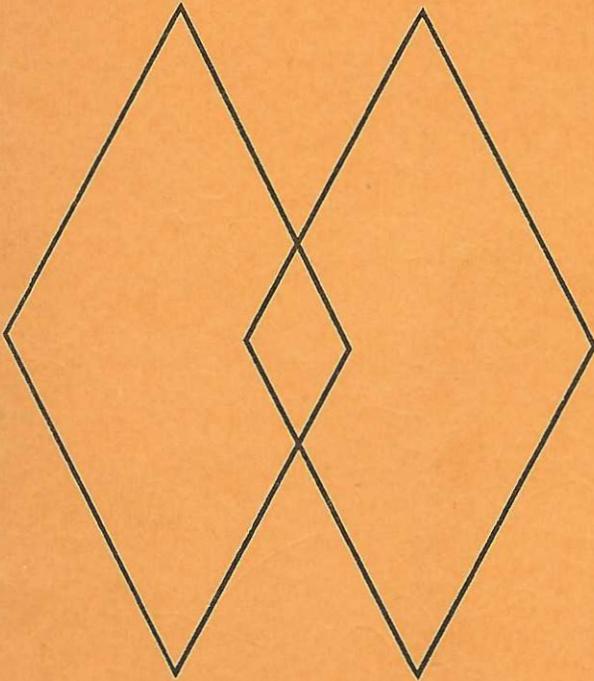


**COLLEGE STUDENT  
COMPANION  
PROGRAM**

Dr. Breggin's 1962  
chapter, pp. 20-27.



**CONTRIBUTION  
TO THE  
SOCIAL REHABILITATION  
OF THE MENTALLY ILL**

**CONNECTICUT STATE DEPARTMENT OF MENTAL HEALTH  
NATIONAL INSTITUTE OF MENTAL HEALTH**

**PROCEEDINGS**

**COLLEGE STUDENT COMPANION  
PROGRAM CONFERENCE**

**CONTRIBUTION TO THE SOCIAL REHABILITATION  
OF THE MENTALLY ILL**

**NOVEMBER 7-9, 1962  
STRATFORD MOTOR INN  
STRATFORD, CONNECTICUT**

## THE COLLEGE STUDENT AND THE MENTAL PATIENT

PETER R. BREGGIN, M.D.

The volunteer-patient relationships described in this paper occur between college students and mental patients on the back wards of a large state hospital. These experiences develop in an informal fashion. Volunteers are free to meet any of the patients on the wards, and the patients, of course, are free to choose their volunteers. Most of the individual students volunteer for an afternoon a week, but there are some volunteers on the ward each day, so that there is daily continuity in the group experience between students and patients. Many of the volunteers develop an interest in one particular patient, and may acquaint themselves with the patient's physician, hospital chart or family. Other volunteers prefer to spend their time in group activities. Either way, the volunteers remain responsible largely to themselves, under the guidance of their own day leaders. These leaders are, of course, in direct communication with the staff and freely consult them as a routine procedure and for special problems.

In listening to this description of a student-organized and student-managed volunteer program, it may help to keep in mind the coincidence that places colleges in close proximity to most of our state mental hospitals. What I am describing is a "domestic peace corps" that is being sent to the frontiers of mental health in our state hospitals. The students are easy to solicit, and eager to organize themselves in anticipation of professional guidance. I am at present in Syracuse, New York, where I was told on several occasions that I could not expect the same intense response as we had from Harvard undergraduates. One month ago I spoke for five minutes to a required sophomore course of 150 students, and suggested they start a program. Within one week, fifty students had organized themselves with their own leader into a volunteer group. The only question is how much the professionals will accept them.

### The Volunteers Need to Find An Adult Role

In his day-to-day work on the wards the student must develop for himself some role which will both alleviate the anxiety and provide a positive fulfillment of his responsibility. The hospital setting does not provide the student with any ready-made role. He must create his own. The student's motivation in creating a role cannot be understood without considering the student's unique position. In our society, the achievement of adulthood is not a clearly marked event. The younger generation, for example, never expects to take on responsibility for the older generation, since the family system separates each generation. For the student who "drains" his father's money for four or more years this realization is particularly guilt provoking.

Added to this is the common phenomenon of conflict between the parents and the child in college. The son or daughter begins to build up his own independence only to have his dependency reawakened on every return home. The conflicts at home not only increase his guilt

about living "off" the family, they very commonly reinforce his feelings of not having reached adulthood.

With a background of frustration in his attempt to reach adulthood, the challenge of mental hospital volunteering takes on a specific value. The student can actually take a position of responsibility for adults. He can stand among them as a person of maturity and status. But the college student's need to take on adult responsibility leaps far beyond the reworking of family frustrations. The student is actively seeking an outlet for the capacities he has been developing through high school and college. It is his answer to the plaint: "You study, study, study at school. You absorb like a sponge, but you never give anything back."

Those students who have the most years of school still ahead are often the most eager for responsibility. They are caught in an insoluble dilemma—the desire to take on social responsibility at even higher levels leads to more and more years of dependency during professional training. By going to the hospital, he leaves this dilemma for a few hours and enters a world where he is desperately needed. No education is required in this new world, no professional status. What is required is "maturity" and he sets out to prove that he possesses it. It is no wonder many students do not call the work "enjoyable." Not only is it too stressful, but for many it is too sacred. Often it is the students' most significant college experience.

### **Volunteer Motivation In Response to the Mental Hospital**

As freshmen and sophomores in college, the volunteers are in their late adolescence. They are uncertain about themselves and about the world around them. They lack the ego boundaries and fixed roles of adulthood, and hence identify themselves with the patients easily, quickly and profoundly. At the same time, they experience a great deal of insight into themselves.

In addition to the adolescent tendencies, the adolescent's fear of loss of control and his rebelliousness encourage identification with the patient, for the patient, too, gives the appearance of having lost control and having rebelled. The student wonders, "Am I sick too?" He projects his own fears of being inadequate or mentally ill into the patient, and assumes that the patient's problems are the same as his own. The shy student imagines that the patients will be excessively shy, the hostile student imagines they will be excessively hostile. The student who is aware of an adolescent kind of role confusion in himself will imagine mental illness as a more global kind of personality disorganization. Often these projections do not represent the student's more serious problems, but at times they do. An important observation is that the student does identify with the patient and does project ideas about his own inadequacy into the patient. Much of zeal the volunteer feels toward volunteering is motivated by this confrontation of his own problems projected and exaggerated onto the person of the mental patient. Of course, not all students respond this way, and there are many other motives at work, but I think the fear of being mentally ill, the identification with the patient and the projection of personal fears into him, explains and describes much of what takes place on the wards.

At the start of the volunteer experience, the fears are especially marked. At orientation meetings, the student audience is obviously tense, and will laugh nervously whenever told that most of the patients will seem as normal as themselves. The first trip to the hospital is even more tension filled: the students joke about being left behind on the wards, about getting lost in some remote corner of the hospital, about mistaking volunteers for patients, about being locked up by the psychiatrists, about going crazy like the patients. Huge embarrassment is experienced when they mistake a visitor or another volunteer for a patient, and outright fear is experienced when someone mistakes them for a patient.

During the initial visits on the wards, the student at first is even more impressed by the similarity between himself and the so-called "mentally ill." Not only is his fear increased, but in addition a tremendous sense of guilt develops. The patient is a human being like himself, but this human being is locked up, called crazy, deprived of his civil liberties, deprived of many basic human conveniences, comforts and privacies, deprived of a self-fulfilling way to occupy himself, discarded by his friends, and isolated from his family. He is treated as one of a group of deviants, led to and from work and eating, and given little personal attention or consideration. His home is a locked barracks . . . When the patient says to the volunteer, "Honest, I don't belong in here, help me get out," or "I'm not really bad, but people want to harm me," the volunteer does not interpret this as paranoid ideation. He thinks instead that something unjust had happened to the patient, that somehow the patient is being treated unfairly. Even while the volunteer may feel the situation is hopeless and very depressing, he feels equally strongly that he must try to do something. He cannot forget what he has seen.

Gradually the student learns to distinguish himself from the mentally ill, to see psychosis with its bizarreness, its primary process, its social incapacitation. He begins to know just how normal and healthy he is by comparison. This recognition of his own health is one of the major satisfactions derived from the ward experience. It is coupled with the satisfaction of practicing an idealized kind of behavior under stress. In notes taken from open-ended interviews with a group of volunteers, more than half listed "satisfactions" involved proving one's own social adequacy or mental health.

### Behavior on the Wards

At the start of volunteering, nearly every college student wants to behave "naturally" with the patients. He hopes to take volunteering in his stride, much as he would a party or a club meeting. This wish stems, first, from our cultural emphasis upon being one's self at all times, upon sincerity and straightforwardness. The adoption of an artificial style of behavior would be frowned upon as showing lack of spontaneity and lack of good allaround behavior. Second, the volunteer's fear of being mentally ill or socially inadequate leads him to stress his own natural behavior as a sign of his own health or adequacy. Third, the volunteer feels guilty that the patient with whom he identifies is treated like a sick deviant, while he himself reaps so many advantages from society as a student. He decides to make the patient feel "just like me" by treating him in a natural fashion.

However, once the volunteer begins working regularly on the wards, it becomes increasingly obvious that his so-called natural behavior is not at all adequate or appropriate. He finds that he can't hide shyly in the corner or can't behave seductively as he does with girls at a party, or that he can't get irritated and walk away, or that he can't try to "one up" the patient in an academic or political discussion. All the idiosyncratic mannerisms or security measures with which he seduces or wards off other people become painfully obvious under the stress of volunteering. The more the volunteer identifies with the patient, and projects his own inadequacies into the patient, the more he doesn't want to harm the patient in any way.

And in addition to this fear and guilt about the patient, the volunteer also fears the unpredictability or the dangerousness of the stereotyped "madman." He imagines on the one hand that the patient can be hurt easily and terribly, and on the other hand that the patient can retaliate powerfully and dangerously. The volunteer's own socially disruptive defenses become obviously inappropriate and he imagines they are dangerous both to the patient and to himself; but he has no set role to adopt in exchange for his natural behavior. He is not a medical student, not a psychologist, not a social worker, not a family member—not even an aide or attendant. He only knows that he's supposed to act naturally, and that "naturally" just isn't good enough.

For some students, this crisis does not fully erupt. These are the students who already have emotionally divorced themselves from other people, so that they experience neither strong identifications nor strong anxiety in their dealings with other people. They can be characterized by the fact that they have many acquaintances, but no close friends. These students are the exception, and they "jump right into" the ward experience, usually as party and outgoing organizers. But the majority of volunteers do face a personal crisis on the wards, a "sink or swim" affair. Those who are able to master their fears and their behavior remain on as volunteers. Those who are not, usually drop out of their own accord after the very first visit, and rarely require overt discouragement from other volunteers or the patients. No formal screening has ever been necessary, and at no time has the hospital staff found it necessary to ask a volunteer to leave. Nor has there been any feeling of real trauma on the part of the many volunteers who do feel compelled to drop out.

Those volunteers who do master their behavior find themselves developing a kind of idealized normal behavior, a "better self" which they practice on the wards. Acting under stress in this ideal fashion provides the late adolescent volunteer with his main satisfaction—overcoming fears of personal inadequacy, fears of being mentally ill.

The volunteer not only tries to protect himself and the patient by ironing out the kinks in his social behavior, he also makes a very specific attempt to bring out all that is normal in the patient. This is an almost universal phenomenon among the volunteers. Because of the fears based upon identification with the patient, the volunteer almost never encourages the patient's pathology—his hallucinations, delusions, social withdrawal, ideas or reference, and socially disruptive behavior.

Thus, while his own behavior is fashioned after some kind of ideal, he also encourages the patient to behave ideally. The volunteer says, in effect, "We are both alike, just as I thought; we are both very healthy."

### The Patient

When the volunteer gets to know the chronic state hospital patient, he becomes convinced that much of the patient's problem centers around his debasing label, "mentally ill," and his degrading impersonal treatment in the understaffed, poorly equipped state hospital. The volunteer says, again and again, that the volunteer himself couldn't remain sane if he himself were locked in the hospital. The volunteer does not treat the patient as a psychotic; he treats him as a normal person who has been brutally forced into a deviant status.

The patient is acutely aware of his deviant status, but he is often at a loss to behave in any other fashion. I remember my very first day on the wards, when a young girl approached me and asked if I were a college volunteer.

"Yes."

"Well, I'm a whore from East Boston, and I get out of the hospital tomorrow. Will you meet me?"

A volunteer who knew her ambled over: "Leave the poor guy alone, Sandy. Besides, why are you talking such nonsense?"

"O.K.," she answered, "but can you think of a better way to meet a college man?"

The patients, many of them incarcerated for years, were without socially acceptable means of introducing themselves to the volunteers. Like the volunteers, they faced the same crisis of undefined roles in a new situation. Many of them initially sought "crazy" or bizarre ways of relating because they thought the volunteers wanted this, or because they lacked a better method. The patients' lack of an adequate role was complicated by a basic distrust of these new intruders, the volunteers. During the first days of the volunteer program, the patients would hoot and jeer the volunteer groups. The patients acted as animals in a zoo performing for the spectators. This gross testing disappeared when the patients came to believe that outsiders might be interested in getting to know them as human beings.

The patients' response to the volunteers was often remarkable. The volunteers knew that few of the patients ever took trips outside the hospital, and they were told that many of the patients would take advantage of any chance to run away. But the volunteers trusted the patients, and the volunteers themselves wanted to spend a sunny afternoon outside the hospital. (Many such examples could be provided of how the volunteer's own spontaneous need to do something interesting brought new meaning into the life of the patient.) Although the groups often contained chronic runaways, never in the first four or more years of the program did an adult patient run away from a volunteer expedition. Similarly, in no instances were volunteers struck by patients,

though many patients were considered quite dangerous and tranquilizers were not yet in full use as chemical restraints. Even the typical manipulative behavior was often dropped as soon as the volunteer made clear he simply was not subject to fruitful manipulation, because he was not part of the hospital hierarchy.

Especially after the volunteers became established in the hospital, it was often hard to tell who was helping whom the most—patients or volunteers. I remember once being accosted by a suspicious patient who was unfamiliar with me. Another patient intervened—"He's a volunteer. Can't you tell decent people when you see them?" I think this was a healthy experience for all three of us, myself who was appreciated, and the two patients who were learning to discover "decent people" in their environment. I remember, too, when an attendant tried to usher me off with the male patients after a mixed party on the female ward. I hardly knew how to convince him I wasn't a patient, but the defense I received from the patients themselves again saved me from further anxiety. I use the word "defense" because it gets across the attitude shared between the patients and the volunteers in the early years of the program. The attitude was one of mutual cooperation against the rather cruel world which had made the patients sick, labelled them mentally ill, and locked them up. In recent years the hospital has become less custodial and more therapeutic, so that the volunteers have begun to identify themselves more closely with the hospital, lessening the intensity of this mutually protective feeling.

Just as the student is working out an "ideal" role, in which he has responsibility, social adequacy, and often a genuine human experience far beyond anything in the past, so too the patient experiences a new kind of role. The patient finds another person who expects him to respond in a normal fashion. He finds that his talk about past work achievements, about past family, about past life, are received well by the students. He finds that what he says is really appreciated, even his dreams for a better future, and that he himself is likeable and liked. He finds that he is given responsibility for himself in meetings with the volunteer, in activities with the volunteer, in trips out of the hospital, in volunteer organized games and social activities.

Chronic hospitalization has a way of making the patient feel that his personality is not very important. A person's personality is the expression of his wishes, and the chronically hospitalized patient is not accustomed to having his wishes fulfilled. When the volunteer appears on the ward, he presents the opportunity for interaction with another human being in which these small, seemingly inconsequential, wishes can be expressed and satisfied. The patient may ask for a cigarette, or even the time of the day, and there is a volunteer who takes the wish seriously. I think this is how the minimum nurturance of personality takes place. If the patient abruptly asks, or wishes, "Boy, I wish I could get out of here for a few hours," the volunteer can immediately respond. If the patient suddenly thinks of writing to his family, the volunteer can always secure note paper, and even help with the letter. If the patient, in a sudden glimmer of health, decides that his clothing is too shabby, the volunteer can walk with him to the dispensary, and then perhaps en-

courage the patient to get a hair cut, or clean his nails, or make any of these small increments of self-esteem that make up a human personality. The patient may even develop enough security to make some simple gift to the volunteer, and the volunteer is there to receive it, and to show his warm appreciation. Sometimes the gift may be unusual—the patient's first spoken words in years. And when the volunteer finally must graduate, and the patient explains how much he'll feel alone, the volunteer may introduce the patient to a new volunteer—a good friend of mine—and remind the patient to write occasionally.

Tied up with the mutuality of the relationship is the fact that the volunteer gives of himself in a way that most professional people are not able to do. The volunteer even talks about himself, a sign of mutuality that is deeply appreciated by the chronic hospitalized patient. The fact that he talks about himself because of his own anxiety is not disruptive to the relationship, because neither the patient nor the volunteer expects any professional "savoir faire" of the volunteer. When it turns out that the volunteer is an intelligent, educated and relatively happy individual—and is still interested in communicating with the patient—the importance of the mutuality is increased.

I think the so-called "dementia" and "hebephrenia" often described as the natural end points of schizophrenia are really products of social isolation on the back wards of state mental hospitals. Added to this actual social deprivation is the patient's knowledge that he is a deviant and that nothing more social is expected of him. Thus he not only loses mutual wish-fulfillment with other people, he actually begins to lose the expectation of it. The volunteer treats this problem directly. He brings personal experiences into the life of his patient, and he makes a direct assault upon the patient's concept of himself as a social outcast.

In the last section of this paper, I'll turn to some of my experiences as a former volunteer, who is receiving professional training and professional experience as a psychotherapist. From this vantage point, I'll suggest that what the volunteer does is to treat not only the patient's deviant status and social deprivation, but also the patient's actual psychotic process.

### **Opinions of A Volunteer Turned Professional**

There is a tendency to think of the volunteer as a poor but expedient substitute for the professional. We tend to think that we would have no need for the volunteer if we had more professional people. As a volunteer turned professional, I'd like to point out therapeutic advantages I had as a volunteer but no longer have as a professional. As a first example: "I'm now responsible for a probated adolescent boy who is hospitalized largely against his will for observation. I wish I might really help the boy, but he knows his feelings may be used as evidence for the need of further hospitalization which he fears. He is afraid to let me know what he's like, because I have police power over him. The therapy is stymied because I am identified with the police, the state and adults in general. I wish I had a volunteer who might help the patient.

Another example: I'm trying to treat a young girl who is experiencing her first schizophrenic break. At first she had all sorts of delusions about me—that I was in cahoots with her parents, that I wanted to take her money away, rape her and practice hypnosis on her. I could help her with these fears because they were unfounded. The real crisis developed when, after a period of great improvement, she again became acutely psychotic. She had sensed my pride in her improvement and sensed that I was using her to show that I could "cure" a difficult patient. She resented this and said, "I'm punishing you by not getting better. I'm going to ruin your reputation." Her criticism was not entirely unfounded; it applied to any professional who relies upon his patients for status, prestige and financial remuneration. She made me wish I were a volunteer again.

The volunteer is free of many such extrinsic motivations. He often consciously understands that the volunteer experience is one of his most intrinsically pure relationships. He sees that the relationship is different from his relationship to his teachers' whom he tries to impress, his parents', whom he tries to break away from, his friends, who may or may not accept him into their fraternity, his girl friends' who may or may not go out with him.

The volunteer makes many unique offerings to the hospitalized psychiatric patient. First, he offers the patient a relationship both free of the social and familial troubles which drove him into the hospital, and free of the professional responsibilities of the hospital personnel and staff. In this sense, the volunteer offers a very idealized kind of human relationship. Second, the volunteer offers the patient a very mutual relationship, in which both partners may expect to grow. This kind of experience is nearly impossible elsewhere in the hospital setting, except among the patients themselves. Third, the volunteer offers the patients those small wish-fulfillments and subtle signs of interest which go to building up an individual's self-esteem and personality, and which are entirely absent in the back wards of a state mental hospital. Fourth, the volunteer offers a multitude of general services by creating and sustaining individual and group activities both on and off the hospital grounds. And finally, the volunteer acts as a kind of buffer between the patient and the community—he makes clear that the patient comes into the hospital in order to be helped by his own community rather than to be isolated from his community.

If the volunteer goes on to become a professional in the mental health field, as so many volunteers do, he brings his experience with him. He has confronted mental illness at a time of great responsiveness and impressionability, in his late adolescence. He brings insight into the horror of mental illness, and he brings a tremendous motivation to do something about it. And while he expects and hopes to help the patient, he remembers how much the patients have helped him develop into a more mature human being. He expects to continue these mutual experiences with his psychotic patients even as a therapist.

The volunteer, then, makes a unique contribution to the treatment of hospitalized psychotic patients. He is more than an emergency measure; he is a worthwhile contribution in his own right. And if he goes on to become a professional, his volunteer experience stamps his professional career with a fresh, strong feeling for the patient.