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RICHARD M. WAUGAMAN, M.D.

CHESTNUT LODGE: AN UNREAL PLACE

Abstract. The author, a staff psychiatrist at Chestnut Lodge from 1986 to 1991, worked there at the same time contributor Liat Katz was a patient. Using her article as a jumping-off point, he offers a personal portrait of the Lodge from the staff perspective, based on what struck him as unique and most salient about the hospital and the hospital community. Among other characteristics, Chestnut Lodge encouraged patients and staff to be themselves. This was one of the core therapeutic features of the Lodge, and it stimulated creativity among its patients and staff. Thus, both were helped in overcoming ubiquitous and often harmful pressures to conform. The author continues to mourn the Lodge, which closed in 2001.

Keywords: Chestnut Lodge, residential hospital, severe psychopathology, institutional transference, intensive therapy for the severely mentally ill, mourning

It was with real pleasure that I accepted the editors' invitation to contribute to this article about my time on the staff at Chestnut Lodge.

I arrived at the Lodge around the time Liat was admitted, but it took me much longer than Liat's 18 months before I was "dis-Lodged." I began full-time in 1986, and gradually reduced my hours when that was allowed, until I worked only 1 hour per week for the Lodge when I left in 1999 (we were always encouraged to conduct our private practices in our Lodge offices, for which we paid rent the last several years). Writing is often a protest against what is lost with the passage of time. The Lodge closed in 2001, and that calamity still reverberates

Address correspondence to Richard M. Waugaman, M.D., 4701 Willard Ave. #204, Chevy Chase, MD 20815. Email: richard.waugaman@georgetown.edu

for all of us who loved that idiosyncratic institution (Waugaman, 2013a, 2013b).

In 1975, I first applied for a staff position at the Lodge. One of my interviewers was John Cameron, then director of research. He kept pushing me to explain why in the world I would want to work at such a challenging institution. In exasperation, I finally said, "I might be crazy enough to do it." "Ah!" he said in his Scottish accent. "You might be daft enough to come here." He then seemed satisfied that I would fit in. Perhaps that was his way of making sure that I would not misuse Lodge patients as targets for the projection of my own disavowed psychopathology.

It would be another 11 years before I felt ready to work at the Lodge, after completing my analytic training. I was told that psychiatrists, like prospective patients, were asked to make a 2-year commitment to the Lodge, but that the Lodge really expected both groups to remain 5 years. A nonverbal expression of this expectation of a long tenure was the parking sign custom-made for each new psychiatrist, reserving her or his place with an attractive wooden post with the doctor's name carved into the wood and painted, looking like something one made for a park ranger.

The medical staff, mainly psychiatrists, had a weekly lunch in the elegant dining room of Rose Hill, home of the widow of Dexter Bullard, Sr., and mother of our medical director, Dexter Bullard, Jr. ("Rusty").[1] We psychiatrists increasingly used his nickname, and he slowly began using our nicknames. One of our more memorable discussions concerned the film *Prince of Tides*. I mentioned that it includes a homosexual rape. None of the others (mostly men) present—they'd all seen the film—remembered that traumatizing scene. This remains my most vivid memory of the dozens of luncheons at Rose Hill.

Perhaps it was at another luncheon that Dr. Robert A. Cohen[2] (Waugaman, 2010) commented that, should the Lodge ever close, its

[1] Dexter Means Bullard ("Rusty"), M.D., was medical director at Chestnut Lodge from 1969 until 1994, succeeding his father Dr. Dexter Bullard, Sr., who led the hospital for 38 years. Chestnut Lodge was founded by Rusty's grandfather, Dr. Arthur Luther Bullard, in 1910. Rusty Bullard died in 1995 (D. M. Bullard, Jr., obituary, 1995).

[2] Robert A. Cohen was a psychiatrist and psychoanalyst who joined Chestnut Lodge in 1946 and two years later became clinical director. After serving as director of the Washington Psychoanalytic Institute from 1959 to 1962 and at the National Institute of

accumulated institutional knowledge would be tragically lost. In 1989, while the Lodge was considering modifying its 4-times weekly individual therapy for virtually all patients, Dr. Cohen asked me to send him a memo about my twice-weekly work with an elderly woman who had used the Lodge as an asylum for many years. Prior to coming to the Lodge, her first psychiatrist was Dr. Austen Riggs[3] himself. I noted that she did not regard my conversations with her as therapy. I wrote, "One anecdote is that she angrily fired a previous therapist when he innocently remarked that he would have to cancel one of their therapy sessions. She retorted, 'Therapy?! I thought you were just coming by to talk!'. . . The twice weekly sessions makes it easier for her to titrate the degree of emotional intimacy that she can tolerate." I once offered to take her shopping for a new coat that she badly needed, but she politely declined, explaining, somewhat cryptically, that "there were untoward forces at work" in her life that she did "not want me to get caught up in."

I also wrote in my memo,

> I know I am not alone in viewing the Lodge not only as an institution in its own right, but also as a model and inspiration to hospitals, patients, and therapists from around the country and around the world. I would greatly regret it if we were to retreat too far from our tradition of intensive psychotherapy. We are now one of the very few hospitals who [sic; it did have its own personality] still place any value on it. This leads me to my other point, the advantages of a five times per week schedule. . . . Seeing [the elderly woman] twice a week has allowed me to see two other Lodge patients five times per week, at their request, and I feel they have both made excellent use of the additional weekly session. I view the more intensive schedule as providing better containment for the emergence of primitive transferences.

Mental Health (NIMH) as director of the Division of Clinical and Behavioral Research and deputy director of intramural research, he returned to Chestnut Lodge in 1980 as director of psychotherapy, where he remained until his retirement in 1991. He died in 2009 (Silver, 2009). (I visited him in a hospice two days before he died, a month before his 100th birthday. He was sleeping when I entered his room. He woke up from his nap, and told me he was dreaming about the Lodge.)

[3] Austen Riggs, M.D., was an internist in Stockbridge, Massachusetts, where in 1919 he founded the "Stockbridge Institute for the Psychoneuroses," later renamed the "Austen Riggs Foundation." Dr. Riggs designed the institute as a center for his system of treatment based on talk therapy combined with structured daily activities that focused on a balance among work, play, rest, and exercise (The Austin Riggs Center, 2019).

A couple of weeks after being invited to contribute this article, I wondered if the editor would be willing to send me the piece that set this special issue in motion. My uncertainty about that unexpectedly brought to mind an us-against-them scenario of Lodge therapists and patients. In turn, that reminded me of an adolescent patient who once asked me to sit facing away from him. Trustingly, but gullibly, I complied. He then poured a quart of fruit juice on my head, explaining later that he could have done much worse. I happened to be wearing a brand-new sports jacket that was ruined (our low salaries made such items a luxury). In my anger, I submitted a bill for the ruined clothing to the Lodge, which graciously reimbursed me. This helped me temper my anger at my patient. Dr. Bullard tended to side with patients when they attacked us. He felt we were usually in the wrong—for provoking the patient, for not treating the patient with respect, for not calling for sufficient back-up when setting limits, etc.

Being asked to contribute this "context" for Liat's piece also brings back one of the many peculiar features of the Lodge milieu. The staff devoted so much of our time to discussing one another's patients that it felt a bit like group therapy on a large scale, with many cotherapists. We heard a great deal about one another's patients over the course of months and years. And we often interacted with these patients in smaller or more significant ways. One patient might be the cashier in the cafeteria that served both patients and staff. We might serve as "interim therapist" for a patient of a colleague who was on vacation for several weeks. We might even receive informal "supervision" (therapy?) from our colleagues' patients. For example, a colleague's patient was once outside my office when he saw me lock my office door when I left for a few minutes. "Mistrustful, aren't you?" were his first words to me once I returned. By contrast, Dr. Bullard had an open-door policy of sorts—he left his office door wide open whenever he wasn't in it. (Didn't I tell you the Lodge was idiosyncratic?)

One religious ideal is to "comfort the afflicted, and afflict the comfortable."[4] Likewise, we felt it incumbent on us when a colleague

[4] "Comfort the afflicted, and afflict the comfortable" was originally coined by Finley Peter Dunne, an American humorist and writer, in 1902, to describe the role newspapers should play in the society ("Observations by Mr. Dooley"). Later this ideal became associated with religion when it was quoted by theologian Reinhold Niebhur. (This, from various sources. See https://www.goodreads.com/book/show/1934616; https://www.dictionaryofchristianese.com [August 5, 2013]; and https://www.goodreads.com/

seemed too self-assured in presenting his or her work at our weekly "medical staff" conference to confront the person with the many subtle signs that the treatment was not really going as well as the colleague thought. By contrast, our empathy was activated by the nearly burned-out therapist, and we were then equally adept at finding contrasting evidence that things were more hopeful than they appeared.

The Lodge's unwritten motto, for patients and staff alike, was "Be yourself." Those words are allegedly among the dozens of maxims inscribed on the ancient temple of Delphi.[5] Just being or knowing oneself is harder to do than you might think, because of the peer pressure of conventionality. Yet it is also deeply liberating. One of my chronic schizophrenic patients at the Lodge conveyed a similar observation when she said, "The unique thing about this hospital is that it's the only place I know where you can say whatever you want. It is so relaxing!"

Many of us who were Lodge therapists continue to work with a few of the patients we first worked with at the Lodge. But Lodge patients and staff have undergone a diaspora since 2001, when the Lodge closed. So, this special issue of *Contemporary Psychoanalysis* becomes an opportunity to reconnect with the Lodge of yesteryear.

Part of the appeal of the Lodge's milieu was the false promise of timelessness. Rusty Bullard used to say, "The Lodge is timeless, like the unconscious." We all deal with transience—and mortality itself—with fantasies of timelessness and immortality. And we are also comforted by the reality that much of what we value may outlive us. Even when an institution such as the Lodge proves to be all too mortal, its ethos may live on.

The 16th-century rabbi Isaac Luria taught that long ago, there was a titanic battle between the god of good and the god of evil. When the latter won, he shattered the god of good into billions of pieces. The spark from one of those fragments is inside every human soul. Thus, our only hope is to work cooperatively for the good.

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quotes/111778-comfort-the-afflicted-and-afflict-the-comfortable. (Also, see Niebhur, R. [1987]. *The Essential Reinhold Niebuhr: Selected Essays and Addresses*. [R.M. Brown, Ed.]. New Haven, CT: Yale University Press.)

[5] "Know Yourself" is a maxim carved into a prominent section on the "Omphalos of Delphi," an ancient stone monument, commonly known as the "Delphi Stone," discovered in Delphi, Greece.

(See https://en.wikipedia.org/wiki/Know_thyself).

The Lodge is no more, but its ideals can live on in everyone who cherishes them.

With the accessibility of psychoanalytic articles on the internet have come challenging dilemmas concerning the confidentiality of clinical papers. Some of us have stopped publishing extended case reports as a result (before I stopped doing so, I wrote about Lodge patients in Waugaman & Searles, 1990; Waugaman 2003, 2005a, 2005b). Having patients write about their own treatments is a wonderful solution to this ethical conundrum. (I stopped writing about patients after one of my Lodge patients read the article I wrote with Harold Searles and said, "I read your article about Alan." She correctly identified which of my Lodge patients the article was about. I haven't been the same since.) Analysts are likewise free to write about their own personal treatment, if they choose. In the past, analysts at the Lodge and elsewhere published clinical work that was, in a sense, "ghost written" by their patients. As with Freud's patient "Emmy von N.," who told him ". . . in a definitely grumbling tone that I was not to keep on asking her where this and that came from, but to let her tell me what she had to say" (Freud, 1955, p. 63), many of the best insights in psychoanalysis have come from patients. They have never received the full credit they deserve.

It is not a surprise that Liat's memories of the Lodge stirred my own: for example, my recollections of Jack Bauer, the gardener, who was widely beloved for his dedication to the healing beauty of the Lodge's grounds. With some 60 acres to care for, he seemed overworked. So, when I'd been there a couple of months, I brought my own clippers to work to trim a hedge that looked badly in need of it (idiosyncratic, no?). It was one small way I enacted my bonding with the Lodge, taking this proprietary interest in its hedges.

In contrast with other psychiatric hospitals where I trained and worked, there was far more of a feeling of equality between patients and staff at the Lodge. Severe psychiatric illness can be scary; psychiatrists and other staff are sometimes unconsciously drawn to distancing themselves from these patients, as though trying to reassure themselves of their own sanity. Harold F. Searles[6] astutely studied these

[6] Harold F. Searles, M.D., who is known as a pioneer in treating schizophrenic patients psychoanalytically, worked at Chestnut Lodge from 1949 to 1964. He died in 2015, leaving a vast literature that is now considered classic in the psychoanalytic literature.

countertransference dynamics. He supervised my work with one severely psychotic patient at the Lodge (Waugaman & Searles, 1990).

The Lodge was known for tolerating a wide range of quirks among its professional staff. (That's what happens when you encourage people to be themselves.) Dr. Bullard, and his father before him, simply required that psychiatrists at the hospital show a commitment to persevering in our difficult work, whatever theories influenced our treatment. Dr. Bert Nayfack,[7] for example, was strikingly eclectic in his approach to his mostly schizophrenic patients. Before Clozapine was approved for general use, he jumped over all the bureaucratic hurdles to get the Lodge to be the first hospital in our area to prescribe this drug, which was, at that time a promising experimental anti-psychotic for our treatment-resistant patients.

Despite his analytic training at the William Alanson White Institute, Bert creatively departed from psychoanalytic psychotherapy with his Lodge caseload. He developed an organic gardening project on the Lodge's grounds to offer work experience for his patients. The produce was sold in local stores. He would come to work on Saturdays to drive his patients some 45 minutes to an impoverished area of Washington, DC, so they could read to underprivileged children. We often found that actively helping someone else had unique value to chronic patients, who otherwise were only the recipients of help. Bert used mutual art projects with some patients, and rebuilt a carburetor with one adolescent. At a staff conference, he once explained that his approach with obnoxious adolescents was to convince them that he could beat them at that game.

The Lodge had a bracing atmosphere of honesty and openness. That could be disorienting at first, but it eventually grew on all of us. In one medical staff meeting, I was especially candid in expressing my views of the financial conditions of the hospital, since Rusty Bullard was not present. I knew some of my colleagues felt financially exploited, but I said I did not think the Bullard family made that much profit from the hospital. I added that releasing the hospital's financial statements to the staff would clarify matters. I realized only later that Dr. Bullard had slipped into the meeting late and was sitting behind

[7] Bert Nayfak, M.D., did his psychiatric residency at Chestnut Lodge, and is now in private practice in Baltimore, Maryland.

me as I spoke. He did then share the hospital's financial statements with the medical staff, while asking us to keep this to ourselves.

The candor that was part of the Lodge's identity could be disconcerting to visiting professionals. We were honored to have Glen Gabbard give a presentation to the psychiatric staff around 1990. He spoke on the "countertransference" that psychiatric staff might feel toward managed care companies, which were then escalating demands for more and more paperwork documenting treatment before (possibly) paying for psychiatric hospitalization. Glen cogently conjectured that we might sometimes displace negative feelings we harbored toward difficult patients onto the managed care personnel. But one of our psychiatrists would have none of it. During the formal discussion after Glen's talk, my colleague said something like, "You sound so rational about an exasperating problem we're having with managed care. I feel it's as though you're being burned at the stake, and you're calmly making observations on the flames and the heat." It may have been Glen's first visit to the Lodge; he looked taken aback.

Some of our behavior toward newcomers probably had features of hazing. One colleague always welcomed new psychiatrists by saying, "You've made a big mistake!" That is, coming to work at the Lodge. He may have felt he was simply verbalizing their unspoken fears.

The Lodge had such strong and widely respected roots in the past that everyone struggled to acknowledge the massive changes that took place in the hospital. Some of us stubbornly resisted a number of those changes, even when the matters were seemingly trivial. I still have letterhead from an earlier era, with the words "Chestnut Lodge" above the address. By the time I was on the staff, misguided efforts to enter the mainstream changed this to "Chestnut Lodge *Hospital*." That was probably an improvement of its earlier name in the 1950s, "Chestnut Lodge *Asylum*."

In 1989, the *Washington Post* (Boodman, 1989) tried to write an "exposé" of the Lodge, exposing our alleged underutilization of psychotropic medications. That was indeed the case in the 1950s. But this article quoted an NIMH psychiatrist who consulted at the Lodge. He said he had examined our charts, and we were using medication appropriately. Rusty Bullard sent a memo to the entire hospital staff (on October 13, 1989), saying "We were deeply disappointed

in the biased and incomplete account of our hospital that appeared on Sunday [in the *Post*]. Many of our longtime friends and associates who were quoted in the article have called or written to tell us that their remarks were taken out of context and did not reflect their conversations with the reporter. . . ."

Because Liat's article focuses on her 18 months in the adolescent inpatient division of the Lodge, I thought readers might be interested in how the Lodge described that section in its brochure from a couple of years before Liat's time there: "The treatment program in a psychiatric hospital incorporates the best aspects of home life and a home living situation. This approach originated in England in the early 19th century under the name of moral treatment, a method of humane psychiatric care that stressed the ordinary aspects of living as central to the treatment program. . . . The primary goal of the ACD (Adolescent and Child Division) is for the young patient to resume normal personality development outside the hospital, unhindered by debilitating psychiatric illness." With respect to the Osheroff lawsuit (again, see Boodman, 1989), it is interesting to read that "Psychotropic medications are used sparingly and are prescribed only after a careful consideration of psychiatric and clinical issues." This statement did not apply to the adult hospital, where psychotropics were used more frequently during my years on the staff.

There are some intriguing parallels between Liat's experiences at the Lodge and my own. For example, she writes movingly of how formidable her houseparent Mike Gleason could be as an authority figure, yet—when she was in crisis after a "tough family meeting"—she saw a "different side" of him that was warmly supportive. Likewise, Rusty Bullard could be warmly supportive in many circumstances, while setting limits as medical director when needed. Before my time, he was promoted to medical director while his father, Dr. Dexter Bullard, Sr., remained on the staff until his death a few years later. As the story goes, one day at a medical staff meeting, a well-intentioned but tactless psychiatrist told the new medical director, "Rusty, you need to be tougher—you need to get some balls." Heeding this advice, Rusty fired that psychiatrist the next day. He clearly saw a "tougher" side of Rusty then.

It has been fascinating to learn from Liat how the adolescents viewed the psychiatrists who worked at the Lodge. She writes that

"Like most doctor–patient dyads at the Lodge, the two men [Dr. Jonathan Tuerk and one of his chronic patients] seem to be in the struggle for survival together." John Fort,[8] late clinical director at the Lodge during my first years there, used to tell us that long-term work with a Lodge patient was tantamount to "adopting" that patient. What a striking comparison! It conveyed the expectation that we would remain committed to our patients through thick and thin. Two more stories about Dr. Fort: More than once, in special conferences when we discussed seemingly intractable clinical problems, I heard him comment toward the end of the meeting, "It's certainly a *dif*ficult situation, but I don't think it's by any means an im*pos*sible situation." That was often what we all needed to hear so we could take a deep breath and persevere. The other recollection I have of Dr. Fort was when Dr. Robert Gruber spoke at his funeral in 1990. He movingly admitted that he found himself feeling so bereft and uncertain about how to cope with this profound loss that he momentarily thought, "Dr. Fort will guide us," only to realize it was precisely Dr. Fort we had just lost.

Liat's "mock game show" with her fellow patient stirs many additional thoughts, especially because it was called "Who is the Patient?" That was also an active question for the psychiatrists at the Lodge. An important influence on many of us was Harold Searles,[9] who was on the staff from 1949 to 1964. He once wrote that he "joked" with his training analyst, Ernest Hadley, that Hadley should get a bed at the Lodge ready for Searles. Searles was perceptive in confronting therapists' unconscious efforts to project their own most disturbed attributes into their sicker patients. Another former staff member, Dr. John Kafka,[10] said that when he and his wife visited the Lodge in preparation for his joining the staff, the social worker who was asked to help them find housing somehow misunderstood and thought John was being admitted as a patient.

[8] John Fort, M.D., joined Chestnut Lodge in 1955 and served as the clinical director until 1965, when he was named associate medical director. He died in 1990. See his obituary: https://www.washingtonpost.com/ … john … fort … /33b95a5f-e5be-4225-a56b-f8d2990dd …

[9] See note 6.

[10] John Kafka, M.D., was a staff psychiatrist at Chestnut Lodge from 1957 to 1967. In addition to private practice, he is currently a training and supervising analyst at the Washington Psychoanalytic Institute and clinical professor of psychiatry and behavioral sciences at the George Washington University School of Medicine (Frederickson, 2003).

Because having a personal analysis used to be a requirement for Lodge psychiatrists, it was in fact true that many of us were patients seeing our own analyst 4 or 5 times per week while we were also treating our Lodge patients at similar intensity, albeit in psychoanalytic psychotherapy.

Of course, the reality is that, before the Lodge began accepting patients with insurance, none of its psychiatrists would have been able to afford being patients at the Lodge. Searles wrote about the patients in his time at the Lodge as regarding their psychiatrists in the same category as the servants in their family homes. An elderly patient I treated who grew up in one of those wealthy families once told me, "Give service!" I eventually realized that's probably what her family told their servants.

Another factor that somewhat blurred the distinction between staff and patients was that a few former inpatients were hired to work on the staff, provided it had been at least two years since their discharge. Such a practice was once not uncommon at long-term hospitals.

Liat gives us an eloquent verbal portrait of being an adolescent patient at the Lodge. The adolescent units were deliberately constructed at a remove from the "adult hospital." Liat's description of the "ghoulish moans" coming from the sickest adult patients made me more aware of how terrifying it must have been for the adolescents at the Lodge, worried they might end up as chronic inpatients (see Carlson, this issue). The ACD was created by Rusty Bullard when he took over from his father as medical director in 1969 (see Bullard, 1990). Rusty was trained in child and adolescent analysis, and had a strong commitment to those patients. Even psychiatrists on the staff who were not trained as child psychiatrists or child analysts were encouraged to include one adolescent in their full caseload of six inpatients. I did that myself during my first several years at the Lodge, and felt privileged to have Rusty as my supervisor for one of my adolescents for a year. His stance was always to encourage a humane relationship with the patient, with less emphasis on technique. For example, if an adolescent asked if he or she should lie on the analytic couch, his answer was "suit yourself." He encouraged us to watch any film our patients found important.

When the patient whose therapy Rusty was supervising neared discharge, we did not yet have adequate community supports for newly discharged patients, especially adolescents. My patient plaintively asked me, "Who will be my Mom, and who will be my Pop?" I like to think this was one influence that led Rusty to greatly expand our clinical support system for outpatients. This eventually included four-bedroom apartments on the second floor of the four new inpatient units, to help inpatients transition to community living; a day hospital; two outpatient day programs; a rehabilitation specialist who helped patients find jobs in the community; and a variety of housing options with varying levels of staff supervision.

Liat courageously discloses her history of being abused. As I reviewed the notes of staff conferences from Liat's time at the Lodge, my impression is that we placed more emphasis on the "here and now" in those days, and did not always explore such histories of trauma, even when we knew about them. We were repeating the early history of psychoanalysis, when Freud shifted emphasis from sexual abuse as the cause of neurosis to intrapsychic conflict as etiological (see, for example, Ringel & Brandel, 2012). That gradually changed at the Lodge. When I presented my work with patients who had dissociative identity disorder (DID) due to childhood trauma, my analyst colleagues at the Lodge were initially skeptical. The few psychiatrists who had no analytic training granted trauma histories more credibility. To be fair, DID continues to be a highly controversial diagnosis (see Waugaman, 2000).

In 1992, Rusty Bullard appointed me as coordinator of the Dissociative Disorders Program. Several months later, he was sitting at the next table at lunch one day. I overheard him tell one of the hospital's clinical administrators, "I don't know about DID. I'm a good interviewer. I've interviewed hundreds of patients, and I've never seen a case of it." Frank Putnam, a national expert, advised me not to set up a specialized inpatient unit for those patients, so I consulted on patients when that diagnosis was being considered. At one of our weekly staff conferences, I was asked to be the formal discussant for a respected colleague. He diagnosed his patient as borderline. When I suggested she might have covert DID, he said he was disappointed in me for "jumping on that bandwagon." Two years later, though, their work got stuck. She was in a trance at the end of many sessions, and

would not leave his office. He asked me to consult with her, which eventually led to his accepting the reality that she did indeed have DID, and was switching in their sessions.

It is a formidable clinical challenge to preserve a strong therapeutic alliance with an adolescent, as well as with that adolescent's parents. This challenge is all the more difficult when the adolescent's problems are severe enough to require long-term hospitalization. Things do not get any easier when we suspect a parent of having abused his or her child. At the Lodge, we may have been even less likely to confront parents with an offspring's abuse because of the myth that our most famous staff member, Frieda Fromm-Reichmann, regularly blamed mothers for causing schizophrenia (see Fromm-Reichmann, 1948).[11] It's as though we had to prove we did *not* in fact blame mothers, or fathers, for their child's illness.

In one of her many striking images, Liat writes that "Chestnut Lodge looked like a stately grandfather." With our adolescent patients in particular, we were in a sort of grandparent role with our patients and their parents. Grandparents sometimes face excruciatingly painful dilemmas about whether and how to intervene when their children's parenting goes off the rails. At an extreme in both settings, courts sometimes have to intercede.

Liat also mentioned the notorious Osheroff malpractice suit against Chestnut Lodge (see Katz, this issue). Dr. Osheroff allegedly claimed that he would have made more rapid improvement at the Lodge had he been given medication. The lawsuit was settled some months before I began working at the Lodge in 1986. However, it cast a long, continuing shadow over the Lodge until the Lodge closed for good in 2001. Because the lawsuit was settled before it went to trial, it technically set no legal precedent, although it certainly has been debated as a landmark case (see Klerman, 1990). Less officially, however, it made it far more difficult for the Lodge to keep its former identity of taking unconventional approaches to the treatment of highly treatment-resistant patients.

Conforming to widely accepted forms of treatment lessens the risk of malpractice suits, even if it deprives some patients of more effective

[11] See also Dolnick (1998) for a critical look at the tendency in the psychiatric community in the late 1940s, 1950s, and 1960s to sometimes attribute mental illness to poor parenting.

but innovative therapies. For example, some Lodge psychiatrists remain convinced that some of their psychotic patients had better long-term outcomes before antipsychotics were used so routinely and so indefinitely. They believed, based on experience, that intensive psychotherapy could be more effective when the patient wasn't psychologically "numbed" by tranquilizers. After the Osheroff lawsuit, this became a moot point, because we no longer felt we could take the risk of treating psychotic patients without the conventional drugs, at conventional doses.

Liat spoke of several subgroups at the Lodge: adult and adolescent inpatients, house-parents and nursing staff, and social workers and psychiatrists. Most of the psychiatrists were in psychoanalytic training or had graduated from it. More psychologists also joined the staff in the years following Liat's stay at the Lodge, many of whom also became psychoanalysts. I believe there were only two psychologists at the Lodge when she was there—Dr. Rebecca Rieger, director of psychology; and Dr. Denise Fort.[12] Dr. Rieger performed psychological testing on virtually all newly admitted patients, and follow-up testing in subsequent years of hospitalization. Although she was, for a time, director of the OutPatient Therapy clinic of the Washington School of Psychiatry, the traditional model of only allowing psychiatrists to provide therapy meant she couldn't function as a therapist.

It was Dr. Denise Fort who broke the barrier, becoming the first psychologist fully accredited as a therapist at the Lodge. Many others followed her. This was clearly a source of great pride for Dr. Rieger. I recall her delight when she questioned a visiting college student at lunch one day, asking why he was pre-med with a plan to become a psychiatrist, rather than getting a Ph.D. in psychology. He replied candidly, "My grades aren't nearly good enough to get into a psychology Ph.D. program."

Some years later, when Dr. Bullard's fatal illness with lung cancer led the Lodge to be sold to a nonprofit community psychiatric center[13] Dr. Bullard's father helped found, Steven Goldstein, a Ph.D.

[12] Widow of John Fort (see note 6). Dr. D. Fort was at the Lodge from 1967 to 1968; and again from 1985 to 1994.

[13] In 1997, the Lodge was purchased by CPC Health, and changed hands again when it went to the Washington Waldorf School in 2001 when CPC Health declared bankruptcy. In December 2003, the property was sold to Chestnut Lodge Properties, Inc., which built residential homes on the former hospital grounds.

psychologist, became the first nonpsychiatrist clinical director of the Lodge. Dr. Rieger asked me how I felt about this. With deliberate irony, I replied, "I'm sure he'll treat us psychiatrists just as well as we treated psychologists in the past." (Ree Reiger was bitter about never being allowed to do therapy at the Lodge. Subsequent psychologists were allowed to do so, and I gather they felt better about how the Lodge treated them.)

Liat makes it clear that she felt cared about by her psychiatrist Dr. Manuel Ross, as well as by Mike Gleason and the other staff on her unit. Her experience in that respect, at least at that time, was typical. The staff at the Lodge did deeply care for patients. Rusty had grown up on the grounds of the Lodge, and he regarded the patients as his equals, never looking down on them. He always made a point of making rounds at the hospital on Christmas Day, a holiday traditionally set aside for one's family. He shared ownership of the Lodge with many of his relatives. But he constantly made administrative decisions that put patient welfare above profits.

For example, if a salaried psychiatrist had treatment time available but for some reason was not thought to be the ideal therapist for a new patient, a more suitable psychiatrist was paid extra to treat that patient if he or she had a full caseload. One of my adolescent patients was discussed in a special, high-level staff meeting after his insurance company refused to pay for further hospitalization. The difficult decision was reached to discharge the patient. But Dr. Jaimé Buenaventura ("Dr. B"),[14] who was the administrative psychiatrist for all the adolescents, somehow "forgot" to discharge this adolescent. A year later, the patient was still at the Lodge, and the insurance company resumed paying—including for all the previous months. I assume they were impressed by the selfless commitment the Lodge showed to this young man. I certainly was.

It was a humbling experience to present one's therapeutic work with an adolescent inpatient at the weekly staff conference. Dr. Buenaventura oversaw the treatment of 28 adolescents. As a presenter, I would work hard to review the complex history of my patient before presenting this patient to my colleagues. When it was Dr. B's turn, he would present an even more detailed history, entirely from memory.

[14] Dr. Buenaventura joined the Chestnut Lodge staff in 1965 and was director of the Child and Adolescent Center (ACD) until the mid-1990s. He died in 2009.

He was eloquent. He once recounted a personal story at lunch. He grew up in Colombia, in South America. His father was in politics, so they lived in the capital, Bogatá. But when he was six years old, his father's party lost power, and they went to live in the countryside. "I hated the lugubrious sound of the cicadas at night," he told us. It turns out "lugubre" in Dr. B's native Spanish is a cognate of our word. On the other hand, after seeing me act in a skit at a going-away party for Dr. Thomas McGlashan,[15] Dr. B told me, "Richard—I did not know you had such histrionic talents." I still don't know whether to feel insulted or not. In Spanish, "histrionico" can mean "theatrical." Or "histrionic."

As I have said, the Lodge encouraged all of us to be ourselves—patients and staff alike. The hospital's ability to encourage individuality and to discourage conformity while upholding high standards of clinical care and research, was, I believe, unique. My impression was that another psychoanalytically oriented hospital, the Menninger Clinic, did not allow the degree of individuality that was prized and protected at the Lodge. This meant that the staff often disagreed vehemently with one another. Stanton and Schwarz's (1954) famous year-long study of one inpatient unit at the Lodge documented that *unexpressed* conflicts among staff members led to increased symptoms among the patients. So we had a tradition of being frank with one another when we felt the other person was taking the wrong approach with the patient. Dr. B tended to be among the most outspoken staff members. He was often criticized for his reluctance to prescribe psychotropic medication to his adolescent patients. After a staff meeting when voices were raised over such a disagreement, I saw Rusty Bullard for my weekly supervision, and I told him, "It really *is* like a family here."

It's easier to be oneself when one's environment respects individuality, despite whatever quirks an individual might have. I had been treating my first patient with DID 5 times per week for several years before I made the paradigm shift of recognizing her actual diagnosis. But I

[15] Thomas McGlashan, M.D., was the director of the Chestnut Lodge Research Institute starting in 1975, where he conducted a follow-up study of 72% of patients treated at the Lodge between 1950 and 1975 (see McGlashan, 1984a, 1984b). Due to the results of this study, Dr. McGlashan later criticized Chestnut Lodge's model of treating schizophrenics with psychoanalysis alone, and encouraged the Lodge to change some of their treatment policies, including more drug treatment (Carey, 2006). Dr. McGlashan is now a professor of psychiatry at Yale.

was only willing to publish about DID (see Waugaman, 2000) after I was appointed as a training analyst. Having credentials, and being at a hospital that supported independent thinking, were both important to me.[16]

In October, 2009, the U.S. Chapter of the International Society for the Psychotherapy of Schizophrenia held its annual meeting in Rockville, half a mile from the now burned-down remains of the Lodge's Main Building (Klein, 2009). The theme of the meeting, in fact, was "The Fruits of Chestnut Lodge." It was moving to hear so many speakers echo Liat in attesting to the deep meaning the Lodge had in their careers. Whether or not they had worked at the Lodge, or even visited it, it inspired their psychotherapeutic work with severely ill patients. Two of us who had come to the Lodge's annual Symposium for some years before joining its staff had the same eerie experience. As we listened to John Kafka's keynote address about his years at the Lodge in the 1960s, we recalled finding ourselves, even now, wanting to go work at that unique hospital one day. For us, it was a moment of time travel, momentarily locking out current reality, so we could put a hospital that had closed 8 years earlier in our future.

For me, one of the highlights of that 2-day conference was meeting Rusty Bullard's younger brother, the psychiatrist and psychoanalyst James Bullard. Jim introduced himself to me a few minutes before I gave my paper. Meeting him for the first time in that setting was much like my time-travelling experience during John Kafka's talk—only Jim was real. With all the mourning for the Lodge that the conference evoked, my emotions turned Jim into a surrogate for his deceased brother, Rusty.

I am moved to share some details of Jim's reminiscences in this article in order to give more historical depth to the portrait of the Lodge that Liat so lovingly created. As owners of the Lodge, the Bullard

[16] My 13 years at the Lodge also contributed to my willingness to go out on a limb and publish some 75 articles, chapters, and book reviews that supported Freud's exceedingly controversial opinion that "Shakespeare" was the pen name of the Earl of Oxford (see References). As I have been writing this article, I faced a dilemma as to conformity. I have been walking half an hour a day in my neighborhood as part of my rehabilitation following knee replacement surgery. I seem to be one of the few walkers who is not walking a dog. So I ordered a clown's leash for an "invisible" dog, as a compromise formation to become a conformist in a somewhat nonconformist way (my 4-year-old granddaughter was the first to walk our "invisible dog," so that worked out just fine).

family and their dynamics had a powerful, if often covert, influence on the dynamics of the hospital.

Chris Keats[17] and I took Jim to lunch both days of the conference, and we were privileged to hear Jim share with us years of his warm feelings about his family's hospital. He had grown up on the grounds where his parents and siblings lived. He remembered sneaking out of the house to visit Frieda Fromm-Reichmann, who joined the staff two months after he was born. He described details of the family farm that surrounded the hospital. For example, Jim slopped the pigs every morning, with the leftover food from the hospital's kitchens. Thirty chickens would be killed each week to provide Sunday dinners for the patients.

Chris and I found that many questions we had long had about the Lodge were answered by Jim's story. We noticed, for example, that Rusty was always secretive about the hospital's finances, and about the salaries of various staff members. When the psychiatrists complained about our notoriously low pay (I found it helpful to think of it instead as an "allowance"), Rusty would tell us the social workers resented us for getting more vacation days every year than other employees did. Without intending to, he subtly set one group against another. So, we were intrigued to hear Jim say that every Christmas during his childhood, he and his three siblings would each get a sealed envelope, containing a gift of shares of ownership in the Lodge. They were told that they had to keep the amount of their gifts secret from one another.

Jim also told us that, as the years went by, he progressed from slopping the pigs to working as a nursing assistant. He remembered giving a so-called cold, wet sheet pack to Joanne Greenberg, future author of the best-selling memoir *I Never Promised You a Rose Garden* (see Greenberg, this issue). When he left for college, he told the staff he planned to return in 12 years to join his father as a psychiatrist on the staff. His older brother Rusty was less willing to return to the Lodge after he completed his psychiatric and psychoanalytic training in Boston. At that point, their father conveyed to Rusty that Jim would replace the father as medical director of the Lodge. Only then did

[17] Christopher Keats, M.D., who worked at the Lodge from 1978 until 2001, serving as director of Adult Psychotherapy during his final years there. He is now supervising analyst at the Seattle Psychoanalytic Society and Institute.

Rusty change his mind, and accede to his father's wish that he come work at the Lodge. Jim thought that their somewhat traditional father wanted his namesake and oldest son, Rusty (Dexter, Jr.), to succeed him. Sadly, Jim and Rusty were not able to form a satisfactory working relationship, and Jim left after only a brief period as a staff psychiatrist. Nonetheless, Jim continued to be deeply influenced by the tradition of his family's hospital. He developed a special interest and expertise in working psychoanalytically with severely troubled patients. When he did inpatient work elsewhere, he introduced some of the practices from the Lodge to other hospitals.

Hearing Jim's story led me to share with him one of my own experiences with his brother Rusty. After I had spent some 18 months being evaluated for possible promotion to training and supervising analyst status at the Washington Psychoanalytic Institute, Rusty asked me one day how the process was going. I admitted to him that I was getting tired of how long the evaluation was taking, and was tempted to throw in the towel. To my surprise, Rusty looked alarmed. I later concluded he believed it would enhance the status of the Lodge to have a fourth training analyst on its staff. But what he told me at that moment was that one of my former classmates in the Institute was close to being appointed as a training analyst. So, years later, I told Jim I wondered if Rusty was repeating their father's pattern of using "sibling" rivalry to motivate people in the direction he desired. Jim said that sounded exactly right.

As I have indicated, talking so intimately with Jim Bullard when I had just met him was an uncanny experience. The entire conference was a mixture of mourning, nostalgia, and time travel. In that context, getting to meet and talk with Jim Bullard felt like having the privilege of going back to a lost era, and having many missing pieces filled in. Our shared mourning for the Lodge, and for Rusty Bullard, served as a powerful bond. The second day of the conference, Jim told us he especially appreciated hearing the many former staff members speak fondly of Rusty and of what Rusty had meant for them.

I am deeply grateful to Liat Katz, and to the editors of this journal, for allowing us all to pay this virtual visit to the Camelot that was Chestnut Lodge.

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Richard M. Waugaman, M.D., is Training and Supervising Analyst, Emeritus, at the Washington Psychoanalytic Institute and Clinical Professor of Psychiatry at the Georgetown University School of Medicine.