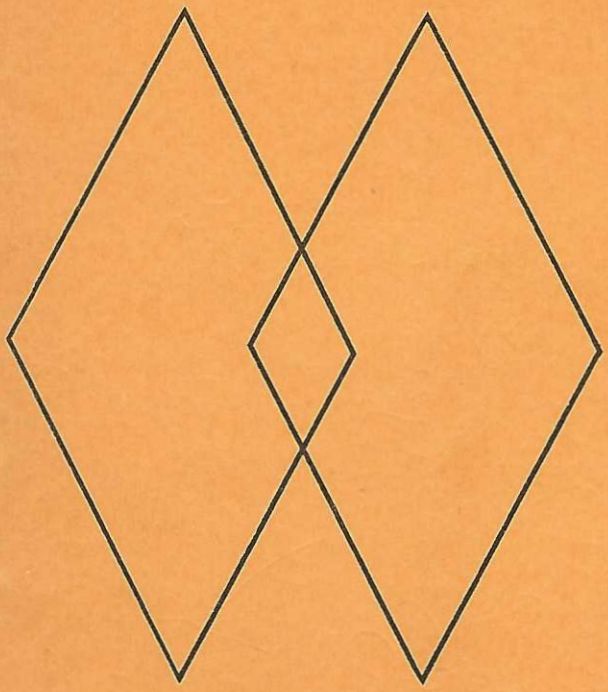
Dr. Breggin's 1962 chapter, pp. 20-27.

COLLEGE STUDENT
COMPANION
PROGRAM



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
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STRATFORD, CONNECTICUT

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INTRODUCTION

On February 26, 1958, the Connecticut State Hospital, (now named the Connecticut Valley Hospital) invited Milton Greenblatt, M.D., David Kantor and a group of Harvard students to describe the development of a special kind of program. A group of Harvard University and Radcliffe undergraduate students, with the collaboration of members of the professional staffs of the Boston Psychopathic Hospital (now named the Massachusetts Mental Health Center) and the Metropolitan State Hospital, Waltham, Massachusetts, had developed a program wherein college students visited the wards of mental hospitals and became companions to the patients. The account of the students, in particular, provided a moving emotional experience to the members of the audience. The enthusiastic response eventually culminated in action in the Fall of 1958 and led to the development of a vigorous College Student Companion Program at the Connecticut Valley Hospital.

Jules D. Holzberg, Ph.D., the Director of Psychological Services at the Connecticut Valley Hospital and visiting lecturer at Wesleyan University, offered undergraduate students in his course in Abnormal Psychology the opportunity to write a paper based upon "field work" at the hospital in lieu of writing the traditional term paper. Approximately 40 of his 50 students volunteered to go to the hospital and meet with patients assigned to them on a weekly basis.

The program has since grown so, that during the academic year 1961-1962 five universities in the State of Connecticut have contributed a total of 95 students who have served as companions to patients at the Connecticut Valley Hospital. As many as 14 professional staff at the hospital, including psychiatrists, psychologists, social workers, occupational therapists, and a chaplain have provided supervision to the students in the course of their experience as companions to patients.

As knowledge of the program at the Connecticut Valley Hospital spread, requests for information about it came to the Department of Mental Health from other state hospitals and also from correctional institutions and schools for the mentally retarded. To meet the press for information, a Planning Committee was formed to organize a conference which would convene representatives from various agencies and institutions as well as Connecticut colleges and universities in order to familiarize them with the various aspects of initiating and carrying out a college student companion program. A request for a Technical Assistance Project grant was submitted to the National Institute of Mental Health and was met with approval. The contents of this publication represent the addresses, student presentations, and summaries of workshops that took place at the conference.

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A WORD FROM NIMH

Connecticut Valley Hospital and Wesleyan University have conducted for several years a college student companion program which has proved of remarkable value to the patients and to the students. It is a companion program in that a given student visits a particular patient regularly and thus the ties of acquaintance can develop into mutual regard and friendship. Possible benefit to the patients seems obvious, for many of them would otherwise have no visitors at all. The substantial benefit to the students may be somewhat surprising. However, the Psychology Department of the University and the Psychological Laboratories of the Hospital have amply documented by test procedures significant gains in students who have participated as companions. The time, therefore, was right to communicate the features of this program to educational institutions not yet participating and to hospitals and other institutions for the mentally handicapped willing to receive the student companions.

This conference and its proceedings were supported by funds of the Research Utilization Branch of the National Institute of Mental Health precisely because of the opportunity indicated above. The aim of a conference supported by Technical Assistance Project funds is to communicate to a new group something that has been achieved and demonstrated by forerunners in a certain area of mental health.

We hope that those who read these proceedings will gain something of the inspiration that characterized the Conference itself.

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PROGRAM

WEDNESDAY, NOVEMBER 7, 1962

10:00 a.m. Registration
12:30 p.m. Lunch
2:00 p.m. Welcome
Wilfred Bloomberg, M.D.
Harry V. McNeill, Ph.D.
2:30 p.m. College Student Companion Program—An Overview
Milton Greenblatt, M.D.
3:30 p.m. Coffee Break
4:00 p.m. Small Group Discussion
6:00 p.m. Social Hour
7:00 p.m. Dinner
8:00 p.m. The Student Companion
Peter Breggin, M.D.

THURSDAY, NOVEMBER 8, 1962

8:00 a.m. Breakfast
9:00 a.m. Impact of Program On Patients and Institution
David Kantor, M.A.
10:00 a.m. Coffee Break
10:30 a.m. Small Group Discussion
12:30 p.m. Lunch
2:00 p.m. Impact of Program on Student and Campus
Jules D. Holzberg, Ph.D.
David McAllister, Ph.D.
3:30 p.m. Coffee Break
4:00 p.m. Small Group Discussion
6:00 p.m. Social Hour
7:00 p.m. Dinner
8:00 p.m. Student Presentation
William Beatty
Nicholas Childs
Janice Regolsky
David Rodgers
Kenneth Woodrow

FRIDAY, NOVEMBER 9, 1962

8:00 a.m. Breakfast
9:00 a.m. Implementation at Educational and Institutional Level
Austin C. Herschberger, Ph.D.
Peter Breggin, M.D.
General Questions and Answers
10:30 a.m. Coffee Break
11:00 a.m. Panel of Discussion Leaders
12:30 p.m. Lunch
Summation
Robert H. Knapp, Ph.D.

A ROLE FOR THE VOLUNTARY ORGANIZATIONS IN THE WORK OF MENTAL HEALTH INSTITUTIONS

MILTON GREENBLATT, M.D.

Our consideration of a role for voluntary non-medical organizations in the work of mental health is predicated on the following assumptions:

(1) That the emergence of the emotionally ill individual from sickness and darkness occurs optimally in a climate of therapeutic human interaction. The therapeutic qualities of human interaction are sympathy, kindness, tolerance, acceptance, warmth, steadfastness, and understanding. Therapeutic persons, in this sense, therefore, abound in nature and are not limited to those enrolled or graduated from schools for professional practice in the field of mental health, although admittedly professional training adds enormously to one's potential, especially in prolonged and intimate contact with patients.

(2) Mental hospitals, generally, in this country are impoverished, not only in terms of inadequate physical surroundings and poor socializing programs, but especially in terms of specific lack of intimate and consistent therapeutic human interaction.

(3) It is entirely consistent with American tradition of community responsibility for the less fortunate that voluntary organizations assist governmental agencies in a joint effort to treat the mentally ill and eventually to prevent emotional disturbance.

(4) The budgetary implications of trying to do the job adequately without voluntary community support are staggering. The states simply cannot afford such a gigantic burden to their fiscal structures.

(5) The authorities of a great many mental hospitals are now welcoming the help that volunteers can bring to patients and the hospital. They see that volunteers supply desperately needed personal services, provide a bridge to the community, and assure patients that the outside world has not forgotten them.

Thus it would appear that the road is open and the time ripe for voluntary organizations to join the effort. Furthermore, considerable initial progress has already been made—for example, in Massachusetts, since 1946 every hospital under the Department of Mental Health has developed a voluntary or auxiliary organization. Experience indicates that these may vary greatly in form and structure, depending on the hospital, its management, and local conditions. No simple prescription can be written for every condition, and we must experiment with an open mind; however, study of successful experiences from the field can teach us a great deal.

Let us begin with a case example, the example of growth and development of the student volunteer movement initiated by Harvard and Radcliffe in 1954 and since spread to Boston University, Massachusetts Institute of Technology, Simmons, Wheelock, Brandeis, Sargent, and other colleges. For many years, students have been visiting mental

hospitals in a perfunctory way in connection with courses in psychology or sociology and a few had given volunteer service, but there was never a strong, formal organization of student volunteers, nor did they come in large numbers until after 1954. Briefly, the history is as follows:

In 1953, the Massachusetts Mental Health Center, an intensive teaching and training hospital associated with Harvard Medical School, joined hands with the Metropolitan State Hospital, a large institution caring for many chronic patients, in the hope of improving patient care at Metropolitan through a pooling of resources and ideas. Some of the personnel at the Mental Health Center began to visit regularly at Metropolitan State Hospital, and in September 1954, the desperate needs of the Met became known to Harvard students, one of whom, Mr. Lawrence Dohan, became excited about the possibilities of recruiting students from Harvard and Radcliffe in order to make a serious attempt to help this state hospital. Mr. Dohan was an inspired young leader who went about his business with great energy and dispatch. He organized a huge rally in September 1954; hundreds of students attended this affair at which staff members of the mental hospitals delivered short talks outlining their needs. Following this, several hundred students signed up for work in the mental hospital; during the ensuing year some 500 college students were taken on visits to the Metropolitan State Hospital or Massachusetts Mental Health Center, of which 300 gave definitive service to the Metropolitan State Hospital. About 200 students came between 10 and 30 times to visit patients and carry out activities; and 9 colleges were involved. Most of the projects undertaken were unusually bold for volunteer activities, and some were probably unique in the annals of volunteering.

Volunteer Organization

The volunteer movement, once initiated, took hold of the imagination of the students and the program engendered enthusiasm, excitement and considerable creative effort. An organization became a necessity to avoid complications and to handle the vast number of activities. It is to the everlasting credit of the founders that they went about the work of integration like well-seasoned administrators. Soon after the first rally a chairman was named from each dormitory, and then charts were drawn up listing the subgroups and the day on which they worked at Met. Transportation was arranged for each subgroup by automobiles loaned by students. Each subgroup of 8 to 10 had a group leader who was responsible for the coordination of his group activities with that of the rest. He was called the Daily Unit Coordinator. He saw to it that everyone had transportation, access to the ward of his choice, and materials to work with. Group discussions were carried on either during the transportation to and from the institution or following an afternoon at the hospital, often with the participation and leadership of doctors, nurses and social workers. At larger meetings on occasional evenings, various groups that were visiting the same patients or wards met to discuss experiences, problems and ways of integrating mutual efforts.

New volunteers were recruited as enthusiasm spread. These were absorbed into existing projects or helped to initiate new ones. With

each new project a project leader was appointed who was charged with the task of maintaining rapport with hospital personnel in his particular area, and he was in touch as well with the Daily Unit Coordinators. The leaders of the larger projects were formed into an executive board which met every other week to discuss the shaping of general policy. This policy group was in communication with the administrative offices of the Metropolitan State Hospital, and on occasion members from this group were admitted to the executive committee proceedings of that hospital. Thus a volunteer organization, initially an informal and rather amorphous activity involving a trickle of students who were giving service in different hospitals, became a large and dynamic effort, concentrating its forces in one hospital with strong leadership and well-structured organization. The mental hospital volunteers soon became the largest single volunteer effort at Harvard, and won an important place in the structure of the Phillips Brooks House, a long-standing social service and community center for Harvard and Radcliffe undergraduates.

Student Volunteer Projects
At The Metropolitan State Hospital

The student volunteers engaged in a variety of projects including foreign language service, music programs, ward improvement projects of all types, sports, and so forth. Several large groups of students were brought to the hospital from time to time to stage shows or concerts. Hospital dances were given with a band, refreshments, door prizes, and hosts and hostesses supplied by the volunteer organization. Group singing, drawing and painting and many games were carried out. During warm weather, patients were taken out of doors on picnics, window shopping, to the zoo, et cetera. The women received cosmetics and beauty treatments. A vast amount of material was brought in, including books, magazines and newspapers, clothing of all descriptions and, in one big campaign, some 250 pairs of shoes. The physical environment was improved by the hanging of pictures or the placing of rugs, and some murals were painted with the active participation of both volunteers and patients. Throughout, volunteers were always ready to listen, advise and encourage.

Some of the most intensive work went on in two social case work groups led by a hospital social worker. Each of the students involved was assigned to one particular patient who had been recommended by the psychiatrist to social service for exploration of possibility of discharge. A volunteer was to help in bridging the gap between hospital and community in whatever sense this could be accomplished, i.e., finding a job, a pension, a rest home, or a life with a relative; and he would then continue the relationship for the remainder of the academic year. The student group could boast that many of the original patients were released from the hospital—a truly remarkable effort considering that all these patients were elderly, chronic, institutionalized people. For most of the students this was a unique experience. "I was shocked," one student thoughtfully stated, "at my own prejudices, and I now have a more healthy and less immature concept of the mental patient and the field of mental health." Each student has become more adequately and

accurately informed about the mental health professions, mental illness, and current preventive treatment and rehabilitative measures.

In many instances the "case-aid" and other experiences helped to crystallize the student's choice as regards future profession. Not a few decided to go into medicine, social work, psychology, or laboratory science, based on their mental hospital experience; and the social work schools, for example, recognize case-aid volunteer activity as a promising method of recruitment for much needed social workers.

Meaning of the Experience To Students

Some insight as to the impact of the experience upon volunteers may be understood from the following personal reports of some of the students.

"The volunteers are pioneers preparing patients who are neglected for the day when they will be aided by a state or national plan . . . what must be emphasized is that any little activity is important. These patients can be helped. If a beanbag has meaning, think of what art or cooking could do."

"The greatest improvement seemed to be taken by the emaciated creature who struck me and swore at me . . . a few weeks ago."

"The first time I went to G-3, there were about ten people in the whole bunch of 70 or 80 on whom you could make an impression. The rest were withdrawn. As time went on, the number who didn't participate went down considerably. More patients talked. At the end the ratio went the other way."

"I think that some of the patients are happier simply for having people to talk to."

"My feeling is that most of the good we are doing is making their lives more pleasant . . . for the most part we are just making them happier while we are there. We can't cure them, at least not in any short time, but I feel the work is worthwhile just to make their lives more pleasant."

"Practically speaking from the economic viewpoint, on any issue for a vote on state hospitals we would all realize how under-financed they are, how much more they need money than a lot of causes that are getting it."

"If there were to be mental illness in my family today, I would be less ashamed, more open, more natural."

"Mental hospitals are not snake pits. At the same time they don't have a cure for everyone. They do the best with what they have."

"I saw the picture, 'Snake Pit,' and thought that things could never be that bad, but they are."

"Before I started I had certain conceptions. I imagined the patients flying around and violent. The first time I went to the hospital, I asked when we would go to the violent ward and was told we had

already been there. I had heard that you couldn't trust the patients. I realize what they're really like. They just sit around and have nothing to do. They're just people afraid of things, disturbed in the mind."

"You come to realize that a mentally disturbed person is a real person. Mental illness is just like any other illness science will want to conquer."

Perhaps the greatest contribution of volunteers is the feeling that they have imparted both to patients and personnel that the community in general cares about the mentally ill.

Reasons for Volunteering

In general it was felt that student motivation was complex, stemming perhaps primarily from intellectual and emotional curiosity and, secondarily, from an "altruistic" desire to help others. The willingness to learn and to understand is often in itself therapeutic, and there may be rich gratification to those who are seeking to study human behavior, for the mental hospital is a strange and wonderful place. "Altruism" or a "do-good" drive may be suspect, for often motivation of this type peters out, especially when patient improvement does not come up to original expectations held by the student. I will not dwell here on deeper unconscious meanings; however, the motive for volunteering may also be in part an effort to find in the hospital experience a solution through vicarious means of their own personal conflicts. This can be entirely sound and mature; the same needs may determine professional choices of any of us and, in fact, play a commanding role in our pattern of life activities.

Problems of Volunteers

As in all important human endeavors, there are problems as well as rewards. It is clear from careful study of student volunteers (carried out by Maeda Jurkowitz[1]) that they frequently encountered feelings of indifference or even revulsion towards patients whose behavior or appearance was not consistent with their code. There may also be physical fatigue from the strain and excitement of the new work, from fear and anxiety about developing relationships with sick people.

After the initial phases of enthusiasm, there may be a feeling of inadequacy that they have not had sufficient training for work in mental health, or there may be pessimistic reaction when patients either do not progress as fast as desired, or when a patient progresses to a point and then relapses. This can lead to guilty feelings and concern about one's own contribution to the relapse in question.

In many instances, the volunteers desired to be with patients far more than was possible due to their busy schedules, and once a feeling of compassionate interest was aroused they had trouble controlling a wish to give ever more. Again and again in reports of volunteers they express

[1]Jurkowitz, Maeda. "College Volunteers in a State Mental Hospital." Senior Thesis submitted to Social Relations Department, Radcliffe College, 1956.

the need to meet more often with staff members to discuss their own feelings in relation to their work, as well as to understand patient behavior better. This suggestion is a highly sound one and, in general, we feel that any workers who come in contact with patients in a continuing relationship should have the support, encouragement and analytical help of a more experienced person, preferably a professional. Group discussion among volunteers alone may be highly successful in allaying tensions, and merely the sharing of experiences of success or failure may give security; but group meetings with a sensitive, professional leader make the most profound impression and give most meaning to the volunteer experience.

In addition to the inner emotional problems of the volunteer, there are also stresses when volunteers attempt to integrate their work with that of ward personnel. A basic gulf may separate students from attendants in many instances. There is a difference in background and training, the attendant coming usually from a lower economic stratum than the volunteer. There is also a difference in comparative age, intelligence and ambition. Because it is their job to feed, clothe and protect scores of patients on a twenty-four hour basis, the attendants have a special view of patients. Attendants depend on their job for a living; volunteers, on the other hand, can quit any time without losing anything. They come as the spirit moves them, out of interest, curiosity or altruism, but not need for money. Volunteers often have more time to spend with patients than do attendants, thus develop identification and strong empathy for them as individuals. We find, for example, that when the question was put, "What do patients need most?" attendants reply in terms of their need for new furniture, better food, et cetera. Few mention acceptance, love or affection. Volunteers, on the other hand, asked the same question, emphasized the spiritual and emotional needs of patients.

Apart from the student's own emotional response and the problem of integrating his services with the hospital activities and staff, there is the problem of the effect of his experience on his school and family.

So far as the school is concerned, we sometimes find the volunteer program taking an unusual proportion of the student's time and interest. Often the volunteer brought back stories of the interest and excitement of the mental hospital that reverberated throughout the university and led to spirited discussions in many groups. (There is even the story of the professor who said, "It is just a myth that patients say they are Napoleon." A student objected in no uncertain terms, saying that his patient in the state hospital claimed to be Napoleon.) The case-aid experience was so enriching that the students on their own volition succeeded in getting an accredited course on volunteering established in the university, instructed by a professor of social relations and a social worker.

How the family took the volunteer program is not too well known. Many of the students, when asked about this, said, "Well, we simply haven't told our families." "My parents think I'm mildly nuts but they let me go ahead." There was one instance at least where the parents thought it was the height of madness for their daughter to be so inter-

ested in mental hospital patients and threatened to cut her off from graduate school training if she persisted. We hope in the near future to get a systematic study of the impact of the volunteer program on the family group.

Can Volunteers Work on Intensive Relationships With Individual Cases

Thus far we have referred to volunteers as participants in social group activities or as case-aids, the latter under the direction primarily of a social worker. However, I can quote a remarkable instance of intensive individual work by a young senior at Harvard with a 61-year-old woman who had been continuously hospitalized for 25 years. The results were truly extraordinary, and I would like to review them with you for a moment. An occupational therapy worker who had known this woman for 15 years and always liked her, wondered whether a student might help her; it was arranged for Student B. to see her regularly, under the supervision of Dr. N. I quote from the report of the student:

"Originally I saw her once a week for two hours. It was too intense in the beginning. She spoke in psychotic jargon and was very anxious. I listened very hard. I believed she wanted to say something. I would make an intuitive interpretation. Certain times you would see her relax and I would know I had made a right interpretation. I began to take her into town with me in my car. At first she was very disoriented. I would introduce her to new situations. I would bring her back to reading, teach her the use of money, show her how to shop, how to dial a telephone.

"I felt I was like a son and like a romantic figure to her. There was probably a physical attraction in the beginning despite the great disparity of ages. She wanted to touch me and was very anxious about it. I checked with Dr. N. who said, 'Bring it up with her, have her verbalize.' Soon she expressed her anxiety by being violent in a hospital baseball game. They put her on a disturbed ward. I didn't like the idea. I visited her there and took her off the ward. I told her then, 'I know you want to touch me.' She was suddenly rational, 'Yes, that's how I feel,' she said.

"I was completely honest with her all the time and she established trust in me. In town she would try to cover up and put on a good show. She became more and more rational.

"About January of this year after a year and a half of visiting and working with her, I found an opening for her in Goodwill Industries. She can sew; that was the one thing she did in the hospital and it worked well. At the beginning she started commuting every day from the hospital. She was anxious, afraid, but I always supported her.

"She has been working there since January and is trying to get a raise. She doesn't socialize at all. They like her because she sits down right away and works. She has begun to live out of the hospital in a rooming house. She's a pretty lonely woman without a family."

The student has been admitted to a medical school out West and has been very concerned about the break in his relationship with the patient.

"I have been cousulting with Dr. N. about this and she suggested the Boston Evening Clinic group therapy one evening a week and facing the situation openly with her. I told her I'm leaving, that I'm sorry I'm leaving, that she's sorry I'm leaving. She's getting started in the clinic before I go. I am optimistic about her weathering this because when I took her to the clinic last week she willingly went in and I waited in the car outside. If group therapy is only a sad substitute for a close relationship, perhaps I can get another student to take my place. However, I am hoping she will accept the group as something I asked her to accept. I will write to her regularly every month so that she can count on hearing from me. Unfortunately, my home is in the West near my medical school. I don't know when I can return East to see her personally."

This instance is truly extraordinary because of the long hospitalization of the patient—25 years—because of the unusual sensitivity and understanding of the student (who comes from a medical family), and because of the unusual success achieved. The patient is not entirely well but, to a striking degree, rehabilitated. Perhaps with patients sick over 25 years this is sufficient success. The careful arrangements that have to be made with patients to tide them over a break in an important relationship are highlighted in this case. They need all the attention and understanding that you and I would need if the only meaningful person in our lives were suddenly forced to move away.

At this point I have a confession to make; namely, that what I have just read to you was written some five years ago at the beginning of the volunteer project development. Yet I find very few words have to be changed as a result of our experience. The pattern that the students set at the beginning has continued strong and undiminished; however, during the five years new ground has been won and new projects attempted. Enthusiasm has continued at a high level, maintained by yearly self-renewal through the acquisition of new undergraduates.

During the interim period, the student volunteer program has spread widely, so that some 50 to 75 new ones have burst on the scene from one end of the country to the other. There is much less fear now that students will cause difficulties to themselves or to patients in this nonprofessional friendship therapy that they provide. Dissatisfactions and criticisms have died down; in fact, many are now talking about a spread of the movement to high school students, and a few such programs have, in fact, commenced.

As the program has settled in, a great deal of attention has been attracted with assistance from all sources. A series of National Institutes of Health and private foundation grants have supported the program and provided for research. Numerous articles and a book have come forth from the study—a book which I hope will be utilized as a basic handbook in the field.[2]

A yearly living-in program by the students has been undertaken, and a unique halfway house for students and patients living together has been developed, supported by the University, the Office of Vocational

[2]Umberger, et al., "College Students in a Mental Hospital," Grune and Stratton, New York, 1962.

Rehabilitation, the State Department of Mental Health, and private foundations.

Finally, the whole motif of citizen participation has received a new dimension of significance. Students in universities are committed to the mental health program, and the general feeling is that if students can do it, who can claim exemption from the responsibilities of helping the mentally ill. The university-hospital relationship has been good for the university, too, helping to remove any shadow of cloistered life that surrounds the university. Finally, this kind of initiative and successful programming, stemming primarily from the community itself, is a long step towards that which we all want—a therapeutic society.

Discussion of Doctor Greenblatt's Address

Following his address, Doctor Greenblatt was asked to comment upon the issue of confidentiality and availability of patients' records to the student volunteers. Doctor Greenblatt observed that students seemed rarely to be interested in the medical records, although access to records was generally not denied. The students recognized the importance of confidentiality and with this, as in other matters involving hospital mores, they "quickly fall into the right ways of behavior."

Doctor Greenblatt pointed out that problems arise related to the student status of the student volunteers. "I have seen occasions where students, especially leaders who put in an impressive amount of work with patients, fail to give as much to their studies as they should or is expected of them. I have seen instances of 'volunteer fatigue' and headaches resulting from feelings of guilt about wanting to quit and problems like that."

The question was raised, how the volunteer activities fit into the broader program of therapy for the patients, particularly where the patient was involved in a psychotherapeutic relationship. In the ensuing discussion, allusions were made to the significance to the patient of a relationship which offered attention, understanding, and acceptance but at the same time was not based upon remuneration. Doctor Peter Breggin stated:

> "We have to understand who these students are and what they are as a category. College students are for the most part in their late adolescence. In this alone they differ from the professional person. Their structural and social habits are different. They are looking for something very special. There are certain characteristics of this age which we have to recognize and distinguish them thereby from the senior volunteers. The late adolescent is not the middle-aged or the young adult. They may be motivated by different needs and have different reasons for volunteering in the hospital. I think, to the extent that we understand these characteristics, the way we satisfy some of these particular needs will effect the success of a volunteer program.
>
> "The college students are in the business of being educated. They know this quite well. This is not true of some of our senior citizens. This influences the way they use the hospital environment. Take the

records for example; it is very important to these college students to read records. They are not reading these records as curiosities; they are looking at these records because they are studying. They orient to these patients in a way that implies that they are beings to be understood. At the same time, and this is characteristic of the adolescent, they have a humanistic ideal, a fervor. I think that it is in this latter respect that the choice of patient becomes very important. The student is working with the impossible. He is overcoming great odds and he is doing something functional. The moral indignation that we all recognize is really quite functional. It is because of these considerations that it is very important for the college student to work with the chronic patient, not with the patient who also can be helped by the psychiatrist."

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 idiocyncratic 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 impressionablility, 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.

IMPACT OF COLLEGE STUDENTS ON CHRONIC MENTAL PATIENTS AND ON THE ORGANIZATION OF THE MENTAL HOSPITAL

DAVID KANTOR, M.A.

The general phenomenon with which this paper is concerned is the increasing use of unpaid college volunteers and their impact on psychiatric patients and mental hospitals.

Within the last fifteen years, volunteer programs—many originating in community groups and others in hospitals and other health installations—have become increasingly important in the continuous services given psychiatric patients.[1] The college student volunteer program, as indicated in a recent survey,[2] is an even newer and more rapidly spreading phenomenon. It has been my privilege to watch and the responsibility to investigate[3] the development of one of these college programs, the Harvard and Radcliffe mental hospital committee of Phillips Brooks House, Harvard University.

Since 1953, undergraduates of Harvard and Radcliffe colleges have been carrying on a comprehensive program of therapeutic activities, largely of their own design, with chronic patients at the Metropolitan State Hospital in Waltham, Massachusetts. This program deserves high praise for the grandeur of what was and is being attempted, for the enthusiasm and intensity of student purpose, and for the high degree of self-sufficiency and autonomy with which they have proved themselves to be most able workers and ingenious innovators. Putting aside the temptation, I shall try, however, not only to praise them for what they do accomplish, but to present some useful framework for understanding what they do not accomplish and why they do not.

Design and management of the student organization itself—matters, as I have noted, that are almost entirely in student hands—have been described elsewhere.[4] Here it is only necessary to say that the P.B.H. program is a skillfully conceived, well-organized, usually smooth-running affair, concerning itself with all aspects of organization perpetuity, recruitment and training, transportation, financing, planning and execution of services, collection and distribution of public relations materials, liaison with hospital and university, and development of new frontiers.

Essentially, these students operate in three separate areas of work, each of which brings students and patients together under fundamentally different conditions. The first consists of ward projects where students work with regressed or apathetic patients, some of the most disturbed

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[1] "The Volunteer and the Psychiatric Patient," published by the American Psychiatric Association, Washington, 1959.

[2] "Survey of College Volunteer Programs" mimeo, unpublished, 1961; on file at offices of PHSG #OM-233.

[3] As former Project Director of NIMH Grant #OM-233, "Study of Student Volunteers in a State Mental Hospital"; and as present Director of OVR Grant #RD-713, "Investigation of a Student-Patient Halfway House."

[4] See Greenblatt, Milton, and Kantor, David, "Student Volunteer Movement and the Manpower Shortage," *The American Journal of Psychiatry*, Vol. 118, No. 9, March, 1962.

to be found in the hospital. Then there are the case-aid projects which bring students and patients together in a sustained and intensive two-party relationship. The third work area is Wellmet, the half-way house for patients in transition between the Metropolitan State Hospital's chronic wards and the outside community. Here students live under the same roof with patients in a cooperative arrangement where they live, play, and work together.

This comprehensive program of service, largely conceived and initiated by untrained college students, is planned to intervene at three stages:

first, in the ward setting,

> where patients' needs are most primitive and basic, and where the goal is minimal—increased social interaction and more meaningful social behavior;

second, in the individual case-aid relationship,

> more demanding for both student and patient, where the goal is more complex—to ready individuals for community living; and

third, in a family-like setting in the community,

> where ex-patients are directly helped to take on the attributes and to perform successfully in productive citizen roles.

Students in the P.B.H. program are concerned with three different patients groups. Our efforts to give a scientifically sound and complete answer to the question, "Does the student program have a measurable impact on patients?", have moved at an uneven pace with each of these patient groups.

This report, following progress being made in our analysis, will concentrate on the impact of students on chronic patients and the chronic ward. First, however, let me briefly summarize volunteer impact on case-aid and halfway house patients.

The general results of the case-aid program indicate that of 55 chronic patients who had been hospitalized for at least 5 consecutive years since previous admission, and who were considered by the staff to be unsuitable for early release from the hospital, or for assignment to regular psychiatric or social service, 20% were sufficiently benefitted by the case-aid program to leave the hospital. The full evaluation story, would, of course, have to compare these results with the fate of a comparable sample of patients un-exposed to volunteers; and readmission figures would have to be compiled and compared. These research procedures are in process. Also being investigated, however, is the clinical improvement achieved in many of the exposed patients who have not left, and the benefits that may accrue from the devoted friendship of a young enthusiastic person representing the outside community and working for the patient without thought of monetary recompense.

As of this writing, twelve chronic patients have been admitted to Wellmet. Diagnostically, the patients selected for residence were predominately schizophrenic. Six of the twelve were males; six, females. The average length of hospitalization was twelve years, and the average

age on admission to Wellmet was over forty-five. Prognostically, these patients as a group were considered poor bets for social survival in a community facility, and, inferentially, even poorer bets to satisfactorily maintain themselves independently in a work or other productive role. Six of these patients have graduated to the community—five of them have gone into work situations, and one has resumed the responsibility for a large family. One of the six has had to return to Wellmet, rehospitalization being averted. Two of the twelve patients were readmitted to the hospital, and the remaining four are in various stages of rehabilitation. Considering the type of patient served, these figures appear very promising.

Even more promising, from the research standpoint, is the opportunity afforded for studying a unique therapeutic social system in action. Wellmet is conceived by the research team as a social system designed to get patients to relinquish the chronic patient role and the behavior appropriate to that role. The family is the institutional model, and the household the medium presumed to effect patient resocialization into "normal" roles. Students and other non-patient residents are thought to comprise a reference group which defines the standards and expectations accompanying the new role requirements. The house system provides the social opportunities necessary for relearning skills and social behavior that are part of the new role. In this type of conception, the students constitute the crucial aspect of the social environment. To illustrate, it is difficult for me to conceive of any social category—other than that of the college student—with the role freedom and flexibility, to say nothing of the motivation, to take up residence with former mental patients.

For palpable evidence of the student volunteer impact on the institution, one need go no further than the historical emergence and social acceptance of Wellmet. Consider the degree of legitimation of student volunteering that is involved in the administrative decision made in 1960 to approve the plan for this unusual facility. In 1954, the baseline year from which change should be measured, administrative and clinical personnel of the Hospital—who have always given the program formal backing—still feared that harm might come to patients or students unless student case-aid activities were carefully defined, limited, and supervised. Some staff were frankly skeptical of the then radical idea of allowing regular individual contacts between students and patients in the case-aid program. At the cooperative halfway house, the amount of responsibility held by students and the amount of confidence placed in them by hospital staff, obviously has been increased many times.

The very existence of Wellmet, then, is manifest evidence of student volunteer impact on the hospital's organizational structure; and the administrative approbation of the Wellmet plan is expressive testimony of important attitudinal changes among hospital personnel.

Our records abound with examples of changes having taken place within the hospital itself—changes in attitudes, procedures, practices, and the like. Here are some specific illustrations.

In 1953-54, a group of strangers passing through closed wards at Metropolitan State Hospital not infrequently triggered restlessness or

rank agitation in patients or evoked from some patient the hostile imputation that the tourists were there to see the "monkeys in the zoo." Today most patients accept the increased human traffic as a natural feature of their particular environment; and many patients anticipate the students' presence as a significant social opportunity, flowing from respect and esteem rather than contempt and disrespect.

Only a few years ago, male attendants insisted that girl volunteers not work on male wards unaccompanied by male students; and, whereas chivalry has not expired altogether in the P.B.H. program, the attendants' attitudes toward patients that prompted this and many similar program inhibitions (e.g., fears about mixing male and female patients from closed wards during social events planned by students, fears about letting patients leave the hospital grounds with students) have proved unwarranted.

Now I am not suggesting that students find volunteering uneventful and without incident, or that all cautionary advice is a figment of some attendant's imagination. For, occasionally a male patient will expose himself while female volunteers are in the ward; and occasionally a disturbed patient may express his or her panic through motoric excitement or verbal assault. Not unexpectedly, however, as you well know, such incidents are, in the first place, extremely rare; and, in the second place, as the environment raises its expectations of patients, the patients respond with higher social performance.

The impact which students have had on one ward at the Hospital illustrates how even very sick patients can utilize social opportunities and higher expectations presented by the students and ward personnel.

As I have mentioned, volunteers at the hospital have traditionally devoted their time to chronic wards, that is, to understaffed "closed" wards in the continuous treatment service. During the first six years of the program's operation, the ward that attracted them the most had the erstwhile appellation "female violent ward," a designation which lost some but not all of its meaning since the advent of tranquilizing drugs. The affinity that developed between students and these noisy and overactive patients seemed to sympathetic observers to yield much, as patient and staff morale perked up, the physical appearance of the ward changed materially, and embellishments such as books, pets, flowers, a mirror, and other items usually withheld from "disturbed" patients were added to the ward, largely under student instigation.

Some observers wisely pointed out that other influences—the drugs, changes in institutional policy, a singularly adroit and devoted attendant —invalidated the right to attribute only to the students the observed improvement in patients and the ward. There was a general clinical consensus, however, that important change had taken place in the ward and that a fair number of patients had consented to the social encounters provided by the students.

In order to test under more rigorous conditions the actual impact of volunteers on patients and their ward environment, two research procedures were simultaneously launched in November, 1959; a controlled

study of the effects of the P.B.H. volunteer program on a group of chronic psychotic patients, and an analysis of the social system of the wards in which the study patients resided. Both of these studies were based upon the conceptualization of the chronic ward and patient as forming a system in which insulation from outside influences, including the larger hospital structure, is preventing therapeutic change from taking place. It was hypothesized that the introduction of an external agent, the volunteer, would break into the pattern of insulation of the ward and the patient and induce changes in both.

Experimental Study

In the experimental study, two chronic wards were selected, one on which the patients were exposed to volunteers and one which served as a control ward. Both wards were closed wards with relatively unchanging populations which had received minimal attention from professional staff and virtually no attention from student volunteers. Prior to the study, patients were transferred between wards in an attempt to start the study with two groups of patients of comparable age (a mean age of about 50 years), diagnosis (predominantly schizophrenic), length of hospitalization (a mean of 19 years), a number of admissions (very few had more than two), and average length of time in hospital since last admission (nearly 19 years). In short, the statistics denote two groups of severely disturbed and withdrawn middle-aged schizophrenic men with a history of continuous hospitalization embracing most of their adult lives.

For a period of 7 months, groups of about 7 students carried out the ward work program in the experimental ward four afternoons a week, each for a period of about two and one-half hours. Using standardized instruments, interview, and observation data, measures of social behavior, psychological functioning, basic adaptational modes, and frequencies of verbal interactions were obtained before, during, and after the experimental period.

In the interest of time I shall not discuss the methods of procedure used in the various portions of the study. The general statements below give some idea of the kind and direction of results obtained.

The Lorr Scale—a standardized instrument for measuring observable social behavior and common symptoms of functional psychosis—was administered by an independent psychiatrist. Analysis of these data, with a revised method of scoring which analyzed separately social and psychological scales, showed:

(1) that there was a significant improvement in the social scales of experimental patients (P less than .01, one-tailed) but no change for rated social pathology of the control patients.

(2) that the amount of psychological pathology did not change significantly in experimental ward patients, and on the control ward there was a significant increase in rated intrapersonal pathology (P less than .02, two-tailed).

(3) that in the experimental ward, improvement tended to be associated with how often the patient does what is expected of him without special urging, how clean he is, and how much interest he shows in his environment (in television, radio, and talk about ward happenings, for example). On the control ward the significant worsening in psychopathology was not associated with change in any particular behavior.

(4) that in the experimental ward there was a significant improvement in over-all morbidity (i.e., in a global sickness-health score) over the experimental period; and there was a significant increase in over-all morbidity among the control patients.[5]

Patients also were administered "The Social Behavior Scale,"[6] a scale developed by the project for use with severely disturbed psychotic patients, first, to assess awareness of and interest in opportunities for social participation which exist in the hospital environment (e.g., dances, movies, work, friends, visitors); and, second, to assess the patients' level of social response to an interviewer. Results of this portion of the study indicate:

(5) that following exposure to volunteers, experimental ward patients showed a significant increase in measured social behavior (P less than .01, one-tailed). The control ward patients showed no change.

Behavior change, as measured by the Lorr and Social Behavior Scales can be summarized more descriptively as follows:

(6) Regarding psychological pathology: in Ward E, 21 of 29 patients scored the same or better; in Ward C, 10 of 27 scored the same or better.

Regarding social pathology: in Ward E, 24 of 29 patients scored the same or better; in Ward C, 13 of 27 were the same or better.

Regarding social interest (as measured by the Social Behavior Scale): in Ward E, 20 of 29 scored the same or better; in Ward C, 14 of 28 scored the same or better.

These results tend to confirm our hypothesis which predicted that patients exposed to volunteers would show improvement in social interest and competence and less, if any, change in more strictly psychological functioning.

I hope I have emphasized enough the fact that both groups of patients were severely disturbed to begin with, and that although the experimental ward patients showed significant improvement they *and* the control ward patients were still operating at a low level of socialization.

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[5]The result is not offered as a test of the hypothesis of the study being reported because of scale construction features which make the scale more suitable for diagnostic purposes than for a time change study, unless the recommended method of scoring the scale is revised. Results above numbered 1-3 are based on analysis using a revised scoring method. Result 4, which is not, is given for the sake of other studies in which the Lorr Scale has been used to study change in patient samples.

[6]Beck, Kantor, Gelineau, "A Standardized Scale for Measuring Minimal Social Behavior."

In another portion of the study, which I can only briefly touch on here, a typology of modes of adaptation to the chronic ward—more or less basic patterns of response found within the ward social structure—was developed and used to rate patients. It was established that volunteers did not materially effect patients' basic modes of adaptation.

In still another part of the study, the nature and rates of verbal communications in the experimental ward were investigated before, during, and after volunteer exposure. It was found that these patients verbally interact at an inordinately low rate, and that the attendant is more active verbally than all patients combined. It was found, further, that frequencies and rates of verbal interaction did not increase in periods when volunteers were not active in the ward; and that when they were active, increase in interactions among patients not directly involved with volunteers was negligible.

On the other hand, there was no question: that patients looked forward to volunteers; that they became motivated to engaged in many interactions with the volunteers; and, further, there were indications that coincident with the general period of exposure to volunteers, the ward communication system, which previously was found to be stable and bounded, showed some change trends away from duty interactions ("Where is the broom?") and toward social-emotional communications ("How are you?" or "Go away!"); and, interestingly, that shifts in the trend lines appear to be associated in time with student program events.

All of the above results are interesting, I think you will agree, not because they clearly show what college volunteering can do, but because they point out with equal clarity what it does not do, at least with the type of patient I have described. I should like to turn next to our study at the patients' wards—the second research procedure mentioned earlier—it is useful now in that it may help to elaborate a framework for understanding what in the social system of the chronic ward may influence what change does and does not take place in patients.

Study of the Social System

When a patient gets to a chronic ward, it may be postulated that a triadic arrangement of interlocking contingencies is affecting his fate. The first type of contingency refers to the psycho-biologic processes which to an unknown degree but in a determinate way effect the course of the disorder, more or less independent of external influence. A second set of contingencies is represented in the patient's extra-hospital social and interpersonal environment that act for or against his return to civilian status, independent, to a degree, of the natural status or course of the illness. A third set of contingencies prevail in the social organization of the mental hospital and the social structure of the psychiatric ward.

From a qualitative analysis of empirical data gathered for two years on the two study wards, it was possible to identify five social processes through which the chronic ward social system functions and achieves its custodial aims of efficient maintenance and control. These five social processes are:

1. *Degradation Rituals*—recurring, patterned behaviors on the part of attendants which tend to humiliate patients and to emphasize the low esteem in which they were held.
2. *Status Differentiating and Social Distancing Mechanisms*—patterned behaviors on the part of personnel which emphasize and maintain a rigid status hierarchy in which the status of patient approaches that of a caste member.
3. *Rigid Social Controls*—recurring behaviors by personnel in support of a system of elaborate social controls backed up by a system of rewards and punishments and an absolute power of authority over patients.
4. *Insulation from the Demands of Other Institutional Systems*—patterned institutional behaviors whose function is to mediate between patients and other institutional systems (e.g., the family, the economy, the medico-psychiatric and therapeutic aspects of the hospital, representatives of the larger community, volunteers, for instance); the mechanism functions to make it unnecessary or impossible for the patient to respond to and meet demands that might be made upon him by these other structures and role systems.
5. *Role Set Constriction*—a further accentuation of the process of insulation from institutional demands that begins in the larger hospital setting, which in the ward, consists of a reduction of the patient's role set to a constellation of two sole partners—other patients and the attendants, and, to a much reduced degree, the physicians.

It was reasonable to assume, on theoretical grounds, that for the chronic ward system to work as well as it does social mechanisms that keep the system going are reciprocally integrated with psychological mechanisms that keep the personality systems of chronic patients going. We sought to and I think succeeded in, demonstrating that particular social mechanisms interact and become locked or integrated with particular psychological processes which theoretically and empirically could be shown to be operating in the personality system of typical chronic schizophrenic patients. These psychological processes are: Identity and Esteem Injury; Interpersonal Anxiety; Withdrawal and Insulation; Psychic Disorganization; and Role and Status Renunciation.

In the light cast by this conceptualization, such behaviors as the physician's abrogation of responsibility for chronic patients, the patient's regressive dependency and excessive withdrawal, and the attendant's impersonal handling of patients are institutionally relevant behaviors that are functional in some ways for the maintenance of the custodial system. The specific social processes which we identified, moreover, may be functionally integrative both for the custodial system and for the insularity-seeking aims of individual psychotics; but simultaneously they may be dysfunctional for the health-producing aims of the institution as a whole and for whatever health-seeking aspirations survive in individual psychotics. In short, the chronic ward may be what we have called a case of functional reciprocation, where equilibrium is maintained be-

tween the chronic ward social order, which must emphasize control and isolation, and a group of individuals seeking insularity and control as a way of coping with stress, and finding it in the organization of the chronic ward.

Our analysis of the ward system furnished us a specific framework for analyzing the volunteer mode of intervention and of evaluating its impact on the ward. Generally speaking, for change to take place, the mode of intervention would have to confront and counteract either the social processes in the ward or the personality processes in patients, or both; it would have to overcome systemic resistances to change, resistances in the social as well as the personality systems; it would, most importantly, have to break up or unlock the reciprocally sustaining integrations between the chronic ward social order and chronic schizophrenic patients.

We currently are applying this analytic frame of reference to a large body of qualitative data, in order to determine actual effects of the volunteers on the ward system. Since the analysis is just getting under way, I cannot make definitive statements about volunteer impact; nor can I convey either the detail or richness of the data. I can only hint, through an illustration or two, at how the volunteer program may be intervening into ward system integrations.

Probably the notion of functional reciprocation is nowhere more apparent than in the interaction of the insularity-seeking processes characteristic of the schizophrenic and the two insulating mechanisms that were found to operate in the social system of the chronic ward.

Motivated by the desire to put off anxiety generated by social experiences the schizophrenic withdraws and insulates himself. According to most functional theorists, he cuts off communications and avoids social reciprocation because he perceives anything coming from the outside as hostile and unpleasant. The insulation from institutional demands, which the system provokes, facilitates and encourages patient insularity by removing responsibility for meeting any outside demands. Demands for performances, involvements, and allegiances with all societal institutions are mediated and many of them eliminated so that they cease to impinge upon the patient's privatized adjustment. Role constriction processed further facilitates patient withdrawal and insularity by reducing the role set to two role partners, one of whom, other patients, are also seeking insularity, and the other, attendants, who reinforce this insularity by the patterned expectation of subhuman performance from patients, by defining his as "out," and by direct rewards for the proper kind of withdrawal.

Well then, what are the volunteers' chances of breaking into this structural bind in which inaction on the part of patients is functional for both of them and the system and helps to keep the whole in equilibrium? Let us look at the data.

During the period of study, volunteers, who presumably had not intruded on the study wards, became a problem to attendants. In our terms, ward system stability was maintained partly because patients did not have role partners differentially located in the structure. Such role

partners introduce moral and value expectations of the patient which conflict with those of the attendant and the custodial system. Constriction of the status and role set of the patients thus helps to maintain ward system stability, while extension of the role set to include the volunteers made for instability.

The attendants interpreted the role of the volunteer in just this way. Having no real choice in the matter of student presence in the ward, the prevailing attitude was, "When the study is over perhaps they'll return to other wards." While volunteers were present in the study wards, one of the two day shift attendants was markedly negative, the second, the charge-attendant, vacilated; although skeptical, he liked the students, and felt they could help him introduce ward changes he always had in mind but somehow never actuated.

The following account of the charge-attendant's vacilation illustrates the way in which the ward system dealt with the volunteers and with an administrative decision to permit outside institutional demands to influence the stabilized affairs of the ward.

> By January, 1960, volunteers had been visiting the ward for more than two months. They and their professional supervisors had succeeded in getting a lot of cooperation, support, and allegiance from the charge-attendant who welcomed the chance to have something done for his patients. Two months later he was uncooperative, and occasionally hostile, but mostly indifferent to the volunteers and their activities. How come this disenchantment?
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> Ward observations document that a sequence of events took place which fit a definite pattern: pressure was brought to bear to bring about a re-alignment of institutional allegiances. The second attendant on the ward began a persistent stream of complaints to his senior. "They," the volunteers, were causing more trouble than they were worth; they weren't helping patients, nor were they interested in the right ones; they served mainly to upset ward "routines"; they left the ward dirty; they didn't care about ward schedules; and they just wouldn't understand why some patients had to be declared unfit to leave the ward, even under volunteer supervision. Attendants from other wards, when they visited, began to criticize the appearance of the ward, "the lowered housekeeping standards," and the unrest volunteers caused in some patients. This pattern of pressure amounted to a campaign of subtle criticisms and intimidations intended no doubt to bring the charge-attendant back in line.
>
> The volunteers and the professional workers apparently had succeeded too well in getting his allegiance, thereby splitting the value consensus of the ward system. The extra-institutional demands made by an outside organization in this instance had to be mediated by other attendants as one of their number had been co-opted.
>
> That the charge-attendant once more conformed is evidenced by the subsequent course of events. Late in February, he called a meeting with the volunteer supervisors in which he presented a list of complaints about the volunteers and their activities. He expressed

doubt about the good they were doing. And he introduced a set of new regulations and the apparent purpose of which was to restrict the volunteer freedom with patients and their effectiveness, and to regulate the impact of their demands upon the equilibrium of the ward system.

As the above illustration shows, disharmony in the ward's normative system is virtually inevitably introduced by students. By regularly visiting the wards, under administrative sanction, students automatically extend the patients' role set. As such, they put demands upon the patients which are incompatible with the demands put upon them by the attendants. Students tend to orient and respond to the patients' healthy behavior and to view patients in humanistic and equalitarian terms. They put pressure on patients to become active, to make demands upon their environment, to use its opportunities; and attendants require and reward a patient's compliance with minimal expectations, and quiescent behavior. Conflict is generated in the patient which can be resolved in one of two general ways: it can lead to deviation from the institutionalized norms, or at least to compromise; or it can lead to further entrenchment into the chronic patient role, accompanied of course by behavioral conformity to the institutionally specified role requirements.

Thus, students and attendants engage in a struggle over the patient's role performance. It is our perhaps too lofty hope eventually to be able to identify some of the factors in the patient group, in the ward system, and in the mode of intervention affecting the outcome of the struggle.

One of the obvious general findings of our analysis to date is that in the struggle between system forces and the outsiders (volunteers) for the definition of the patient's role performance, the institutional pattern in large measure prevails.

It does so in large part because the ward social system holds all the cards. Even the well-intentioned individual attendant cited above had to step back and re-align himself to custodial system expectations. The volunteers, in their assault on the ward social order, were only able to intervene temporarily in a stable and established system. They were not able to offer an alternative structure capable of competing with the latent function of the chronic ward, namely, insulation from the threats implicit in interpersonal relations.

The objectively measured change in these chronic ward patients reported earlier represents, in the light of the subsequent discussion, a compromise on the part of patients. Given the odds, against them, it is a tribute to the student volunteers that they produced quite so much change in these patients as they did.

In the case-aid program, students have even more success, not just because they worked with better patients, but because they have more bargaining power. In the sustained and intensive friendship role, students are in a more strategic position to influence a patient's willingness to take a chance on alternative opportunities and structures such as nursing home, job, and family. And when, as at the student-patient halfway house, volunteers go so far as to provide a complete and enduring substitute structure, their impact on patients improves further.

THE SIGNIFICANCE OF THE COMPANIONSHIP EXPERIENCE FOR THE COLLEGE STUDENT[1]

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Our early interest in the college student as a companion for the mentally ill patient derived from the humanistic orientation of the value of this kind of experience for the hospitalized mental patient. Operating under the impact generated by the last World War, that pointed to serious limitations in the care of hospitalized patients, our state mental hospitals were subjected to the humanizing influences of the idealism provoked by the clash between the democratic forces of humanitarianism and the authoritarian forces of fascist ideology. How could the victory over the international dehumanizing forces not lead us to an attack on our own cultural institutions that fostered similar dehumanizing experiences? Foremost among these institutions was the state mental hospitals, which could not resist this cultural movement which demanded significant change in the manner in which the mentally ill were to be cared for.

One of the striking forms that such change took was the opening of our hospitals to the citizens of our communities, and the consequent growth of our volunteer programs in the hospitals. In essence, the volunteer programs were testimony to the long suppressed notion that patients were human beings and that all human beings need people. Thus, we began to see our citizen volunteers moving into the hospital to meet patients and to provide those human interactions without which normal people cannot long remain well, and without which mentally ill people cannot become well.

Out of this cultural movement it was a "natural" to see the college student as an important contributor to this humanizing process of the mental hospital. But what we failed to recognize then was that this movement of the college student into a relationship with a patient was an important experiment in personality change not alone in patients, but in the students as well. As I have lived and worked with the Companion Program for the past several years, I have come to the unequivocal conclusion that to ignore its significance for the student himself is to ignore what I believe to be one of the signal contributions of the Companion Program. It is my pleasant, although conceptually difficult task to discuss with you the nature of the personality changes occurring in our college companions and to assess the significance of these changes both for the college educator as well as for those in mental health settings.

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[1]This paper is based on experiences with college students serving as companions to chronically ill mental patients at the Connecticut Valley Hospital. In this particular program, students generally volunteer for an academic year, spending two hours per week at the hospital. The first of these hours is spent by each student with his patient that he has either selected or had assigned to him. The second hour each week is sepnt in group supervision where approximately six to ten students meet with a member of the hospital's professional staff to discuss their experiences with their patients.

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I should like to advance the proposition that students participating in the companion experience undergo changes in personality that are not unlike the changes that have been observed and reported as occurring in psychotherapy—that is, student companions after the companion experience perceive differently, think differently and probably learn and feel differently. Those of us working closely with these students have sensed that their attitudes undergo change and that their interpersonal relations may similarly undergo alteration. It has often been argued as to whether the changes in psychotherapy are superficial or profound. With regard to the Companion Program, at first we felt that the changes in our students were more superficial (changes in knowledge of and attitudes toward mental illness) but recent completed investigations suggest that there may be more profound and possibly more enduring changes that occur. It would not be surprising to me to learn that our student companions become more successful in their prime task of being scholars, although we do not as yet have evidence for this.

We know that personality change in psychotherapy is firstly dependent on the nature of the individual, that is, some people can effect personality change more readily than others. What can we say about college students that make them peculiarly susceptible to personality change? It is possible, it seems to me, to suggest certain similarities between students entering college and individuals in psychotherapy without implying that college students are all in need of psychotherapy. In a recent book on the American college, Sanford (1962) draws an important analogy between the beginning college student and the individual appropriate for psychotherapy— . . ." both the student and the promising patient exhibit a 'condition' that cries out for change, and both reveal a heartening potential for change." Both the beginning college student and the prospectively successful therapy patient exhibit ". . . prejudice and narrowness of outlook, shallow and transitory interests, lack of creative phantasy and foresight, want of discipline in thinking, values derived automatically from childhood experiences or from a contemporary parochial system and so adhered to rigidly." Sanford further indicates that many college students, but far too few, leave college with certain personality changes that resemble those occurring in psychotherapy. They become ". . . relatively broad in outlook and open to new experience, independent and disciplined in (their) thinking, deeply committed to some productive activity, possessed of convictions based on understanding of the world, and on (their) own integration(s) of personality." These are indeed profound changes and can and do occur in college students without the prior anguish and suffering that motivates people for psychotherapy.

If I may further quote Sanford, "The student, in a strong part of himself, wants to become an educated person, just as the promising patient wants to get well, but at the same time he would like this to happen to him without his having to give up the habits, the adaptations, the ways of looking at things that have served him well in the past." Thus it is that some of the striking and most important changes in college are those which occur after resistance to new learning has been overcome—a phenomenon strikingly familiar to the resistance that must be overcome in psychotherapy. Finally, the relative pliability of the

college student must be considered another significant factor that is likely to make him amenable to personality change.

I have perhaps belabored this point in order to stress my conviction that the college student, by virtue of what he is, is an excellent representative of those qualities that have been recognized to be vital for personality change. This argument should not be misinterpreted to mean that I believe all college students are equal in this potentiality for change. Rather, our own research suggests that the students volunteering for the companion experience are probably, more than the average student, susceptible to such change. What are some of the qualities that differentiate our companions from the average student even before the companion experience? Our companions are probably characterized by a somewhat higher level of diffuse anxiety, but these students as a group do not manifest any significant clinical symptomatology that distinguishes them from the average students. In other words, they may be slightly more uncomfortable in interpersonal relations, but they are not in any significant way deviant or abnormal people. Possibly as a function of their greater discomfort in interpersonal relations, they are significantly more sensitive to their own motives and the motives of others. They are more emphatic in their relationships to others and are generally more perceptive. The are also, more typically than the average student, drawn to want to help others. One may see this in the values they espouse. Unlike the average student, they identify with social and religious values whereas the typical student seems to be drawn to values which are more materialistic. As a group, they are likely to be less extroverted and more intense. These qualities of the companions, based on a recently completed study, describe the companion as an individual with a readiness for personality change in that their qualities resemble clearly many of those found in successful therapy patients (Knapp and Holzberg).

I should now like to turn to the heart of our problem today—what is there inherently in the companionship experience that facilitates or contributes to personality change in students who seem peculiarly susceptible to such change? Ideally, it would be well if we could begin with some understanding of the motives that encourage the student to volunteer as a companion. Unfortunately, we have no definitive data on this, but we have been able to assess from discussions with students some of the motives that some of them bring into the program. For some students, it is an opportunity for intellectual broadening with regard to a significant social problem; for others, it has vocational implications as for the pre-medical and pre-clinical psychology student. Some students see it as a genuine opportunity to render a service to a sick segment of humanity. For others, the experience is seen as providing an opportunity for self-understanding, emotional stability, and effectiveness in interpersonal relations. Still other motives are surely at work. It is probably correct that no person enters the program for any one single motive, but rather as a function of several motives in dynamic interplay.

While the motives that bring the student to the program are many and varied, it is quite certain that the students are alike in one important respect—a state of anxiety can readily be observed in every group of students commencing the compaanionship year. Why are the students

anxious? Is it the hospital? Probably. Is it the patients and the student's anticipation about them? Probably.

For many of the students, there is a stereotype that they bring into the program concerning the mentally ill individual, a stereotype which is often likely to be as correct as it is incorrect. They understand that patients are alienated from other people by virtue of tendencies that disturb or offend others. They envision the patient as being "strange" and this quality of strangeness often generates within the student the traditional hostility to the stranger. The student has learned that some patients are unpredictable so that one may not have clearly defined expectations with regard to patients. Finally, if they have not come with this perception, some of them will surely learn it—namely, that many of the patients will initially tend to reject overtures of help and sympathy because they deny their illness. Certainly it is these kinds of conceptions that many of the students carry with them that builds an anticipated sense of anxiety in the students.

However, we would suggest that their anxiety is probably more personally derived and has to do with the way the students perceive themselves and their competencies and skills in dealing with an unquestionably difficulty interpersonal problem—working with a regressed and often socially resistive human being. The latter interpretation of their anxiety is derived from two kinds of observations on the course of the students' participation in the program. The period of initial anxiety gives way to a sense of exuberance that brooks no problems, no defeats, no failures—the students are determined to cure their patients, eliminate their symptoms, return them to home and community, even after 10, 15, or 20 years of illness and hospitalization. But, as predictably as day follows night, this period of unrealistic optimism yields to a period of despair and pessimism, almost bordering on depression. The earlier period of exuberant excitement thus becomes understandable as a response to deal with the failure of the patients to attain the goals set by the students. To this, the student then responds with a pattern of behavior that is unmistakably self-punitive and self-derogatory—"I am a failure."

I would suggest that it is at this point that the students' personality changes begin to occur. For it is here, precisely at the point of experiencing failure, that the role of two important ingredients of the Companion Program come into play—the group of students and the group leader.

In a number of significant ways, the group and the group leader fulfill critical functions in effecting the personality changes that I believe occur. Initially, the group and its professional leader play an important role in reducing the initial anxieties of the student. The significance for real personality change occurs, though, at the point where the student begins to verbalize his feelings of frustration and consequent failure. He is able to express it in the group and in this way release the feelings so that they can be externalized and thus examined more rationally. He learns in the group that he is not alone in his frustrations, that he is therefore not uniquely a failure, but that others have the same feelings. He is

given support and reassurance by the leader and the other group members and is in a sense protected from his own self-derogatory attitudes. He learns that one may suffer frustration and even failure and yet earn the respect of others—a basic human need—for the heroic efforts he has made in behalf of his patient. If there are any residues of anxiety, the group can help him to feel less anxious and more comfortable. As he operates in the group within this context, he unquestionably begins to learn about himself, his unrealistic expectations, his self-produced feelings of failure. In a very real sense, he is exposed to a situation that now permits him to grow as a human being, aware of himself, his frailties and his strengths. Very clearly, he has created the opportunity to learn about himself in an area of vital concern to all people—in his relationship to another human being.

The question may be asked whether any experience of "failure" cannot be utilized in this way to encourage personality growth. How about frustration and feelings of failure in academic subjects? While I believe that failure under such conditions can be used for constructive personality change, the uniqueness of the companion experience is that the failure occurs in an interpersonal context. It is therefore felt more personally and more intimately. In essence, personality change has meaning only if we recognize that personality as a process and as an end result is deeply embedded in an interpersonal context.

I wish to direct my remarks to the issue of "feeling worthwhile" as a factor in personality change. Whatever the students' motives for entering the program, there is always a feeling of respect that is earned by each companion. He becomes aware of the fact that many diverse people are interested in him, and concerned about him, such that growth in personal worth may be anticipated. The hospital administration welcomes him. The nursing personnel show interest in him, and the group leader shows interest in him. The group of students are interested in him. Last, but not least, the patient begins to show an interest in him. It would be inevitable that such interest would support the students' perceptions that others see him as possessing worth. Furthermore, the willingness of others to listen, the absence of criticism, the acceptance and approval even after the expression of feelings of failure, all of these further the feeling of personal worth and self-esteem. I wish to stress, too, that the relationship between student and patient serves to provide the student, as well as the patient, with a sense of personal worth and self-esteem, important contributing factors in personality change such as occurs in psychotherapy.

Following the period of frustration and defeat, the student shows another remarkable change. His expectations regarding himself and for the patient become tempered and he enters a period of relatively realistic assessment. He begins to demand less of himself in his therapeutic ministrations with the patient. A sense of confidence returns, but this is not the unrealistic exuberance that knew no bounds of reality. He is now realistically optimistic. And it is at this point that one begins to see the real intellectual learning about mental health and disease, psychotherapy, hospitalization and related problems. He has now become a serious student of human behavior. Concurrently, he is now able to re-

late to his patient with minimal anxiety, without the disruptive effects of his self-imposed, unrealistic ambitions. He can now relate to another human being with realistic confidence. He has now become a companion in the true sense of the word—unafraid, secure, worthwhile and respected. Here, I believe, lies another factor in understanding the personality changes in companionship—the achievement of a successful relationship. Success is the best teacher and nothing enhances positive personality growth more than success in the course of human involvement. The students have tried out their new knowledge of themselves as well as their patients and this success can only further the process of personality change.

That the companions view their experiences as success experiences can be detected from a questionnaire study conducted at the end of the first year of the program (Holzberg). Of the students who responded to a questionnaire specifically designed to determine the students' evaluations of their experiences, 84 per cent reported that their patients desired the companionship and sought to maintain it. A typical student comment was: "She seems to appreciate my visits and attention." Seventy-one per cent reported a change in the direction of greater verbal interaction between the students and the patients. Sixty-five per cent reported that the patient showed positive changes in self-confidence. Sixty-four per cent reported greater interest on the part of the patient in his surroundings. A comment of one of the students with regard to this is: "She is more interested in activities at the hospital. She began helping with aged patients in the infirmary. She is generally more aware of herself and her surroundings. She began corresponding again with friends outside the hospital." Another student reported: "It has brought him out from his withdrawn state. He is first starting to show significant improvement." Fifty-five per cent of the students reported positive changes in the patient's personal appearance. Forty-eight per cent reported that the patient's social behavior in relation to companions, other patients, et cetera, had undergone improvement during the year. The students also reported changes in the basic psychopathology of their patients. Forty-two per cent of the students reported that their patients showed improvement in terms of realistic thinking, e.g., reductions in peculiarities of thought, and forty-six per cent showed improvement in their mood state as reflected in the reduction of depressive indications. On an overall basis, seventy-one per cent of the patients were considered by the students as having shown improvement during the companionship year. Data such as these, combined with the observations of our group leaders, lead us to feel very strongly that for most of our students the companionship experience provides the opportunity for a genuine experience in successful interpersonal relationships.

It is of some importance to underline the unique significance of the success in the Companion Program—success not only in dealing with the patient, but success in understanding himself. To be sure, these students are for the most part successful in their scholastic work. Many of them have been successful in athletic enterprises. But the experience with the patient provides a unique success experience—success not in the realm of manipulation of ideas as in academic work, success not in the realm of physical prowess as in athletics, but rather success in the art of human relatedness.

There is one aspect of this success experience that I feel is critical if we are to answer the question of whether any other successful interpersonal experience, say with a normal person, would not have the same implications for personality change. Here must be stressed the central problem of youth, particularly college youth who are subjected to a prolonged period of dependency on parents and other significant adults. This is the problem of identity—youth's quest for the answer to the question, "Who am I? What am I?" A significant parameter of this problem is the search for the answer to the question, "Am I a boy or am I a man?"

It is within this context of the problem of identity that I wish to place the previously discussed issue of success in a difficult interpersonal challenge. The student learns many things from his successful experience with the patient which helps the student to redefine his ambiguity in identity and to emerge with a clearer self-concept of himself. To take but one example, the identity problem "Am I a boy or am I a man?", is surely given a new articulation that permits the student to see himself grapple with an interpersonal challenge that the society of adults have labelled as hopeless. He has met this challenge—he has taken on a man's burden and has acquitted himself well, not only in the eyes of others but in his own eyes. It is this experience of clarifying his own identity that I believe must be looked upon as perhaps the most crucial aspect of the companionship experience that provides the psychic fuel for personality change.

I would now like to report on some of the investigations conducted over the past several years which have led me and my collaborators to this position on personality change. Our first study on the effects of the companion experience on students demonstrated striking changes in knowledge about and attitudes toward mental illness, hospitalization, and related problems (Holzberg and Gewirtz). A group of companions were compared to a group of students not in the Companion Program but similarly involved in social service activities with YMCA, Big Brother, and other community groups. Both groups of students were administered a questionnaire dealing with attitudes toward and knowledge about mental illness. The knowledge items, rather than being of a technical nature, had as their referent common everyday conceptions that people have about mental illness. Both groups were given the questionnaire at the beginning and at the end of the academic year. The results were clear-cut. The two groups, not significantly different from each other at the outset, were significantly different at the end of the year, and the significance of this difference was at a level well beyond chance expectancy. The companions, in contrast to the control group of students, had gained in terms of knowledge and positive attitudes. The changes in knowledge were not an unexpected result considering the nature of the experience. What intrigued us was that attitudes had also undergone a change. Research in attitude change has so clearly demonstrated that such change is so often a function of personality change, that we were now compelled to examine certain personality attributes that seemed potentially susceptible to change.

From our contacts with students, as well as from the reports written by some of our companions, we sensed that a relevant area for study would be that of self-acceptance. Studies of the difference between the

self (what am I) and the ideal self (what I would like to be) has been an important area of investigation in psychology for some time. This has been the basis of significant psychological studies on the effects of psychotherapy which have demonstrated that patients successfully treated in psychology show less discrepancy between the self and the ideal self after psychotherapy as compared to before psychotherapy. Utilizing, with slight modification, a technique used in previous research in psychotherapy, we asked our companions and a control group of non-companion students to describe themselves as they were on a personality inventory and how they would like to be on the same set of items (Holzberg, Gewirtz, and Ebner). This was first given at the beginning of the academic year and then again at the close.

At the beginning of the year, the two groups were comparable in terms of the degree of self-acceptance, defined as the difference between the self and the ideal self. Our control subjects, the non-companions, tended to become less self-accepting from the beginning to the end of the academic year. We are unable to understand why students in general should become less self-accepting as the year comes to a close unless this be a reflection of the general pessimism that increases and reaches a crescendo with the final examination period, or whether it is a more general personality change characteristic of students as they move from freshmen to senior status. What impressed us was that our companions become more self-accepting over the passage of the year, and this finding is again at a level of confidence beyond chance expectancy. We had now moved from the areas of growth of intellectual understanding and positive changes in attitudes to the demonstration of more central personality change—that companions showed greater self-acceptance as a function of the companionship experience.

Our third study was concerned with the area of moral judgment. Again, we had observed research in psychotherapy that had indicated that successfully treated patients showed a relaxation of moral judgment. We are not suggesting that these patients show a breakdown in morality but rather that they become more moderate in the area of moral judgment—rather than thinking in terms of black or white, they can think in terms of shades of grey. This suggested to us our third study of the companions. The companions and a control group of non-companion students were presented with a catalogue of statements of behavior (Holzberg, Gewirtz, and Ebner). While the statements dealt with many areas of life, we were concerned only with those dealing with heterosexual attitudes and attitudes toward aggression. Both groups of students were asked to judge each statement of behavior in terms of the extent that the student felt that the behavior should be approved or disapproved. Here again, the same procedure was followed—students were asked to rate the behaviors at the beginning and at the end of the school year. Our results here are somewhat more complicated but nonetheless unambiguous. At the beginning of the year, there is a moderately significant difference between the companions and non-companion student group. The companion students began the year presenting a picture of greater moral severity—they tended to be more disapproving of behaviors pertaining to heterosexuality and aggression. This beginning

difference in the two groups may be related to our earlier report of religious values occupying a more central role with the companions. While there is some tendency, although not strikingly significant, for the control group to become more disapproving as the year comes to a close, the companions showed the quite startling shift from earlier disapproval to more approval, a shift which is again comfortably beyond chance expectancy.

Our studies have thus far demonstrated a cluster of changes—changes in the direction of realistic understanding of mental illness, changes in more positive attitudes toward the mentally ill, changes in greater self-acceptance, and changes in greater tolerance for heterosexual and aggressive behaviors. We are currently examining changes in our companions in other relevant dimensions of behavior—reduction in anxiety level, reduction in the tendency to be repressive, and a reduction in authoritarian attitudes. The data for these studies have only just begun to be collected.

As I approach the conclusion of my discussion, I anticipate two critical questions emerging from this group. From those of you in education may very well come the question of the relevance of my report to those concerned with the education of students. This I feel is most obvious. The companion experience emerges as a critical contribution to the general goal of the college and university educational program—the student emerges with a broadened perspective with regard to a significant social problem. He undergoes a transformation of knowledge and attitudes that is consistent with what is to be expected of an educated person. He is furthermore being influenced as a human being—he is demonstrating growth from an overdefensive and rigid person to one who is more tolerant and more accepting of himself and others. I am fully committed to this as an experience consistent with the best traditions of a liberal education.

The second question is at first more perplexing. Those of you in mental health settings may question the relevance of the knowledge of personality change in students to the missions of our mental health settings. Only the most myopic view would suggest that there is no relevance in the changes in our students for mental health programs. In fact, I would advance the position that even if patients receive no benefit from such a program, changes in the students would be critical for the mental health movement. I base this judgment on a recent report which has amply documented our relative failure in educating our citizens to the problems in this field (Joint Commission of Mental Illness and Health).

We are working in the Companion Program with young men and women who are the future leaders of American society—leaders in government, business, the professions, science, the arts, et cetera. We are providing by this experience for the development of a cadre of Americans whose individual and collective voices will influence the shape of things to come in mental health. By demonstrating the significant personality changes, we may reasonably assume that the change in knowledge and attitudes are not superficial but deeply ingrained in the personalities of these students. I can only anticipate with excitement the powerful

voices of leadership that will be speaking for mental health in the next generation—a prospect that fills me with an even greater dedication to the Companion Program and to these remarkable students.

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THE COMPANION PROGRAM IN ITS EDUCATIONAL CONTEXT

DAVID MCALLISTER, Ph.D.

Doctor Holzberg has given you some extremely interesting results of the research he has conducted into the meaning of the Companion Program for the students who have participated in it. From my side of the picture, as a sort of faculty advisor and recruiting officer, the value which the students attach to the program is most encouragingly apparent. The expressions of interest one hears on all sides is one indication, but a more solid indication is the number of students who actually join the program. This number is greater each year—close to sixty this year from Wesleyan.

I would like to say something about the relation of the program to our educational enterprise in general. There is a strong kinship between the anthropologist and the psychiatrist—between anthropologists and any "case-workers"—in that we and they are ultimately confronted by individuals and this confrontation is the core of our research, our theory and our practice. It is the relevance of this experience with individuals to the college curriculum that I want to stress in my remarks here.

A college, no less than a hospital, is an institution. We college professors, no less than the inmates of other institutions, can become habituated to the routine, the deprivations and the privileges of our isolation—in a word, we can become "institutionalized." We find ourselves wondering at the impatience of the students who have to serve out a term of four or more years. It seems to us to be perfectly normal to live this way forever.

One of my students wrote a paper describing Wesleyan University as an anthropologist from Mars might see it. It was a tour de force in demonstrating how abnormal a community we really are. I remember that he described it in a series of paradoxes: a society whose imports were young men and whose exports were paper documents; a society whose "priesthood" was married and led family lives and whose laity was celibate and had no family life at all; a society where only the priesthood earned money and whose laity only spent money, and so on. There are other ways in which the abnormality of the college situation can be described, but one of the most crucial is the loss of the individual's sense of himself as a unique and valuable entity.

Our education in its search for general propositions has a tendency to abandon the individual. This is particularly true, of course, in the sciences where the natural world seems to include man only peripherally or, when he does appear, it is as a phenotype or some other type or as a statistic. In the social sciences, too, objectivity seems to require that man be studied as the bearer of institutions or the indicator of trends. Not the individual but "economic man" or "renaissance man" or "authoritarian man" demands our attention. Here too, the quest is for generalizations, laws of behavior (even though now it's human behavior). And even in the humanities, the subject of all their discourse is somehow hidden beneath the systematics which they develop as respectable aca-

demic disciplines. Perhaps that is why the word academic has come to connote meaningless. An academic question is one that's neither here nor there and has no bearing on your life or mine.

No doubt this impulse to de-individualize, to generalize, has its great value. It creates at least the appearance of order in a sea of events and in the natural sciences it has yielded fantastic control over the environment. The result has been the tremendous prestige of the natural sciences and their methods that you are all familiar with. But another result of this tremendous prestige has been an understandable but unfortunate attempt to imitate these methods in areas where their application seems to me to be dubious. Political "science" ignores the individual almost as coldly as does marxist dogma and so do philosophy and even religion in their haste to assume the mores of academic respectability.

The result is a dehumanized curriculum, even in the humanities and a kind of remoteness in the scholarly world which somehow has become synonymous with "wisdom" but which might be likened to a kind of anomie.

Of course, this state of affairs has not gone unremarked or unlamented and some very interesting efforts have been made to remind the student of his own individuality at least. In our Freshman humanities course there is an effort to offset the emphasis on cerebration with a "Humanities laboratory." Note the amusing reliance on terminology from the sciences which gives us an institution which by its title seems self-contradictory. But the idea is sound—these are workshops in the creative arts and give every student the opportunity to engage himself in the flow of events around him and to stamp his own impress on some little section of his world. At Harvard, the Freshman Seminars are an effort to do somewhat the same thing in the world of ideas by stressing the value of the individual personal response and avoiding the whole idea of grading—itself a dehumanizing device of standardization.

These seminars, which in some instances at least, took on the quality of a group exploration in self-discovery, meant so much to some of the students involved that one group at least could not bear to disband at the end of the freshman year. The experience was such an antidote to the institutionalization I have been describing that they rented a house and made arrangements to continue together as a kind of Utopia in the midst of the academic desert.

Another remedy for the abstraction of the individual has been the departure of the student from the ivied walls for varying lengths of time into projects which all have the quality of real life—are situations where the student becomes an individual again. These include jobs, usually with a social service content, travel in order to learn a language, and most recently, travel on service missions such as Crossroads Africa or the Peace Corps.

These forms of "detached service" are a most encouraging sign in the academic world because they make it less academic or perhaps because they give a new and more human aura to the word "academic."

I would like to suggest that the Patient's Companion Program is a particularly valuable form of detached service and that it performs a unique function in returning the student to a focus on the individual.

A summer job or a spring semester job in the outside world certainly fills this function to a certain degree. At least the student is removed from a milieu where the very air he breathes is the mist of abstraction and he returns with a perspective somewhat approximated to (or at least informed by) that of the everyday world. His morale is greatly improved by working with people who envy his opportunity to receive a college education. He has even found that "real life" can be not a little boring, and studies that sometimes seemed meaningless may thus take on a new luster.

The Companion Program can serve many of these functions of an "in-service" job, and serve them better. If it is perspective by contrast that is useful to the student, this program provides it and the contrast is all the more poignant because it is with another institution. If life is boring or tedious at a routine job how much more so it can be on a parlor ward where, beyond a few obviously specious jobs, there is nothing to do but sit and wait for another agonizing day to crawl past? If it would be good for your soul to have a sense of your own worth as an individual who has something to offer to another individual, how fully this is realized when you learn that the high point in your companion's week is that brief hour of your visit.

It is often true that the more serious the illness of the patient the greater this impact of a human being who needs your companionship. The result is often a sense of maturity and responsibility that is otherwise rare in the student world. A Companion I knew well went to the hospital one day and found that her patient had been unexpectedly transferred to the hospital at Northampton. She was deeply distressed that she had not had the opportunity for the good-byes and good wishes that human relationships ordinarily call for at such a separation. She could not bear the thought that her patient friend might have assumed that she did not really care whether he left Middletown or not. She journeyed to Northhampton at great cost in time and effort, since she had no car, and made the proper farewells. I would never have heard of the incident, though she was a student of mine whom I saw nearly every day, if it hadn't been told to me by some other students who found her stranded in Northampton at two in the morning and brought her home.

A trip to a foreign country has been found to open our students' eyes to new value systems and sharpen their appreciation for our own culture in a way that is impossible in the world of books alone. Such trips have been found to be so effective that we have come to regard them, not as frills in the educational program, but as basic education that we wish could be available to every student. We invent every device possible to create these opportunities—language study is the most frequent rationale, but I wish we could be honest enough to say, "Purpose—just to be in France, Mexico, Poland!" The result is shiploads of students going abroad and, in the course of classroom discussions, frequent relevant references by these students to their experiences.

I am not going to claim that the Companion Program equals or surpasses every other detached service project in the college world of today, but I would like to show the analogy that strikes me between this program and student trips abroad. Just a few minutes away from their classrooms, our students find another culture, a new world with its own value systems and philosophy, its class structure, its systems and expectations. In a world where the key word might well be "institutionalization" our students find themselves in the least structured role in the whole social fabric. They are almost like Captain Cook when he first sighted the Sandwich Islands—their potentiality for introducing revolutionary changes into this subculture are very high.

Some years ago the American Friends Service Committee (Quakers) instituted a series of mental hospital weekend service programs that were the forerunners of the present Companions. The idea was to bring young college people into contact with the hospital world and the patient in an immediate way and in a teaching context as well. After a briefing by hospital staff, the young people worked on the wards in whatever capacities could be arranged, and ate the noon meal with the patients. Then there were outdoor sports with the patients and a late afternoon picnic. This was followed by a party for the students and finally a long and thoughtful assessment of the whole weekend experience, again with hospital staff present.

Two such weekends were held at Middletown and seemed highly successful in terms of the deep impression made on both students and the hospital. I mentioned revolutionary changes that can be brought about by newcomers, like Captain Cook in the Sandwich Islands. My impression is that a sacred custom in the main dining hall at Middletown had been the separation of male and female patients. The students, however, insisted on eating with the friends they had made on the wards. Though it created a considerable stir, some of the girls ate on the men's side and some of the young men ate on the women's side of the dining hall. In those days it was also rare for anyone other than patients to eat the diets prepared for the patients. Two time-honored segregation practices were challenged on these occasions and I understand the hospital has been more relaxed on both counts ever since.

To return to my comparison, it seems to me that the Companion Program opportunity has some of the same cultural value in the education of our students as a trip abroad but it contains a special quality of its own, again related to the realization by the individual that he as a person has an impact and reality that seems denied in much of the academic world.

My last contrast is with specifically service oriented extracurricular opportunities for our students. The most dramatic of these are such exciting programs as Crossroads Africa or the Peace Corps.

The experience at the hospital, like foreign travel, is an adventure into a foreign culture, but in many ways it is a more exotic culture than can be found in any overseas direction; and the opportunity for real depth in personal contacts are greater than in most travels abroad.

The new emphasis on service in the experience abroad is closest to the Companions' ideal. Rather than merely bringing relief and "know-how" we are learning how important it is to give of ourselves—not only our time and our effort, but, far more importantly, of our sympathy, our emotional and spiritual commitment. In training for the foreign programs it is emphasized that wherever we go the people have much to teach us. Their music, language, culture and philosophy represent the product of long ages of growth and development, often strikingly different from our own. Our appreciation of these things and our eagerness to learn about them is an important guarantee of our reciprocal giving and mutual respect.

As Doctor Holzberg's paper has shown, the Companions take away from this program even more than they bring to it. They find release from their own institutionalization and a sense of their own individual value in the eyes of new friends who need and appreciate them.

Actually there are few such opportunities anywhere to make contact with a fellow human being and maintain this contract for a considerable length of time, in which the principle basis for the companionship is solely a shared humanity. Usually one gives money to worthy causes and feels a twinge of guilt because it is only money. We all know that what our fellow humans need from us is ourselves, our commitment, not our money which is only a symbol of ourselves. The Companion Program is unique among service opportunities for our students; it is a real humanities workshop.

It is not only the college world that abstracts itself and eventually falls prey to doubts as to the reality of its own existence. Our society in general has developed alarmingly in the direction of isolation, loss of touch with the neighbors, loss of any sense of community. The result seems to be an increasing intolerance, an increasing fear of anyone different from the image we have of ourselves. We are ripe for demagoguery, mass hysteria and other manifestations of a loss of touch with our essential, individual humanity.

In this situation the confrontation of society with those whom it has particularly isolated, with our fellow humans in hospitals, prisons, schools for delinquent or retarded children, may help to reverse the tendency towards separation. Not only college populations but the population at large can be enormously helped by this imaginative new direction in human relations.

KENNETH WOODROW, WESLEYAN UNIVERSITY:

One thing that struck me as I was listening to Doctor McAllister's talk was the great similarity, perhaps more than most people realize, between a university, such as Wesleyan, and a mental hospital. In both cases we find two distinctive phenomena: first, would be a depersonalization, something that you find in a great many institutions; and second, a sense of boredom. This may seem strange to you. Here we are, in a university setting, how can we possibly be bored with all this stimulation around us? There are several reasons for this. First of all, we find that for the most part we are separated from anything that has usefulness in daily life. We take courses that have academic relevance, but where are the things we talk about applied? There is an appearance of order; there is a very complex hierarchy in both the university and in the hospital, but it seems sometimes that it's "much ado about nothing."

In this great setting, with different ranks and positions and everything that goes with them, what are the students getting out of it? What are the patients getting out of it? There is just no sense of involvement. I think one of the reasons sciences are more respected on a campus than the humanities is that the student can see more immediately that the sciences have an application; you can do something with the sciences, what can we do with the humanities? This may not be valid, but it's the way the student mind often thinks: "If you can do something practical, why waste so much time on these different things and what do we get out of it in the end?"

Doctor McAllister referred to the "Humanities Workshop." Among the students, this is affectionately known as the "Humanities Wasteshop." The reason for this is that we can't find any practical use in this. What good is it doing outside of ourselves? There may be use from the standpoint of broadening out intellectual horizons, but most of us really are not, as the New York Times magazine section happens to say, immediately concerned with our intellectual horizons. We are not interested in knowledge for knowledge's own sake; we are interested in doing something with it.

Doctor Holzberg mentioned that, as students, we have various motives for going into the companion program, and he listed four. We have intellectual motives; we are trying to find out what insanity is, so we go there with the hope of learning something about it. We may have vocational interests, because we're interested in psychology or psychiatry. We go there for service, which ties in with what I said before about doing something for somebody else besides ourself. We also go for self-understanding. We figure that by understanding what "Kooks" or "Crackpots" are, we may better understand what we are because there's a little bit of "Kook" or "Crackpot" in us as students and we see it.

We usually start with this overwhelming desire to do something useful, to do something for somebody other than ourselves, so we go over to the mental hospital. Once there, we find similarities to our own situation.

There is boredom. The patients sit around in the wards because they have nothing to do. There is an experience of depersonalization. They are rounded up and they go to lunch and they go to dinner and they have to get up at certain times, but they really don't have anything to do during the day. Often times, students have the same ideas. They get up feeling sluggish and apathethic, the way the patients do. There is not really anything to do. They go to the classes, but if it doesn't have any meaning they don't take an interest in it. The student again is similar to the patient in the mental hospital, in that he is in an institutional setting. There is the complex hierarchy that I mentioned before, which leads to the feeling that the students' goals aren't the goals of the administration of the university, the same way that the goals of a patient may not be the same goals that the hospital seems to have. To give one example, the university goal may be knowledge for knowledge's sake, whereas the student goal may be to do something useful with the knowledge he acquires. The university may be interested in research, but the student is interested in research for the sake that it may have some use afterwards. The university, then, seems to be interested in knowledge in the abstract; the student is interested in use. At the hospital, the patient's primary goal is that he wants to get out. The hospital, on a practical level, is interested in keeping him clothed, keeping him fed and providing adequate sleeping quarters. Too often, from the patient's viewpoint, the hospital does not seem to be interested in therapy, but in keeping him alive and busy. Many patients tell the students things that they wouldn't tell the psychologist: "Sure, I joined the occupational therapy or music therapy, that's the quickest way to get out of this crazy place. If the doctor's think you're interested in doing things, they tend to think you're pretty good, so we just get involved in all these different programs."

Of course, in addition to the similarities I have pointed out, there are large differences, but because of the similarities we go over to the mental hospital. At first we go in on an equal footing, not as somebody who's coming to work with a patient, but to see what these people are like. We go in and we don't talk down to them, we talk to them, directly. Perhaps as students go through the program and spend more than one year in it, they do tend to come in and feel almost as sort of quasi-staff and this does change the student's relationship to the patient as time goes on. But originally, when we go in, we feel that we have pretty much the same viewpoints. Also, we try to be impartial as we go in and not take the idea that these people are sick. A hospital encourages the idea of sickness in the patient. When we go into the Connecticut Valley Hospital, it is approximately nine months before we get to look over the charts. You don't go in and know that the patient is diagnosed as a paranoid schizophrenic and then look for the traits you learned are associated with paranoid schizophrenia. The idea is to go in and look at the patient as a person and perhaps later check what you have observed with the psychiatric diagnosis.

What do we get out of being in this companion program and what do the patients get out of it? Again I'm trying to draw similarities, though in a sense it may be unfair to do so. We both have a goal of clarification. Many times the patient may express the fact that he wants to get out,

but he really doesn't want to get out. In speaking with a patient over a year of time, we do try to crystalize his goals. Maybe his dissatisfactions with the hospital become greater than the inertia of just staying there because it's the easiest way out for him. Sometimes your talking about activities outside the hospital realm tends to involve a patient with the world outside the hospital and maybe he sees that it is worthwhile to get out, that maybe there is a better life than staying in the hospital. The students' goals emerge in terms of self-identity: what do we want to do with our lives? In being a companion to a patient we do have an increased sense of identity, knowing who we are. It is hard for a student to place himself in society as a whole, when most of his time is spent strictly within an academic setting. A student may be on the bottom of the totem pole, academically or in other ways, but when he goes to the hospital he suddenly finds that he is better off than anybody else around that he can see, and this helps place him in better perspective with regard to his place in the whole society. Another thing that the student gets out of his experience as a companion is just the plain pleasure of being involved in something outside of his own immediate interests. He is not studying for an exam which advances his own academic goals; he is not going to the movies to get vicarious pleasure or to watch big flashy cars go across the screen; he is doing something for somebody else and it is in this doing somebody else, in doing something that requires active involvement that a great many of the students find pleasure.

JANICE REGOLSKY, WESLEYAN UNIVERSITY:

Doctor Holzberg mentioned something about the way we felt when we first went in. I think many of our group felt at first, that we could effect magnificant cures. We thought that we were going to change these patients and get them out of there. But, after awhile we got to accept their little abnormalities and we looked for a different sort of progress, a much slower progress than we had expected at first. We didn't see any great changes, but we were overjoyed at little things, like a patient being better dressed one week than the week before, or his posture being a bit more upright or perhaps he didn't make as many inappropriate remarks. These were the kind of changes that we began to look for.

We could not appreciate how difficult it really would be to get these patients out, because we couldn't really see what precisely was wrong with them. When we talked to our group leader, we kept pushing for him to get our patients changed to better wards. We kept saying, "Well, why can't this patient leave. You know, he seems pretty normal."

Later, we got to see that our patients would have a lot of difficulty coping with the world. much as we wanted to see them get out. The first misconception that had to be corrected was that there couldn't be lightning cures and startling changes. We found that schizophrenics were not what we had been led to believe from books and movies.

WILLIAM BEATTY, YALE UNIVERSITY:

I would like to explore the dynamics of the student-patient relationship and attempt to delineate its potentialities for the improvement of the

patient's state of mind, his attitude toward other people, and his general adjustment to the hospital. I would like to illustrate the effects of this interaction in the context of a case from my own experience, a patient with whom I am presently working. The patient is a middle-aged, white woman of working class background. She is shy and withdrawn, although she can be drawn out in limited conversation. She is extremely distrustful of all strangers although she seems unable to specify any particular reason for her feelings. She is noticeably uneasy in small or large groups and seeks to avoid all such contacts. She has been hospitalized since graduation from high school and her initial venture into supporting herself. She is not clear about these matters, being unable to state definitely her age or the type of job she held.

The patient is in many respects typical of the chronic schizophrenic: withdrawn, distrustful, and totally incapable of exerting much influence on her environment. Her outward appearance and general problems are quite the usual ones confronting the student in his initial attempts to meet and understand his patient. The only peculiarity in this case is the patient's conception of the kind of relationship which exists between herself and the student companion. She perceives the relationship as a dating situation frequently manifesting her insecurity and fear of being rejected by queries such as, "Do you want to get another girl?" (addressed to me). This type of identification while not strictly typical is not at all uncommon.

Besides a history of unsuccessful relationships ending in rejection for the patient, something else can be inferred from these statements. The patient has stated that she never dated or went to parties while in high school and does not attend social functions at the hospital. Therefore, it seems reasonable to suppose that lacking much personal experience in relationships with men, the patient, relying principally on vicarious experience assumes that the dating relationship is the only type of contact possible between men and women. It is equally possible to suppose, in addition, that all of the patient's other experiences with men (assuming now that she had some) ended in failure, and she fears further rejection.

Faced with such a dismal past what can I as a student companion hope to accomplish by seeing this woman once a week for seven months, broken by vacations and examination periods. My first problem is to try to develop some kind of trust in the patient for me. If she can come to feel that our relationship is of a different order than her previous experiences then there is a possibility that she can become less suspicious of people in general, particularly other patients and hospital staff members, thus becoming more accessible to professional treatment and, she may come to perceive my relationship to her in a different and more realistic light.

I would tend to believe that these benefits could result from any companion-patient relationship. First and most important, the student provides the patient with a real and close friend, someone who demands very little of the patient and sincerely seeks to understand his other problems. Most patients have been unable to form and maintain such friendships in their past experiences. Indeed, difficulties of this kind represent an im-

portant part of their problems. But the companion can provide the patient with a kind of reliability and security which he has never before enjoyed. From this hopefully comes trust in people and society. I feel it necessary to emphasize that the fact that the student is a member, not of the hospital staff, but of the outside world who receives no visible recompense for his expenditure of time and effort gives him a certain advantage in establishing the trust which must form the foundation of his relationship to his patient. Patients are well aware of the special position of the student and express their feelings in subtle ways such as by wearing lipstick and dressing up nicely on days they meet with their companions.

Secondly, assuming a degree of trust between patient and companion has been established, the student may be able to get the patient to engage in a greater amount of reality testing. In actuality such progress is rare, but the mere association with someone from the society outside the hospital world cannot help but exert some degree of positive, if temporary influence on the patient's perception of himself and the external world.

DAVID RODGERS, YALE UNIVERSITY:

I would like to speak on what the Middletown Companion Program has meant to me as a student, focusing on its value as an educational experience. But I begin by immediately qualifying and expanding what I mean by the word "educational."

Most of our education is extraordinarily superficial—consisting of the cultivation of memory, of the accumulation of information in one way or another. Although this education does prepare us for professional careers within our society, it does not really help us to meet the immense complexity of our entire human existence. The failure of our present education is that it does not effect the center of our personalities—it only modifies the surface. The greater part of education is irrelevant to our most profound and immediate problems of everyday life, problems arising out of our relationship to ourselves, to other human beings, and to the entire universe. Our education makes us hyper-intellectualized; but this is only a fragmentary kind of education, since it fails to influence us as total persons. That our development as total human beings is the real function of education, becomes clear when we realize that the purposes of education are inseparable from the very meaningfulness, or meaninglessness, of our whole lives.

As an educational experience, a program such as that at Middletown goes beyond the accumulation of information, and to a significant extent becomes a kind of total education, effecting us not only intellectually as college students, but also profoundly as persons. It is a kind of education that is freed from the limitations of the abstractness and verbal irrelevance of education in classroom college situations, being a form of learning based upon immediate relationships to individuals different from ourselves. Whereas the university world tends to be relatively isolated from the whole of society, the Middletown program gives us the op-

portunity to do more than simply talk about problems, to confront these immense personal and social problems and to help in solving them. This particular contact with the reality of mental illness has very important effects on our intellectual life as college students. Courses in psychology and sociology become much more relevant, and the essential interrelatedness of these two fields is far clearer. We also begin to see more deeply into other related fields such as philosophy, religion and art. Sometimes the stimulation to interest in the vast area of human behavior which this program gives, becomes primary in influencing our choice of professions, leading us to careers in social work or private practice as psychologists or psychiatrists.

Over and above the effects of such an experience as the Middletown program on us as college students is the more profound change it brings about in us as persons, which is what I meant before by the phrase "total education." Our present education gives us little or no insight into ourselves, into who we are (in a total sense), why we act (interior and exterior) as we do in everyday situations. Certainly the consequences of this lack of profound self-awareness are clear—alienation, confusion, unhappiness, covert or overt violence, immense suffering and misery for ourselves and other people. However, we can not be taught (as in a university) who we really are—rather an expanding awareness of our total identity grows out of our direct relations with other human beings. In the Middletown program we soon abandon a "saner than thou" attitude toward our companion-patients and see that their problems are not entirely different from our own, only much more severe; and thus insight into their problems becomes an illumination of our own. The simplest way to express this is to say that we look at things differently than before; our attitudes and general world view become more flexible and expansive; we are more critical, but in a creative sense; we see deeper into the realities of our existence and thus become sensitive to and capable of understanding the immense problems and suffering below the surface of our own lives and those of other human beings. This very understanding and acceptance we begin to transform, "this wretched and magnificent life that is ours," (Camus).

NICHOLAS CHILDS, TRINITY COLLEGE:

Tuesday night I completed a week of performance as Daddy in the **American Dream,** by Edward Albee. He is a member of the so-called "Theatre of the Absurd," which, as you probably know, is a cadre of high priests who expose and ridicule the superficiality which they find characterizes contemporary American life. There are many of us, I think, who can agree, that everything is not peachy cream and even if we question the methods employed by these artists of sardonic nonsense, certainly the very existence of the State Mental Hospital, is a manifestation of the less admirable human capacities. The companion, in his concern for his fellows and/or himself, has an opportunity to ameliorate the situation, to dispel some of the loneliness and some of the sense of worthlessness so keenly felt by the patient and himself.

I had a companion at Middletown last year who was difficult to communicate with as he didn't like to talk very much. I would like to give you

just an example of a conversation that we had, which filled practically half an hour.

This took place shortly after Thanksgiving. I asked him if he had had a nice Thanksgiving, and he grunted, "Yes."

I asked him what kind of food he had. He said, "Meat."

"What kind of meat did you have?"

He said, "Turkey."

"Well, did you have any dessert?"

"Yeah."

"What kind of dessert did you have?"

"Pie."

"What kind of pie?"

"Minced."

And this just went on and on and on like this. It was very frustrating in the beginning, but a certain amount of my frustration turned to admiration, because so many of us just make all of this superficial conversation, we say things that are completely unnecessary. This man just didn't say these nonsensical things. I admired him for it. Look at it through his eyes. Everybody tends to look at things from his own point of view; if you're a clergyman, you look at it from the moral point of view; if you're a psychiatrist, you look at it from the medical point of view; if you're a psychologist, you may look at it from a professional point of view, but I think as untrained students, we go in and we just look at it from the people point of view. What keeps up our interest? Well, because they're interesting people. They have these peculiarities, but we find the peculiarities interesting and charming. There are disappointments. Sometimes your companion doesn't seem to like you, sometimes he doesn't want to talk to you. We find these same disappointments in normal friends. Normal friends let you down too. And, if you really do have an interest in a normal friend, if he gets up and has a grumpy day, you just don't stop being friendly with him. You let it go and you pick up again the next day or the next week.

I often talk about my experiences in Middletown and my friends have come to expect that I'm going to make some comment about it. They ask me how my day went, when I come back, very much the way they would ask if I had come back from Smith or Holyoke. It's the same general thing; we just talk about somebody else. The thing I remember after going over to the hospital for the first time was that on my mind was the question, "What is insanity?" Somebody completely unacquainted with mental hospitals pictures insanity the way is is often depicted in the movies: somebody yelling and running up and down in the corridor. You may spend a year or two years at the hospital and never see anybody like this and this contrast is very revealing. You come back to the campus and you talk about this with your friends in the dormitory or in the fraternity

house and they question you about the hospital. I think one of the important functions we serve is to spread information about what a mental hospital is actually like. I understand that the current notion is to have mental hospitals in cities where they are not so isolated, but the fact is that now most of them are fairly isolated and a great majority of people have never been to a mental hospital and are unacquainted with exactly what insanity is, other than the distorted image they have picked up. When you talk to people they expose the stereotyped images they have and you can try to set them straight, in light of what you do know to be true.

THE GROUP DISCUSSIONS

Short of presenting a full transcription of the group discussions, it would not be possible to transmit the enthusiasm and spirit which characterized the deliberations lasting more than two days. Lest the impression be given that there was a revival atmosphere throughout the conference, it should be said that there were sharp questions and critical appraisals of just about every aspect of a companion program that was introduced into the conversations. The issues touched upon covered a broad range and each group contributed an individual focus and provided distinctive ideas to the total production of the conference. In what follows, an attempt will be made to state briefly some of the thoughts which emerged from the group sessions.

THE PROGRAM

Four centuries or so ago, the insane were equated with heretics and were regarded as being diabolically possessed and were consequently treated as offenders against religion. This concept eventually yielded to one which regarded insanity as the equivalent of criminality and the deranged man was imprisoned as an offender against the social order. This image was in time superseded by the proposition that insane persons were ill and that they had to be quarrantined. This doctrine has prevailed down to our time. Over a period of time, the realization has grown that there are many among the multitudes who have been hospitalized, some for extensive spans of time, who need really not be sequestered and whose lives would be appreciably enriched where they helped to re-establish or build anew relations to the "outer world." The companion program in its way represents a movement on the part of sensitive, bright young people toward the re-establishment of such bridges between the hospital and the community.

Our society is fostering a growth in institutionalization. Increasing longevity and greater and more far-reaching demands for education, for example, are contributing to the development of a variety of institutional programs to deal with needs of people on a larger scale than was heretofore necessary. The basic problem is to retain concern for human values and to prevent the institutions which will multiply from becoming so rigid that they will crush the people whom they set out to serve and in so doing bring about their own collapse.

The companion program brings together two individuals: one, lost in despair and in retirement from life; the other, representing a high kind of idealism, the openness of youth, and the promise of attainment. When you put two such people into a relationship of companionship, a dialectic exchange is set into motion which, through the mechanism of identification, may pull the schizophrenic out of the depths of despair and his isolation from the world.

The therapeutic outcome of the program is of unquestionable value. More basic and far-reaching, perhaps, is the establishment of an important means of communication with the community. From a long range view, the companion program may contribute toward changing the public's attitudes toward mental illness, because the student participants are without doubt the core from which the community leaders of tomorrow will come.

THE HOSPITAL

The institution is like a great putty giant. It is characterized by massive inertia, so that applications in practice change long after ideas have been developed. Introducing students into such an atmosphere tends to challenge the system. The professionals move in specialized world's, even to the point of speaking their own language. The student runs right over the ruts. He helps overcome the inertia of the institution.

The companion program, in almost any of the forms in which it has been considered, involves bringing in a group of people who are individualistically oriented, compassionate, liberal, empathic and putting them into a culture which is designed to be functional, efficient, and custodial. The programs described thus far have succeeded, perhaps, because of the good fortune in having been introduced at institutions that were relatively forward looking. It is conceivable that this conflict of culture might prove very severe in other kinds of settings, where there is less sympathetic administrative leadership.

The hospital tends to make the patient dependent. Often, it reduces him to the status of child, and then deprives him of the warmth and individual recognition which are essential to the social growth of any human being. Time and again, student companions wondered why the patients were treated as children.

SCREENING AND SUPERVISION

It is important to realize that the patients select the student as much as the students select the patient. It is a mutual process, if they are put into a situation where they are free to make such a choice. One of the most important features of the program is the professional supervision offered the students. Groups of eight to ten students are supervised by a psychiatrist, a social worker, a psychologist, occupational therapist, or a nurse. The supervisors remain with the same group throughout the year. This kind of supervision tends to simplify the original screening procedures. Aberrant behavior on the part of the student is checked through the supervisory process, so that a natural screening process is at work and

students are not deterred from volunteering by elaborate screening devices. Some group leaders have preferred to bring a larger number of patients than students together at the initial meeting. This has presented a problem because it inevitably meant that some patients were rejected, without regard to their wish to have a companion. Other leaders have brought together the same number of patients as students, relying on them to select each other.

The hospital must make a commitment to provide supervision to the student in the same manner that the student is required to make a commitment to the patient. Students who were not supervised, or who were exposed to supervisors who were not really interested in the program but were merely carrying out an assignment, were the ones who lost interest and suffered disappointment. It is a mistake to talk someone into taking on the responsibility of supervision if he is not convinced of the significance of the program and the value of his contribution as supervisor.

THE PERSONNEL

It is important to overcome the initial fear of the psychiatric aides that the students will interfere with the performance of their duties. It has been observed that aides who have participated in the Remotivation Program have reacted in a more accepting fashion toward the students, possibly because they have come to feel more secure in their own status as contributors toward the treatment program. A possible source of conflict between students and aides is that the aides tend to see their role as caring for "sick people" and consequently they reinforce "sick behavior." The students start out by questioning the notion that the patients are "ill," thereby presenting a viewpoint which almost immediately comes into conflict with the way the aides conceptualize their role.

THE PATIENT

At the outset, the patient is often protective toward the new student. He acts as a representative of the hospital and tries to make the student feel comfortable. The students are often the ones who are ill at ease coming into a new setting and meeting patients who present an unknown entity.

There are patients who resist this kind of enterprise and try to avoid it. It is obvious that some of them are frightened at the prospect of entering such a relationship. Initially, this behavior was not accepted and the patients were required to attend the group meetings with the students. If by the end of the period of joint group meetings the patient is still too frightened, then it is assumed that he is not ready for this experience. This is not a program that is applicable to all patients at the hospital.

There are some indications that men responded differently than women. At the end of the year, the men seemed more socially adapted, more interested in the things going on; whereas the women seemed more anxious and regressed. It has been suggested that when the man loses his companion, he loses a son, a male rival and consequently is relieved of a burden of conflict. The woman patient loses a son, but also a lover and

therefore the separation is more painful for her. It is possible that women students might have altered the outcome appreciably with respect to this variable. There were not enough of them in the program at Connecticut Valley Hospital to permit conclusions.

Many of the patients come to the companion experience through the Remotivation Program. This program is extended to the most regressed patients by psychiatric aides. The aides who have been trained to act as Remotivators make use of a great variety of materials as stimuli to the patients in an effort to produce responses. In many instances, the objectives may be as modest as to get a patient to say his first words in years. The Aide-Remotivators have been recommending patients who have shown movement in the direction of accepting some kind of relationship for inclusion in the companion program. The relationship with the student is itself a step in the direction of a more intense involvement in a group psychotherapy experience for the patient.

A number of patients enjoyed the companion experience so much that they contrived to have more than one companion. One patient saw two companions on the same afternoon. There is nothing intrinsically wrong with this. One can have one friend; one can have four friends. Having multiple companions is not encouraged, in order to extend the program to as many patients as possible, but when it occurs, whether by accident or contrivance, nothing is done to disrupt it.

THE STUDENT

The student and the patient are at the opposite poles of life, yet bound together by a mutual hunger for communication. The student comes to the hospital not knowing what would be appropriate behavior toward the patient. He lacks the training of the professional and has no acquired techniques to sustain him in such a situation. If he is going to remain in relationship with the patient, he is forced to undergo a process of self-evaluation and experimentation with response to the patient. This may be why the student undergoes changes such as occur in psychotherapy while the patient too gains a therapeutic benefit.

The student comes to the patient with no specialized objectives, other than such general motives as a wish to learn, a desire to provide pleasure in someone's life, and the possibility of working with someone who needs help. The very asset that he brings is his lack of dedication to certain principles and preconceptions. He is not obsessed by treating or testing. He offers friendship, thereby freeing the patient from having to cope with the problems of his illness and permitting both of them to concentrate on the unique aspects of the mutual companionship.

The student introduces something unique and greatly needed in the chronic ward. He does not deny that the patients are "sick" but he orients to them as though they were well. The students recognize intellectually and emotionally that the patients present pathological behavior, but they reward the adaptive behavior, the social response. Professional people are trained to relate to pathology; the students are not. This may be their special virtue. They are not on the alert for signs of deviance, conse-

quently they orient more readily to the patient's normalcy and possibly induce more normal responses in this way. The students' attitudes represent a departure from the patients' usual environment. Ordinarily, the patient is surrounded by people who see him chiefly as a sick person. These are strong forces in the patient's experience and together with his own pattern of insulating and isolating himself keep him operating at a constricted social level. The students bring with them different attitudes and the possibilities of different responses and relationships.

One of the decisive outcomes of the companion experiences for the students was their increased self-acceptance. Doctor Knapp, ventured two interpretations:

"1. The students begin to see that the discrepancy between their ideal and their self is really a very small thing compared with the range and variety of human vicissitudes and problems. So, just by broadening their imagination in regard to these matters, their own sense of difference from their ideal becomes less important to them and therefore radically reduced.

"2. One of the great problems with college students is that they cannot see that anything that they are doing is really of high seriousness or importance. It is true that becoming educated is very important, but to the student it seems that the rewards are deferred for a period of years. There are really very few things they can do between the ages of eighteen and twenty-two which are of really direct and human importance from their viewpoint. Here is something they can do which gives rise to a general feeling of prowess and self-esteem, or a sense of decency in their regard for themselves which is related to the fact that they are doing something effectively for a real, live human being."

PROGRAMS OTHER THAN MENTAL HEALTH

Since the end of World War II, society has been moving in the direction of humanizing the mental hospitals. The culture demanded this change whether the hospitals wanted it or not. Some are still resisting, but the die is cast; they must change and they will change. The prisons, for the most part, remain what they have been for a long time. The cultural force compelling them to change has not yet gathered sufficient stength. This means that the culture is not ready to support what the volunteer can do in a prison in the same way that it does what a volunteer can do in a hospital.

There are conditions in the correctional institutions which might pose limitations on the relationships which could be developed. In the hospital, the student can come and go with a great deal of apparent freedom. In a prison setting, unless we can change the conception of a prison, the only contact the student may be able to have would be over a narrow table, with a barrier up the middle. He may shake hands with the prisoner when he arrives and when he leaves, but he has no way of taking him out, even for a cup of coffee or a dish of ice cream.

Would such a program help develop a different understanding on the part of our culture? One of the qualities of the students is that they are

not willing to be stopped by what the community is willing to accept. The student of our times is in ferment. In some countries, he may seek to overthrow the government; in ours, he tries to overthrow cultural lags, by creating something different in the community or an institution.

Student discouragement comes from professional discouragement. The literature dealing with the treatment of the sociopath tends to be pessimistic, whereas the student is stimulated by the more hopeful outlook for psychotic patients. The sociopath, no less than the psychotic patient, is utilizing certain behavior mechanisms. If it is possible to introduce a microcosm of the world into the social setting of the ward and by reinforcing positive behavior bring about changes, then it should be possible to utilize a similar approach in a correctional setting. The problems may be difficult, but not insurmountable.

The chronic patients at the hospital, the population with whom the students have, for the most part, had experience, are at least as forebidding at first meeting as the older prisoners could be. It might be worth bringing the imagination and perseverence of the students into the prison setting. There are two objectives which the companion program could serve in a correctional context. First, the students could try to bring about an understanding in the prisoners of the requirements of community life, chiefly by interpreting the community to the prisoner—a task which correctional workers admit they have not carried out with the degree of success they would like to achieve. Second, the students could become a significant, new voice in interpreting the offender to the community. The student regards the patient as someone less fortunate than himself and in need of help. Society has a different attitude toward the criminal offender and regards him as someone who should be punished. If the student can learn to think of the criminal as someone who is in need of help, the evolution of social attitudes in this regard may be significantly speeded.

There is no doubt that the mental hospital holds a large fascination for many of the students. They are attracted to a setting which includes psychiatry, psychology, and human phenomena which excite great curiosity. In this sense, other settings, e.g., schools for the retarded and correctional institutions, might be at a disadvantage. Students may be less aware of the scope of these other programs and may, with broadening of their knowledge and understanding, find equal interest and challenge in working with children in the training schools, young offenders in the correctional schools, or older risoners in the state prison. College students have participated in summer programs at the training schools and also at the Connecticut State Farm for Women. In the latter instance, so many of the women have no contact with families or friends; no one visits or writes. The college girl was seen as someone who cared enough about the plight of the incarcerated women to choose to work with them at a time when they could have selected any other kind of temporary employment. The younger women, especially, formed close relations with the college girls and took them as models for behavior. A particular kind of gratification for the college student was the strong emotional need and affectional clinging exhibited by the children in the training schools. For many of the students, this was their first experience of being able to fulfill another person's emotional needs in this way.

What would happen if a number of college students suddenly descended upon a cottage at one of the training schools for the mentally retarded? The children never were normal so that even the ones who are relatively well-adjusted socially would tend to react in ways that might lead to chaos after the students left. This would place a demand on the cottage parent to prepare the children for this kind of experience and to cope with the disappointments, jealousies, and rivalries which would be set off. A smooth transition could perhaps be achieved by introducing the students into the institution through an activity, such as a dance, rather than precipitating them into the cottage.

IN CONCLUSION

There are many motivations which bring the college student to the companion program. The suggestion has been made that the intensity of involvement and commitment to other human beings provides the student with the "moral equivalent of war." This endeavor has also been compared with the Peace Corps and it was suggested that similar types of persons are being drawn to both of these experiences. There is substantial evidence that the students entering the companion program are drawn predominantly from those pursuing the social sciences and the arts, although biology students and physical science majors have also participated.

It would be erroneous to envision the hospital as a monster which consumes human beings, be they patient or otherwise, and the students as knights errant come to restore justice to the downtrodden. At several points in each of the discussion groups, the question was posed whether the students were not really engaging in psychotherapy and that the supervision offered was a way of training them in this role. Apparently it is of prime importance to some persons to have a clear-cut definition of role for anyone who becomes involved with the patients, even to the point of super-imposing a role concept when in actuality no definitive one exists. It is noteworthy that during the course of discussion the point was made that psychiatric aides sometimes feel threatened by the students because they see them as rivals with preferred status. Whether from positive or negative predisposition, it may be that psychiatrists, psychologists, or other professionals cast the student companion into a role which approximates their own and then either approve or disapprove of students functioning in this way for any variety of considerations. One conclusion seems warranted in this regard: to force the student into a mold which would determine permitted behavior, in the hospital and with the patient, would rob the companion experience of its unique qualities for both the student and the patient. Vitality, hope, and enthusiasm are the singular qualities of youth. The view the hospital takes of the students may range anywhere from the attitude that they bring with them, a rejuvenating spirit to be welcomed by patients and staff alike, to the conviction that they are unwelcome intruders into an ordered hegemony and will be tolerated until the first discomfiture of patient or staff. Clearly, as in any new venture, there is much to be learned in order to make the most of the possibilities that are being offered.

IMPLEMENTATION OF THE COMPANION PROGRAM AT THE COLLEGE LEVEL

AUSTIN C. HERSCHBERGER, Ph.D.

There are four problems to be solved at the college level, the first of which is selecting the coordinator or liaison person between the institution and the college. The solution of this problem will probably be unique to the two parties involved. In some instances it will be a member of the faculty; in others, the administration. In any event, the individual who undertakes this aspect of the program should be interested in the program and should be willing to spend a good deal of time early in the semester in working with students who are interested in entering such an experience. After the organization at the campus level has been achieved, the duties of the coordinator almost cease to be, with only an occasional need to solve an isolated problem.

The coordinator faces the three main problems: publicity about the program—the dissemination of information; collection of information—pertinent data regarding the students; organization of the collected data to fit the schedules of the students and the times available at the institutions. Let us examine each of these problems in the order mentioned.

Publicity or Dissemination of Information: Since the program is primarily a student activity, it is well to get one of the existing organizations on the campus to sponsor the organization and information meetings. At some colleges there exist groups who are committed to service activities. Enlisting the aid of such an organization is of especial value in that their sponsorship serves to divorce the program from the Department of Psychology and underscores the fact that the program is open to all students, not just those students who happen to have taken or are taking Abnormal Psychology.

Having enlisted the good will of such a service organization, the next important item is selecting a time for the first information-giving meeting. Since a college campus is always a busy place, it is important to select an evening with as few conflicting events as possible. Once a relatively free date has been found, it is necessary to inform the student body of the time, the place and the purpose of the meeting. Two techniques seem to be conducive to getting a sizeable attendance. (1) Posters which are calculated to create an interest in the program are placed at strategic positions throughout the campus. (2) Each student on the campus receives, by way of the campus post office, an advance notice of the meeting. Included in the notice is a brief but concise description of the companion program along with its requirements, that is, its commitments regarding regular visiting and time involved. The day prior to the meeting a second notice is placed in the students' post office box. This second notice contains a form on which the student can record the information necessary for his participation in case he is interested in joining the program but unable to attend the meeting. This form is then returned to the coordinator.

Obviously the information meeting can be organized in a variety of ways. The following is a description of one format which has been found to be quite successful. The President of the sponsoring organization, or his designated representative, should chair the meeting, introducing the general subject matter and the various people who are to speak. The institution which is to work with the students should be represented by one of the professional staff, preferably that department which is to be responsible for the student activities. He can cover the program and its content in a general manner not only from the viewpoint of the hospital or training school, but also from the expectation of the individual to be visited.

Probably the best salesman that can be found is a student who has had prior experience in the program. Their spontaneous enthusiasm, genuine interest are quite effective in communicating to the audience the benefits which the student can expect to receive from participating in the program.

Finally, that individual who is the coordinator of the program on the campus can summarize the requirements for participation in the program, paying particular emphasis to the moral commitment the student makes to visit regularly throughout the school year. This latter point serves as an effective screening device for those who are only mildly interested in the program.

Collection of Information: The number of students who can be accommodated in the program at any one campus depends upon the professional staff available at the participating institution, the number willing to participate and the time they have available for such participation. For many colleges there will be an additional factor of distance which will automatically exclude some of the less interested students. Since the activity of a good many individuals has to be integrated, the following information from the student is needed: free periods in the student's schedule when he is able to participate in the program, ideally one full afternoon free; if transportation is a factor, whether or not the student has a car he is willing to use, and its capacity; the student's mailing address and telephone number. Having obtained this information, the students are informed of the mechanics of organization and are told that they will be notified shortly as to which group they have been assigned and with whom they are to ride, along with the time of departure for their particular institution.

Once this information is collected it should be organized in some usable manner. Again, the particular system which the coordinator adopts can be quite idiosyncratic. The following, however, is offered as a suggestion. It is useful to make a master chart with a column for each afternoon. The students' names are entered in those columns indicating the afternoons when he is free to participate. If he has a car, a parenthesis with the number of passengers he can accommodate is placed after his name. For example: If John Doe can participate on Monday, Wednesday and Friday, his name is entered in the three appropriate columns, and should he have a car and is able to take five passengers, the completed entry would be, John Doe (5) in each column for the appropriate day.

Once this kind of master chart is compiled it becomes a relatively simple matter of working out with the Director of the program of the institution involved the composition of the groups who are to visit and when they are to visit, as well as assigning the name of their professional supervisor. Having worked out this aspect of the program, the student is then notified as to which group he has been assigned, who he is to go with, and to whom he is to report. This seems best done by a second meeting of the students so that they can be introduced to one another as well as providing an opportunity to answer last minute questions. Experience has shown that late Sunday evening is a good time for such a final meeting. Students who have been away for the weekend have returned, and those who are studying welcome a short break of this kind.

For the most part this completes the work of the coordinator. Students have proven themselves to be quite reliable and little or no further effort is required on the part of the coordinator. Fortunately, students who start the program are, for the most part, quite faithful, but there are those who do leave the program, in most instances quite early in the year. This brings about the problem of keeping track of drop-outs. Insofar as is possible, it seems best to interfere as little as possible with the students once the program is organized. Constant attention to the students' activities tends to destroy the program. Students seem not to like to be constantly watched.

Probably the best way to keep informed as to drop-outs is to assure the student that if he feels it necessary to withdraw from the program that he should notify the coordinator of his decision at the earliest moment. Certainly no student should be reprimanded or censored should he withdraw from the program and his reasons, if he states them, should be taken at face value.

A final word of caution seems appropriate here. A large part of the successful continuance of student participation in such a program is due largely to the students themselves, not only to just those who are in the program, but to those who hear about the program from other participating students. Part of the good will which students feel toward the program, even though they may not be participating, can easily be damaged if but one student who applies to participate is forgotten or overlooked. If a place for a student cannot be found, he should be notified in person, immediately, and a satisfactory explanation be given.

The above discussion represents the minimal organizational scheme necessary to introduce and maintain the Companion Program at the campus level. Students are quick to respond and to accept responsibility and challenge; likewise, they are quick to resent too much supervision. For these reasons the best kind of supervision after the program is under way seems to be the least supervision.

SUMMARY OF DISCUSSION FOLLOWING DOCTOR HERSCHBERGER'S ADDRESS

Problem: How can students effect any modicum of "social reform" in current institutional routines in the face of well-organized, rigid patterns of administration.

1. Institutions operate in an atmosphere wherein they must be sensitive to public opinion, public pressure and criticisms.
2. Administrators must, of necessity, operate with a somewhat conservative bias since the continued existence and implementation of existing procedures depends upon the public.
3. Impetus for change should come from actively engaged medical personnel, psychiatrists, nurses, aides, psychologists, rather than students.
4. Students who have participated, however, can form a nucleus for a later, well-informed public.

Problem: Is the Companion Program distinct from the usual volunteer programs?

1. Administratively, there must be some exchange between the hospital personnel who are in charge of volunteer programs for the purposes of record keeping, insurance problems and such basic administrative details.
2. The Companion Program, in contrast to the very extensive volunteer programs, is a distinct, didactic relationship. Because of this, the professional direction is independent of the volunteer administrative staff.
3. Patients are deliberately selected for students, patients who, having minimal outside contact, are in the remotivation program, and who show some sign of response.
4. Students meet in groups of six to ten after each hourly visit for consultation and advice with a member of the professional staff.
5. Lastly, the usual "prohibitions" and "cautions" of the routine volunteer programs seem not to be applicable because of judicious patient selection. Students are free to improvise and innovate with one exception, permission from the ward psychiatrist is necessary for the patient to leave the hospital grounds. To date, no crucial incident has occurred. The only admonition given to the student is that he is to use good taste.

Problem: How does an institution prepare itself for the sudden appearance of these bright, alert, responsible students.

1. The instigation of the program in Boston found the institutions not prepared and many conflicts did occur, but compromises were effected.

2. Schools for retardates would have to face problems of fighting by charges over students, but it is predicted that the situation would soon resolve itself. A further suggestion was made that a gradual introduction could be effected through the use of existing co-ed social activities.

3. Relying on the reported experiences of others, one companion program was conceived of and carried out under specific plans which involved the whole institution. This program experienced little or no difficulty.

Problem: Should participation in the program be given college credit; extra credit in a concurrent course in addition to the benefits of the program itself.

1. To attach the program formally to any college course would rob it of its basic impetus—one individual who has decided that it is worthwhile to share one hour a week with another, this "another" who is, for the most part, forgotten.

2. Students presently participating in the program are identified with many academic disciplines; majors in history, English, political science, economics, fine arts, languages. Perhaps fewer come from abstract quantitative disciplines, but even they are represented. College credit would tend to eliminate many of these, the implications being that only psychology majors could or should participate.

3. Course credit for field work defeats the purpose of the program. The student tends to remain a student, an observer, a diagnostician rather than becoming a friend. This, again, defeats the purpose of the companion program. Neither, is it meant to be a kind of psychotherapeutic catharsis for the student himself.

Problem: How much and what kind of orientation is given to students prior to their arrival at the hospital? What screening is involved?

1. Organization and orientation at the campus level is a function of the faculty-member coordinator.

2. The purpose of the program, what it entails, the personal commitments necessary are stressed at a "rally" usually under the auspices of an existing campus organization.

3. No screening is done because:

   a. Screening implies knowing the predictors of success in the program and being able to detect such variables. The auspices of an existing campus organization.

   b. The lengthy commitment screens out many.

   c. Obvious misfits screen themselves out early in the program.

   d. Transportation and distance problems are a factor in eliminating potential misfits.

e. Emphasis upon friendship rather than "therapeutic" serves to exclude some of the zealots.

4. Emphasis upon the companion aspect reduces the need for the student to probe, to want to see records. A not uncommon occurrence is a patient revealing "secrets" to the student that he has withheld from probing professionals. More pertinent to the relationship is the general attitude that "when you meet a friend you do not ask for his case history."

SUMMATION

ROBERT H. KNAPP, Ph.D.

I appreciate very much performing the office that you have assigned me, that of summarizing the general import of our Conference. May I say at the outset that I think it has been a singular success and that my task was very much lightened first by the spirit of buoyancy and hope that has animated our proceedings and secondly by the unusual concurrence of our thoughts and reported experiences. We have heard from two representatives here from the Harvard Program who were not previously associated with each other and therefore report independently. In addition, representatives of the Connecticut Program involving Wesleyan, Trinity and Yale have spoken to us. I cannot recall a single instance in which any significant contradiction of reported experience has arisen. I cannot believe this is because we are docile and timid people and conclude rather that there is some fairly firm and consistent pattern which has been experienced on several independent levels and which has been recognized plainly for what it is by all. I could not help thinking when I came here that this conference might illustrate the oriental fable of the blind men who investigated the elephant and, as you will recall, described him as a tree trunk, a wall or a piece of rope, depending upon which part of the elephant's anotomy was seized. But no such thing has happened. Concurrence and, indeed, remarkable consistency of report has characterized our proceedings.

I should like to make some further preliminary observations. I have attended many conferences, contrived at the whim of a particular sponsor or foundation, and listened to weary and uninspired papers delivered to distracted and disinterested audiences. The precise opposite, it seems to me, has prevailed at this conference. Here, there has been an intentness of concern and a very clear ring of sincerity that has distinguished all presentations before us. No person could doubt, listening to our student participants or to those of our older associates here, that these men are speaking out of the profoundest convictions. The air of this conference has been charged to a degree that I have not known before with intense sincerity and a sense of imminence.

We have been convened here to discuss a new type of experiment in human relations. This experiment involves "an adventure in intimacy," to use Doctor McNeill's happy phrase, between two classes of people who normally would have only rare or transient encounter. This is an experiment which involves the intimate juxtaposition of chronic psychotics, most long past their youth, lost in despair, withdrawn and ideationally aberrant with, on the other hand, a group of young men and women standing at that hour in life of highest promise, of greatest courage, and of most poignant idealism. The question that we have considered here is the nature of this relation, what peculiar effects it works on both parties, and what meaning this has for the public's future attitudes towards the problem of the mentally ill.

At the outset I think it very important to point out that this movement did not emerge from among professional psychiatrists nor was it con-

ceived nor is it managed by psychologists. As indeed with most highly original things, it was conceived in youth and with a sort of innocence—first conceived actually by an undergraduate at Harvard. He presently found some helping hands within the psychiatric and psychological professions, as well as among some peers who joined him in his conception that a sort of missionary enterprise might be organized around visitations to the mentally ill. We are dealing here, therefore, essentially with a youth movement, conceived by youth, manned by youth, sustained by youthful idealism and not with a formally organized system springing from theoretical psychiatry, psychology or social work. In plain fact, this movement, both at Harvard and at Wesleyan and elsewhere, is organized and led by students with only minimal faculty or professional supervision.

The forms that this confrontation of youth at its highest moment of promise with the chronic schizophrenic takes is various. We have heard Mr. Kantor speak of the ward pattern, the patient-aid pattern and their latest venture in the Halfway House. Whichever of these forms obtain, and I shall not endeavor to effect any nice distinctions regarding their effects, we must recognize that it is a didactic confrontation of the highest poignancy. I have searched through the annals of literature and mythology in an effort to find some symbolically appropriate encounter. I find myself reminded inexorably of the Biblical story of David and Saul. It will be recalled that Saul was stricken with a malaise of spirit that immobolized him and kept him within a tent while his armies lay in peril and confusion. It was David, in the springtime of his youth, who brought to the afflicted soul of Saul some healing message that enabled him to shake off the fetters of his affliction and rouse himself to the resumption of his powers and position.

A considerable section of our discussion, but especially the papers presented by Doctors Holzberg and Breggin, has addressed itself to the psychodynamic aspects of the exchange we have been describing. With remarkable consistency Doctors Holzberg and Breggin have described the stages of evolution that commonly have characterized the attitudes of the Companion, their initial apprehensions, present high hopes, the gradual perception of the limitations they confronted, and the final maturing and campassionate insight into the plight of the mentally ill. Both have suggested some kind of mutual identification has occurred here such that, at its best, the patient borrows some of the vital optimism and courage of his Companion while the Companion, for his part, gains a sense of wisdom and charity that is personally and spiritually enlarging. With particular reference to the student, we should note that he stands at an hour of life when the constraints of habit and of well-defined role have not settled upon him. At the same time his capacities for sympathy and feeling are at their high tide. This probably makes possible some special kind of psychological investment in the Companion relationship that might prove difficult or perhaps impossible at another age.

A further observation should be made concerning the student. He is not bringing to the patient any technical knowledge of psychology or psychiatry. He is not, in the formal sense of the word, a therapist. What he does bring lies almost entirely in the domain of a friendly and gener-

ous gift of self and sentiment. Indeed, many of the benefits which appear to accrue from this relation may derive from the plain fact that the Companion has no intellectualized system for confronting the patient and the patient, for his part, perceives the Companion not as a paid professional healer but as another human being in whom some unexpected spark of generosity impelled him to share the patient's misfortune.

Mr. Kantor has given us some very valuable insights into certain concrete ways in which this program operates within the hospital situation. He has described the various forms that the Companion Program may take and has with special force discussed the problem of chronicity which lies superimposed upon the initial schizophrenic alienation. He has enumerated all of the various institutional factors, specifically five in number, that make for the peculiar poverty of ward environment. One might also describe this condition as analogous to a patient with tuberculosis who on being confined to bed presently suffers from bed-sores, failing digestion, and muscular atrophy. Mr. Kantor has strongly suggested, and I believe all have concurred, that the Companion Program represents a powerful countervailing force to the chronicity syndrome. He has taken time to observe too, quite wisely, that the formal staff of most hospitals, especially at the attendant level, tend to be guided by rules of efficiency and convenience which aggravate the problem of chronicity and stand in opposition to the ideals and practices of the Companions. Thus, between the custodial staff and the Companion there stands a kind of ideological gulf which may, if not adroitly managed, cause frictions and conflict.

Let us turn more specifically to some of the gains which this program might bring to all parties concerned. Initially it was clearly intended to provide some kind of service or solace to the chronically mentally ill. Mr. Kantor has presented some statistics on the Halfway House experiment, on ward ratings and on psychological measurements related to the Student-Aid Program. Nothing yet may be declared here with inflexible finality. But it must be admitted that in all three instances there appear to be promising statistical evidences of therapeutic gains from this encounter, especially with respect to the alleviation of the chronicity syndrome.

Few who were initially involved in this program would have expected that there would be highly demonstrable character changes in the participating Companions. However, Doctor Holzberg has been able to show, at significant statistical levels, that students taking part in the Program gain markedly in tolerance and also in self-esteem. It should be noted, too, in passing that he has demonstrated that students volunteering for the Companion Program differ from those not volunteering primarily in terms of social values but not in terms of intellectual differences, or differences in psychopathic propensities.

It was Doctor McAllister, who in reflecting upon the problem of the young college man, observed the forces in the college environment and the intellectual life of our time that make for depersonalization and a sense of ineffectuality. He and others have told us of the frequent instances in which the Companion has described his experience as a

counter-poise to the educational depersonalization of our system. We must conclude, therefore, that to an unexpected degree the student is likely to be an educational beneficiary of this program and the nature of his benefit is not in the systematic intellectual domain, but in the domain that we might call ethical, religious and aesthetical development. It may properly and correctly be called "non-intellective education," a vital conception but vaguely realized by educators in our time.

I should like, finally, to note in connection with the educational aspects of this program that participants have repeatedly alluded to its parallel to the Peace Corps. Doctor McAllister has spoken of the program as representing an excursion to an exotic land. Doctor Breggin has specifically alluded to the Peace Corps as have others. Doctor Greenblatt has spoken of the parallels between Companions and pioneers, and Doctor McNeill, I believe, spoke of the Companion Program as an excursion from the academic cloister. I think the analogy to the Peace Corps is entirely justified and I suspect that the type of person entering the Peace Corps differs little from those joining the Companion Program. And if the Peace Corps be a success, as most would now grant, may not this also become a significant spontaneous youth movement in our and future times? One thing is surely certain. We have here, as in the Peace Corps, been able to discern the fullness of that altruistic fund that characterizes our contemporary youth, and which has been by many too frequently suspected.

There is a third benefit which should accrue from this program which Doctor Holzberg has alluded to as a development of a cadre of future opinion leaders who have a first-hand and sympathetic grasp of the problem of mental illness. Nothing can be said concerning proof that such a cadre is being formed, but the presumption is overwhelming, especially when one examines the reports and statements freely submitted by former Companions. In this sense alone this problem would be justified as a form of public education.

I should like to bring this discussion to a rapid close. If we look at the history of attitudes towards the mentally ill, we can distinguish, I think, three definable stages. In the first, the mentally ill were considered to be demoniacally or diabolically possessed and, as such, religious and heretical pariahs. This attitude gradually gave way to the idea that the mentally ill were somehow the equivalent of criminals and should be kept in chains of bondage. A century and a half ago this attitude began to yield to the notion that the mentally ill were diseased and should be kept in severe quarantine and isolation. It is only in our most recent times that we recognize the folly of custodial quarantine and see the necessity to establish some bridge for these stricken persons, however tentative, to the heartland of our society. I submit that the Companion Program represents a most promising effort towards the establishment of such a bridge.

Certainly at this Conference, we have shared a kind of earnestness, sincerity, and concurrence of both experience and sentiment that is unusual. Growing out of it, we have come to the realization that we may have here, like the small cloud on the horizon, a new approach to the

management of the mentally ill which may in history come to be seen as a primary innovation. This small cloud may, on the other hand, pass over some other hill and not be seen again in history. We can only conjecture which. But I think that, practically speaking, we all concur on the need to carry out some further and more sensitive kinds of research on the effects of this program, both on patients and on the character-education and development of the Companions. The results on hand are promising and need only supporting elaboration to carry them forward. We have left relatively unexplored among us the question of how the Companion Program might be adapted to other kinds of institutions, (correctional and custodial) and to patients other than chronic schizophrenics. The development of this further inquiry must await some future occasion.

May I thank you very much for your patience in hearing out this summary, and may I trust that I have faithfully represented the substances of our Conference.