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CHESTNUT LODGE, THEN AND NOW

WORK WITH A PATIENT WITH SCHIZOPHRENIA AND OBSESSIVE COMPULSIVE DISORDER

IN THE THREE SECTIONS of this article I summarize the history and evolution of Chestnut Lodge (Silver, 1989), present aspects of my ten-year ongoing treatment of a woman with both schizophrenia and obsessive compulsive disorder, and then comment on the work. The Lodge opened in 1910. It has had four medical directors: Ernest Bullard, then his son Dexter, Sr., then the latter's oldest son Dexter, Jr., and now Wayne Fenton. Each is a forceful and creative representative of his times. It has had five directors of psychotherapy: Frieda Fromm-Reichmann, then Otto Will, Ping-Nie Pao, Robert Cohen, and now E. James Anthony in the adolescent hospital and Christopher Keats in the adult hospital. Tracing the orientations and written contributions of each of these clinicians provides a history of the Lodge (Fromm-Reichmann 1950; D. Bullard, 1959; Sacksteder, Schwartz & Akanabe, 1987; Pao, 1979; McGlashan & Keats, 1989; Anthony, 1990). It is a microcosm and model of American psychiatry, with a proud record of primary influence in two branches, one administrative, the other academic or theoretical. Currently, as throughout the mental-health field in the United States, we struggle to accommodate to rapidly shifting, externally imposed changes. Life is more hectic, less centered. Lodge clinicians usually work elsewhere part of the time, and have less time to confer with each other. We are burdened with nostalgia and grief. Our mentors have all died or retired. The Lodge boundaries probably will soon shrink from sixty to twenty acres. Our nonhuman environment (Searles, 1960) is diminishing.

The founder, Ernest Bullard, had previously been Superintendent of the Wisconsin State Hospital for the Insane, across Lake Mendota from Madison. He believed both in rest cure and work therapy, saying that it is better for people to grow real roses than to make artificial ones (E. Bullard, 1916), neatly foreshadowing Joanne Greenberg's (1964) autobiographic novel from the Lodge, *I Never Promised You a Rose Garden.*

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Wisconsin's Governor Robert LaFollette, Sr., had wanted to hold political functions on the hospital grounds. Bullard said this would interfere with patient care. LaFollette said "find other work." Bullard came east, to open his own sanitorium. He focused on Washington, D.C., figuring that if there were a depression, the federal government would look after its own. He found the Woodlawn Hotel, empty for eight years, in Rockville, Maryland, a little town near Washington.

The hotel became the hospital's Main Building. The family lived on the first floor, patients lived on the upper floors. Ernest Bullard ran his place alone and without vacations, advising families, as was then routine, to send family members at the first sign of madness for the best hope of cure (McGovern, 1985). In 1931, Ernest Bullard died, and his son Dexter Bullard, then thirty-three years old, took over, giving himself five years to determine the direction of the place. He was in analytic training, noticing the similarities between dreams and psychosis, and thought of giving the sanatorium an analytic focus. In 1935, Frieda Fromm-Reichmann came to the United States looking for work. Her former husband, Erich Fromm, called Dexter Bullard's analyst, seeking opportunities in Washington.

Fromm-Reichmann had already run her own sanatorium in Heidelberg. She was a training analyst with the Berlin Psychoanalytic Institute, and she wrote and taught. She was among the founders of the Frankfurt Psychoanalytic Institute. She had the stature and expertise Bullard needed, and together they put the Lodge on the world map. Bullard built her a cottage on the Lodge grounds when Menninger offered her a job. Her book *Principles of Intensive Psychotherapy*, still available in paperback, was read by nearly all psychiatrists until very recent years. She laid out rules resonating with her Orthodox Jewish upbringing and her training as a major in the Prussian Army: "should" seems the most frequent word, and "not" comes in second. She defined therapy with patients beset with hostility combined with grandiosity and impulsivity, patients who believe that their anger is so intense and real that to feel resentment can actually kill the person towards whom it is directed. She was a firm and warm mother to her patients, colleagues, students, audiences, and readers. She fostered the creativity and courage of the staff; Harold Searles, Alberta Szalita, and Otto Will emerged as outstanding innovators.

Harry Stack Sullivan, never formally on the staff, strongly influenced Lodge styles and attitudes. His 246 lecture-discussions, held at the Bullard residence and attended by the medical staff, form the basis for his posthumously published (1956) *Clinical Studies in Psychiatry.*

In 1943, Sullivan, Erich Fromm, Frieda Fromm-Reichmann, Clara Thompson, and Janet and David Rioch formed the New York Division of the Washington School of Psychiatry. Thus the William Alanson White Institute began. Six years later, in 1949, the year of Sullivan's death, the official tie with Washington was broken. We nonetheless share a common lineage that treasures the therapeutic value of countertransference. Ferenczi's and Groddeck's influence on the Washington area came through Fromm-Reichmann's active orientation (Silver, 1993). It contrasted in many respects with the classical style, which advocated neutrality, a blank screen, and passive yet alert evenly hovering, but deemed people suffering psychoses untreatable analytically. Fromm-Reichmann stressed the analyst's responsibility to keep the work moving forward, to let the patient know where the analyst stands, and to summarize the highlights of each session, not letting the patient erase the session from memory before he or she left the room. With her training analysands, however, she worked in the orthodox mode, as attested by her analysand and colleague Robert Cohen.[1]

Although still an active presence at the Lodge until his death in the early 1980s, the senior Dexter Bullard officially retired in 1968, and his son, Dexter Bullard, Jr. (or Rusty), took over. The Lodge modernized. Staff members often resisted some changes. Rusty developed our adolescent division and school. He oversaw the design and construction of the new adult buildings.

No patients lived in the old Main Building. He felt strongly that we should medicate our patients; he hated cold wet sheet packs. He found the exclusion of psychologists from the medical staff an anathema. He wanted a hospital where poor as well as rich could be helped. He wanted an ethnically, racially, economically diverse patient and staff population. He wanted people to talk clearly and simply to each other, not wielding the authority of jargon. He succeeded with all these changes. He encouraged an extensive group-therapy program and day, partial hospital and community programs. He strengthened programmatic supports for patients who were no longer inpatients.

[1]Christopher Keats, M.D., recently reminded me of an anecdote Bob Cohen told us about his analysis with Fromm-Reichmann. She had been almost totally silent for a few sessions. Cohen had said, "I'll bet you'd be saying more to me if I were in a seclusion room on Main III smearing feces." Fromm-Reichmann answered, "Probably," and continued listening.

He gave Tom McGlashan enormous support in his extensive follow-up study (McGlashan, 1984a,b; 1986a,b). McGlashan announced at the 1983 Lodge Symposium, hosting about 500 clinicians, "Frieda and Dexter embarked on a grand experiment. The data is in. The experiment failed." We were horrified. He had just said that only one-third of the patients treated between 1950 and 1975 were moderately improved or recovered. I felt this could have been read differently, because the total group had been everyone else's one-third that did worse. We were a hospital of last resort. In any case, we were well into the medication scene before the Osheroff case.

When Rusty was diagnosed with lung cancer, he appointed Wayne Fenton as medical director. Wayne, previously Tom McGlashan's assistant and a prominent research clinician in his own right, has strengthened the hospital fiscally. He advocates a far simpler medication regimen than is the current style. He has established the Lodge as a research institution working closely with the National Institute of Mental Health. He kept us on a steady course as we moved toward the historic moment when, in August 1996, the Bullard family sold the Lodge to the nonprofit Community Psychiatric Clinics, itself founded by the senior Dexter Bullard, Frieda Fromm-Reichmann, and others, and now under the leadership of Steven Goldstein, Ph.D. We have come through a year of extraordinary change.

The recent history of psychodynamic treatment of psychosis is being written in short paragraphs. Its practitioners worry: Are we headed for extinction or will we come through this crisis strengthened, integrating the dramatic advances in psychopharmacology, which yearly bring new, clearly superior medications? These new medicines often release chronically psychotic patients from what were schneiderian negative symptoms of schizophrenia or what may have been parkinsonian side effects of phenothiazines. Chronically psychotic patients usually don't need chronic inpatient care, but often live in, and contribute to, their communities. They don't need us like they used to. As they respond to risperidone, clozapine, olanzapine, and other agents, they are less likely to maintain grand mountains of obdurate pathology.

Now theoreticians less often garner acclaim for magnificently developed theory. Both patients and doctors are becoming more simply human than otherwise, more willing to acknowledge dependency on each other, and more ready to acknowledge their dependency on a secure

place in which to shuffle through routines and rituals. Our pace has quickened: we no longer have the luxury to relinquish familiar defenses until we have developed better ones. In keeping with international trends, we now meld approaches into an assertive "psycho-bio-social" strategy of treatment, while accommodating to the pressures of managed care (Shore & Beigel, 1996).

Case Presentation

I have worked at Chestnut Lodge for twenty years, needing first to master psychoanalytically oriented techniques, then working with psychopharmacologists and experts in behavior modification, and learning the language of lawyers, bankers, and developers as I organized an attempted employee buyout bid. My work with forty-four-year-old Jody provides me with security of professional identity, and I am grateful to her. We've been together since January 1988.

I will illustrate our interpersonal approach, in which therapists actively use their personalities, hoping to develop a comfortable working relationship with each patient. We follow each patient's lead, sharing activities in which the patient feels relatively calm, while listening for transference themes, and being alert to shifts in countertransference.

We see shared playfulness as intrinsic to a return to mental health. We monitor body language, our patients' and our own. We don't mask our reactions with blank expressions. Our patients know where we stand. Fromm-Reichmann encouraged supervisees to make each session an adventure (Fort, 1989). She recommended that therapists routinely summarize for the patient the contents of each session, highlighting the transitions in content and mood, and articulating their impressions of the unifying issues. The therapist bears continuing responsibility to keep the work moving forward. We do not leave it to the patient to do essentially all of the verbal work in a free-associative mode. We work at putting ourselves in the patient's place. Fromm-Reichmann advised that we assume patients' body posture and expression as a way to feel oneself into their emotional stance.

To help patients conquer their anxiety, we must understand our own. And we must monitor our narcissistic needs, and not require our patients to supply us with success. Stubbornly persistent work with patients who do not necessarily improve is humanistically important, but more vitally

it keeps us in touch with our own primitivity—our psychotic and tumultuous aspects. In that sense, I value Jody as a powerful supervisor and therapist for me.

Jody has suffered since her mid-teens from both schizophrenia and obsessive-compulsive difficulties, the two worst psychiatric illnesses to have in combination, as McGlashan's Chestnut Lodge follow-up study demonstrated. She has received psychotropic medications, in various complex combinations, throughout her thirteen years in Lodge programs. She never had the traditional time to clear the medications out of her system, something both her former therapist and I advocated. Currently, each day she receives clozapine, thiothixene, clomipramine, lorazepam, atenolol, divalproex, and lerothyroxine. I am deeply grateful to Jody's administrative psychiatrist, Dr. Faulconer, who prescribes these medications, and to Abby Brahin, who guides Jody in filling her pill box each week so that Jody can take her meds unsupervised. In phases of our work, I tried unsuccessfully to manage each of these functions. Drs. Marvin Adland, Richard Wyatt, and Judith Rapoport have provided fruitful consultations. I should add that now probably well over half the Lodge patients have just one psychiatrist who serves as both administrator and therapist.

Jody arrived at the Lodge in 1982; this her eleventh institution and perhaps fiftieth hospitalization. She has never held a job. She has required constant intensive efforts since her breakdown at age seventeen. Her parents, their insurance company, and Medicare have funded her treatment. She has resided on almost all of the Lodge units.

Her aggressive infantile dependency persists, but with steady slow improvement. Refusing to wear a wristwatch or to look at the hall clock, she used to stand at a crowded nurses' station demanding: "What time is it? Tell me again. What time is it? Are your sure? Let me repeat it just one more time. You said it was fifteen minutes after, that is past, that is a quarter after or what was it? Fifteen minutes after? Don't interrupt! Now I have to start all over again. I told you not to interrupt. Now, could you tell me again what time it is?"

Taking her meds, while other patients waited in line, tested the staff's ability to resist murder. "Are you sure this is the right pill? Are you sure I just took that pill?" She took hours in the shower or when dressing herself, sometimes coming naked into the general living area, demanding help. She loudly and publicly declared to me or others, "I don't know

how far down to pull my panties. How far down do you pull them when you go to the bathroom?"

She has had phases of immobilizing depression, dreading that if she got going, she might act on suicidal impulses. During these regressions, I met with her in her room; she would still be in her nightgown. After weeks of staying in bed, she gradually rallied and would fix herself a glass of coffee. That is, she poured a spoonful of freeze-dried coffee crystals into a glass, turned on the cold water, filled the glass, stirred the mixture, backed off, stepped forward and stirred it again, repeating this while the water was still running. She repeatedly asked if she had stirred the coffee enough and asked whether the water was still running. I was reduced to asking, "Would it help you if I threatened to pour that stuff down the drain if you don't turn the water off?" She rewarded me by turning off the water and going to the place where we sat and talked.

For her first five Lodge years, she worked with a senior therapist whose office was across the hall from mine. She screeched at him, sometimes for the entire session, her voice easily piercing both closed doors. He aggressively challenged her sadistic dependency. Together they achieved her move to a rented apartment a few blocks away. He diminished her barrage of phone calls to her parents, in which she described wild tortures, imprisonments, and arbitrary punishments. But she wore him down with her demands for a new therapist.

She requested a female therapist, and Dr. Cohen asked me to treat her. I was horrified. I'd never fired a Lodge patient, figuring that as long as one chose to work at the Lodge, one chose to work with very sick people, not just certain sick people. I'm too proud of not quitting. Searles (1979) has written eloquently about the dedicated physician whose helpfulness masks an unconscious sadism and a need to keep the patient ill. It would be therapeutic for both Jody and me, I often have felt, were I to fire her.

So, I dreaded treating Jody. Astoundingly, she made a super first impression. That first session, coherently and with warm humor, she outlined her complicated history, recalling her many hospitalizations and therapists, not only by name, but by their strengths and weaknesses. She said I looked like her high school best friend, with whom, she later told me, she had sexual encounters, and then was abruptly dumped.

During her middle years at the Lodge, she had her own apartment five blocks away. She was proud of it, but couldn't cope with loneliness and

disorganization, and was unable to make simple decisions. Her phone calls to evening staff escalated: "Should I drink a cup of herbal tea or have a decaffeinated soda? I forgot how to set my alarm clock. How do you do it? Should I take a bath or smoke a cigarette? I'm not sure my last cigarette is completely out. How can I be sure?" She relied on taxis to get to and from her apartment. Taxi drivers refused to convey her because she didn't pay promptly, but would stare intently at her money, or would finally get out only to slam the taxi door repeatedly.

If we did not readmit her, she threatened suicide. Once, she threw lawn furniture around and threatened staff with lit cigarettes, screaming, "I'm so lonely I can't stand it." Until recently, she lived in the Frieda Fromm-Reichmann unit, which houses eighteen patients and is staffed by one house manager. She liked it there. Her regressions and morning difficulties have been far milder than previously. To reduce costs, she has moved to a hospital-managed group home across the street from the hospital.

Jody is the youngest of two girls. During her first trimester, Jody's successful businessman father contracted nearly fatal polio. Her mother dreaded that the foetus had contracted polio and frantically considered abortion. Her father, almost totally paralyzed in both legs, was frustrated and rageful, a "holy terror." Mother catered to him and Jody's sister, and hired a nanny for Jody. This woman later told Jody that her sister belonged to her mother, but Jody was hers. The mother fired the nanny when Jody was five, because the woman undermined the mother's attempts to raise Jody. I believe I am that nanny for Jody, and that Jody dreaded showing loyalty to me, fearing that her mother would have me fired. She certainly has threatened to *have* her mother fire me.

At first Jody was a bright and popular kid. At overnight camp, she took over the kitchen on Parent's Day and baked cookies and cupcakes for everyone. The director said his life would be a breeze if he had 100 Jodys at the camp. She revealed this secret about two years into our work. Nobody had imagined she had such potential, that she had once enjoyed generosity. At that time, she refused to do even the simplest task if it involved helpfulness. *She* was the patient, and the other person had no right to ask her to do anything. She proclaimed this in an orgy of raging repetition, invoking the authority of her father and Grandma Ada and threatening law suits and criminal charges. I imagined she was being her childhood father.

Even with her escalating disorganization, just before her abrupt breakdown in her last year of high school, she was so popular that in her

junior year the captain of the football team and the valedictorian competed over taking her to the prom. She was always in accelerated classes, had friends and extracurricular activities. Her college board scores were respectably in the 600s. Then, as talk of colleges began in earnest, her obsessive illness escalated. She spent evenings starting homework, crumpling it up until the floor was littered with wads of paper, and in the end completing nothing.

Her mother thought a trip to Holland on the Experiment for Living would help. When it was time to go to the airport, Jody had not packed. Mother threw clothes in the trunk and rushed her to the airport. In Holland, Jody decompensated, having "eye reactions" in which she experienced others as reading her thoughts through her eyes. Recently, she described how the group kept going to museums, looking at pictures, and she would get so bored, she couldn't keep looking at pictures the way the others could. She simply couldn't handle the independence of the trip, and obviously could not go off to college either. Metaphorically, she suffered a life-threatening and paralyzing illness, a mental polio.

Once home, she began in treatment with the family's psychiatrist who at first advised her not to tell her parents about her psychotic thoughts. Her eye reactions were so intense, her parents dreaded that she would pull her eyes out. Her psychiatrist, who had also treated the father and sister over the years, placed her on haloperidol, hospitalized her, and then suffered a fatal heart attack. She was the only family member who did not cry on hearing the news. I've told Jody I believe she has felt responsible for her father's nearly fatal polio and reacted to the psychiatrist's death as further evidence that she has murderous powers. She has said that I should really watch out myself, and then redundantly asked if I were going to stop working with her.

After that first convivial session, she subjected me to her adamant resistance, usually couched in pseudo quotations of her parents or former psychiatrists, who commanded that she not repeat, or told her not to think about, whatever I'd just asked about. Her voice would grow louder. I set firm limits against her raising her voice, calling it a form of assault. I told her I couldn't stand it. My mother yelled at me a lot, I said. Jody angrily said I had no right to talk about my mother. We were here to talk about her mother, who is perfect.

In this phase, she brooked no interruption, and whined unceasingly that she should be home with her wonderful parents, away from this disgusting place with its disgusting people. In one session, I silently

imagined myself as the Misfit, from Flannery O'Connor's (1953) short story, "A Good Man Is Hard to Find," in which some escaped convicts kidnap and murder a family. My facial expression probably went from pained to smug as I recalled the Misfit shooting the grandmother, then saying, "She would of been a good woman if it had been somebody there to shoot her every minute of her life." I silently imagined a pale pink circle appearing mid-chest on Jody's gray sweater. It gradually enlarged and the center turned a deep red. Abruptly, Jody interrupted her litany, raging: "You could get shot for saying things like that. You could get hauled into court. I'm telling my father."

Now she recalls very hostile things her formerly perfect mother yelled at her. Jody is owning her ambivalences. And I gradually became aware of my paradoxical reaction to Jody's berating of me. I reacted with the same smug scornfulness when my mother yelled at me. I thus became my childhood self, and Jody became my mother who seemed crazy when she yelled. Perhaps Jody sensed that in a way I liked her yelling, because I became again a child, silently ridiculing my mother, who was then far younger than I am now. Temporarily, we had defeated the passage of time. Jody stopped yelling almost completely. One time, though, as a session drew to a close, I summarized what I thought had been a consensus, saying that while she desperately needs to have people with her, she also needs to keep them at a painfully great distance. She said quietly, "You're right, Dr. Silver," and then screamed repeatedly and menacingly, "Fuck you!"

So, until Medicare's recent pressure, we met four times a week (now we meet three times weekly). The Monday session has been discontinued. Previously, if she had gotten behind schedule, I accompanied her to the blood lab (she is receiving clozapine) or, if she was "stuck" in rituals, I met with her on her unit. The next two sessions would be held in my office.

She likes to receive a snack, but she has an enormous appetite. At first, I would offer her something and she would keep badgering for more, while accusing me of defeating her efforts to diet. We gradually arrived at a routine: she may request two small crackers with peanut butter. For a while, this correlated with her paranoia, and predicted whether she would accept me and my remarks that session. Claiming she wasn't hungry meant she dreaded taking in my ideas. Now, orality is not so central. We have many interesting snackless sessions. Usually mid-session, we sit outside together while she smokes a cigarette.

For our last session of the week, if she has been generally prompt and if I have the energy, we drive to a local pastry shop or restaurant or grocery store. At first, these outings could be exasperating and embarrassing, as she counted and recounted her change, or asked for minute descriptions of the pastry items or the calorie counts for the various soft drinks, while other customers waited; or she would address me loudly as Dr. Silver, referring loudly to "the hospital." I set stern limits, which she accepted.

Throughout, she has resisted interdependency. Her theme song goes, "I've seen 100 doctors before I came to Chestnut Lodge, and they all told me not to think about my problems. I think Grandma Ada is right. In her opinion, you want me to think more about you than about myself." Until recently, however, Jody claimed to commune with all her family members in hallucination. She quoted them whenever she disagreed with the other person. That way, she couldn't "get in trouble" for what she said. Initially, whenever I confronted her on this, she changed the subject, and then seemed panicky that I would call the unit and she would lose all her privileges, or that I would have her put in seclusion. I have never done so, nor has she ever needed seclusion. It took me ages to realize that she used seeming panic as a diversionary tactic, to change the subject, claiming to dread my potential criminality. I often said this was criminal on her part. She thus robbed us of potentially interesting understandings.

She alienated herself by calling her fellow patients "vegetables." When this happened in my presence, I said I wondered why she was so cruel to herself. Why did she need people's hatred? She explained that if her parents understood how bad the place was, they would take her home. I said she must know they would dread her contempt as much as those around here did. She then adamantly insisted that she had only love for Mommy and Daddy. She ought to be living with them. She has tried to obtain this by wearing down institutions, rather than by increasing her self-reliance. In a moment of comfort, she confided her fear that as soon as she became independent, her parents would say, "Finally, you're on your own. We never want to see you or hear from you again." She revealed that her family was not so perfect. There were raging fights in which mother hauled Jody out of the shower when she had been obsessionally stuck there for hours.

In a family session, after putting her parents and me through her rituals, she said, "It's hard to explain. I'm much healthier than the other

patients on my unit, but I'm also much sicker. I can't decide anything. And I can't tell what's real, what people are saying and what my voices are saying. I can't stand the feeling. It's a wonder I don't kill myself. It's so difficult to get through the day."

As she became less rigid, I no longer could predict the mood of a session from its beginning. For example, she arrived about ten minutes late, saying she was late because the nurses were late with her meds. I said I thought there was more to it. She had been pruning the hours at the end of sessions to go to the unit for her meds and had been taking frequent breaks, trying to get just the right distance from me. She had been coming late recently, whereas previously she was dependably prompt. I said perhaps she could take more responsibility for the lateness. She became defensively angry, insulted me, and said that—according to her father—I shouldn't be trusted. When I gave her an exasperated look, she said, "Now you're acting crazy. You may be more crazy than I am." Abruptly, her mood brightened. She showed me the rhinestone earrings and bracelet she had purchased on her own. She stood over me, so I could see the jewelry better. Beginning with "I'm not sure I should tell you this—I'm not sure I can trust you," she said she planned to go to a hospital dance the next evening.

It turned out she was preparing to sing torch songs at the Lodge Saturday night coffee house. People told me they were moved to tears by the warmth and professional quality of her renditions. Thus we learned that in high school she had been in a musical comedy club. Now she and I sing together in sessions sometimes. These duets cheer me up. I tell her so, and we continue singing, although earlier my gratitude frightened her, and she would call me "lesbian." Lately, she has creatively modified the lyrics. "Getting to know you" got changed to "getting to kill you, getting to kill all about you, getting to kill you, getting to hope you kill me," which really could be the theme song of her illness.

She rarely mentions her childhood. I heard the following account only once. When she and her older sister were young, "before my nervous breakdown" (it is rare that she acknowledges mental difficulties), the family went to a dude ranch. She rode in the advanced group, and her mother urged her to get her more timid sister to try riding also. On the trail, directly ahead of Jody, her sister's horse was stung by a bee and "lifted up on its legs and raised its hands or arms or whatever and threw my sister off, and I burst out into hysterical laughter and she got very angry. She had broken bones—broken ribs—and Mommy had to take her to a clinic. She was in a lot of pain. It made me phobic about horseback riding." Here, she allowed honest reporting to break through her redundant saga of her perfect family toward whom she felt only love. She had triumphed over her older sister.

I later told her about the time my brother and I (he about four, and I seven) played our game of calling through the support pipe of our swing set. "Hello down there," we would call. My brother climbed up first. He yelled into the pipe, and was stung around the mouth by hornets. I told Jody how I had stood on the ground nearby, immobilized with horror and fascination, and said, "I still feel guilty that I didn't go to help him right away. Sibling rivalry. Mixture of love and hate."

Previously she would have angrily retorted that she didn't want to hear about my life. This was her time. She was going to tell Mommy. Doctors X, Y, and Z would never do that. I had no right to do that. She was the patient. Certainly standard analytic teachings amply support her stance. I intended, however, to intrude with personal material, hoping to help her to accept other people's spontaneous contributions, rather than to tell them brusquely, "I don't want to hear that. I'm not listening. You have no right to say that to me." At first, she denied any sibling rivalry: she simply loved her sister. Then, quietly, she said she resents that her sister is so disappointed by Jody's difficulties that she rarely contacts Jody. I was amazed when she added, "Maybe I should call her."

A few weeks later she said she was going on a Lodge-sponsored shopping trip to a bookstore. Before, she only bought clothes. For perhaps the first time since her breakdown at age seventeen, she considered reading a book. She never actually did this. She described how hard it is to read. She isn't sure whether she just read a particular word or line. Thus, recently I was astounded when she said that during a visit to her parents' home she had read the psychology section in the encyclopedia. She found it interesting and was surprised that she already knew about many of the issues discussed. "I've learned a lot here," she said. Stunningly, she added, "I'm glad you still have the patience to work with me. I know my problems aren't easy. Are you going to keep being my teacher?"

I feel grateful to her for her warmth, and grateful, too, for clozapine, and for her behavior modification team. But narcissistically, I wish my work with her was clearly the key element in her progress. When I asked her permission to report on our work, after a few silent seconds she said, "Yes, but don't take all the credit." She said I should mention

Patty Sullivan (the house manager on the Fromm-Reichmann unit), Peggy Meyer-Wilson and Dr. Heinssen (who head the behavior modification program), Abby Brahin (her clinic nurse), Mike Murray on evening staff, and Betsy Kwako, her social worker. I expected to hear Dr. Faulconer's name added when she said, "And don't forget the miracle doctor." Instead, she first named Dr. Judith Rapoport, who had urged a major increase in her clomipramine.

Jody appropriately challenged my narcissism. But additionally, because we are a symbiotic cluster of personalities, she thus acknowledges to her various inner selves that they have a big support team here. She then told me to add to my report, "The relaxed side of Chestnut Lodge is its best foot forward." Immediately, she qualified her remark, saying, "I'm not really relaxed here either. I have some fears about Chestnut Lodge—the hospital itself." I don't think she was referring to its survival, but to its (that is, her own projected) vengefulness.

She spends most of her days in the Meyer behavior modification program, where she masters food preparation and clerical skills. When Jody began there, she amazed everyone; once again, as in our first session, she was initially a star worker. Inevitably she became immobilized by anxiety, and spent literally months unable to get out of bed until early afternoon. Then over the next year, she gradually reached an equilibrium in which she is perhaps at her most relaxed since her breakdown. Attending a recent family reunion, Jody actually helped with the dishwashing and food preparation, something she had never done since early teenage. Her family, including Grandma Ada, congratulated her on being so at home in the kitchen.

Recently she arrived for a session eager to go to the Pastry Place. I wasn't up for it. She had earned the outing, and I felt guilty about letting her down. I offered to treat her to a soda from the machine downstairs. As we walked there, I said I felt guilty. She said, "I don't *ever* feel guilty." I said, with surprise, "That's too bad." "Why?," she asked. "Because guilt is part of the full range of human feelings. It must be in there someplace and you're not letting yourself feel it."

Down in that basement hallway, she said, "Two months ago, we went to that Mexican restaurant, remember? And you changed the arrangement; even though you invited me to go out to eat, you insisted I pay for my own meal, which wasn't fair and it wasn't right. I didn't pay for it, and you haven't asked for the money. What did I get? I think it was a taco salad. I think it was five dollars or five-fifty or six or maybe it was almost ten dollars. I have the money now. I've earned it in the program. Do you want it?" I said five dollars would be fine. I commended her repeatedly, redundantly, gleefully for this new and spontaneous and clear demonstration of responsibility. I added that we both knew that we each pay for our own food. Her reminding me of her debt showed, I said, that she is capable of feeling guilty and of using it to strengthen her relationships.

This spring, Jody astounded me by speaking philosophically. She said, "You know, I am very frightened of Mommy and Daddy dying some day. But even more frightening, really the most frightening, is knowing that some day I will die, and then it will be over. I won't exist anymore." She looked terrified and asked, "Are you angry at me? Are you going to stop being my doctor because I said that?" I was startled. "Why would I be angry at you for saying something so fundamentally honest? Were you frightened I would be angry that you are reminding me that someday I will die?" She answered, "Mommy is the best mommy in the world. She wants all the conversations to be superficial and boring. I'm not supposed to talk about things like that." She had never described "Mommy" as insisting on superficiality before. Perhaps she is getting bored with her hallucinated Mommy.

She missed the next two sessions, regressing into her rituals. I didn't pressure her. In the next session, I said we have seen such a clear pattern of her doing something well and then getting frightened and getting stuck. I recalled her telling me long before that she was afraid if she ever got well, her parents would say they never wanted to see her again. Was she frightened, when she acknowledged dreading her own mortality, that I would see her as all better and that I might then say our work is done? She was quiet for a minute and then said, "Yes."

Recently, as we walked together on the Lodge road, she began with her usual Monday morning carping about the Lodge and how she should be living with her parents. She went on, for what I thought would fill the whole session, about how the Lodge has made her worse and how she never had these problems before she came here. Without missing a beat, she said, "And if you believe that, I'll tell you another one." We both burst out laughing. She talked about the weekend: she had straightened up her room and done three loads of laundry, and even dusted. We walked further down the road, and she sang a Joanie Mitchell song she'd been listening to while she worked.

They paved paradise;
put up a parking lot with
a pink hotel, a boutique
and a swinging hot spot.

Don't it always seem to go
that you don't know what
you got 'til it's gone?

Discussion

Jody would appear in the McGlashan study as unchanged after years of treatment. She has loyal Lodge friends, but she is not living on her own, has not held a job, and has not developed an intimate sexual relationship. In fundamental ways, however, she has changed profoundly. We often feel comfortable, trusting, open, and spontaneous with each other. That comfort must inevitably influence and reflect all of Jody's interpersonal dealings, whether with other actual people in her life or with the people in her mind.

I now feel that her illness is not so much one of unbridled narcissistic cravings as one of extremely primitive guilt. I believe she feels responsible for her father's polio, the destruction of the family's hopes, and then the death of her first psychiatrist and her father's nearly fatal car accident. She has imprisoned herself in hospitals, forcing those around her to subject her to cruel and unusual punishment. She has experienced herself as subhuman, unfit to be among even the most difficult among us, and has compulsively behaved hatefully, thus forcing rejection. She has accused those around her of being such a criminal, hoping then to identify with our efforts to maintain self-esteem while imprisoned and tortured by her. Now she is less vindictive towards herself, and is granting herself longer probations and even well-deserved pleasures.

During the years of work with Jody, I have observed a gradual cohesion in transference and countertransference as she has become more confident in her surroundings and herself. Transference has become less driven by the affect of the moment. At first, envy and jealousy dominated. I no longer shift from being girl friend one minute, mother of a toddler the next, and demonic ruler of the universe soon after. The room is occupied simply by her and me, rather than by all her relatives whom she often experienced as communicating with me, ignoring her. Early

on, they shifted in age: she experienced me as looking after her two nephews, who ranged in age, in such hallucination-driven sessions, from infancy to their actual mid teens. Concurrently she was fluctuating wildly into different ages of her own development. I differentiate this from more routine regression to a certain level of development. Parts of her psyche came forward behaving as if transformed, and she, as director of the cast of characters, cast me in roles about which I needn't be informed, because there was no self-motivated other person, the analyst, to be related to in those phases. The characters in this chaotic drama occupied the stage. I then felt as removed from the action as would a drama critic seated in the third row, who, however, could wield her power to affect the life of the production, which I could kill with a bad review. I had felt utterly shut out when I imagined shooting her in the chest. Her response to my gaze was "you could be shot for saying that." She demonstrated forcefully that at some level she was exactly attuned to me.

In the transition phase, she saw me as less jealous of her regarding her hospitalized situation. Her wariness diminished, and she gave herself longer spans of time to think and reflect; increasingly, she shared these reflections. She differentiated herself, me, and the Lodge, whereas earlier, if she were aware of an angry thought or feeling in herself, she became panicky, wanting to leave my office, because she dreaded that I was the source of this anger. But then if she left, she dreaded that I would call the nursing staff and command them to punish her.

Gradually, she has been able to see life on a longer continuum. This is illustrated within the affect of vengefulness and projection. At first she seemed convinced I would capriciously fire her immediately, irrevocably, and without warning. Next she believed I was going to the Director of Psychotherapy who was persuading me to continue. Then we went through a phase that only gradually became clear: she had believed that when the following July would come, when new young staff arrived, I would then "rotate off her case." She could not communicate this concern directly because she believed that I would then shift responsibility for this decision and pretend it had been her fault, her idea and wish. So more recently, when she said she hoped I will continue to be her teacher, I felt we had succeeded in building character structure where before there had been chaotic characters. She still was clinging to denial of her profound emotional and mental difficulties, but now I am acknowledged, after this decade of effort, as actually being her doctor,

someone she hopes will continue working with her. I am in her lyrics: "Getting to kill you—getting to hope you kill me." We talk about projection: she may fear I will stop working with her when she has wanted to stop working with me. She owns her use of projection, and told me that on the weekend she thought I was going to stop working with her, and then remembered our saying, "Behind the fear is the wish."

Earlier, our identities depended on the stage's setting. When we were on outings, she was convinced that she and I had nothing to do with the Lodge. The dynamic of my getting her in trouble somehow was irrelevant. Driving onto West Montgomery Avenue, it was no longer as if I, as agent of a punitive Lodge, would retaliate. The Lodge was behind us both geographically and temporally. Now, as we eat pastry or sip lemonade, we discuss the events at the Lodge and work on understanding our own interactions there.

This moves us to the domain of character formation. Early in our work she proclaimed loudly and repeatedly that she could not function, and she demonstrated this dramatically. Simultaneously she knew she had the capability to do these various simple tasks, and knew she was trying to wear us down, so that we would give up on her and she could return to a hostilely dependent relationship with her mother. She dealt with her fear that I would get her in trouble—that is, that I would punish her for her felt criminality by relying on projection. I was the criminal. We've had countless examples of this and have discussed very many of them. The proportion of as-if helplessness is diminishing. She is more often believable in her helplessness, and thus those helping her are not so prone to react angrily (this includes staff as well as strangers in the community, such as check-out clerks at the grocery store). Recently, on a Friday afternoon, she again hystrionically begged to be readmitted to the hospital. But in our first session of the week, without my even asking, she reviewed this event, saying a housemate was insisting she wash her dirty dishes. She had done so Friday evening and had had a good weekend. She had figured out, had then remembered, and then spontaneously shared this neat piece of self-analysis, and had not then dissolved in anxiety over showing so much self-reliance.

As I review my presentation, my observations fall into a rhythm of then and now, not so much a before-and-after, but like the phases of the Lodge's history, a marking of transitions, like stanzas. Our work, like the Lodge, is continually evolving. Termination seems as unthinkable as would the closing of the Lodge.

Myths have developed about the Lodge and its "golden years," which sometimes bedevil me. The myth, as I met up with it on a speaking tour in Germany, seems to be that the Lodge at its prime cured schizophrenia through classical psychoanalysis. I sent a copy of my paper (reporting on my work with Jody) in advance to one of the hospitals and was told, "You may not read your paper at my hospital. It shows too much the deterioration of Chestnut Lodge, where you take the patient to restaurants. This is the work we expect from our specially trained nurses, escorting them to the rehabilitation programs. You may read it at the other places, but here, Dr. X will present a case and you will discuss it. Here at our hospital we follow the principles of Fromm-Reichmann." I answered, "I am opposed to this change. Holding sessions away from the hospital is not something recent. If you read Fromm-Reichmann or Searles carefully, you will see many such examples. This is old Lodge. We need to discuss our different understandings of these principles of treatment." I wish I had then quoted Fromm-Reichmann (1939): "For example, one day I took a catatonic patient who asked for a change of scene to a country inn for lunch, another time to a concert, and a third time to an art gallery" (p. 120). "Nothing matters except that the analyst permit the patient to feel comfortable and secure enough to give up his defensive narcissistic isolation and to use the physician for resuming contact with the world" (p. 123).

Chestnut Lodge has become a beacon. Seen only dimly at a distance, it becomes to the idealizing viewer something different from both how it is and how it was. Our work has always been messy, filled with improvisation and complex tensions and with the uniqueness of each patient's and each therapist's personality and style. Therapists' questions increase as treatment progresses. Spectacular results were and are rare. We mark progress by modifications, not transformations. Therapists use their interpersonal skills, trying whatever seems promising, then bringing their work to the review of their colleagues.

Meanwhile, this doctor's criticism highlights an aspect of the old Lodge which was not so nice. While Fromm-Reichmann was very critical of work with patients that left them spouting psychoanalytic jargon and canned psychodynamic formulations, the setup of conferences and seminars promoted the development of such formulations by the staff therapists, with clearly elitist aspects. On the units, nurses were not rarely reprimanded for talking at length or intimately with patients. They were advised that early in a meaningful revelation the patient should be en-

couraged to bring this to their therapy. Nurses might be chided for demonstrating unanalyzed competitiveness with the doctors. The patients' days were quite boring, compared to the challenging and focused program in which they are now enrolled. There was an intellectual hierarchy. At the weekly Wednesday conferences, one patient was presented, the therapist would speak for forty-five minutes, followed by the administrative psychiatrist, social worker, and a member of the nursing staff. Another medical staff member would present a formal discussion. General discussion, dominated by the medical staff, followed. The transcripts of these conferences are extraordinarily rich.

All this served as background and preparation for the yearly symposium and other analytic meetings in which the papers were often highly technical, and were a challenge to audience members. Searles has, somewhere, quoted himself saying gleefully to his wife, as he worked on such a presentation, "They won't get through this one with an acetylene torch." Resonating with the larger psychoanalytic community, we developed our own grandiosity that complemented the psychotic grandiosity of our patients. We had our private language (resonating with our patients' neologisms), which may have isolated us from the wider mental-health profession that addressed the needs of the severely mentally ill. (Searles also said of those Wednesday conference general discussions that the doctors' comments reminded him of the movie *Fantasia*, where volcanoes spew lava in the planet's molten days. Each volcano is quite totally unconnected with the others.)

Now we are more pragmatic, less personally competitive regarding theory. We are not looking for individual results, that is, who is the better therapist. There are too many variables to allow such rivalry. How do you weigh one's interpretations against a medication change, group therapy, or the new job? We are more clearly involved in team efforts than we were in our glory days. This more level playing field brings with it a blurring of professional boundaries. The patients are actively part of their treatment teams, participating in these meetings. I believe that their guidance of their individual treatments is also more readily acknowledged.

This case presentation illustrates the mysteries of madness. We still don't know why Jody broke down. We can point to stressors: her father's devastating illness and his and the other family members' reactions to it; her involvement in a lesbian relationship and abrupt abandonment; marked difficulty leaving home, when she was sent to Holland (although

earlier ventures away had gone well); a brittle, immobilizing perfectionism that made college work impossible. Vamik Volkan (1995) describes the sudden emergence of psychosis as like an intrapsychic dinosaur egg bursting open, or like the creatures hatching from their victims in the movie *Aliens*. The alienated psychotic individuals are fundamentally as mysterious now as ever. The medications we prescribe have actions we cannot determine. Psychopharmacologists describe them as "dirty," adding that dirty may be good because we need to influence multiple complex systems not yet delineated.

In closing I will highlight a few clinical principles.

(1) Psychotic patients need just the right degree of intimacy, and the correct physical distance from the therapist and her hospital office. This varies through the week: most distant at the start, then closer, then distancing again as the weekend approaches.
(2) Patients oscillate in reliance on magical thinking. The therapist is more menacing at the beginning of the work, and then at the start of each week. The hospital is seen as more menacing after a lonely weekend, when the patient will expect retaliation for her angry feelings.
(3) Over the course of treatment, we routinely see a gradual decrease in reliance on denial. Now my patient can laugh about her many problems, whereas before she adamantly denied their existence. Increasingly she teaches me about her treatment.
(4) Each patient puts us in touch with complementary aspects of our own personal dynamics. This essentially selfish motive holds us in this complex adventure, and makes our other more prosaic, healthy relationships often seem less vital than this intrinsically mysterious relational work.
(5) This is active and responsive work in which the therapist aims at intuitive clarifying resonance.

On that speaking tour in Germany, someone referred to me as an "actionist," differentiating this from her Kleinian orientation. "Actionist"—I am growing to like this label, happily tracing a lineage through Fromm-Reichmann to her mentors, who included Groddeck and Sandor Rado. They in turn were inspired and influenced by Sandor Ferenczi and Otto Rank, who wrote about active, maternal intervention.

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