological side will be marked by great openness and experimentation. As a result, the chief characteristic of community mental health centers will be a new fluidity in generating, supporting, and evaluating life styles. More difficult to foresee is how critical canons will emerge or gain acceptance. A grim religious reminder comes to mind: Enthusiasm has always destroyed both criteria and its devotees (Dionysus needs Apollo).

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