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Interview with Dr. Otto Allen Will, Jr.

M. Guy Thompson, Ph.D. and Sharada Thompson

The following interview was conducted on May 1, 1992, by M. Guy Thompson, Ph.D., and Sharada Thompson at Otto Will's home in Point Richmond, California. Dr. Thompson met Dr. Will in 1983 and subsequently saw him in therapy for a brief time. Dr. Will was one of the principal inspirations for Dr. Thompson's decision to found, in 1988, Free Association, a psychoanalytic training program emphasizing phenomenological and interpersonal perspectives. Dr. Will supervised students there, and with his wife, Dr. Beulah Parker, convened an ongoing clinical case conference until his death in November, 1993. Mrs. Thompson was supervised by Dr. Will at the Free Association during her analytic training. This interview was conceived as the first of a series of reminiscences by Dr. Will on his career as a psychoanalyst and psychiatrist. Sadly, it is the only interview that was completed before his death.

Interviewers: Dr. Will, your training as a psychoanalyst is remarkable in that your principal influence as a clinician was Harry Stack Sullivan, with whom you were in analysis. Yet, you are a member of the American Psychoanalytic Association, an accrediting body that rejects Sullivan as a bona fide psychoanalyst. You were subsequently Director of Psychotherapy at Chestnut Lodge, where you succeeded Frieda Fromm-Reichmann and distinguished yourself as one of the most gifted psychoanalysts in America working with a schizophrenic population. Later, you became Director of Austen Riggs, where you enjoyed even greater renown as an administrator. We would like to start by asking you about your evolution as a psychoanalyst and the experiences you believe helped shape your development. Perhaps we could begin with your decision to become a psychiatrist.

Dr. Will: When I graduated from college I worked for a while as a travelling auditor for the Western Division of General Mills. Then I decided to go into medicine and to study psychiatry. Yet, what I saw of

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psychiatry in medical school was very disillusioning, and the department of psychiatry at Stanford—this was in 1935—didn't seem to me very strong. Anyhow, there wasn't anything in the teaching that stirred me up very much. The treatment in those days was pretty disheartening, particularly for anybody who was psychotic. In the first place, they didn't pay much attention to psychotic patients, and in the second place they were accustomed to using rather severe forms of treatment with that patient population, such as, for example, injecting 15cc's of horse serum into their spinal columns to see what it would do. In fact, the serum created a fever, with the idea that it might kill any organisms in their nervous systems that might be causing them difficulty. After that came insulin-coma therapy. I remember one psychiatrist insisted that his patients take the insulin in order to instigate convulsions, which lasted for a period of about four hours. I saw one patient die after insulin coma. Then came electroshock. In those days, almost every patient, it seems to me, got electric shock. I remember one patient at St. Elizabeth's Hospital [Washington, D.C.] received eight shocks in one day, if you can imagine that.

Interviewers: They sound like unusually cruel forms of treatment. What were the diagnostic criteria for administering these treatments at that time?

Dr. Will: This was mainly for people who were diagnosed as schizophrenic. Manic-depressive patients were also treated in the same fashion. This was all so disillusioning that I decided to switch to internal medicine and pediatrics. I subsequently received a fellowship in internal medicine to the Mayo Clinic, but I never got there because the war came along and I went overseas. I joined the Navy and was assigned to a small ship in July of 1942 which made landings on Guadalcanal. We were in a division of six World-War-I-vintage destroyers, a very makeshift operation to say the least. The flagship was sunk the first day, and within the next few days two more were sunk, so that half the division was gone in three or four days.

Interviewers: What were your duties aboard that ship?

Dr. Will: Although I hadn't been trained to do any surgery in any of my residencies, I was the sole doctor aboard my ship. There wasn't any other staff and we didn't have an operating room or any equipment to speak of. We would simply strap two typewriter tables together and carry on. We couldn't use ether for anaesthesia because it is explosive and the ship might be fired on when we operated. Consequently, we

gave the wounded seamen intravenous morphine—half a grain injected very rapidly—which would knock them out for a very brief time. I didn't operate on abdominal wounds since most of them either died or were sent ashore. I have to say I learned quite a lot.

Interviewers: Your experiences there sound very far removed from a person who had intended to become a psychiatrist. Do you feel that the war helped you in your personal or professional development?

Dr. Will: Well, I gained a lot of self-confidence! I remember when I went to the commanding medical officer in Norfolk before my assignment to that ship and I said, "I've never been trained in surgery, but I'm pretty well qualified in medicine, and if I were assigned to a larger ship with a senior officer who's a surgeon, I could be his assistant." I'll never forget his answer, and I'm glad he gave it. He said, "Do you have a medical degree?" I said, "I do." And he said, "I hope you have a good trip!"

Interviewers: It sounds like it was an extraordinary trip, to say the least. What happened when you returned from overseas?

Dr. Will: When I came back from overseas, because of my previous interest in psychiatry and the Navy's shortage of psychiatrists, I was sent to St. Elizabeth's Hospital in Washington. That's when I heard Sullivan speak. It was a new experience for me. Psychotic patients were shown in an entirely different light. I was accustomed to hearing patients characterized in the most technical terms, whether it was dementia praecox, schizophrenia, or something else. But to Sullivan they were just people who were troubled one way or another. This was also when I heard Frieda Fromm-Reichmann speak, and I was very impressed by her for similar reasons. I was assigned to the Navy unit at St. Elizabeth's and worked with David Rioch, a most remarkable man, who suggested one day, "Why don't you get some therapy?" He suggested that I call Sullivan, which I attempted to do with great difficulty as his phone was always busy. I finally got through to him one day and said that I'd like to see him in therapy. He said, "Where do you live?" And I said, "Well, I live in southeast Washington." He said, "That's too long a trip for you to make over here to Bethesda." And I said, "No, I can make the trip all right." "Well," he said, "what's your rank?" I said, "lieutenant commander." He said, "You don't make enough money to see me." I said, "I can pay my way!" So he said, somewhat reluctantly, "Well, all right."

So I had to take a bus and streetcar out there to see him. He always had five dogs in the room with him, a mother and her pups. They frequently

interrupted the session by running out the dog door, barking at the garbage collector. One day I said to Sullivan, "Those dogs…." He said, "Yes, what about them?" I said, "Well, I'm talking and they get up and bark and that distracts me." He said, "Oh yes, Doctor, I know. But what can I do about it?" So I knew that the dogs weren't going to leave, and that was that!

Interviewers: How would you characterize Sullivan's style as a therapist? Was he relatively active, like Ferenczi, or more reserved, like the so-called classical analyst?

Dr. Will: He was a very quiet therapist, he didn't talk very much. I don't mean that he sat there in enforced silence. That wasn't his point. But if he had something to say it really meant something. He rarely made interpretations like, "This is your father …" and so forth. For example, one day I was very angry with him for some reason or other. He was quite frail as he was very ill—he had a bad heart and had an oxygen tank in his room. And I said to him in anger, "I'm so angry I could throw you out the window." And he said, "No doubt you could." And later, when I got up to leave, I felt embarrassed and kind of ashamed of myself and I said, "You're really not like my father. My father used to say 'no' to me in a certain way that seems an awful lot like you do, so I suppose my anger is an example of father transference." Sullivan said, "No Doctor, I don't think so. I think at the moment you don't like me very much, and at the moment I don't care very much for you either!" [laughter]

Interviewers: Did he typically distinguish between transference and nontransference phenomena, or did he question the very concept of transference phenomena in the first place?

Dr. Will: I would say that his main approach was to get to the data. He said that if you got the data, he believed that most people were smart enough to make use of it. I suppose that was his way of conceptualizing the idea of free association, that you simply allow patients the opportunity to speak their minds and the rest will follow. So he didn't have the need to take one little thing to pick on and then say, "Oh, that must be a mother transference." He'd try to get a lot of things in the open until his patient could say for himself, "That's the way my mother used to behave." He thought you learned things better that way, instead of having it spoon-fed to you. One of my friends who was also seeing Sullivan was having a very hard time, he told me. At the end of a session, Sullivan

said to him, "Doctor, I wish I could give you a helping hand, but I don't know how, so I guess we'll just have to plod along together." And my friend told me that was very encouraging. Sullivan didn't give him some trite interpretation or something, but what he did say, in effect, was that we study this and learn what we can from it and work it out together. He was a very subtle person.

But, getting back to your question, he didn't believe that transference explained everything and that often, without realizing it, analysts invoke transference interpretations in such a way that one's behavior can always be blamed, in effect, on one's "unconscious." The effect that his comment had on me—that we simply didn't like each other at the moment—gave me an extraordinary sense of freedom. It meant that I could feel however I was prompted to, as could he in turn, and that that was perfectly acceptable in terms of the relationship that we shared. Somehow, that seemed terribly forgiving to me, and it made a powerful impression.

Interviewers: Were there ways that Sullivan did, in fact, remind you of your father?

Dr. Will: There were important things that emerged from my work with him, especially due to his ill health and my own and my father's history of sickness. After I came back from overseas in 1943 I entered St. Elizabeth's Hospital and for some time experienced recurrent pain in my abdomen. I finally discovered that it was a tumor and had to have most of my stomach removed. I weighed 210 pounds when I was operated on, and a year later I weighed about 150. I had a very slow recovery. I had to take five or six different medicines, go on a special diet, couldn't drink Coca-Cola or alcohol, and so forth.

Finally, I consulted an internist, since I wasn't feeling any better. I sought his advice on whether I should go to Harvard or the clinic at Pennsylvania University, and I'll never forget what he said to me. He said, "Doctor, I don't think they can help you at either one of those places. I don't think anybody could blame you for being a gastric cripple. Lord knows you're having enough trouble. But, it's up to you. You have to decide whether you want to be a gastric cripple or not." I'll never forget that. I walked out of his office that afternoon, went into a bar, and had two martinis. It didn't kill me. I didn't get well right away, but bit by bit, after a while, I did. Within six or seven years I was able to eat most things without any trouble. But it was very helpful what that

man said to me when he did. Rather than go around and say, "I have this terrible trouble, I was operated on, and now I can't eat anything," I came to terms with my situation and somehow changed my attitude about it.

Interviewers: How did your work with Sullivan affect your struggles with your own health? We understand he was quite ill when you saw him, as were you.

Dr. Will: Seeing Sullivan suffer from his increasingly poor health brought this issue home to me in a very special way. My father also suffered from terrible health. When I was born, my dad began to hemorrhage from tuberculosis. In those days, people with tuberculosis went to New Mexico or Colorado to be in the dry air and sunshine. So, my mother went with him to New Mexico when I was six weeks old and left me with my grandmother and a black lady who took care of me. I didn't join my mother again until I was three years old. One of the things I've always been sorry about concerns a time when I went to visit my mother's sister in Oklahoma and she told me that a black lady wanted to see me. I went over to the black section of town, as it was segregated in those days, and I went to this house and the black lady came to the door. She threw her arms around me and cried out, "Oh, my baby, you've come back to me." Of course, I didn't know what she was talking about! It wasn't until I was in my forties that my mother told me I had been taken care of those first three years of my life by that black lady. My mother had felt ashamed about leaving me and didn't want to tell me. I was always so sorry that I didn't know who that black lady was when I had the opportunity to get to know her.

Interviewers: What a remarkable story. It sounds like your own struggles with your health played a significant role in your capacity to sit with other people's suffering. You must have, in turn, felt protective of Sullivan's infirmity.

Dr. Will: I was. I think that this allowed for a special bond that I felt with him, as he was in poor health the entire time I knew him and there was something about the way he was able to bear it that inspired me to lend whatever strength I possessed to him.

Interviewers: What could you tell us about his technique? Did his poor health affect his capacity to work effectively?

Dr. Will: He never used the couch with anyone, I don't think. He positioned the chairs at right angles, so if I were sitting there looking straight ahead, he might be sitting in his chair looking the other way. He could see out of the corner of his eye, but he wasn't staring at you. I

found that arrangement perfectly satisfactory. In terms of his health, I think he managed okay.

Interviewers: What about the duration and frequency of sessions?

Dr. Will: The sessions tended to last ninety minutes. That was pretty much his standard practice. I saw him twice a week for two and a half years, until he died. He sometimes saw people three times a week, but he felt that twice a week was really quite sufficient, especially with his use of the lengthier session. Sullivan preferred to allow more time for something to happen during the course of a session, rather than having shorter sessions every day. I can only say that this arrangement suited me very well.

Interviewers: Were you formally training with Sullivan at the time you saw him in therapy?

Dr. Will: At that time—this was in 1947 or so—Sullivan was still involved with the Washington School of Psychiatry, where he gave seminars and participated in analytic training. He suggested at one point, "Why don't you go into the [Washington Psychoanalytic] Institute?" There wasn't much formality to it. I just spoke to the head of the Institute—I think it was Edith Weigert—and she said, "Sure, come along." That's all there was to it. Things were terribly informal in those days.

Interviewers: Could you tell us a little something about what it was like to train with him?

Dr. Will: I wasn't actually formally supervised by Sullivan, though I did discuss my patients with him in my therapy sessions and he offered advice and other comments in the way of help. I attended his lectures that became the book The Psychiatric Interview, and generally identified with him to a considerable extent, so that I endeavored to model myself on him in my practice. I found him to be a very wise and helpful person. When he had something to say it was obvious that he had thought about it, and it invariably made a lot of sense, in my opinion. He didn't engage in chatter. When he had something to say he said it, and you could take it or leave it. It was up to you.

Interviewers: It sounds like Sullivan gave his patients a lot of credit for possessing some native intelligence in the treatment situation. Would you characterize him as uncommonly forthright in his behavior with you?

Dr. Will: Yes. He said what was on his mind, if he thought it was important. I remember one day at the end of a session he said, "I'm a little troubled." I said, "What's the matter?" And he said, "I'm afraid I'm

beginning to like you." He could be softhearted, but he could also be sharp-spoken, though I don't recall his ever being that way with me. They like to say he didn't tolerate fools lightly and that at meetings he wouldn't hesitate to speak his mind. That was something I never saw. He once said to me, "Do you know why I decided to work with you?" I said, "No, why?" And he said, "Because that little dog likes you!"

One day I was sitting in my office—Sullivan had gone overseas—and the door opened and Dexter Bullard, the head of Chestnut Lodge, came in. He said, "Harry's dead." And for a moment I didn't even know who he was talking about. I always called him "Doctor Sullivan" and he always referred to me as "Doctor." I rather liked it that way, both formal and endearing at the same time. I was quite devastated.

Interviewers: Could you tell us about the circumstances of his death?

Dr. Will: When I saw Sullivan he couldn't drive because he wasn't very strong. I drove him down to a meeting one evening with Brock Chisolm, who was head of the World Federation for Mental Health, a remarkable guy who was a captain of artillery in the Canadian army back in World War I. In World War II he was head of the Canadian Medical Services. So I drove Sullivan down to meet him one evening for cocktails across from the White House. Sullivan was planning a trip to Berlin to meet with the head of the American forces, when Berlin was occupied by the French, British, and American troops. So we sat down for a cocktail. Chisolm said to Sullivan, "Harry, I don't think you ought to go to Berlin." Sullivan said, "Why not?" And Chisolm said, "Because I don't think you'd survive the trip." And Sullivan said, "Do you think I'll live very long if I don't go?" Chisolm said, "No, I don't." Sullivan said, "Well, I'm going." And Chisolm said, "I knew you would." So, he went and met with the general there, and then went on to Prague to give a lecture. He died on the way back, in a hotel in Paris, from a ruptured artery. In an article he wrote in 1924, in a footnote, he said, "Should I die at the age of fifty-six of a rupture of the middle meningeal vessel…." And, of course, he did die at the age of fifty-six. It's an odd thing, isn't it? He was cremated and they sent his ashes home to put them in Arlington Cemetery.

Interviewers: It sounds like Sullivan was quite ill during the two and a half years that you were seeing him.

Dr. Will: Oh, yes. He had a very bad heart. As I hadn't finished my analysis with Sullivan when he died, after a while I began to work with Frieda Fromm-Reichmann. I was with her for about six years or so. She was at our house the night she died. I remember driving her home after

she paid us a visit—which she often did—to play with our little boy. I was chatting with her on the way home about a patient I was seeing, and as she got out of the car she said to me, "Don't get too involved." I saw her to the door, and then I got a call later that afternoon that she hadn't gone to a party she was supposed to attend. I went to her house and found her lying in the bathtub, dead. Like Sullivan, she died from a heart attack.

Interviewers: Goodness, you lost both of your analysts during the course of your therapy with them. What impact did that have on you?

Dr. Will: Yes, that's true. I decided not to go on with any more, for better or worse.

Interviewers: Could you tell us something about your experience with the Washington Institute after Sullivan and Fromm-Reichmann died, when you were working with Clara Thompson? Was it a close-knit group of people at that time?

Dr. Will: Yes, I think it was. Clara Thompson was there for a while before she left to go to New York. On the other hand, there was feeling on the part of some that Sullivan's approach wasn't "classically" analytic—whatever that means—and that the training should be more classically oriented. Many of his students were divided that way, and I suspect that is still the case.

Interviewers: Was the pressure to become more classical coming from within the group or from without?

Dr. Will: I think it was coming from within. The first analytic society in the United States was in New York, I believe, in 1910. Then about twenty years later, around 1930, other institutes were formed. In the 1930s the Washington-Baltimore Institute and the Washington School of Psychiatry came into being, as did the Chicago and Philadelphia Institutes, all of which were affiliated with the American Psychoanalytic Association. Though Sullivan's ideas became increasingly controversial as he moved further away from Freud and closer, I suppose, to Ferenczi, there was a time when Sullivan's emphasis on social theory was harmonious with what was happening in other institutes, such as the one in Chicago. Some people regarded Sullivan as more of a social scientist than a psychoanalyst. I can only say that for me, I'm very grateful that I had the opportunity to work with him, and with Frieda Fromm-Reichmann whose ideas were very compatible with Sullivan's. They were both remarkable people.

Interviewers: What became of your relationship with the Washington

Institute after your training? Were you then involved with St. Elizabeth's and Chestnut Lodge?

Dr. Will: I taught a beginning course in analytic technique for eight years. I don't think it was a typical course of that type, because I didn't limit the course to the more conventional texts—such as, for example, people like Fenichel—but I included books by Sullivan, Glover, and so on, to give students a sense of diversity. I emphasized a rather broad approach to what I considered analytic treatment to be. After a while I became a training analyst, though I didn't train an awful lot of people as most of my activities were with Chestnut Lodge.

Interviewers: How did the environment at the Institute evolve while you were there and after? Did it's emphasis become more classically analytic as time went on?

Dr. Will: Oh yes, I think so. I would expect it is very much so now. I haven't had direct contact with the Washington group for a long time. Things gradually got worse between the institutes that were affiliated with Sullivan—the Washington School, the William Alanson White Institute—and the American Psychoanalytic, until there was a complete break between them. Somehow, I've always managed to have cordial relationships with all of them, though I don't know how.

Interviewers: What were the issues that gave rise to the break with the American?

Dr. Will: I don't know, exactly. We just weren't following the rules of the American. The American was becoming more dominant. In the earlier days these institutes were more self-sufficient. But the American increasingly became very controlling. I'm pretty much out of touch with it now, but my impression is that if somebody is admitted to an institute for training, it has to be approved by a committee from the American, even if nobody on that committee knows the applicant personally. When I was a training analyst, we were asked to hand in a monthly report on our trainees, but several of us refused to do that because we saw it as a violation of privacy. They eventually dropped that requirement.

Interviewers: Your name and reputation are more closely associated with Chestnut Lodge than with any of your other affiliations, and you frequently speak of your time at the Lodge as the best years of your professional life. Could you say something about your experience there?

Dr. Will: I used to go to conferences at Chestnut Lodge when I was at St. Elizabeth's Hospital. I was tremendously impressed by the informality at those conferences and how everybody could speak up and pretty

much say whatever they had on their minds. The atmosphere was quite different from the more formal conferences I attended at St. Elizabeth's. Sullivan had suggested to me that I check the Lodge out, believing that I would like it there. And he was right, I did. It was an extremely congenial and supportive environment to work in.

Interviewers: Chestnut Lodge was one of the first hospitals in this country to utilize a psychoanalytic orientation in the treatment of schizophrenic patients. Was it a psychoanalytic hospital at that time?

Dr. Will: Yes, it was, though the patients weren't treated in "classical" psychoanalysis. All the staff were analysts, though.

Interviewers: The Lodge must have been a very exciting place during the first few years you were there.

Dr. Will: It was. Frieda Fromm-Reichmann was there, the first Director of Psychotherapy. She was a very remarkable person. And Edith Weigert was there, too. Sullivan came out and gave seminars there. It was a very satisfying environment to work in and to learn something about treating very disturbed people. The atmosphere was very alive and, of course, that made it easier to deal with the difficult patients that were treated there. No one had to worry too much about whether one's technique was this way or that. I found it very interesting.

Interviewers: Did your technique differ dramatically in your work with schizophrenics from that with your other patients?

Dr. Will: No. I saw all my patients as just people. We just tried to talk to each other, is all. I remember one woman that I worked with I had to see in [ice] pack. I'd go in there and she wouldn't talk; she'd just spit at me. One day I was sitting in a chair on the ward and I thought she was in her room, but she wasn't. She suddenly came down the hall, picked up a big chair to hit me with, and I managed to deflect it. I got up, but I was frightened and angry. I grabbed hold of her, twisted her arm, and shoved her into her room. She had a stripped room because she broke everything that was in it, so all that was in there was a mat on the floor. We stumbled and I fell on top of her onto the mat. I'll never forget it. She was perfectly quiet, and then she said, "Well, doctor. You have finally touched me." And she was never assaultive again.

But she did begin to smear feces all over the place: herself, the wall, everything. Before I'd come up to see her, the nurses would clean all this up. Then one day it occurred to me that this was a crazy thing for me to do. When I'd been overseas the wounded were brought in from the shore, literally picked up in the water, and my pharmacist mate and I

would strip them down and wash them. A lot of times they were covered in mud, and before we could perform any surgery we had to make sure they were clean. So, I told the nurses not to clean this woman up just because I was coming to see her. When I visited her, she sat there on her mat, covered in feces all over. I got a mop and cleaned up the floor and the window. Then I got some water and I took her gown off while she sat there on a little stool. I washed her body and her hair till she was perfectly cleaned. She never smeared herself in feces again. I suppose you could get into trouble for doing that sort of thing today!

Then she began to talk. She kept on this way and we met on a regular basis, and soon we figured that she'd be able to move out of the hospital. Then her mother came to visit. We told her mother how pleased we were with her progress and how she would be an outpatient fairly soon and that she could to on to University, and so on. Well, the mother went home, and a few days later we got a call from her saying that she wanted her daughter transferred to a hospital close to where she lived. I objected to that, but her mother insisted on it.

I reluctantly drove this patient down to the railroad station. She cried, and then she put her arms around me, weeping. Then she got on the train and went to join her mother. About a week later her mother called me and said that she didn't know what had happened to this woman. I asked, "What's the matter?" She said, "I went to see her at the hospital, and she just sat on the floor and didn't recognize me and didn't say anything." I said, "Did you sign anything for a special treatment?" And she said, "Yes, I did." I said, "I think she's had a prefrontal."

And she had. I felt absolutely terrible about it. God, what an awful thing! I learned later on that after visiting her daughter at the local hospital, the mother went home and the chauffeur met her at the train station. She said to him, "Where is my husband?" And the chauffeur said, "Your husband said he had something to do this afternoon and couldn't meet you." So she went home, but didn't find her husband in the house. A little later she went down to the basement and found that he had hung himself. Then she went back to the hospital, got her daughter, and brought her home.

Interviewers: What a tragic story, though not an uncommon one, we suspect. It must have been just as uncommon in those days to treat schizophrenic patients exclusively with psychotherapy as it is now. Were you ever obliged to use any form of medication with the patients you saw in psychotherapy?

Dr. Will: No, never. At the Lodge, of course, every patient who was admitted had either been treated with insulin or electroshock before we saw them. The Lodge didn't give it to them, but they had been treated with it wherever they had been before. We had practically no first-time admissions at the Lodge. All our patients had already been treated someplace else. I never treated anybody with medication. I don't see many patients now, but if anybody wants to see me I tell them that if they feel they need medication, I'm not the guy to see. Frankly, I don't know that much about it, nor do I care to. If I thought that one of my patients was going through a very bad time and could be helped with some medication, I would refer that patient to someone who would prescribe him some. But I can't say that that ever really happens with me.

Interviewers: Most of your clinical career, it seems, was spent at the Lodge, and later at Austen Riggs. You've become something of a legend at both of those institutions, and your attitude about the use of medication and the like has aroused considerable controversy. How would you compare your experiences at the two places?

Dr. Will: Well, I was at Chestnut Lodge for some twenty years. I succeeded Frieda as Director of Psychotherapy there after she died. After I left the Lodge I went to Austen Riggs, where I stayed for eleven years. Of course, the two places were quite different. The Lodge was very large and had a closed unit, whereas Riggs was very small and was completely open. Robert Knight, who had been Clinical Director at the Menninger Clinic, went to Riggs in 1947 and became their Medical Director. He died in 1967.

When I came to Riggs, a third of the patients came and went within thirty days, because they went there principally for diagnosis. I didn't think that made much sense. I couldn't understand why anybody would go up to this little town [Stockbridge] just to be diagnosed. I decided to change that policy so that patients would agree to stay for at least a year.

What's more, some of the staff who were in analytic training there only stayed for about a year, and then they were gone. I decided to change that too. I don't remember exactly, but I think we asked them to stay for a minimum of four years. It seemed to me that you got pretty good training in that amount of time.

Interviewers: We understand that the relationship between Austen Riggs and the Western New England Psychoanalytic Institute [New Haven] was very tight at the time you were appointed director. Did you change that too?

Dr. Will: Staff members would travel down to the Western New England Institute for therapy and to attend conferences, and so on. I felt that I needed to put a stop to that. I didn't like the idea of people having to make that long round trip two or three times a week when it wasn't really necessary to do so. It seemed to me that it took their minds off the thing that mattered most, which was their relationship with the patients and the staff at Austen Riggs. So I set up a program in which we analyzed our own staff members at Riggs. We had some problems, of course. But I felt that was all we could do. There weren't any analysts living in the local community at Stockbridge, so the senior analysts on the staff at Riggs would analyze the younger people. That arrangement had certain advantages too, because certain things couldn't be ignored. If your analyst was criticized in a staff meeting, for example, you knew about it. And if you didn't mention it to your analyst, your analyst could say, "What did you think of that, what so and so said about me today?" Though this arrangement is considered fairly unorthodox today—and even then—I thought it was necessary to experiment and not be tied to a rigid formula that didn't necessarily fit the situation.

Interviewers: We've heard from analysts at the Western New England Institute that your decision to change the previous arrangement caused a lot of controversy. It sounds like some of them were concerned that this "Sullivanian"—you—would come to town and ruin the setup that had been so carefully put in place there along more classically conventional lines. Did you sense any of that when you arrived?

Dr. Will: There was a lot of gossip when I first came up there that I was going to "change" Riggs. As one of the staff members said to me, rather angrily, "I suppose you want to make this into Chestnut Lodge North!" In fact, I did have the idea of putting in a closed unit to complement Riggs's traditional open program. But I decided not to do that, much to the relief of that staff, I might add!

There was a lot of concern that we would somehow turn Riggs into a more conventional mental hospital, which was ridiculous. Anyone who had ever been to Chestnut Lodge would have realized that if anything, the atmosphere there was more intimate and relaxed than it was at Riggs, where, as I said, the staff came and went to New Haven on a regular basis. It seemed to me that their fears were somewhat misplaced. I thought that all the changes we made rather improved the place. We required that all the therapy staff members go into therapy with someone,

not just the ones who were in analytic training. And we worked very closely with the nursing staff, to help them work with the more disturbed patients that we began to take on. None of them had had that type of experience before. They didn't know what to do with patients who were really seriously disturbed.

Interviewers: It sounds like Riggs wasn't as accustomed to working with a population as severely disturbed as the one you worked with at the Lodge. After the changes you made there, would you say that the patients you accepted at Riggs were nonetheless less psychotic than the ones at the Lodge?

Dr. Will: Yes, they were. We couldn't take care of some of the severely disturbed patients like we could at the Lodge, because Riggs was an open hospital and people could just wander off if they had a mind to. So we couldn't accept patients at Riggs who would have to be restrained on a regular basis or who would require us to use cold packs, and so on. But we found that if you start working well together as a team, you can take care of a lot more disturbance than you thought.

Interviewers: We see that our time is up, but before we stop we would like to ask you one last question. We understand that R. D. Laing visited Riggs in 1972, while you were still the director. How did you two get along?

Dr. Will: It was very interesting. We had a very nice talk and we seemed to be able to understand each other about therapy. He impressed me a lot. Of course, he was quite a celebrity then, and he even had a film crew following him around to all the places he was visiting in America. He asked if they could film our conversation and I agreed to it, though I was thinking to myself, "This is a little too much!" I had heard about Laing's work in London, and a lot of the rumors I'd heard concerned me some. But as I said, we talked together and nothing that he said sounded extravagant to me. He impressed me as a very capable person, and a very sensitive one.

Interviewers: Your career parallels Laing's in some respects, in that you were both trained analytically and, in spite of arousing a great deal of controversy in your unconventional methods of treatment, you have always been significantly identified with the psychoanalytic community. Where do you see yourself now, given the direction psychoanalysis has taken? Do you still feel a strong kinship with it?

Dr. Will: I enjoyed my experience at the Washington Institute very

much, both as a student and teacher. I don't know what it would be like now, but my guess is that it is a rather typical, "classical" institute. I'm not sure how much I have in common with that way of thinking.

Interviewers: Do you see this as a trend amongst the analytic institutes?

Dr. Will: I don't know if I would call it a "trend." The institutes, I think, by their very nature, tend to be rather rigid. You have the training analysts and then you have the supervisors and you learn the theory and so forth and so on. I gave a graduation talk to the class at the local [San Francisco] institute a few years ago, and I remember that I wanted to congratulate them for having finished a long bit of hard work. And I said to them, "I also want to tell you that now that you've graduated, you're free to think!" It seems to me that you get kind of caught up in a rigid, vicelike structure, if you aren't careful: "This is the way it's done, and this is the way you do it," and that's that. I'm not so sure that you can even avoid it. Some of the students there seem to like it that way and others don't. They choose to become analysts for a variety of reasons. If you want that kind of experience, it's still pretty good training and usually a pretty good faculty. I think, though, that the more centralized influence of the American tends to pull the institutes into being pretty much like each other.

As I say, I'm glad I had the opportunity to be in an institute when I did, with the kind of people who were there at that time. If I had to do it now, though, given how times have changed, I think I would pick a different profession!

Interviewers: Dr. Will, thank you very much for your time, and for a most enlightening conversation.