Psychosynthesis Research Foundation

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March 1, 1969

Dear Colleague:

The sixth meeting of the 1968/69 series of Psychosynthesis Seminars (held on the third Friday of each month) will take place on Friday, March 21st at 7:30 P.M.

Our speaker will be Dr. John Parks, Director, Comprehensive Care Centers, Lexington, Kentucky; his subject: "The Application of Psychosynthesis Principles and Techniques to a Community Mental Health Program." Following his talk will be the usual group discussion.

We trust it will be possible for you to be with us.

Cordially,

JACK COOPER, M.D.

Date & Time of Meeting: Friday, March 21, 1969 - 7:30 P.M. prompt.

Place:	"Directors Room", mezzanine floor, Park Sheraton Hotel, 7th Ave. & 55th St., N.Y.C. (There is a public car park across the street from the hotel.)
Speaker:	John H. Parks, M.D.
Subject:	The Application of Psychosynthesis Principles and Techniques to a Community Mental Health Program.

PSYCHOSYNTHESIS SEMINARS

1968/69 SERIES

Sixth Meeting: March 21, 1969

Speaker: John H. Parks, M.D.
Comprehensive Care Centers
201 Mechanic Street
Lexington, Ky. 40507

Subject: The Application of Psychosynthesis Principles and Techniques to a Community Mental Health Program.

Participants:

A.J. Brodbeck, Ph.D.
Martha Crampton, M.A.
Jack Cooper, M.D.
Rena Cooper
Abraham Elizur, Ph.D.
Mrs. Elizur
Virginia Glenn
Frank Haronian, Ph.D.
Frank Hilton
Hilda Hilton
Emanuel D. Kotsos, M.D.
Victorija Mickans, M.D.
John Parks, M.D.
Paul G. Smith, M.D.
Rev. Ted Smith
Wm. Swartley, Ph.D.
Wm. Wolf, M.D.
Shirley Winston, M.A.

Psychosynthesis Research Foundation
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Introduction

Dr. Jack Cooper: Tonight we have Dr. John Parks who is the Director of the Comprehensive Care Centers, a community mental health center, located in Lexington, Kentucky. John graduated from Harvard Medical School in 1950. I met him in Charlottesville, Va., in 1964 and it was following that and talks with Dr. Swartley that he began to work more and more with psychosynthesis. It is my pleasure and privilege to present Dr. John Parks.

Dr. John Parks:

I have been down in Kentucky two and a half years, working with a community mental health project with the underlying wish to work towards the actualization of the whole man using the principles of depth psychology particularly as spelled out by psychosynthesis.

Community mental health is the big thing in Kentucky; in fact, it has been lauded by the National Institute of Mental Health as being the pioneer state in the nation with a unique approach to community mental health. This movement started four years before I arrived in Kentucky. I'd like to give you some history on the national scene, then on the Kentucky scene, and finally I will show where we came in, and will try to outline for you some of the ways in which we use the principles and techniques of psychosynthesis uniquely applied to community mental health.

On the national scene, in the early and mid-1960s there was a widespread ferment and restlessness in the fields of psychology and psychiatry. There was a growing realization among psychiatrists and psychologists that they were not yet meeting the vast community needs for psychological services; and that there needed to be a total restructuring of mental health institutions and community programs. This led to a new program instituted by the National Institute of Mental Health whereby millions of dollars were allocated for both construction and staffing of community mental health centers.

Particular guidelines were set up on the Federal level and each state had to abide by these guidelines in order to qualify for the Federal money. The guidelines are: that each State present an integrated regional approach for mental health for population groups that range between 50,000 and 200,000 persons. This would be called a "catchment area", or a "catchment region", and then be designated as a "Community Mental Health Center Region" under a given State program or plan. Federal monies in gradually diminishing quantities would be funded into this region over a period of 51 months. The rest of the budget would come from the State, local governments and fees that are charged for services rendered.

This program was patterned after the social-psychiatry programs in England and Europe, where they had gone further than the United States as regards social psychiatry. For example, in Amsterdam, there are emergency services - psychiatrists working with the police, etc., much more community oriented - which meet the emergency where it is. The British hospitals have long been advanced in social psychiatry; and it was a visiting of the British and some of the European hospitals and psychiatrists that led NIMH to set up this Community Mental Health Program for the United States.

The crucial thing about the European programs - and guidelines were set up in the United States to match these - is that you have a total comprehensive approach to a person with a mental illness; one in which you would have access to many, many services and types of therapeutic groups. Whatever the need might be, you just didn't go to a private analyst or to a State Hospital, but you looked at the total situation and then dispatched the patient to wherever he would best get his needs met.

This meant that five essential services were required by the Federal Government in order to qualify for Federal funds; and these were: you had to have an inpatient service, outpatient services, partial hospitalization (day care and night care), emergency services, and consultation and educational services. These are what are talked about in Federal terminology as the five essential services of the Federal Community Mental Health Centers Act. In summary this is the Federal plan; and Kentucky was first among the states to write programs suited to the Federal guidelines.

To turn to the Kentucky scene: Kentucky is a poor State; half its population lives in a mountainous region. There are many poor and unemployed persons so that Federal money is a big thing in Kentucky. Kentucky politicians keep their eyes on Washington all of the time. It is not like some of the richer States where Federal money is more suspect. In Kentucky everybody goes after it! The Mental Health Department for years had a less than adequate budget. The Department saw this Federal money and made a big crash attempt to qualify for it through an early planning commission in Kentucky. Kentucky was a year or two ahead of most of the other States.

The planning started in 1962, which was four years before I arrived, whereby the total citizen representation of each mental health region asked for improved mental health services. The unique quality of the Kentucky plan was that the plan was in the hands of the lay citizens and not in the hands of the mental health professionals; too many psychiatrists and psychologists and the community mental health program goes dead! There has been a long-standing unfortunate dichotomy in the United States, with the lay groups and the Mental Health Association on one hand, and on the other, the professional groups (of the American Psychiatric Association and the American Psychological Association). This lay group and the two professional groups were never able to work together constructively and creatively to plan for new improved mental health programs.

In Kentucky a unique situation arose that made it possible for a <u>community</u> based mental health program. A planning commission set up in Kentucky of both lay and professional citizens planned for mental health and mental retardation boards for 20 regions of the State. Each board was to be composed of a representative group of lay citizens without a predominance of mental health professionals. At the present time Kentucky has 18 out of the 20 regions operating and active. First we organized the mental health-mental retardation boards, then we obtained the Federal money, and then we recruited the staffs. Kentucky is the leading State for community mental health centers as far as the Federally supported and the community-lay citizen board direction is concerned.

My particular Region is Central Kentucky, with the main city, Lexington. Central Kentucky is the Blue Grass Region of Kentucky noted for many world famous horse farms. Lexington is a fast growing metropolis of about 200,000 persons. The University of Kentucky is in Lexington, there is an airport, and many mental

health facilities. We have a Psychiatry Department in the University Medical School; Eastern State Hospital (which serves Central, Northern, and Eastern Kentucky); the Veterans hospital which serves about four or five States as a psychiatric center; we have the U.S. Clinical Research Center for Narcotic Addicts which is one of the two hospitals in the U.S.A. specializing in the treatment and research of narcotic addiction. Working in these institutions are the usual mental health professionals fulfilling traditional roles. There are approximately 15 psychiatrists in private practice in Lexington.

The group of citizens incorporated as a private - non-profit corporation, becoming the Central Kentucky Regional Mental-Health-Mental Retardation Board Inc., which then set about to organize and carry out a mental health survey. Despite all of the above mentioned numerous facilities and psychiatrists there was much that was not being done. In 1965-1966 the Board surveyed ministers, teachers, doctors, hospitals, schools, those caretakers and institutions that would be particularly concerned about mental health in Central Kentucky. Nine counties were surveyed by questionnaire, with follow-up small group discussions.

The outcome of the survey showed that children were in need of increased services; gifted children needed additional attention; adolescent problems were not being dealt with sufficiently; the need for marital counseling was large; ministers needed help in doing counseling themselves and in referring severe problems to appropriate treatment resources. Alcoholism was seen as a tremendous problem with many alcoholics never having received any treatment whatsoever. So, despite all of the existing mental health institutions and private psychiatrists, there was demonstrated in the survey tremendous needs.

The Central Kentucky Regional Mental Health-Mental Retardation Board as a result of the survey came out with the proposal: "We want to sponsor an organization to coordinate existing mental health caretakers and institutions, to assist them in meeting unmet community mental health and mental retardation needs, and then we need to provide new services to meet needs that cannot be met by already existing caretakers and institutions."

The Central Kentucky Regional Mental Health-Mental Retardation Board is empowered to apply for, handle, and raise monies, and then to hire a staff. The Board obtained money from the Federal Government, from local city and county governments, from several United Community Funds, and from the State of Kentucky. After obtaining the money, the Board requested me to come as the first psychiatrist-director in August 1966.

The Board has eight very active working committees: Personnel, Finance, Facilities, Planning, County Liaison, Public Information, Retardation and the Professional Advisory Council. These committees started functioning early during the process of the mental health survey. Ministers, doctors, judges, and community caretakers met to carry out and discuss the implications of the survey. Later when we moved into programming, the use of the same committees continued. As director, I am responsible directly to the President of the Board; my job was to hire staff and then go ahead and do something new in mental health. We have hired over the past two and one half years, two additional psychiatrists, two psychiatric nurses, six social workers, six psychologists, four mental health educators, as well as clerical and administrative personnel.

As one contemplates the community mental health movement in the U.S.A.,

the question frequently discussed in the American Psychiatric Association and the American Psychological Association is, "Is community mental health anything really new or is it just old wine in new bottles?" Now we have had inpatient departments, outpatient departments; we have had Day Treatment Centers; we have had emergency services and consultation. What really is new?

Well, I would like to argue towards the position that there is something new, and that there is a new movement, a new being that exists in Central Kentucky that did not exist before. This being we chose to term "The Comprehensive Care Center." I think the best way that I can explain to you this new movement would be to diagram it. (See next page. Ed.)

This is the concept of the Comprehensive Care Centers. Here we have a circle with another circle around it. This center inner circle is the so-called "employed staff". We are the people who work for a salary, and for this Board.

But around us, this second circle, is a group of volunteers who do not work for salary but are vitally interested in our programs. They are in our group therapy, in our day care centers, they are involved in our outpatient treatment. So, when you talk about staff, you have to think of both the paid staff and the volunteer staff.

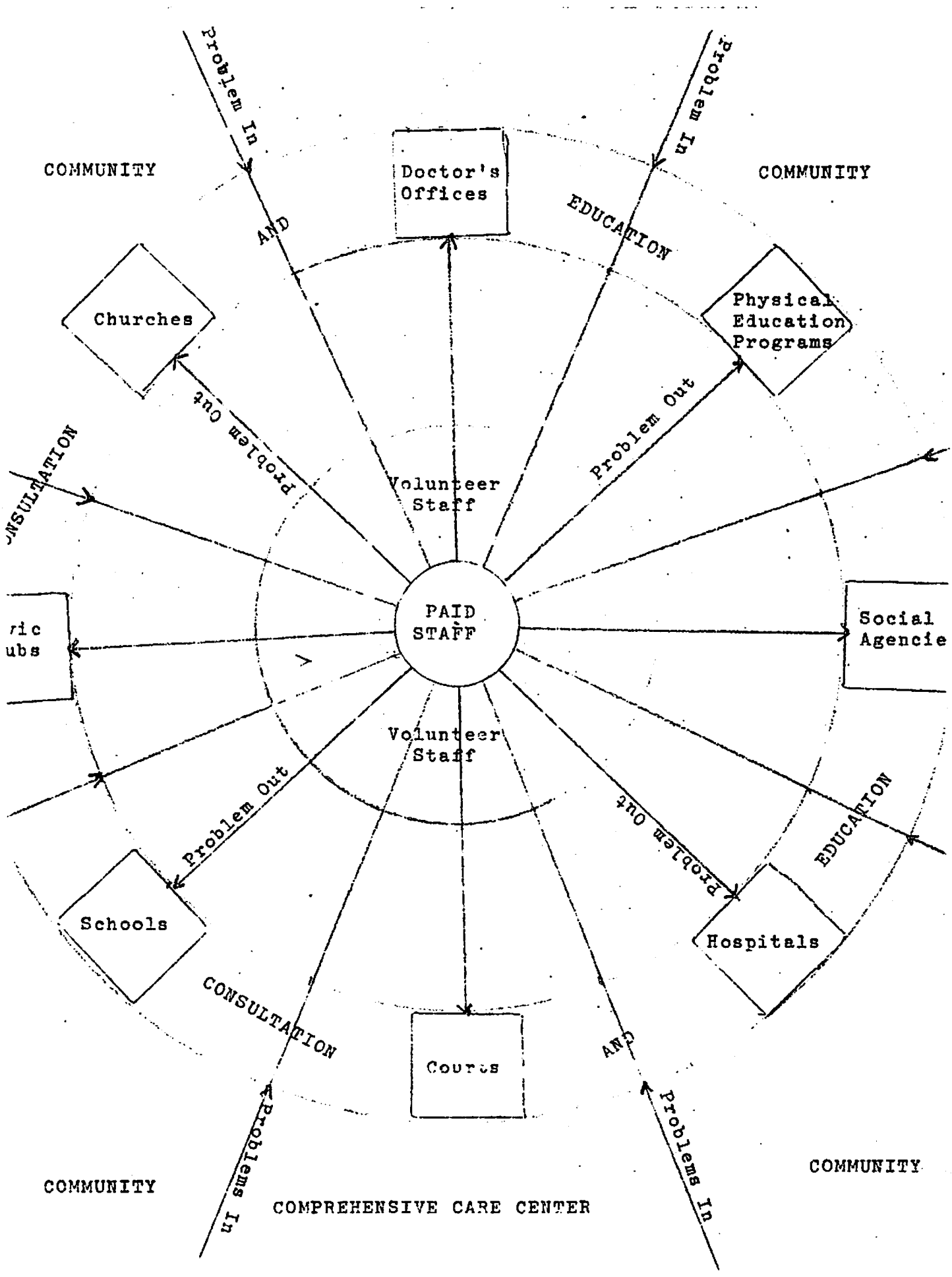
Now the concept of what we do that is new is really crucial to community mental health. Taking one of the essential services, which is the Emergency Service, we have said "We will do something for any person that comes to us or calls on the phone, at any time of the day, 24 hours a day; all you have to do is to put in a call, or walk in, or otherwise make it known to us what the situation is."

Now we do not limit this. We do not say "You must have a depression before you come in, or have a marriage problem." We feel that we are comprehensive. We say "If you have any problem, come in. If you have a physical problem. and you have heard that we do something, come in. If you have an emotional problem, come in. A children's problem, come in. We take anything!"

Now this is difficult; you can get flooded, but we particularly set it up with that in mind. So in a sense you can regard this inner circle as a "communications nerve center", you can regard it as the spinal column and the brain.

We do not exist in any one building; we have eight clinic buildings around; and we have persons working in the State Hospital, in the churches; and we have a continuum of about 20 geographical locations. This organism is not a building, and you cannot say "In that building we exist." We are in the community. I suppose we are primarily more in Lexington; most of us live there and we are more involved in this community of 200,000; but we are taking responsibility for 13 other counties that surround Lexington so that geographically we are not even in Lexington. We do have a boundary and serve two catchment areas with a total population of 320,000. It is hard to pin us down geographically; but we are pinned down to a concept.

The important institutions (shown on the diagram as the series of squares surrounding the circles) are the schools, the Courts, the hospitals, the doctors and private psychiatrists, etc,, the recreational facilities, the various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physical education programs, the social agencies - the public assistance workers and welfare agencies, etc., the service groups such as Rotary Clubs, the civic societies; industry and the churches are important.

Now we have the concept not only of the flow in to the Center, but we have the concept of the staff going out. This is where we differ from other institutions. When a problem comes in here to the central nerve center of the operation - they either arrive geographically "in the body" in one of our ten outpatient clinics, or they call on the phone and they are asked to come "in body." But if they cannot come "in body" we go out "in body," so that the two bodies meet.

By the way, this staff is a mixture of people; we have an ex-catholic priest who is married and is a marriage counselor; we have the traditional social workers; we have people with their degrees in education; so we have got educators, medical people and guidance counseling people. Our staff from a discipline point of view represent medicine, psychology, education, social service - the volunteer staff consists of businessmen, ministers, housewives - in short any educational discipline.

At first, we did not get many calls, now we are really flooded with calls and it is a question of how to handle the volume. We have set up a consultation and education program; on our diagram this is the big circle embracing all the agencies. This means that the core staff and volunteer staff is setting up education and consultation programs to every important community care giver. All institutions and persons caring for the whole person are on our lists as places and persons with which we need to develop intimate personal relationships (Haronian: Private practitioners too?) Yes, private practitioners.

Our consultation and education plan is where we go out and set up workshops - workshops for the Whole Man - mental health workshops that would assist people in seeing the whole concept rather than the concept on which they are stuck. Comprehensive Care Center stands for service to body, emotions, mind and soul of the Whole Man. You have the four parts, and if a person or institution is stuck, say, on the body, you would emphasize that part, etc.

Our plans therefore include getting out into the community and starting educational groups; it is the group approach. We haven't gone too far in the implementing of this. Most of the work we have done so far has been with agencies. We have met in groups with public health nurses, public assistance workers, school teachers and with ministers. We have done the most consultation with ministers and social workers. We have in mind all of the other groups.

We approach a group then with a case-centered approach. Let me explain what we did with a recent ministers group. A mental health educator and myself conducted a 12 week seminar for 12 ministers. We asked them for cases, any person who had come to them for help. We gave them some material which allows them to have fuller understanding of the case in terms of these four parts (body, emotions, mind, soul). We then ask them "How do you conceptualize the problem? What kind of problem do you think the person really has to solve?" To complete this course we ask every minister to analyze five different persons. We also ask him to use the materials and, together with another minister, analyze himself. This means that you both look at five other persons and yourself in the terms of these four categories.

We have materials printed up especially for this. For instance, if a minister hits on a schizophrenic, then we help him to understand that he is dealing with a severe problem which probably calls for referral to a professional. A milder problem, such as mild anxiety or an existential problem of meaning, he may continue to handle himself. We set up a diagnostic group session of 12 people and get them to look both at themselves and five other people. When they are through they get a certificate of graduation, and have permission to use our materials - the diagnostic kit. This diagnostic kit, by the way, is interesting in that it gives the person courage to do a whole lot of things that he wouldn't do without it. It has in it the writing of a biography, the Cornell Index, the Mooney Problem Check List. After an individual client has completed the kit, the minister is taught to rate the severity of the problem. We are not trying to set them up as amateur psychiatrists or psychologists but to get them to have the feeling of the whole person and an understanding as to the severity of problems. In regard to these twelve ministers - we came to know the resources in their churches - they make many referrals to us, and we are sending many people back to them.

That is where the answer comes to the problem of when, say, you have 100 people calling in, "What's going to happen?" What is happening is that now we are handling about 50% of these problems ourselves, but we are increasingly sending them to this minister or to that social agency. We are sending them to people whom we know have personally worked on themselves and have a true conceptualization of the whole person. We don't just send them to anybody - or we would lose everything. We are becoming a materials center and also a consultation center where we can assist people; we answer a lot of questions on the phone and then we encourage a minister or social worker to carry on with the case himself.

So we see ourselves as a diagnostic group centered in the philosophy of the whole man - we take the responsibility of teaching this diagnosis to the whole community. Our staff has the feeling of being constantly over-worked and constantly over-burdened; there is great enthusiastic excitement however about what we are doing. We are always thinking about what new steps we can take tomorrow; what are the new varieties of workshops we could conduct, what are the new ways of approaching the community caretakers?

Now we have this concept of treating everybody coming in. Eventually we envision ourselves sending everyone out - we don't want to be in a curative business. At the present time, we are running 39 groups; these groups are the core of our active treatment service. We have several marriage counseling groups, children's groups, adolescent groups, groups for young adults, groups for divorced men and women, social groups, art groups, and other types of groups. We are training ministers and gifted lay persons to be involved in treatment.

So this is the concept of what we call the information, screening and referral function of the Comprehensive Care Center. It is a new concept in community mental health.

To conclude, I would like to review some of our ongoing programs where paid staff work side by side with volunteer staff.

First our alcoholic treatment program. There are about 6,000 alcoholics in Central Kentucky. We have a fairly active AA, with approximately eight AA groups meeting regularly. Middle class or upper middle class alcoholics hide their

illness. These are occasionally "dried out" by their private practitioner, but they have received no treatment for the whole man. The lower class alcoholic is the frequenter of jails in Lexington - city jail usually has about 50 alcoholics every Monday morning. Before the Comprehensive Care Center came into existence, various groups, each in its own way, were treating alcoholics. The Courts used fines and jail sentences, the doctors used drugs and brief hospitalizations, the psychiatrists tried psychotherapy with a few, etc. What we have tried to do is: to encourage the development of a treatment chain where there is communication between all links of the chain. We have tried to link together the inpatient treatment unit at the State hospital and the outpatient clinic at the Comprehensive Care Center, which is composed of a professional group of therapists working side by side with AA group therapists. Each group in the alcoholic clinic (of which there are five) has both a professional and an AA group therapist working together as co-therapists.

We have another group with an educational approach involving the City and County Courts. On the morning when the judge decides whether the alcoholics have to stay in jail for ten days or pay a fee of $13.75, he may allow them to be probated to an educational course conducted by the Comprehensive Care Center. We have a deal worked out with the judge; the course consists of four group sessions. It is a group composed of about ten out of the 50 people who are locked up in jail each weekend. The judge picks out about ten who he thinks have a little more potential or motivation than average. During the group sessions there are AAs mingling in the audience. There is a set routine of educational material; there are movies discussing physical damage alcohol incurs on the human body; there is a discussion regarding psychological and emotional problems stemming from drinking. During these four weeks we cover various topics and themes that affect every alcoholic. We hope to get people thinking in terms of this educational approach. We also hope that some of them will go into the next link of the treatment chain, some may enter a real therapy group. If any are in really bad physical condition, they may be willing to enter a voluntary one-month intensive treatment program at the State hospital - another link of the treatment chain. A more gifted or psychologically talented person is encouraged to attend individual therapy sessions and, later, a more specialized self knowledge group.

We have three or four ministers involved in our alcoholic clinic who have been in our ministers' case study group. Another link in the chain is Alcoholics Anonymous. AA is always ready to help out, and we hope that many of our clients will get into AA. We have a strong AA group in Lexington and the ones who really stop drinking completely are the ones who go to AA meetings every night for the group support.

The way our alcohol program exemplifies the principles of psychosynthesis is that you have the concept of cooperation and coordination with many groups working together. This is a prototype for all of the Comprehensive Care Centers programs. We are not there to necessarily replace what anyone else is doing, but we are there to forge links in a treatment chain advocating always coordination and cooperation. Central Kentucky is notorious for agencies each going about its own business, independent of all other agencies. Many social agencies have been noted for this type of behavior. We are having meetings with the agency directors and are trying to beat this "each man for himself" attitude. Our alcohol program exemplifies the principle of the links and the necessity for the coordination and cooperation of all phases of the approach to

the alcohol problem. We have one director, a psychologist, who has three AA people who work very closely with him - lay persons working with one professional. They go out into all of these other programs and work with others; and this director exemplifies in his own personality the principles of cooperation and coordination.

I have attended many of these group meetings and when an AA member is present there always exists in the group a seriousness and sense of self, of "a power greater than oneself"; the superconscious or the unconscious dimensions of the personality are always in focus. I have known many other treatment programs which have neglected what you might call the spiritual dimension so we are very grateful to the AA persons in adding this dimension to our programs. It is sometimes difficult to get the lay person to work with professionals. We had some growing pains here but now are functioning fairly smoothly.

I would like to return now to the discussion of educational groups for clergymen. Church groups need to become more aware of their importance as a therapeutic community. The whole crux is the minister; if the minister does not have it in him to see the whole man, and how to use groups, he will not be able to set in motion a therapeutic community. In our ministers training group we pick out the ministers who have the potential of growth. This is one important point I want to stress. As we conduct educational workshops for all physicians, all ministers, all teachers, etc., we try to keep our eyes open for people who might have what you might call a "psychological potential", the ones who seem to understand the concept of the Comprehensive Care Center, and the actualization of the whole man. For these special questioning persons, you may arrange didactic psychosynthesis, or encourage such a person to join a more advanced self knowledge group. You give this to the ones who are asking for it; you have to be willing to go slow, and work with the ones who show the sensitivity and let the other ones go.

Some of these more motivated persons will approach us individually without us ever having met them in a formalized workshop. For some of the people who are particularly interested or show more motivation into going more fully into psychosynthesis techniques, self knowledge, and meditation, we do set up special classes. I have been conducting for the last eight weeks a sort of meditation, self knowledge class. We have been going over the concept of the whole man and have been encouraging students to start self observation.

This was started as a lecture series, to give them concepts and have them read books. Many of them wanted experience, wanted to get more of this and asked for individual interviews; at this point one can start using psychosynthesis techniques as therapy. You have to be concerned about what the client really wants. You have to be discriminating as to whether or not you will accept him. We have accepted in this lecture series psychologically minded ministers, teachers, housewives. After lectures for about four months we moved slowly into group discussions where various concepts were discussed (not necessarily personal problems). The group then decided to spend four days together and as a group experience some of the group psychosynthesis exercises.

In our kind of organization, staff development is crucial. Our staff meet weekly as an encounter group. The staff members have varying concepts of the whole man and this is a problem. I have found that four or five of the staff

are deeply concerned about self knowledge and spiritual problems; I talk with them individually. In the encounter group we work on interpersonal problems, in the 'here and now'. Not all staff members want to go within. I wait until they ask me questions to see if they really want any individual work. There is a built-in selection process for staff members. If a person is pretty rigid, institutionalized, he won't last. He will only stick it out for a few months and then become so anxious he leaves.

We have had staff meetings taking the encounter group form for about three months. Some of the hostilities in the group are being looked at; there is a lot of pain now in the open and expressed. The staff is asking, "What is the point of the whole thing? Is there any possibility of cooperation?" They are asking this question; they are cooperating in the day-to-day work but they are wondering if it is really possible to cooperate and whether you can be that open-minded. I feel that the personal growth of the staff member is very necessary to our vitality.

I will not go into any details of the techniques, for you have covered those in a lot of the other seminars here. Certainly in the select group, those who have approached us and asked for depth approaches, we try to provide either an individual or a group depth experience. There is a very crucial point here which has been neglected by some group leaders; we select gradually over a period of time those who will be ready for the depth experience. In other words, we have to have a feeling that this person needs and is ready for a depth experience. This is somewhat different from many human relations workshops and sensitivity training workshops where I do not think there has been adequate preparation for what follows. I have a lot of caution, I have seen a lot of people go into these things and then they do not know how to assimilate the experience. Sometimes they get into therapy and maybe it was a good thing; but our approach has been to <u>prepare</u> very gradually and slowly and then select those who are suitable. In other words, we do not force it or necessarily make them go into a two or three day workshop and attempt to break down their defenses, because they may not be at the point where they need their defenses to be broken. If they are going to break they will break anyway, under what is happening just in everyday life; we tend to <u>not</u> promote a too rapid breakdown of defenses.

This is the way we must proceed because all the time we are under the scrutiny of the community. In a way, we have to take what might seem to be a more conservative view just because we are a new agency and we cannot come out looking too suspect or too "far out". Everybody is looking at you and they know what is happening; the eyes of the courts, of the ministers, and so on are always on us. So I think we are learning to discriminate where we should go in depth and where we should not.

I think that that is sufficient and that we could now move into a discussion. Here are copies of a brief statement of the program in Kentucky and a chart which attempts to capture the organism of the Comprehensive Care Centers.

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DISCUSSION

Crampton: I am interested in your involvement of volunteer workers in your program. Have you trained some of them to do therapy? What sort of things do they do?

Parks: One of our best setsof volunteers are these AA persons. They have not been formally trained but they have been in AA groups for about ten years and so know something about people. We have been working with them as co-therapists and the problem was more to learn to work together - the professional and the AA workers. The training is really just being in our setting; and we are willing to put our people in their setting; so that I would not say there is any training; it is just getting into action; they fit into our program and then our clients are referred to their program. Of course, a group is training, in a sense; I mean, they are aware of the levels of man, they are pretty sensitive people. They do some reading, although two of them are not intellectual at all and don't read books such as we intellectuals like to read, but they have a feeling for all of this.

Elizur: It seemed to me that you put the emphasis on diagnosis. You are sending out and you are giving rather short term training...do you consider also supervision?

Parks: Yes, you see, as soon as we train these 12 ministers we have a relationship and they are always calling us so that we are supervising over the phone. There are 550 ministers and we do not have relationships with all of them, but the ones who have been in our groups are always calling up. There are many times when they present a case and ask "Can I handle it or should I send the patient in to you?" Usually one gets a feeling about it and tends to tell them to keep it unless it is something really serious. So, yes, we are supervising, particularly the ones who have been in our workshop. Now for people who have not been in our workshop, we have not set up any training; they are inclined to ring up and say, "Take them off our hands," and we have a hard time communicating with them. Either we do it all or they do it all; they don't seem to understand. But with the ones who have been in our workshops, it's a cooperation, so that maybe we give the medication and they do the therapy.

Elizur: So the supervision is only occasional, on the phone - there is no ongoing supervision?

Parks: No, there are too many, it would tie up our people - we only have 20.

Elizur: Is it possible to set up groups of those people who have been trained, to let them meet together amongst themselves so that they would have some support among themselves, so that you would only have to come in when necessary?

Parks: That is already happening; it is happening with the ministers. We have been working on marriage counseling. I haven't been there recently but it is still going on weekly - like the circuit rider in the Methodist church, you get it going and then you come by every few months or once a year. The other possibility that we have been thinking about is to use a sort of "canned media," a tape or something from headquarters that will stimulate them and then they will carry on on their own. They need to feel that someone is interested in them from the outside. I had this psychosynthesis group in Charlottesville with Jack Cooper

and when I left, it fell apart; each one went his own way. They get too identified with the professional or the leader. This is the problem that I do not yet understand all the dimensions of; but it is to get them feeling a momentum on their own without you being there. I think the key is to find the leaders with self-actualized personalities, and then let there be one man like that in the group. That is more the approach I am going after. In other words, you will have many groups and then you get one person out of each to meet with you, or something like that. I haven't figured it out completely.

Haronian: Did you read Dan Malamud's talk that he gave in December when he talked about "Simulated Family Groups"? What happens in those groups is that once these simulated families are set up - four to seven members in a family - they become autonomous groups, and they meet alternate nights. They get to know each other and practice the techniques they have learned in the overall group and they develop relationships, so it is very effective.

Parks: I think that is the way we are going, to think of a crucial use of materials. There could be printed materials, like lesson 1, lesson 2 and so on.

Haronian: Another question: you say you have 39 ongoing groups and yet you speak of your work as essentially diagnostic and referring out. What are the 39 groups?

Parks: Well, I was talking about the future somewhat. We are doing a lot of active therapy. (Haronian: You did not say much about that.) That's true; I mentioned the alcohol group. (Haronian: What are these other groups?)

In the Child Guidance Clinic we have, I think, four married couples; and there are two groups of single parents - where there is only one parent in the family. We have two adolescent groups, and we have one group of children of 9 and 10. Other groups include: Socialization group for adult retardates, socialization supportive for men and women, marital counseling for ages 18-30, drug abuse group for men and women, a self-growth group, a group for vocational rehabilitation, individual and group psychotherapy exercises for clearer self-observation and awareness, group for self understanding, a group for patients who have just left the state hospital, a social group for emotionally disturbed patients needing resocialization, intake group for alcoholic patients, counseling group for spouses and family members of alcoholics, intensive groups for alcoholics (3 groups), three groups for patients in the Day Care Center, a group for mothers of children with problems, marital counseling for couples over 30, marital counseling for ministers and wives, orientation to marriage counseling for pastors, socialization for residents and former residents of the state hospital and school for retardates, supportive group for women only, a group for young adults with emphasis on behavior change, after care follow up group for chronic patients, and self-actualization groups.

Haronian: Are these more conventional groups or are they more experientially oriented. Is there anything essentially psychosynthetic about the approach?

Parks: As regards the group leaders in the Child Guidance Clinic, both of these men are psychologists; one is an Ed.D. and the other Ph.D., and they have read the humanistic materials, they have read Psychosynthesis and they use this. They are family oriented; they are "here and now" oriented. One of them is a more intellectual guy and is always shooting questions and to some extent he is hung up in his own intellect; the other is more "going with the process," and

consequently he does go more in depth. Both of these therapists go into the schools one day a week with teacher groups. In other words, they don't just handle children. They go into the elementary schools and work with groups of teachers. Both are acquainted with psychosynthesis techniques. Others that are group leaders have no knowledge of the techniques - it's about 50-50.

You see, one of our problems is that there is a tremendous amount of work to do and only 20 people; so all the time you are making priorities and trying to do everything at once. It is a good thing - like trying to organize chaos! You have to see where the thing is naturally jelling, where is the natural point to put a priority. And I must admit that the first year was very depressing. I was very anxious - people were telling me to do various things and there was no progress because I did not want to impose a program; I wanted to see where people wanted to move, and what the people were saying concerning their needs. We had the mental health survey indicating certain needs, but I wasn't really well enough known; so you just don't walk in and tell people what to do. We have judges and school superintendents, etc., and you have to understand what they want to do.

Haronian: Who maintains contact between that central core and all these agencies. Do you do it alone or have you other people working with you?

Parks: Well, I do some of it myself, plus my staff, the 45 member Board and volunteer staff. As regards the volunteers, we must have about 12 pretty active ones who will work 12 hours a week. Most of them have had no official formal training. They have been in groups and some of them are already professional - we have a social worker who works with us and we have one doctor who gives us time, and a number of ministers who give time, and some teachers.

We are not jelled enough to train. We are about ready, I think, to announce and set up a training program; we must think of a way of selecting talented people, people who have a gift and not just people who have been in a State Hospital and want to help - we want people with something on the ball. The trouble with mental health volunteers is that you get ex-patients and they just cannot do it - they, themselves, need to be directed and organized. They don't have the coordination within themselves to be any kind of a volunteer.

We shall be setting up a training program next summer; we are getting five students who will work for us for the summer. We are at the place with volunteers where I think we are going to get the best ones from the ministers who we have found are sensitive, read in psychology and experienced enough with people to know what they are doing.

Mickans: I would like to hear more of your experience with teachers in the schools.

Parks: We have worked with the faculty of Berea College of Nursing with a three day workshop. It was really a three day encounter group. What happened there would be typical of what would happen in any encounter group. Many of these people after the three days went on to personal therapy. This was an opening experience; it was quite threatening. This was an earlier experience where perhaps we "came on" too rapidly.

As far as teachers: we now have one program on every school level. I have two Montessori teachers in individual psychotherapy; we have a program with

elementary school teachers in three of the ghetto schools - what we did there was to have brief discussions to get the teachers concerned about interpersonal relationships with students. In other words, what they do, say, if they make a home visit and realize that the kids are not eating properly. We had a two-day workshop for these elementary school teachers where some of it was talk, but it was talk geared to the whole man. We asked them to say how they helped students in addition to the usual textbook approach and how they dealt with the whole student. They are already person oriented. It has already been going on and there were many very concerned dedicated teachers there who stood up and said what they had done; the meeting developed a very high morale and commitment to really help the underprivileged children. This was done before September, in August, the time when teachers are getting ready to go back to school.

Some of the individual teachers have come back to work with us in more specialized groups. We have a junior high, a senior high, and also a college program. There are about 12 institutions of higher learning in Central Kentucky and we meet with all 12 of them every two months. We are getting to know each other better and will probably have a one or two-day encounter group this summer. The high school program will be largely set up to train teachers in evaluating, diagnosing,and treating mental health problems and in giving them specialized materials to assist them in this task.

In the elementary schools we are working with operant conditioning, one of the psychologists is interested in reinforcing positive behavior. So, it is hard to summarize all that we are doing with the schools. In a recent meditation group,which is composed of people I have met in my community undertakings, we have about eight teachers, Montessori teachers, elementary school, high school and college teachers. So the teachers are coming back for more specialized work. We go out to them in other ways, we get to know them, and they come to us for specialized work. Always the idea is to go out to them, then they will come back to us for specialized work and then we send them back to others.

Wolf: May I ask what you mean by meditation group? What do you do, what is the procedure?

Parks: What we have done is that I have given some talks, using Maslow's categories. Then I would ask for a period of silence, ask a person to recall some of the peak experiences of his life in, say, a ten minute silence. I would ask them to review the most meaningful five minutes in their life, sit there and think about it, and then think beyond it. I have used other books, but largely Maslow. I would have them think about levels of being and feeling, of values. I have used talks of other psychologists on values such as Sorokin and various authors mentioned in the Psychosynthesis Bibliography. I stress particularly the whole man. I would spend a couple of sessions talking on the body, and the body as being part of the whole. Perhaps more than anything I have stressed body and peak experience. Thinking functions and emotional functions, they already know about, but I might talk some about these too, as part of the total whole man situation. I direct the group to read this book or that book.

As far as meditation is concerned, I ask interested group members to keep a diary, something along the lines of Progoff's technique. They review

their lives in terms of value and in terms of peak experiences, crisis and "crossroad experiences." This is a diary type of meditation that they would do at home, to think about this and work at it every day. It is a type of inner thinking. This is the essence of what we do. (Wolf: Do you get together once a week?) Yes, it has been a weekly course, running for ten weeks. It is going to end with a retreat, and as yet there has been no pick-up point established; we don't know where it will go. In other words, the course should have a beginning and an end. We have found that in working with teachers and ministers it is good to say that there is an end, such as "after ten weeks we quit." No one has ever really finished, but they will go on to where the next thing is. Courses can drag out and do no good. I have been in married couples groups that blew apart; or ministers' groups that dragged out, so it is good to have a set period - "let's do it and then finish!"

Elizur: With your 39 groups do you set limits, like a year or so?

Parks: Yes, we have time limits, we were talking about the meditation group which is rather specialized, but in these 39 groups there is more traditional group therapy. I would say that about 8 of these are time limited. Particularly there are time limited parents groups in the Child Guidance Clinic - they meet for 8 or 10 sessions. Now a lot of the problems can be solved in that time. At the end of that time there may be two or three who are still severe problems but we can then put them in another group. (Elizur: This is more like a discussion group?) Yes, we use educational material for all our groups. In the group work I did before I went to Kentucky it was more experiential but since I came to Kentucky we have used a lot of educational materials. In other words, there are things on marriage for people to read; there are things to read on the body - of course, it depends upon their intellectual level. We have all ranges of intelligence and a lot of these people are not readers. With those it is a little harder but if a person reads fairly well we do prescribe reading. In just about all of our groups we do that. We give them something to think about, to work on, and then of course the crux is to discuss what has been read. If you don't show a correct follow-up they will think that you are not interested in what they read. We use bibliotherapy, the Progoff diary therapy, we use the reading-a-book-therapy - the sort of Great Issue approach, where we read and discuss a great issue. But the "great issue" has to do with them; it is the issue of them knowing themselves.

Brodbeck: As you now look at the community, do you see things that you did not see before?

Parks: Well, I am learning a lot about myself! I think I am learning to be a lot more observant of what people are - to ask "at what level is this guy?" I used to be pretty non-discriminating, so I am learning that another thing is what I think you can call the political or conservative approach, to go in on a didactic level, to really be talking on two or three levels at once; and certain ones will hear what they want to hear and others will hear what they want to hear, and yet you don't say anything bad. And another thing is that I think one's own spontaneity becomes developed. I know that I am much more spontaneous than I used to be, less introverted.

I believe the inner and the outer has to be coordinated; you have to be both inner and outer. Also you have to react quicker; it is more of a test; it is practically a test all the time - whether you are going to say "yes" or "no."

I know I am making many more decisions - there is a decision to make every minute, and this makes your mind work faster. Then you start wondering what is your relation as a finite person to the community and to the world; and this is an inner question that you are asking yourself. (Question from floor: What answers are you getting?) Many answers, and I think I am moving in the right way. When I was involved in analysis, working in the university, I did not feel to be helping anybody. I was giving courses that sounded nice but I felt that I was too far away from people. I had two people in psychoanalysis and saw 10 to 20 patients but I did not feel that I was really doing anything, I did not feel I was really giving anything to the community, and now I feel that I am. So I am myself better, although I am much more frustrated, more depressed.

Brodbeck: Do you see communities any differently after having been exposed to this program; for instance, do you see New York any differently than you did before?

Parks: I have enough trouble with 400,000 people! (laughter). How do you become intimate at the right level in the shortest time possible? I don't know exactly what you are trying to have answered but I have seen a lot of broader aspects of people. I have been cooped up in mental hospitals with psychiatrists, and this is sick! At least, I am now talking to some other people - teachers, other leaders and community people, and people who are not sick. I see a community as having a lot of healing potential in its own self, and my job is to find out where it is and plug into it. A community has tremendous power, and some of these teachers are tremendously self-actualized people; but the thing is how to find the resource and then use it. The job is to find what are the resources, the human resources - the fact that a man is a teacher does not mean that he teaches anything. I am trying to find people who can teach, who can heal. I feel that it is still very personal - I have to know 515 ministers, I have to know every teacher, but yet I have the feeling that it is still one to one. But I do have a better idea of what people do; I guess my horizons are broadening.

Smith: Do you make much use in problems of the most overlooked agency of all, the police, who are always ready and there?

Parks: Yes, we work with workshops with the police. Our alcohol program has much contact with the police - we participate in the training course. We are in close telephone communication. We thought of having a police radio in one of our cars! I had never had to deal with police when I was sitting in a little ivory tower, but now I am talking to them all the time - and with lawyers, who represent persons appearing in court. Here I am talking to judges, talking to lawyers. We haven't really set up any training of police; they are already quite good and we can learn a lot from them. They could set up a workshop for us, and then we could learn how they handle emergencies. Sometimes, we are very presumptuous; you know how all these mental health people go down and train police! But we have felt that really they should train us. We have coordinated with them in cases such as a psychotic who won't come out of a house, or many emergencies having to do with alcoholics. They call us a lot; we are getting to know each other but we have not yet really decided to set up a program. We are working together to handle problems and we don't quite know what sort of program to set up.

Elizur: Do you get a lot of suicidal calls?

Parks: We have this suicide answering service - we call it our Emergency Telephone Service. It is not advertised as a specific suicide service, we just have an emergency mental health number; but we get a lot of suicide calls. The words "comprehensive care" to many people means suicide. It means everything, but we have three or four suicide calls per week (Elizur: How do you handle it?) We have a staff schedule by which one of the staff is on call at nights; and depending on what evolves, we try to keep them talking and try to locate where they are, their address, and whether they really mean it or not. We oftentimes coordinate with the police; and if necessary, we will have police help us on it. We usually try to get an immediate face to face contact, to get to where we can talk with them face to face. Of course, there are many different kinds of calls; sometimes it has to do with taking pills; we have to find out how much they have taken and whether it is likely to kill them and so on. We have tried to set up some guidelines and we have pharmacists on call who answer questions as to whether the dose is lethal or not. We have 400,000 people in our area and we only get four suicide calls a week, so our answering service has to be far more comprehensive than just for suicides.

However, we are toying with the thought of a special service. Some of the ministerial students at one of the theological seminaries would like to do it and just call it a suicide number. We may do that, if they will man the phone.

Haronian: Do you have any figures yet as to the effectiveness of the program on the community, any kind of psychological data, anything that would indicate what the effect is? And the value of the program?

Parks: No, we are getting a psychologist from the University of Kentucky to start an evaluative process, but none of the figures we have now mean anything. We have impressions, but we do not have statistics that would back up anything. Our referrals have increased. I think we have the good will of the community. We have a good feeling among the judges, the school superintendents, and we are making friends with people, so we have a subjective feeling that we are getting somewhere. As regards actual cases, we are trying to study that but we do not have detailed information. We are going to try to get it.

Winston: Is there any change in community attitudes towards mental disease? By which I mean, is there any greater acceptance of people who have psychological problems?

Parks: There is still a lot of stigma. Sixty percent of the people who come for our services earn under $5,000 per year. They are predominantly poor people and they are pretty ignorant, and anything that smacks of mental illness is threatening. They are considered "loony" and it is a stigma. There is not too much enlightenment; it is not like Cambridge where the thing to do is to have a psychoanalysis - up at Harvard everyone has a psychoanalysis! But I would say that in some of our groups I get the feeling that some of the people are seeing mental or emotional stress as more of an opportunity; their approach is that a crisis or a problem is an opportunity. We take this approach with the caretakers in the community that we talk to. I remember one teacher and a little negro boy who could not talk. She was a Head Start teacher and the little boy couldn't talk at all; he came from an unhappy family situation. She would come by and stand next to him or put him next to her seat, and she would just go over and touch him about every hour; and he started talking in about three or four

weeks! Then she told the story - that is the sort of story we use in our workshops, success stories - of how this child was talking and getting along with the others, and reacting; and as she told this story, in about five minutes all the other teachers were crying. So you get them all feeling as to what happens; and if you can structure the thing so that they tell positive things - it is almost like Christian Science testimonials - you get an enthusiasm. This teacher said to me"This one experience meant more to me than any other experience I have had as a teacher"; to help somebody who is down; then it becomes an opportunity, and it is certainly not a thing to be regarded as a terrible misery but something that really becomes a challenge and an opportunity to grow.

Cooper: The main thing seems to be to give them confidence and for them to know that they really are doing something - this stamp of approval.

Parks: Yes, this is very important.

Winston: Don't you run the risk though of working up a lot of enthusiasm and then they find out it is not all that easy?

Parks: Yes, but then they will call on the phone...

Cooper: When they get depressed and despondent bring them back in.

Brodbeck: You raised the question of newness. I suppose that the most innovative detail in this particular cultural milieu is your meditation group. In a sense this is the seed of a new culture that you are introducing, and do you have any plans to have that diffused out among all the other groups by the people who have experienced it in the way that you have just been reporting - telling other people about it, having it diffused naturally by sharing experiences?

Parks: Well, that is what is happening - someone tells somebody else and so on. We haven't programmed or structured anything. We have these mental health diagnostic kits and the whole man is shown there; the values, the superconscious are there as much as all the other parts of man. We ask everyone who uses this diagnostic kit to really inquire into this - to apply the kit to himself. We plan to expand the kit and we have already written it over again twice. This is part of every one of our diagnostic training groups - the four parts of man. I think that in humanistic psychology, the third force psychology or in psychosynthesis, these aspects, the superconscious states, are more emphasized; although we don't want to talk about them prematurely because I think that can do harm, if you start talking about your spiritual experiences too quickly. So right now we tend to keep it as a rather specialized group, and let it grow by osmosis. If we pick people up in these other training groups who are more interested, we feed them into the "meditation" group; but I do not plan to do any structuring.

Smith: It strikes me that you have a tremendous model for meeting mental health needs, but it is also based on a certain centrality of power, having the funds available and so on. Now supposing others in the community would like to do something similar, which is a good thing if you have federal funds, is there some way in which you can start somewhere on this outer circle and then work towards this kind of central organization?

Parks: Well, we want to get out of being a Federal thing; and we have to get out

of it anyway, for we have only 51 months of Federal money. Twenty-five percent of our budget is now from contracts with the schools and fees. One of the limitations on mental health programs in some of the states is that you cannot treat anyone with higher incomes. For instance, in California, you cannot treat anyone if they make over $5,000 a year; in Michigan you cannot treat anyone if they make over $5,500; so they are limited to the poverty group to do the mental health program. But we are not limited, we can treat anyone, so that we do charge and it ranges from zero to $30 an hour. We do have some considerable number of $30 an hour patients. We are looking to the schools for funds and have already received $15,000 for school contracts with the teachers. We haven't done anything at all with industry although we have been asked to run public relations workshops with the University and are negotiating with industry. The way that I look at it is that we should replace the Federal money completely by state money, local contracts and fees. You have got to serve poor people and that is why I think it will always be a public program and why we will have state money involved. We also have money from the local county governments, and this depends on the good relationships with the county judge and the people. The Federal Government never did want it to be Federal, they wanted to get out of the business. There is a movement now to try to get some continuing Federal support and maybe we will get that; I don't know.

Smith: That hardly answered my question. Suppose a group of school administrators or ministers see where this organizational structure is good, is there any process by which they might work towards something like that? Does it have to be somebody who starts at the center and then moves outwards? Can you start on the outside and then work inwards?

Parks: I don't know; there are a number of private psychiatrists who are opposed to Federal NIMH programs and some of them run a very good community minded operation. Dr. Abraham Lowe who started Recovery Inc. handled a thousand patients as a private psychiatrist in Chicago. He got groups going in houses and on weekends. He saw them maybe 15 minutes a month and the rest of the time was group therapy. They would talk and he would come around like a circuit rider; he would send records and would train his leaders, and they would treat the patients. Our own Dr. Jack Cooper handled 8,000 patients as a director of an outpatient department in Houston, Texas, so you can start anywhere. The concept starts with the person with a service motive. I think that the problems of our institutions have been that the psychiatrists are crammed into their little state hospitals or private offices and are sheltered from the community needs. I think the whole nation is now going community minded with the poverty problems, the racial problems and so on. Now the time is right for mental health persons who want to move. It can be done with your own funds or with somebody else's.

Haronian: Part of the answer to the question is that any agency in the community can become the sponsoring or the initiating agent for a community comprehensive mental care center which gets Federal support. If that agency sets up a plan which provides the five points (Parks: It has to satisfy the State plan too) then they take their plan which provides the five major types of services to the State agency which shepherds it through, so to speak. Now if it does not involve bricks and mortar and the State does not like the plan, the local agency that wants to set up a comprehensive service can go direct to the local Federal region agency and seek an okay from there. If, however, it is a bricks and mortar plan, a staffing plan, it cannot go without State approval. So any agency can do it,

the church, a family service agency, any agency that thinks it has the guts and influence to organize a plan. In many areas general hospitals are serving as the core of a plan.

Cooper: There is a tremendous competition right now for Federal funds, but they disappear so rapidly; one year they give it to you and the second year they cut it down and the third year you have to go hunt elsewhere for funds.

Parks: Kentucky got six times or so their share, they got more money for this than any other state in the Union. They organized four years ahead and the Commissioner went gungho after that money and got it! Now it is a question of survival; can we replace Federal monies by local fees, contracts, etc., before the 51 months of Federal monies dwindles to nothing. So far we have just managed to bring in new local money to balance the amount of Federal money we are losing.

Brodbeck: What do you think of religious organizations attempting to do this without professional people such as psychologists and psychiatrists and so forth?

Parks: I think that community mindedness can start anywhere; the Episcopal Church has done a lot and so have some of the others - I can think of ministers making creative use of physicians, educators and psychologically talented persons in their parishes. Churches of the same denomination are working together drawing on National leadership. Churches representing different denominations will not cooperate with each other. For example, in Lexington the ministers' organization is the weakest organization in the town; it is the opposite of the Medical Association. The latter have a tremendous organization; they charge high fees, you go to meetings and know everyone, but in the ministers' organization they rarely meet; and when they do, they are all obligated to their own hierarchy and they are not particularly interested in cooperating with each other. There are, however, some liberal, open-minded ministers and I should say that the younger you get them the more psychologically minded they are. Psychology has to be the linking discipline. In other words, you have to have a minister who has had his own personal psychosynthesis, his own analysis, a minister that studies the whole man. And if you get a man like that then he could start something. I knew one minister who started depth groups, he was a Methodist, Frank Kimper, who worked with us in Charlottesville for a year. He went to graduate school, took more psychology and now teaches psychology in a seminary! Earlier in his career he had turned a small Methodist Church upside down. He didn't break the structure but each Wednesday night he had a depth group and didn't advertise it in the Church bulletin. They met Wednesday night in couples and then the group split into two groups, the two groups split into four, and pretty soon he had 50% or 60% of the whole congregation in groups. This was all done very quietly because some of the conservatives on the Board of Trustees would have opposed it. He never wanted them to vote on this, and yet he had half his church involved in the depth approach. It is possible to do it, but watch what you put in writing!

Cooper: I think the Rev. Smith here can tell us what is happening in Westchester County with the ministers and pastoral counseling. They come from small towns all around; they learn this technique and they then take it back to their own towns and start practicing it. And it is very successful.

Parks: Yes, and this happened in Charlottesville. Some of the ministers now are using the techniques which we taught them.

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