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“THE FULL STORY BY NO MEANS ALL TOLD”: Harry Stack Sullivan at Sheppard-Pratt, 1922–1930

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Harry Stack Sullivan (1892–1949) is well known for his interpersonal theory of mental illness, but little is known about how he actually worked as a clinician with patients. This article examines a pivotal time in Sullivan’s career at Sheppard and Enoch Pratt Hospital in Baltimore from 1922 to 1930. Using clinical records as well as published writings, the article focuses on 2 crucial issues that are not fully addressed either in Sullivan’s published writings or in past studies of him: first, his treatment as a gay psychiatrist of patients who he believed had homosexual orientations; second, the intellectual and institutional paradigm in psychiatry that influenced his practice. Finally, this article addresses the circumstances surrounding Sullivan’s departure from Sheppard-Pratt, suggesting psychiatry’s limited confrontation with the social stigmatization of homosexuality.

Keywords: Harry Stack Sullivan, homosexuality, the new psychiatry, clinical work

Harry Stack Sullivan arrived at Sheppard and Enoch Pratt Hospital, a private mental hospital in a northern suburb of Baltimore, in late 1922. He was a 30-year-old physician experienced in surgery and internal medicine, but with little work in psychiatry. Although Sullivan was ambitious, few would have foreseen that, during the following 7 years, his reputation as a psychiatrist would flourish. He became the director of clinical research at Sheppard-Pratt in 1925. More important, his success in the treatment of young male schizophrenics—he claimed that 48 of 78 acute cases he treated exhibited “marked improvement”—became noteworthy in the history of American psychiatry.¹ However, little is known about how Sullivan actually worked as a clinician with patients. The aim of this article is to reexamine this pivotal time in Sullivan’s career, using clinical records as well as published work. After a brief look at the format of Sheppard-Pratt’s clinical records, it takes up two crucial issues that were not fully addressed in Sullivan’s published writings and past studies of him: first, his treatment as a gay (although not openly so) psychiatrist of patients whom he considered had homosexual orientations; second, the intellectual and institutional paradigm in psychiatry that influenced his practice and its limited confrontation with the social stigmatization of homosexuality.

What made Sullivan’s achievements with male schizophrenics possible? Some have argued that it was his unique approach to mental illness. While working at Sheppard-Pratt, this argument goes, Sullivan applied his emerging “interpersonal theory,” which located the causes of illness in a patient’s “failures” in interpersonal relations.² He believed that these failures occurred because of

The quote in the title comes from Harry Stack Sullivan, “Regression: A Consideration of Reversive Mental Processes,” *State Hospital Quarterly*, 11 (1926): 208–217, 387–394, 651–668 (quote is from p. 212).

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social and cultural “inhibitions.” For example, a number of patients were believed to have masturbated and then collapsed into psychotic confusion. Biological theories of mental illness, influential during the 1920s, held that masturbation was harmful in itself. In contrast, Sullivan attributed the illness to the common belief that masturbation is abnormal. As a result, those who had masturbated rejected that part of their “self,” producing personality dissociation and perceptual confusion.³ To remedy mental disorders, therefore, psychiatrists needed to explore life histories of patients and to encourage them to accept even unpleasant experiences as part of themselves.⁴ By redefining mental illness in social and cultural terms,⁵ Sullivan was said to have removed the stigma from the mentally ill, particularly schizophrenics, and thus was able to cure many. In his view, schizophrenic episodes were not alien to a normal mental process but were “common among adolescents . . . having trouble in their social adjustment.”⁶ If doctors regarded schizophrenics “as (ordinary) persons, . . . attempted to discover what continued to . . . interest . . . them, and . . . adjust the environment . . . in harmony with these peculiar findings,”⁷ the recovery rate would increase. The problem was not on the side of patients, but rather in a society that failed to offer a therapeutic environment. What doctors should have done was respond to patients’ needs.

Past studies have assumed that Sullivan did just that. For example, in her biography of Sullivan, Helen Swick Perry argued that he established amicable relations with patients, on the basis of his published 1929 statement: “we found that intimacy between patient and employee blossomed unexpectedly, that things which I cannot distinguish from genuine human friendship sprang up . . . , that any signs of the alleged apathy of the schizophrenic faded, . . . and that the institutional recovery rate became high.”⁸ Sullivan’s former colleague David McKenzie Rioch argued that the central issue of Sullivan’s approach was to “respect . . . patients as human beings.” In the hospital, Sullivan was always “on the patients’ side” and attacked “anyone who derogated, molested, or neglected . . . patients.”⁹ Gail A. Hornstein made a similar point, arguing that Sullivan “tried to create an ideal environment in which young male patients experiencing their first schizophrenic break could have an experience of ‘benevolent intimacy’ . . . reinforcing a sense of shared humanity for all concerned.”¹⁰

Such characterizations, derived from Sullivan’s published writings, capture one aspect of the psychiatrist’s clinical practice. However, as Risse and Warner, among others, have suggested, theories and procedures presented in published works often differ sharply from the practice described in clinical records. They observed that “[c]linical case histories can be used to give new clues about the production of clinical knowledge.”¹¹ Sullivan is a case in point. He had not yet formulated his interpersonal theory when he was working at Sheppard-Pratt and had never used the term *interpersonal* before 1927 in his writings, both published and unpublished.¹² Rather than applying the interpersonal theory to clinical work, he created it out of his interactions with patients. Thus, it is crucial for our understanding of Sullivan to examine his work on the basis of clinical records instead of using his theory as a proxy for his clinical activities.

An analysis of clinical records reveals that Sullivan’s clinical work involved both a professional and a personal commitment. During his first few years at the hospital, he engaged in routine practices that offered young doctors opportunities to observe the work of their more experienced colleagues; yet as he became acquainted with the hospital and its patients, he realized that he was dealing not

only with their problems, but also with his own. As we read verbatim transcripts of his interviews with patients, we find moments when we are not certain whether Sullivan was talking as a doctor or, more simply, as someone who was understanding and willing to listen to, talk to, and learn from others. Moreover, some of his patients appeared to have recognized these moments and asked him if he had a troubled past similar to theirs. I do not argue that the combination of personal and professional commitments in clinical settings is unusual, but how Sullivan formed ties between his personal and professional experiences at this crucial time in his career needs fuller examination.

Sullivan frequently discussed homosexuality with his patients.¹³ As recent studies have noted, most patients as well as attendants in “Sullivan’s Ward” at Sheppard-Pratt, which he designed and took charge of in 1928 or 1929,¹⁴ were homosexual men.¹⁵ This focus on homosexuality was therapeutic, as Sullivan believed that internalized social stigmatization and an accusation of homosexuality were the major cause of schizophrenia.¹⁶ However, as the psychologist Michael Stuart Allen has observed, it is difficult “not to ask if Sullivan’s work at Sheppard-Pratt was motivated by other than purely scientific concerns.”¹⁷ Around the time when Sullivan started his ward, he began a relationship with James Inscoe that would last the rest of his life.¹⁸ Considering the fact that the psychiatric profession in the 1920s defined homosexuality as a mental illness, it is likely that the choice Sullivan made in his personal life had a significant, if implicit, impact on his professional life.¹⁹ This is not to argue that being a gay man fully determined his clinical practice; instead, this is to show that his perspective helped him develop unique clinical techniques and some of the focal points of his interpersonal theory: the concept of “participant observation” and the critical stance toward social “inhibitions” that he believed defined and discriminated against the mentally ill.

Turning to the examination of the institutional and intellectual setting of Sullivan’s clinical work, I focus on his selective treatment of patients. Sullivan chose some patients for intensive treatment and research while expressing no interest in others. Without doubt, he had a set of criteria that reflected the hospital’s preferences as well as his own personal affinity to certain types of patients. Analysis of these criteria will help us understand the ways in which Sullivan, the institution he worked for, and the psychiatric world at large defined mental illness, therapy, and themselves. Among the criteria of selection, as discussed later, was an ability to communicate verbally that is clearly tied to the development of psychoanalysis during the first decades of the 20th century.

The second basis for selection that I examine is the diagnosis. Often, a patient’s diagnosis depended on his or her ability to respond to doctors’ expectations and institutional requirements. A diagnosis was a consequence of therapeutic interactions and negotiations rather than a name applied to a clear-cut problem. Sullivan’s selection of patients reflected not only his own interests but also the hospital’s desire to overcome the traditional image of mental hospitals associated with the care of chronic patients and transform itself into a modern institute for research and treatment of mental illness. Sullivan’s criteria of selection were not unusual in the psychiatric world of the 1920s; rather, they demonstrate how doctors grappled with the issue of selection in their everyday practice when the intellectual world was going through important paradigmatic shifts. Finally, I examine the circumstances in which Sullivan resigned from Sheppard-Pratt.

Sheppard-Pratt and Its Clinical Records

A word about Sheppard-Pratt and the format of its clinical files²⁰ is useful as a preface to examining Sullivan's work there. In the 1920s, Sheppard-Pratt was one of a number of mental hospitals where the paradigm called the "new psychiatry" prevailed.²¹ For 3 decades following its opening in 1891, Sheppard-Pratt functioned more or less as a charitable hospital, accepting patients of all ages and classes who needed long-term institutional care.²² After the appointment in 1920 of a new medical superintendent, Ross McClure Chapman, who was an exponent of psychoanalytic practice,²³ the hospital became increasingly oriented toward short-term treatment and research involving younger patients at earlier stages of illness, most of whom came from the middle class.²⁴ This followed the tenet of the new psychiatry, which advocated making treatment accessible to not only chronic patients at state mental hospitals, but also patients with acute and/or minor problems at child guidance clinics, psychiatric wards in general hospitals, and private clinics. Like doctors at other leading psychiatric hospitals such as McLean near Boston and Chestnut Lodge in Rockville, MD, those at Sheppard-Pratt focused on careful examination of patients' life histories in order to understand their problems and help them adjust to society.²⁵

The standard clinical file at Sheppard-Pratt in the 1920s had eight parts: an admission note, a family history, a personal history, a record of a physical examination, a record of a mental examination, clinical observations, one or more conference reports, and a discharge note.²⁶ Conference reports are of great interest because they recorded conversations between a team of doctors and a patient, which often were an in-depth examination of a patient's life experiences. Usually two or three typists were present to transcribe a conference. This careful recording of doctor-patient conversations started early in 1926, soon after Sullivan became the director of clinical research at Sheppard-Pratt. Earlier, in 1922 and 1923, conference reports were brief summaries and did not include records of words exchanged between doctors and patients. In 1924 and 1925, doctor-patient conversations were included in conference reports, but they were minimal. This suggests that conferences were short or that doctors did not think the documentation of conversations particularly important. It is likely that Sullivan encouraged the expansion of conferences after the model of the new psychiatry and its verbatim documentation.²⁷

The primary purpose of the conference was to settle on both a diagnosis and a prognosis, so that doctors could agree on a treatment plan for a patient.²⁸ Another important purpose after Sullivan became director of clinical research was to decide whether or not a patient was a useful subject for his intensive treatment and research. When he found patients suitable, Sullivan initiated a series of special interviews with them. In several cases, he launched special interviews before the first group conference. Perhaps he found those patients desirable subjects of special interviews on the basis of his first impression. In any case, most of the selected patients were young males diagnosed as schizophrenic. Their files include transcriptions of special interviews in addition to the standard eight parts.

The transcriptions of special interviews show ways in which Sullivan's personal and professional identities interacted as he talked with patients with minimum formality. The interviews usually took place in Sullivan's office, where there were just a few others (usually one or two other doctors and stenographers)

to witness them. There were no prearranged questions; thus, doctors and patients could say whatever their conversation suggested. Discussions of homosexuality occurred almost exclusively in the course of special interviews.

During his first few years at Sheppard-Pratt, most of Sullivan's activities revolved around conferences. In 1923, he attended 103 first conferences, which amounted to almost half of such occasions. In 1924, 1925, and 1926, this pattern remained the same, except that, as far as the existing files tell, Sullivan carried out one special interview in 1924. Contrary to the scholarship on Sullivan that has emphasized the innovativeness of his method,²⁹ there were other doctors who had more than a few special interviews in their offices in this year. Thus, it is more appropriate to say that Sullivan *developed* the method of the special interview along with other doctors at Sheppard-Pratt, rather than to say that he *invented* a new model of therapy.

The growing interest in interviewing patients and transcribing conversations allowed Sullivan to formulate his approach to mental patients. As he came to have more special interviews with selected patients, he became less concerned with regular hospital activities. In 1926, his first full year as director of clinical research, he attended 247 conferences. In 1927, the number decreased to 87. In contrast, he had 14 special interviews with 7 patients in 1926, and the number increased to 34 with 13 patients in 1927.

Strangely enough, clinical files for 1928 and 1929, years when Sullivan was said to have engaged in the most intensive treatment of schizophrenic patients in his ward, include only a few records of special interviews. In a 1931 article, Sullivan implied that he treated about 250 male schizophrenic patients on an individual basis.³⁰ However, the patient files include only 24 individuals who had one or more special interviews with Sullivan between late 1922 and mid-1930. There are three possible explanations for this. The first is that Sullivan may have kept files of selected patients separate from those of patients who were not selected, either in his office or home, and destroyed them at a certain point to protect the patients' confidentiality. This is unlikely, however, because every patient at Sheppard-Pratt was given an admission number, and the files are almost complete as far as we can tell from the serial numbers.³¹ A second explanation is that he may have kept for himself the records of special interviews and later destroyed them. This is more likely than the first explanation, because clinical observations for patients whose files did not have records of special interviews often included comments such as "the patient has been interviewed by Dr. Sullivan."³² If this was the case, the special interview records that this paper examines reflect about a tenth of the selected patient population, dating mostly from 1926 and 1927.

A third possibility is that the 250 patients he claimed to have treated included not only those whom he engaged in special interviews but also those whom he intensively interviewed during conferences. In fact, there are a number of patients whose conference records include unusually long conversations with Sullivan. Unlike typical staff conferences concerned with diagnosis and prognosis, these interviews in the course of conferences seem to have aimed at treatment as well. Even if this was the case, though, it is likely that a certain number of special interviews either were unrecorded or were recorded but no longer exist at Sheppard-Pratt. The records I examine, especially those from 1928 and 1929, are those that happened to find their way to clinical files. As I show here, their contents offer clues to the standard that Sullivan used to select interview records

to include in clinical files. Although limited in its number, these records (and their relation to conference reports) will help us understand how special interviews influenced Sullivan's clinical approach and theoretical stance.

A Homosexual Psychiatrist and His Patients

Special interviews offered occasions for both Sullivan and his patients to talk about matters not raised in more formal settings such as conferences. As one might easily imagine from the comment made by Arthur Linton, a former Sheppard-Pratt attendant, that "all of Sullivan's patients were young male homosexuals whom he personally picked from the general hospital population,"³³ one of the issues they talked about only during special interviews was homosexuality. Sullivan was struggling to communicate with patients who had concerns about their sexual experiences and fears, and he developed a highly interactive clinical approach, seeking his patients' input at least as much as he attempted to offer his insight to patients. Moreover, special interviews revealed a strong connection between his personal and professional commitments, contributing to the early formation of Sullivan's interpersonal theory.

As we look at special interviews chronologically, there is a constant tendency to include discussions of homosexuality. However, 20 patients' files from 1926 and 1927 included records of special interviews, whereas only 2 patients' files from 1928 and 1929 included them.³⁴ This is a crucial change, because it suggests that Sullivan's clinical approach was shaped in front of others but that it became more secretive (and, thus, its record was not included in clinical files) in later years. In a 1926 conversation with a patient in his mid-20s, we can see one of the earliest examples of Sullivan's special interviews revolving around the issue of homosexuality. In spite of the presence of two other doctors, who remained silent after a few exchanges at the beginning of the interview, Sullivan and the patient freely discussed the latter's feelings for another male patient.

Patient: Well—about this fellow *** over here—I began to love him and it was discontinued because I was removed from that ward.

Sullivan: Had your love for him been permitted to develop—what would have been its end?

Patient: Wouldn't have been an end.

Sullivan: Would have gone on forever, increasing?

Patient: Wouldn't have amounted to anything . . .

Sullivan: What was lovable about him?

Patient: Just a mere fact of his being alive—that's all.

Sullivan: His extreme misery had nothing to do with it?

Patient: It might have been.³⁵

Sullivan and the patient conversed with the apparent assumption that they could talk about love between men without embarrassing themselves. To understand the unusualness of such an assumption being shared by a doctor and a patient during a psychiatric interview, we have to remember that homosexuality was officially con-

sidered a form of mental illness until as late as 1973.³⁶ In a patient's confession of his love for another man, most of Sullivan's contemporary psychiatrists would have recognized a decisive sign of illness. However, Sullivan took a different route, exploring the patient's affectionate feelings and their expression.

Patient: Sometimes when he was hollowing [*sic*] and crying—and whining—I would hold him and he would go right to sleep. Maybe if you doctors try some of that instead of so many orders and theories.

Sullivan: It might be misunderstood.

Patient: Yes—I know you are handicapped. And these orders of attendants—they knock people around—if the attendants had more intellectual powers and the doctors more manual powers I think it would be possible.

Sullivan: In your own case would it have helped? Shortly after you came here if someone tried to be physically affectionate to you, would that have helped?

Patient: Physically affectionate? There is no such thing as physical affection.

Sullivan: Well, pardon my ignorance. If one of them had held you, caressed you, or something of that kind?

Patient: If one of them had shown that he wanted to . . . I didn't want any actual holding or caressing—no.

Sullivan: Why not?

Patient: I just wouldn't—I don't know.

Sullivan: What is the difference between you and ***? It worked with ***. But you say you wouldn't care for any physical demonstration of that sort.

Patient: It would seem unnatural to me.

Sullivan: But it seemed . . . natural when you did it to him?

Patient: Because he had a trust.

Sullivan: Which you lack?

Patient: Yes.³⁷

The patient's suggestion that doctors hold patients to comfort them turned the conversation in a new direction. Evidently, Sullivan was intrigued by the patient's suggestion. He was aware of its potential risk but wanted to know more about the patient's view of the doctors' use of "manual powers." This particular patient seems to have backed off a little when it came to the application of manual powers to himself. Particularly, the words "physical affection" seem to have annoyed him. Sullivan's following comment is interesting, because in asking the patient to excuse his "ignorance," he seems to have expressed his respect for the patient's opinion. By describing physical contact with different expressions such as "hold," "caress," and "physical demonstration of that sort," Sullivan showed his willingness to use language that sounded more acceptable to the patient. The following exchange further highlights Sullivan's eagerness to have the patient's input.

Sullivan: If he had been suspicious it would have been bad business for us to hold him and fondle him?

Patient: Yes—but you could have found some way to remove his suspicion.

Sullivan: Would you mind telling me what would be the best way? . . . What means would you recommend for me to overcome the suspiciousness?

Patient: . . . Your kindly and sympathetic attitude would be something.

Sullivan: Would it work with you?

Patient: Yes—it would work with me.

Sullivan: Here is a case in which you can be kindly to a patient and we cannot; because [we are] . . . restrained from doing that.

Patient: Well—your being here is—it rests on your reputation. Does it not?

Sullivan: If you are asking personally—It does not. Continue.

Patient: It does not? . . . I feel certain that it does. . . .

Sullivan: If you failed [to get well] you will expect the social organization, to wit; your loved ones, to punish us—would you not?

Patient: No—no—no. If you do what you thought was right—why, that's all a man can do. I don't think that you can do what you don't think was right here.

Sullivan: Explain. You have said [earlier] that you don't think that I could do what I thought was right here. Now explain that to me, if you will.

Patient: . . . If you thought that holding any one was right . . . of course, you could do that, but something more than that I don't think that you would do it . . . In that case about *** . . . I think you would be embarrassed to hold him . . .

Sullivan: Would you be embarrassed to permit me to do them?

Patient: I might—I don't know.

Sullivan: And what would bring about my embarrassment and your possible embarrassment?

Patient: Your fear to do something foolish.

Sullivan: . . . May I ask what that means? . . . I suppose it connects with some experience of yours . . .

Patient: I have been afraid to wear a beard.

Sullivan: Foolish, then, would be something that opened one to the disdain or criticism of others.

Patient: Yes, —exactly . . .

Sullivan: Suppose then, that it was done secretly?

Patient: That would be all right.

Sullivan: . . . The rub is not what other people may think of our doing, but what you think of it, isn't it?

Patient: Yes—that's what concerns you and me.

Sullivan: So why need we drag in these people who prohibit our methods?

Patient: I think—that—that situation exists between you and me.

Sullivan: And that's all there is to it, isn't it—just what you think?

Patient: Exactly.

Sullivan: The other fellow hasn't a thing to do with it?

Patient: No.

Sullivan: It is just you and me?

Patient: . . . Exactly.³⁸

In response to the patient's earlier reference to "trust," Sullivan tried to explore a way to remove the suspicion that doctors might abuse their power. Then their conversation turned to the professional "restraint" imposed on staff, the "reputation" that doctors have to maintain, and the "social organization" that would accuse them if they failed. It is clear that both the patient and Sullivan were aware of the unconventionality of using physical contact between doctors and patients as a form of therapy. The patient helped Sullivan bring the discussion to a new stage when he said that doing what one thinks right is "all a man can do," suggesting that despite all the negative implications of physical contact, what really mattered was that doctors do their best with sympathy and sincerity. Sullivan indicated agreement by maintaining that what was needed was to overcome embarrassment between "you" and "me"; in other words, what mattered was a feeling of security in actual interpersonal relations, not appropriateness in abstract professional or social standards.

Considering that this interview occurred in October 1926, it is likely that it captured one of the moments when Sullivan was moving toward the introduction of physical contact into his practice. As Arthur Linton later confirmed, "The patients could hug, embrace, and kiss the attendants without feeling rejected, odd, embarrassed or humiliated."³⁹ Contact was restricted to attendants and patients. Bernard Robbins, another psychiatrist at Sheppard-Pratt, made this clear when he said, "All contact was left entirely to . . . aides."⁴⁰ The reason for this distinction is not known, although it is possible that Sullivan was too concerned about negative reactions of the social organization to allow doctors to take part in the therapy. At any rate, the therapy encouraged patients' acceptance of their own homosexuality, rather than recovery from sexual "anomalies," as one of the most respected psychiatric textbooks during the 1920s suggested.⁴¹

This early interview demonstrates important features of Sullivan's work with his selected patients. First, the patient, not Sullivan, suggested using physical contact between doctors and patients for therapeutic purposes. Second, Sullivan was eager to learn from the patient about possible ways to facilitate the physical contact. His willingness to listen to patients' needs is affirmed in his published work but not in the context of physical contact between doctors and patients. It is

shown in the interview, although nowhere in his published writing, that he was well aware of the method's radicalism and suggested its application in secrecy so that doctors and patients could minimize their embarrassment.

The following exchange suggests another feature of Sullivan's clinical practice that he did not mention in his published writings: that it carried personal as well as professional meanings for him.

Sullivan: What do you suppose you would do if somebody held you?

Patient: It all—depends who—and when—and how.

Sullivan: You feel you would enjoy the experience don't you?

Patient: No—I feel—I wouldn't enjoy the experience . . .

Sullivan: . . . Explain why life is too short for you to try experiments in secret, in receiving the affectionate attention of some of your fellow-men.

Patient: Well—just not interesting—that's all.

Sullivan: And yet it seems to me that that was what you recommended—that we should do that toward patients, including yourself.

Patient: No—I don't remember that.

Sullivan: Do you have any recommendations to make in that particular?

Patient: Well—yes, I would recommend that you go along some high road and find a way to make your living and then if there were any men to help—help them. As a side line—not as a business.

Sullivan: Then you would perhaps suggest that as a preliminary we destroy the existing social system?

Patient: Yes. I would recommend that—I would fight for it. That I would live for and die for.

Sullivan: Do you think that life might be a little too short to accomplish this?

Patient: Yes—I do. Therefore—I am going to get what I can out of it.

Sullivan: Now so much for you. But we continue to be in relationship of the Staff to the patient. While you feel you can't overthrow the social system and reduce everything to a delightful primitive state, what would you recommend we do in the meanwhile, between the Staff and the patient?

Patient: . . . I wouldn't let any man I couldn't trust sleep with me—would you?

Sullivan: I have let men I didn't trust sleep with me—yes.

Patient: I mean if you were a woman.

Sullivan: I can't imagine it . . . In this true marriage—when the social system is gone—will that be determined by transcendental means or what? What will determine your being a true husband and her a true wife?⁴²

Now they were discussing the idea of physical contact between men in the

existing “social system,” which seems to have meant much more than the “social organization” they mentioned earlier, an overall social system that differentiated appropriate and inappropriate behaviors as opposed to specific groups of people that circumscribed the doctor–patient relationship. Both doctor and patient started to disclose their personal lives as the conversation extended its scope to the social system at large.

Sullivan’s comments suggest that he had some doubts about marriage. He seems to have given a preference to what he called a “delightful primitive state” of human relations, which was not bound to social norms and institutions. Thus, he was picturing a therapeutic circumstance in which individuals who had failed to achieve socially preferred love relationships (between men and women) were encouraged to construct relations with others without being preoccupied with the consequences. If so, it is unlikely that Sullivan meant that “sleep[ing] with” a man he did not trust was a bad experience. It is likely that he recognized certain benefits in sex isolated from conventional love and trust and wished to offer similar benefits in a therapeutic setting. He saw connections between his personal life and his work, and he was comfortable enough with his selected patients to talk about personal experiences he believed relevant to therapeutic activities. Such close connection between his personal and professional experiences, especially those associated with homosexuality, has rarely been addressed in studies of Sullivan, not to mention his own published books and articles.

Sometimes, Sullivan’s openness seems to have been encouraged by his patient’s knowledge of homosexual communities. Here is another patient in his 20s whose interview with Sullivan occurred in February 1927. This time, no other doctors were present, but Sullivan noted that the patient had been “under rather close supervision” by another doctor, and this doctor had “talked with me [Sullivan] at great length” about the patient’s situation. The doctor, Partridge, one of the two present at the 1926 interview that has been already examined here, seems to have collaborated with Sullivan in the treatment of homosexual patients. In this interview, the patient made it clear that he recognized a homosexual tendency in himself. Sullivan asked the patient if he thought the tendency was uncommon among people of the patient’s age, and the patient replied that he believed the tendency “exists in quite a number of people.” Then the patient mentioned a friend who was “associated with a group of people [in] Washington—artists and of talent and better class,” and claimed that “among them homosexuality seems to offer quite a good deal of food for jest.” In response, Sullivan asked:

Sullivan: Have you seen any of the homosexual society’s members go mad? . . .

Patient: Can’t say that I have . . .

Sullivan: I think there is a large number of the more cultured who are frankly homosexual . . . I have received exceedingly few of them as patients in many years past. I have received a great number of people who are terribly concerned lest they are homosexual . . . If one says, “To hell with everything, I am going to perform fellatio,” the chances are all his training which is directed against immoral practices . . . will come in conflict with his impulses to do it and he will find it . . . ungratifying . . . And I surmise you are

one of a large number of people who start by masturbation, . . . and then gradually grow to a heterosexual adjustment possibly with a homosexual stage . . .

Patient: Do you mean that a persona who had no mental tension and no concern about it—that he could masturbate as often as he cared without injuring himself?

Sullivan: I think if one had . . . no notion of the evil of masturbation, he perhaps would do himself a wee bit of good.

Patient: What is the hope in my case?

Sullivan: To some extent that is determined by your early training and by the weakness and uncertainties in your self-esteem. To a larger extent it is determined by the actual desire you have to get into life, rather than sitting off in a corner and thinking.

Patient: . . . There has been in my mind some trance—rather some homosexual coloring concerning—

Sullivan: I think it would have been very unfortunate for you to marry the first one you came in contact with. I do believe you will gain experience which will probably diminish your interest in homosexual fantasies . . . I . . . regard you in need of some sexual experience before you . . . select a satisfactory wife. I don't advise you to go looking for it, but if it comes your way, take it.⁴³

This exchange demonstrates Sullivan's belief that homosexuality was not a mental disorder, but rather one of the stages of human sexual development. Sullivan's idea was similar to Freud's hypothesis of "bisexuality in everyone," in that he believed everyone is capable of choosing a person of the same sex as an object of sexual desire. Both recognized certain affinities between heterosexual and homosexual mechanisms and questioned the latter's abnormality.⁴⁴ However, Sullivan differed from Freud when he suggested that homosexual tendencies could facilitate one's sexual development. If one were to rid oneself of preoccupation with one's homosexual tendencies and/or experiences, one would be able to proceed from the homosexual to the heterosexual stage of sexual adjustment. It was a positive recognition of homosexuality, in the sense that it viewed the socially constructed notion of "abnormal" and "immoral" homosexual practices—not homosexuality itself—as the cause of mental illness. At the same time, however, Sullivan seems to have accepted that homosexuals were less mature than heterosexuals, recommending that the patient "gain experience" with women to be relieved from "homosexual fantasies." It seems as if he could criticize social prejudice against homosexuality but could not accept homosexuality as a full equivalent of heterosexuality in terms of its degree of maturity.

The patient, too, recognized the inconsistency in Sullivan's view of homosexuality and brought it up at their next interview. This time, Sullivan believed that the patient was concealing his thought and tried out what he called "an experiment" to get the patient to talk.

Sullivan: Let us try an experiment and now let us be very candid—will you tell me something about myself. We are trying a practical test.

Patient: Well, your manner has seemed to be rather affected . . . especially your enunciation and manner of treating patients . . . I have often wondered why it is [that] you have never married . . . And then I tried to . . . find some association between your choice of work and the reasons you have never married—your professional manner didn't seem affected but I had an intuition that it was the result of some effort anyway. And you seem to be under some strain—that is about all, I think.

Sullivan: All? My goodness! Now you are trying a test as a literary person.

Patient: I should have to look at you. I should have to see all of your face.

Sullivan: Do I have to keep my eyes open?

Patient: No—seeing all your face enables me to form opinions and theories.

Sullivan: Do so, please. I wish to hear them.

Patient: Well, you are not averse to beating around the bush a little and evading the real truth of things just for the purpose of getting a person's mind easy. In other words, certain things which you advocate you don't really believe in yourself sincerely—but by that I mean sex questions.

Sullivan: Do go on.

Patient: I am just trying to formulate facts. You seem to be trying to get away from yourself more than you realize and I have often wondered just why a person takes up this sort of work. . . . I know attendants at an insane asylum take up that certain sort of work for certain reasons—and I was wondering if psychiatrists in an institution take up that work for same reasons.

Sullivan: Do tell your reason why attendants do take up.

Patient: To a great extent they take it up . . . because of their homosexual traits . . . they take it up . . . because they feel a certain affinity for the patient . . . a man is interested in a certain thing and there is a reason for it.

Sullivan: You see you are continuing a description of me.

Patient: You look on things in a sort of calloused way . . . you . . . gave me the impression that marriage was an excellent thing yet I knew you had never married . . . I know that attendants have traits along that line—homosexual traits and they usually come to this sort of work—a great many of them, not all—because they are afraid of being outside of such a place. It gives them a chance to really be a patient without being one actually. May also give them a feeling of superiority where none exists.

Sullivan: . . . Will you smoke one of these? . . . Have you any idea that my thoughts would be any good to anyone but me—those that I don't let people know?

Patient: No, I don't suppose so.

Sullivan: Do you feel cheated because I don't say everything I think?

Patient: No—I merely noticed that.

Sullivan: Do you think I have been sincere with anything to you.

Patient: Yes, I think you have been sincere about everything, but I couldn't help but wonder whether they were not, well somewhat of an insincerity of your remarks about masturbation and sex—I thought possibly you were, might say taking the best road out of the difficulties which I was in or thought I was in.

Sullivan: If to avoid argument you should be interested in your characterization of me—do you remember it well? Because if you don't, I will be glad to give you a copy of it. It would be much more illuminating than anything else you have said.⁴⁵

The patient confronted Sullivan by asking why he had not married if he really believed in the union between men and women, making it clear that he had the impression Sullivan was a homosexual, even though Sullivan concealed it from patients. Sullivan, as the patient suspected, might have taken up the profession of psychiatrist because he shared “homosexual traits” with mental patients and, thus, felt close to them. This was a shrewd observation, forcing Sullivan to cross the boundary between his personal and professional personas, which he had maintained, in the patient's observation, with some “effort” and “strain.” Sullivan's response to this observation was forthright, but when the patient made the further comment that many psychiatric attendants were homosexuals who found peace of mind and even unreasonable feelings of superiority in their work with mental patients, Sullivan was silent. This silence was indicated as “. . .” in the transcript, and it seems as if he admitted that he needed a break when he offered a cigarette to the patient.

Perhaps Sullivan needed a break because what the patient said touched the “thoughts” he believed he did not “let people know.” He seems to have concluded that there was no point in concealment with a person of the patient's insight, asking if the patient had ever felt that he was “cheating” or “insincere.” As the patient's comments suggest, Sullivan seems to have wished to keep his personal and professional lives separate; yet as he immersed himself in these interviews, he realized that there were times when the boundary had to be crossed.

Throughout his career as a writer and a practitioner, Sullivan pointed out how important it was for a psychiatrist to establish a professional attitude in interacting with a patient, claiming that a “psychiatric expert” was to seek “the data needed to benefit the patient,” and should not attempt to get “personal satisfaction” or “companion[ship]” from his patients.⁴⁶ As shown in the special interviews examined above, Sullivan did not always find it easy to demarcate personal and professional relations. In the early years of his psychiatric career, Sullivan recognized a powerful connection between his personal and professional experiences and thus found it impossible to step aside from doctor–patient interactions to examine them as an outside observer. To communicate with patients, he had to participate in these interactions without holding back from referring to his personal experiences.

The 1927 interview reveals another clue as to ways in which Sullivan participated in therapeutic relations. When the patient told Sullivan that he should see all of the latter's face, Sullivan seemed to have turned to the patient, asking if the patient wanted him to keep his eyes open. This suggests his openness to the patient. Sullivan often expressed such openness to those whom he selected for

special interviews but not to others. In fact, more often than not, the tone of his speech during special interviews differed from that during conferences, including accommodating expressions such as “would you mind telling me . . .,” “explain . . . if you will,” and “. . . please.”⁴⁷ This also is the case of his special interviews with patients from Sullivan’s Ward, treated in 1928 and 1929.⁴⁸ These expressions seldom, if ever, appeared in his conversations during conferences with patients who were not selected. In extreme cases, he seemed more interested in dictating to patients than in listening to them. Although some of this can be attributed to the difference in format of special interviews and conferences, it is nonetheless clear that Sullivan cultivated special relations with his selected patients, including a considerable degree of openness, understanding, and, as Sullivan himself believed, “intimacy.”⁴⁹

In the interviews with selected patients, most of whom were diagnosed as schizophrenic, a number of ideas and practices can be found that anticipate major concepts in Sullivan’s interpersonal theory. First, Sullivan expressed a distrust of the social system. What should matter in his clinical work was a relation between “you” and “me,” not what others might think. Psychiatrists were to assist patients to understand ways in which the social system exercised its power in their relations with others. This view suggests the ideas of social inhibitions and interpersonal relations that he developed in the latter half of the 1920s, arguing that mental illness had its origin in a patient’s “failures” in interpersonal relations and that these failures occurred because of sociocultural “inhibitions.” A psychiatrist’s work was to invite a patient to participate in an interpersonal relation in which inhibitions had minimum effect, so that the patient could reassume contacts with others.

In the interviews I have examined, the prime examples of inhibitions were those on various forms of sexual activities, such as homosexual relations and masturbation. Out of 20 patients Sullivan selected for special interviews in 1926 and 1927, 15 made clear references to concerns over their sexual activities, including 10 patients who expressed worries about a possible homosexual tendency. As early as 1926, Sullivan expressed his belief that the social stigmatization of homosexuals was the main cause of schizophrenic difficulties.⁵⁰ Later, Sullivan included other forms of sociocultural inhibitions (e.g., racial and religious preconceptions) and identified them as causes of mental illness and prejudice against its victims.⁵¹ Thus, Sullivan’s initial focus on sexual issues helped him develop his unique, socially oriented psychiatric theory.

In his interpersonal theory, Sullivan argued that a psychiatrist, as a “participant observer,” had to “interact . . . with his patients in the context of life as it has to be lived.” To be sure, he carefully defined the purpose of this interaction as understanding a patient in his or her relation with a psychiatrist, not as developing personal “companion[ship]” between a doctor and patient.⁵² However, this did not mean that a doctor disclosed none of his personal experience to his patient. The special interviews we have examined suggest that, behind Sullivan’s lucid theoretical formation of “participant observation,” there was a difficult struggle to use his personal memories and feelings for therapeutic purposes. His selected patients recognized the struggle and responded with their own suggestions and opinions. Their interactions were intense and intimate, especially considering the general prejudice against homosexuals as either “ill” or “sinful.” Such interactions influ-

enced Sullivan's views on doctor–patient relations and had a significant impact on the creation of interpersonal practice and theory.

Doctors and Patients in the Paradigm of the “New Psychiatry”

What happened to those patients who were not selected for intensive treatment and research? How did Sullivan treat them, and how were they represented or not represented in his published work? In what follows, I examine patient records with a focus on two sets: one of a patient selected for special interviews and the second of a patient who was not selected. Comparison illuminates the standards that doctors used to make different diagnostic and therapeutic decisions under the influence of the paradigm of the new psychiatry. Dating from 1928 and 1929, the last 2 years of Sullivan's association with Sheppard-Pratt, the two sets of records show how his method of practice had changed since 1926–1927. The first patient was typical of those who were not selected, in terms of the file's content and the tone of his conversations with the doctors. Moreover, this patient was a young male diagnosed as schizophrenic, the most likely kind of patient to be selected for special interviews with Sullivan. His case, then, will suggest reasons why he was *not* selected.

The second patient was also a young male diagnosed as schizophrenic. Sullivan had a special interview with him *before* the first conference; thus, the file provides more information about the diagnostic process than do other files that include a record of a conference but not much about preceding interactions between a doctor and a patient. Sullivan was a main presenter in this conference, explaining his interpretations of the patient's problems and the progress of treatment.

The first and only conference for the first patient occurred in August 1929. Eleven doctors were present in the conference room—including Dr. Burling, who was in charge of the patient, and Sullivan—as well as three typists. The patient also was present. For Dr. Burling, this was a patient whom he had observed daily during the past few weeks. For the other 10 doctors, he was an inpatient whom they might have come across in a dining room, in a ward hallway, or out on the lawn, probably without knowing his identity. They might have been associating his face with a name and symptoms for the first time.⁵³ Dr. Burling presented a summary of the patient's personal history and present illness to the other doctors. Then, the conversation with the patient started. The first doctor to speak, Dr. Hill, focused on the patient's feelings when he had to go to a sanitarium.

Hill: I understand that you . . . went to [a sanitarium]. Can you tell me about . . . how were you feeling?

Patient: I wasn't exactly feeling as strong as I thought I should feel. I was very irritable—I got mad very easily, and couldn't get along with people.

Hill: . . . How were you feeling—what was the difficulty . . . ?

Patient: I got tired very easily . . . I was superintending construction work, and that was pretty hard work.

Hill: That was when you began to have the first difficulty?

Patient: That was when I first began to notice my weakness.

Hill: . . . How did this weakness show up first?

Patient: Well, I . . . think it was just lack of exercise.

Hill: How did you know you were weak?

Patient: I just didn't feel well.

Hill: Can you tell me something about how you did feel? . . .

Patient: Well, I just didn't seem to have the strength that I thought I should have.⁵⁴

Seeking the patient's self-perceptions, Dr. Hill posed open-ended questions that allowed the patient to answer in any way he pleased. The patient's response to Dr. Hill's last question was same as that to the first question. A result of Dr. Hill's approach to questioning was the accumulation of the patient's words around his feeling of "weakness," not a conversation that headed in a particular direction.

Dr. Pattrell, the next interviewer, followed a similar strategy of encouraging introspection.

Pattrell: Did you feel as though your mind was your own . . . ?

Patient: I knew the difference between right and wrong, but as far as being able to concentrate, and talk for any length of time, I just wasn't able to do it.

Pattrell: Do you have that difficulty now?

Patient: No, I am feeling a whole lot better now.

Pattrell: What do you think that's due to . . . ?

Patient: Well, various things . . .

Pattrell: Mention one, will you?

Patient: Exercise—improvement in physical as well as mental.

Pattrell: How long has it been since you have been working?

Patient: February.

Pattrell: You drank considerable since you stopped work?

Patient: No—I have been in sanitariums since I stopped work. I drank for a while after I stopped work.⁵⁵

The patient's decisive responses caused Dr. Pattrell to change the subject from self-understanding to the patient's drinking habit. Like Dr. Hill, Dr. Pattrell allowed the patient to drive the conversation to a considerable degree.

Sullivan's reaction to the patient was very different. He returned to the point at which Dr. Pattrell gave up.

Sullivan: Is it your general impression that you are now well mentally?

Patient: I feel a whole lot better than I did when I first came here

Sullivan: . . . What is it that is helping you here?

Patient: I think everything is.

- Sullivan:* That is not very illuminating. I asked with the notion of getting some information about it?
- Patient:* I think the outdoor exercise, as well as having agreeable companions—somebody to talk with, and discuss different things with.
- Sullivan:* . . . That has been beneficial to you in some way?
- Patient:* I think so.
- Sullivan:* Perhaps you can explain that to us.
- Patient:* I don't think it needs any explanation.
- Sullivan:* You seem to have a number of positive opinions that amount to nothing in general, and a sort of dearth of positive opinions that are illuminating or helpful to us. Do you feel that you are in the midst of enemies just now?
- Patient:* I haven't looked upon the doctors in that light.
- Sullivan:* Might I inquire as to why you are so very evasive and secretive in answering questions?
- Patient:* I didn't know that was the case.
- Sullivan:* . . . Would you mind answering my question?
- Patient:* I thought I had answered it.
- Sullivan:* You haven't. You have been evasive about it.
- Patient:* What question are you referring to.
- Sullivan:* The last one that you did not answer honestly, directly, and to the point—to wit: Why are you evasive with us?
- Patient:* I am not evasive with you.⁵⁶

Sullivan was determined to direct the conversation to the patient's specific experiences, rather than the general impression the patient had of them. He regarded the patient's positive opinion of his mental state as a sign of the continuing severity of his mental illness. Sullivan's criticism of the patient's alleged effort to keep something secret seems harsh, particularly because the patient did not necessarily appear evasive except on one occasion, when he said that he did not think his earlier comment "need[ed] explanation."

Sullivan adopted a strong—even confrontational—tone in the conference, in contrast to Dr. Hill and Dr. Pattrell. Nonetheless, in comparison with his colleagues, Sullivan's exchange with the patient seems closer to a conversation than an examination. Frequently he expressed his thoughts, rather than putting questions, actively participating in and even dominating the conversation.

The next portion of the conference was devoted to compelling arguments about the nature of the patient's problems and of mental illness in general. In response to the patient's continuing "evasiveness"—at one point, he asked Sullivan to change the subject—Sullivan became increasingly blunt.

Sullivan: Of course I don't want to change the subject so much, because I am still wondering if there is any possible hope for you.

Patient: I thought that we had already discussed that and decided that there was.

Sullivan: You perhaps did that. I still feel extremely gloomy about you . . . Why are you so very, very, very afraid to admit the symptoms that you actually have? . . . Do you feel that you would have no self-respect whatever if you talked very frankly about the queer things that have been happening to you the last year?

Patient: I don't know of any queer things that have been happening.

Sullivan: . . . Would you have any self-respect left if you admitted you had had a serious mental disorder and you still had it?

Patient: That's a peculiar question. Admitting things you see when you don't see them.

Sullivan: . . . Well then, I return to the questions with which I started about 25 minutes ago—Why—for what possible reason—to what end—to accomplish what—are you so secretive and evasive in answering our questions, and in dealing with your experiences?

Patient: Well, I will just have to repeat the same answer that I gave you 25 minutes ago.

Sullivan: That was?

Patient: That such wasn't the case. I am very frank.⁵⁷

Sullivan thus revealed the reason he was forcing the conversation in a certain direction. He was attempting to get a sense of the patient's prognosis, which he found "extremely gloomy" at that point. That the patient avoided exploring his experiences because he was afraid of losing his self-respect by revealing his "failure" was not an unreasonable assumption: Many patients worried about the loss of self-respect by admitting the fact that they were ill. One of the contemporary patients at Sheppard-Pratt, even after a diagnosis of catatonic schizophrenia, claimed that there was nothing psychotic in his behavior, and thus he saw no reason for staying in the hospital. Later, he confessed that he was extremely ashamed of having a mental breakdown. He felt that "having a mental breakdown hurts in many ways. Some people when you go back think nothing of it, but there is the other type of person, who will draw the line."⁵⁸

As he said in his published articles,⁵⁹ Sullivan believed that it was crucial to recovery for patients to overcome the fear of admitting their problems. He had encouraged the patient to take the first step toward improvement in the earlier part of the conference:

Sullivan: Do you think you have very much chance of escaping the accusation of having mental disorder some day?

Patient: . . . Why certainly.

Sullivan: Where did you get the idea that mental disorder was a matter of accusation, anyway . . . we don't accuse people having typhoid so where did you get the accusation slant on it?

Patient: Well, I always thought a mental disorder varied a whole lot . . . a person went wild and had no control at all . . . But that wasn't my trouble.⁶⁰

In these exchanges, Sullivan was attempting to offer the patient a different view of mental disorder, suggesting that he did not have to be ashamed of his mental difficulties, just as he did not have to be embarrassed by physical troubles. However, the patient did not change his stance, refusing to give up his "secretive" attitude—at least in Sullivan's eyes—by claiming that what Sullivan was saying was irrelevant to his trouble. Sullivan's encouragement to admit a repressed "failure" in the past did not work.

After the patient was excused from the conference room, Sullivan decided on the diagnosis of "schizophrenia-paranoid type" with a poor prognosis and recommended that the patient be transferred to a state hospital. As if to confirm the prognosis, the patient's behavior became less cooperative after the conference, according to the case file. In January 1930, the clinical observation noted that he had developed "a technic [sic] to avoid important questions."⁶¹ No physician could establish a rapport with him. About a month later, the patient was in fact sent to a veteran's hospital for custodial care.

This was an unsuccessful case for Sullivan, as he acknowledged after the patient left the room:

[I]f he [the patient] is grilled, and grilled, and grilled, . . . that cordial attitude toward us would swerve, and he would come in and express an amazing delusional system. What can be done with them I don't know. I have often been very much disappointed with experiences with patients whose general attitude was like this . . . They are sometimes very dangerous people. I don't believe there is any way of treating them. I have never gotten a clue. I think it is perhaps our duty to do what we can to elicit sufficient delusional content to leave no doubt as to the fact that he is seriously ill, before we get rid of him. I am afraid that state hospitals don't do so awfully well at keeping these people, because they don't really get very much to tie onto. It's not commonly possible, I guess, to subject a person to even an inadequate examination as I did him this morning.⁶²

What made Sullivan consider his examination "inadequate"? One of the strongest possibilities is his feeling that he failed to bring the patient's delusion to light. But when this conference is compared with successful interviews Sullivan described in his published work, it seems that it was not just a matter of not having been able to pin down symptoms. He had developed a set of preconceptions during the conference: The patient was getting worse, and the reason was his general attitude of evasiveness from fear of admitting his illness. Such preconceptions went against what Sullivan emphasized in his writings in the late 1920s: Psychiatrists have to respect mental patients, ceasing to see them as patients but instead regarding them as ordinary individuals and offering an environment agreeable to them.⁶³ We have already seen such concerns displayed in his special interviews with selected patients, in which Sullivan expressed interests in patients' opinions and suggestions. Throughout this conference, however, Sullivan seemed more interested in finding what interested him than what interested or was potentially efficacious for the patient.

One can argue that the purpose of the conference was to decide on a diagnosis and a prognosis, and therefore, what took place at the conference was not relevant to successful interviews that Sullivan described in his published writings on

clinical practice. However, those writings did not make a distinction between different kinds of interviews—special interviews on an individual basis and group interviews in conferences—asserting that a doctor’s respect for a patient is crucial for *all* “psychiatric interviews.”⁶⁴ In part, because of such generalizing discussion, aspects of Sullivan’s clinical practice that did not conform to what he wrote have often escaped researchers’ attention.⁶⁵ Gail A. Hornstein, for example, says, “Sullivan was like a Zen master, totally present to the patient.” He could even reach “nonverbal” patients who were “unresponsive to everyone [else].”⁶⁶ This characterization may not be untrue, but his practice did not always work in such an ideal fashion. Not unlike other psychiatrists, he had unsuccessful cases that did not produce the results he wanted.

Sullivan’s domineering presence in the conference examined here is another example of what has not been well represented in past studies of Sullivan as well as in his own writings. In a 1927 article, for example, Sullivan emphasized the importance of encouraging patients to talk:

The ideal interview is one in which the physician offers only the orienting questions to cover the most recent activities of the patient, mention of the particular topics on which he desires the patient to talk, and such provocative interjections as “And–,” “And then,” “Continue,” “Which seems to mean what,” and the like. With comparatively inaccessible schizophrenics it is often possible to obtain two or three thousand words in an hour without supplying the patient with anything of “explanation” or “interpretation.”⁶⁷

Sullivan seems to have been frustrated with some patients’ deficiency at verbal communication. Selected patients were “good” patients in the sense that they could communicate their self-perceptions. When talking to them during conferences—both before and after a selection was made for a special interview—Sullivan seemed friendly and understanding. Occasionally, he called patients by their names, instead of “you” or “the patient.”⁶⁸ A typical description was that a patient “has been quite uniformly cooperative . . . [his] attention has been excellent, manner has been agreeable.”⁶⁹ Or, he found such a patient to be “intellectual.”⁷⁰

Far from being accommodating to uncommunicative patients, Sullivan told one female patient that he “must interrupt you because you neglected to give me the answer to my question.”⁷¹ To another female patient who complained about “the cold suavity of Dr. Sullivan”⁷² and refused to explain her problems, he responded, “Then we will have to decide that you are so sick.”⁷³ To a patient who Sullivan believed avoided answering questions, he said, “Be quiet, I am tired of hearing you talk.”⁷⁴ Typically, these patients were described as “evasive.”⁷⁵ In the end, it was Sullivan’s belief that “if a person can’t talk about what is going on in his mind, it is rather difficult for a physician to be very much good to him.”⁷⁶ Sullivan’s emerging interpersonal approach could not deal with those who did not take what he believed was the first step in a therapeutic relationship—talking about their problems with apparent candor. Sullivan’s message, “You don’t have to be ashamed of your failure,” worked as a therapeutic encouragement in many special interviews. However, the same message fueled the tension between doctor and patient in an unsuccessful conference.

The conference examined here took place just a few years after Sheppard-Pratt embarked on special interviews, under the strong influence of the new psychiatry. Different doctors placed emphasis on different subjects—some expressed interest in their patients' dreams, whereas others, including Sullivan, pursued sexual topics. In any case, intensive "talks" and the careful transcribing of them were new developments in the hospital's therapeutic culture. The doctors wanted and needed patients who could respond well to this innovative approach. At the same time, they were willing to "get rid of"⁷⁷ those who were unwilling to talk, without holding a special interview with them.

Sheppard-Pratt used other therapeutic approaches besides interviews, such as occupational and recreational classes, yet these activities did not count as much as the ability or willingness to communicate when it came to a decision to select a patient as a subject of special interviews. Often the doctors' comments were quite explicit: "[The patient] will not, or cannot, delve deeply enough into his unconscious processes to make him a valuable case for research work," one doctor said in a patient's discharge note.⁷⁸ Of another patient who doctors thought had "scant interest in anything psychoanalytical" and was "a little scornful and skeptical of anything to be gained by personal analysis," they concluded, "The issue is not solved nor will it be solved without . . . intelligent cooperation on his part."⁷⁹ Some of the patients who were not selected for interviews showed notable progress in occupational classes and often were reported to have become more cooperative with other patients and attendants. However, these improvements were not good enough to warrant selection for intensive treatment and research. Considering the fact that just a small percentage of Sullivan's patients had special interviews with him, it is apparent that the selection process constituted an important—and at the same time, routine—part of Sullivan's clinical practice in the 1920s.

Like patients selected for special interviews in 1926–1927, those from 1928–1929 expressed willingness and demonstrated an ability to communicate their ideas and feelings. With one of the patients admitted in 1929, as noted above, Sullivan launched a series of special interviews before the first conference, although only one transcript of these interviews remains in the patient's file. During this interview, Sullivan made one thing clear: He did not want the patient to be evasive. When the patient insisted that he had no "difficulties" at all, Sullivan replied, "Now I am struck by the fact that you act as if I am examining you . . . whereas I am merely trying to get your recollection of the development of the illness." The patient refused to talk for a while but eventually confessed that he was extremely "self-conscious. . . with a lot of people" and became so nervous as to develop habits of "blinking or twisting the eyes—moving . . . teeth and fingers—and . . . do[ing] things over again."⁸⁰

Unlike many others diagnosed as schizophrenic, who demonstrated their confusion and disorientation, this patient seemed very "sane" in his interactions with Sullivan. The records show him understanding Sullivan's questions and giving rational answers. He never lost the sight of the logical track of the conversation. Indeed, this applies to the patients from 1926 and 1927 whose records we have examined and prompts a simple but important question: Why were these individuals diagnosed with schizophrenia? This is a difficult question to answer. It might be possible to consider them in light of the *DSM-IV*—the current internationally applied manual of diagnosis for mental disorder. However,

that would impose today's perspective on what happened in a different historical setting. There was a nationally shared standard classification of mental disease during the 1920s, but its application remained loose in private hospitals in particular.⁸¹ Furthermore, the manual itself was not complete: Under "Dementia Praecox (Schizophrenia)," for example, it explained that "this group cannot be satisfactorily defined at the present time." Sheppard-Pratt seems to have used the descriptive definitions proposed by Kraepelin and Breuler, as well as the psychoanalytic principles established by Freud as its criteria for diagnosis.⁸² A diagnosis of schizophrenia, however, could vary from hospital to hospital or from doctor to doctor.⁸³ Thus, what a psychiatrist meant by "schizophrenia" in the 1920s might have differed significantly from "schizophrenia" as currently defined in the *DSM-IV*.

It would be more appropriate to examine the diagnosis in terms of Sullivan's definition of schizophrenia, which he framed in contrast to what he considered a psychopathic personality. Schizophrenia, according to Sullivan, is a state in which a significant portion of a patient's personality has disintegrated. In the early stage of that process, the patient experiences panic, anxiety, hallucinations and delusions, and withdrawal from reality. The 1929 patient expressed anxiety about his "attitude toward. . . human relationship." During the special interview, he mentioned a strange feeling of being talked about and laughed at by people, which could have been a mild form of delusion. He also said that he could not be interested in people, which might be interpreted as a sign of dissociation from reality. However, these symptoms also could suggest a psychopathic personality, which, Sullivan believed, involved profound feelings of defect. One of the patients who were not selected for special interviews, diagnosed in 1928 as having a "psychopathic personality," was said to have been "morose, unable to sleep, . . . emotionally upset, occasionally wept." It is difficult to tell whether these behaviors were less schizophrenic than what the 1929 patient diagnosed as schizophrenic called his unusual "sensitiveness."⁸⁴ By his own standard, it seems that Sullivan could have diagnosed the latter patient as having a "psychopathic personality with incipient schizophrenia," a "psychopathic personality with recurring psychotic episodes," or even "psychoneurosis in a psychopathic personality," as he did for other patients.⁸⁵ Indeed, the patient's diagnosis at his discharge was "psychopathic personality without psychosis," as if to suggest that other doctors disagreed with Sullivan's diagnosis of "incipient schizophrenia" and decided to change it.

Why, then, did Sullivan diagnose him as straightforwardly schizophrenic, possibly despite other doctors' disagreement? Perhaps unrecorded behavior suggested the seriousness of his disorder. As Sullivan argued in his published work, the psychiatrist could learn much about a patient's condition from careful observation of facial expressions, intonations, and gross behaviors. Sullivan even advocated the making and analysis of photographic and phonographic records of interviews.⁸⁶ Perhaps something about this patient's behavior made Sullivan believe that he was schizophrenic. This possibility suggests a limitation of clinical records in reconstructing cases. As Sullivan stated, "Stenographic records . . . leave much to the imagination of the third person."⁸⁷ On the other hand, the record of conferences often included descriptions of unusual behaviors of a patient, such as "patient hesitates" and "[patient said something] with deep feeling."⁸⁸ If behaviors were particularly abnormal, it seems, stenographers often took note.

Another possible reason for Sullivan's diagnosis is the uncertainty of schizophrenia itself. For example, in a staff conference with an Italian-born Catholic patient who was in the hospital for a few months in 1928, Sullivan and a colleague discussed cultural problems of diagnosis:

Sullivan: Do you imagine the diagnosis of schizophrenia is made too frequently among the foreign born?

Martin: That is my opinion. When we find ourselves with something strange we are inclined to label it as schizophrenia when it may be due to difference in race. I have in my mind Osmena and certain Jews, then these Italians. I would like to see what the Italians call manic-depressive and what they call schizophrenia.

Sullivan: I think Doctor Martin has raised an important question . . . If we make a diagnosis of schizophrenia because we are not able to get any information from the patient and do not understand him, we are making a serious diagnosis on very poor grounds.⁸⁹

Although the 1929 patient was not foreign-born or the son of immigrants, some selected patients from 1926 and 1927 were. It is possible that they received a diagnosis of schizophrenia because of their ethnic characteristics. It is also possible that the doctors did not really understand the nature of their illness and, hence, gave them a catchall diagnosis. A conference report of a patient from 1927 suggests the fluidity of diagnostic criteria:

Martin: I think he [the patient] has some personality warp . . . just now he has passed through a schizophrenic stage—I think there is a psychopathic personality behind it all.

Sullivan: I agree I think he has schizophrenia.

DIAGNOSIS: Schizophrenia⁹⁰

When one doctor's diagnosis disagreed with another's, the director of clinical research, Sullivan, made a final decision. None of his colleagues ever challenged Sullivan's diagnosis during conferences. In this light, it is plausible that Sullivan gave a diagnosis of schizophrenia because certain patients' life histories included what he believed to be a cause of schizophrenia, a certain kind of trouble concerning sexuality, particularly homosexuality. Indeed, Sullivan said during a conference in 1928 that he did not believe the patient was schizophrenic "because he has made heterosexual adjustments in numbers."⁹¹ Sullivan might have seen some patients as schizophrenic because events in their life histories fitted what he believed were the causes of schizophrenia.

Sullivan had an extra incentive to diagnose patients with schizophrenia and then discharge them as either recovered or improved. When he diagnosed the 1929 patient, he noted, "I am recommending his discharge as Recovered from Incipient Schizophrenia. Needless to say, this is for statistical purposes."⁹² This can be seen as an effort to raise the recovery rate of schizophrenia at Sheppard-Pratt. In fact, the hospital discharged a considerable number of patients diagnosed with schizophrenia as improved. Between 1927 and 1929, 193 of 572 patients⁹³ were diagnosed as schizophrenic, and 111 of them were discharged as either recovered or improved—57.5% of the diagnosed group. During the same era, the

national average rate of recovery and improvement combined was under 40%,⁹⁴ suggesting that Sheppard-Pratt applied generous standards for evaluating recovery. Indeed, as the superintendent, Chapman explained that “cured” meant that a patient could “return home and take up his normal activities, although at some time in the future a second break might occur,” whereas “much improved” meant that a patient “might seem normal, but there was a question whether under the pressures. . . they would remain stable.”⁹⁵

Without doubt, these standards should be considered in light of the hospital’s statement that it was not an institution for long-term care: It would not take chronic cases. This was the kind of short-term service that the new psychiatry sought to develop. To show that schizophrenia could be cured quickly had a significant implication, because it was the category that included the largest percentage of the patient population at mental institutions.⁹⁶ If *even* schizophrenia could be cured, other mental disorders would follow.⁹⁷ The time when psychiatry was confined to the care of hopeless cases was over. As Chapman reported, it was the hospital’s policy to admit “only cases offering hope of recovery.” Sullivan, who specialized in schizophrenia and was willing to discharge many as recovered or improved, seemed a perfect fit for the hospital and for the psychiatric paradigm the hospital followed.

Sullivan’s Departure From Sheppard-Pratt

As it turned out, however, Sullivan had committed what others believed an unignorable offense, which the hospital could not overlook. That was his introduction of a new method of therapy, perhaps as early as 1928, involving “affectionate” physical contact between male attendants and patients. As noted earlier, Arthur Linton, an attendant in Sullivan’s Ward, said that “young male homosexual” patients could “hug, embrace, and kiss” attendants at the ward, who were “latent homosexual” themselves. Bernard Robbins recalled that the Sheppard-Pratt administration was concerned about physical contact: “Actual homosexual activity between the attendants and the patients was not encouraged. On the contrary, when it did occur on accident, it was regarded as an exploitive situation, as a seduction of the patient by the attendant and the attendant was dealt with by rather forthright dismissal.”⁹⁸ William Elliot, an attendant in Sullivan’s Ward, also recalled derisively, “Sullivan was getting vicarious experience in working with these young homosexuals . . . He was able to make the direct contacts he wanted. This is the only way he satisfied himself.”⁹⁹ To complicate matters, Sullivan, as noted above, was living with James Inscoe, who was said to have been a “male hustler” and also a former schizophrenic patient.¹⁰⁰

Sullivan apparently tried to keep his new therapy secret. For example, the transcript of his special interview with the 1929 patient emphasized problems of what the patient called “[his] attitude toward human relationship.” The most common topics of special interviews during 1926 and 1927, homosexuality and masturbation, were not specified. However, we know that Sullivan and the 1929 patient discussed these issues during unrecorded special interviews, because of Sullivan’s case presentation in a conference 2 months after the recorded interview:

He was seen . . . on August 23 [the date when Sullivan had the recorded interview] . . . From that time to this, we have had quite a few interviews . . . The patient has

never made . . . a good social adjustment . . . The father in this picture is characterized by his inability to actually deal with the sort of problems that his son needed his help on. For instance, one day, they were sitting in the library, and the patient was engaged in fantasy of a sexual nature, and the father rather startled him by turning to him and saying, “***, what are you thinking about?” . . . The boy then said he was thinking of . . . homosexual intercourse. The father was . . . embarrassed and said, “. . . I’ll talk to you about that soon.” Nothing has been said about from that date to this. The boy had no real sexual instruction. He engaged in some virile activity when he was around the age of nine, and some feeble attempts at homosexuality when he was around 13 . . . His homosexual venture was the cause of . . . self-condemnation . . . Throughout my work with him, we have both felt it important to deal with the sexual aspects of life.¹⁰¹

We cannot know to what degree Sullivan’s summary reflected the patient’s story, because we do not have the transcript of the doctor–patient conversation about the patient’s concern over “his homosexual venture,” but it is clear that they discussed this matter over a period of 2 months, during “quite a few” special interviews. As we have seen, conference records reveal that a significant proportion of special interviews were either not recorded or recorded but not filed.

The same applies to another selected patient from 1928, diagnosed with schizophrenia, whose file included one record of a special interview. During a conference, the patient referred to his fear of another male patient and “sex fears,” which he apparently discussed with Sullivan. The recorded interview, however, barely touched on these fears, an omission suggesting that there were other unrecorded or unfiled special interviews. These interviews may have mentioned physical contact between patients and attendants and, thus, would have been too controversial to be included in the patient’s files. This is, of course, a conjecture because of the lack of explicit sources, but we have already seen that, in 1926 and 1927, records of Sullivan’s conversations about the possibility of physical contact between patients and attendants were filed, perhaps because such contact had not yet been put into practice. Although we cannot know for sure, it seems reasonable to speculate that later, when such practice became a part of Sullivan’s Ward, records that referred to it would have been perceived as too controversial to be placed in official files.

This secrecy did not last for long, however. The hospital staff had begun to call him “Miss Sullivan.”¹⁰² Chapman was particularly worried, because he was the one who had hired Sullivan and given him unprecedented autonomy. During a conference for the 1928-selected patient, Chapman expressed strong interest in the treatment the patient had received at Sullivan’s direction:

Chapman: Have you observed patients being treated in the hospital—is your observation pleasant or unpleasant?”

Patient: A pleasant one

Chapman: Have you been treated with considerable courtesy or have there been exceptions

Patient: I was very much terrified and tormented by the Coronel [sic, refers to another inpatient], and wanted to be removed . . . from immediate contact with him; but, instead, I was put in more immediate contact with him

Chapman: . . . Who worked that out?

Patient: Dr. Sullivan.

Chapman: Dr. Sullivan put you there purposely for that?

Patient: That's what he said.

Chapman: Have you been considerably treated or have you seen at any time any ill treatment of patients . . . ?

Patient: Nothing that could be called ill treatment¹⁰³

Chapman did not reveal what he might have suspected but he later decided to let Sullivan leave the hospital. In retrospect, he justified his decision: "We must not forget that there was always a question . . . how long we could count on him? He had never been able to adapt himself to many of the people about him."¹⁰⁴ Chapman was openly worried about Sullivan's demand for more control and what many considered his uncooperative character. Also, it seems likely that Chapman was concerned about Sullivan's controversial clinical methods. Indeed, Sullivan was well aware that he had been causing a "problem" for the hospital. When Clifton Read, one of his closest friends in the 1930s, asked if Sullivan had written about "what went on in his ward," Sullivan "grinned and shook his head, [saying that] all he could do was suggest in a footnote."¹⁰⁵ Apparent in Sullivan's reaction is that the need to hide his clinical approach not only from the hospital but also from the broader psychiatric community.

In his ward, Sullivan had trained attendants so that they applied what he believed the most effective treatment. It was attendants, not doctors, who engaged in physical contact with patients. As William Elliot recalled, Sullivan "was in the ring but he wasn't playing." He was "just like a ringmaster. You jump but I am not going to jump."¹⁰⁶ Sullivan projected himself on these attendants, rather than acting himself. This seems to have been his way to draw a line between his personal and professional selves in 1928 and 1929. However, the distinction did not prevent his departure from Sheppard-Pratt. In March 1930, he sent a letter of resignation to Chapman, who accepted it immediately. Despite his successful treatment of schizophrenic patients and his willingness to further the hospital's application of the new psychiatry, Sullivan's clinical practice involving physical contact between male attendants and patients was more than the hospital could tolerate or even bring to an open discussion.

The comparative analysis of Sullivan's published writings and unpublished clinical records shows practices influenced by the new psychiatry of the 1920s: a strong focus on verbal communication and a frequent use of the diagnosis of schizophrenia. What is also brought to light is significant features of his treatment of his special patients, whom he believed were homosexual and schizophrenic. Through his interactions with them, he developed his interpersonal theory, as well as a unique clinical approach involving physical affection. This was a compelling, if controversial, method of treating schizophrenia that challenged the social stigmatization of homosexuals and, implicitly, criticized a psychiatric profession that failed to address difficulties imposed upon homosexuals by a homophobic society. Sullivan attempted to reduce these difficulties for his patients at Sheppard-Pratt. At the same time, his story suggests how hard it was to publicly

confront the stigmatization of homosexuality in the psychiatric world of the 1920s, even at a hospital where the new psychiatry was influential. Neither Sullivan nor the hospital brought his approach to homosexual patients to critical debate but kept it hidden. In the 1930s and 1940s, such an inhibition in psychiatry was to further circumscribe Sullivan's theory and practice as a gay psychiatrist.

Endnotes

1. Harry Stack Sullivan, "The Relation of Onset to Outcome in Schizophrenia" in Harry Stack Sullivan, *Schizophrenia as a Human Process* (New York: Norton, 1962), 236–244 (originally published in *Schizophrenia [Dementia Praecox]: An Investigation of the Most Recent Advances*, Vol. 10 [1931], 111–118); Helen Swick Perry, "Introduction" in Sullivan, *Schizophrenia*, pp. xi–xxxi; Arthur Harry. Chapman and Miriam Chapman, *Harry Stack Sullivan's Concepts of Personality Development and Psychiatric Illness* (New York: Brunner/Mazel, 1980), chap. 11; Helen Swick Perry, *Psychiatrist of America: The Life of Harry Stack Sullivan* (Cambridge, United Kingdom: Belknap Press, 1982), chap. 23; David McKenzie Rioch, "Recollections of Harry Stack Sullivan and of the Development of His Interpersonal Theory," *Psychiatry*, 48 (1985), 141–157; F. Barton Evans, *Harry Stack Sullivan: Interpersonal Theory and Psychotherapy* (New York: Routledge, 1996), 34–35; Gail A. Hornstein, *To Redeem One Person Is to Redeem the World: The Life of Frieda Fromm-Reichmann* (New York: The Free Press, 2000), 97; Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, United Kingdom: Harvard University Press, 2001), 198.

2. Arthur H. Chapman, *The Treatment Techniques of Harry Stack Sullivan* (New York: Brunner/Mazel, 1978), chap. 11; Perry, *Psychiatrist of America*, chap. 23; Nathan G. Hale Jr., *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917–1985* (New York: Oxford University Press, 1995), 176.

3. Sullivan's comment in "Stenographic Report of the Character Education Research Conference held at the Chicago Theological Seminary under auspices of the Religious Education Association" (New Haven, CT: Yale Divinity School Library Special Collections, 1929), 106.

4. Harry Stack Sullivan, "Research in Schizophrenia" in Sullivan, *Schizophrenia*, 186–202 (originally published in *American Journal of Psychiatry*, 86 [1929]: 553–367); Harry Stack Sullivan, "Archaic Sexual Culture and Schizophrenia" in Sullivan, *Schizophrenia*, 206–215 (originally presented at Sexual Reform Congress, the Third Congress of the World League for Sexual Reform in London, 1930).

5. Researchers have argued that Sullivan's major contribution was his effort to introduce sociocultural factors into psychiatric and psychological practices and theories. See, for example, Gerald N. Grob, *From Asylum to Community: Mental Health Policy in America* (Princeton, NJ: Princeton University Press, 1991), 283; Philip Cushman, *Constructing the Self, Constructing America: A Cultural History of Psychotherapy* (Reading, MA: Addison-Wesley, 1995), 177; Hale, *The Rise and Crisis*, 177.

6. Sullivan, "Research in Schizophrenia," 202.

7. Harry Stack Sullivan, "Schizophrenic Individuals as a Source of Data for Comparative Investigation of Personality," *Proceedings: Second Colloquium on Personality Investigation* (Ann Arbor: UMI, 1930), 43–48 (quote from p. 46, the colloquium held in 1929).

8. Perry, *Psychiatrist of America*, 195–196. Sullivan's original statement is from Sullivan, "Schizophrenic Individuals," 47.

9. Rioch, "Recollections," 144–145.

10. Gail A. Hornstein, *To Redeem One Person*, p. 126.

11. Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine*, 5 (1992), 183–205

(quote from p. 197). See also Larry R. Churchill and Sandra W. Churchill, “Storytelling in Medical Arenas: The Art of Self-Determination,” *Literature and Medicine*, 1 (1982): 73–79.

12. Sullivan’s first use of the word “interpersonal” appeared in Harry Stack Sullivan, “The Onset of Schizophrenia” in Sullivan, *Schizophrenia*, 104–136 (originally published in *American Journal of Psychiatry*, 84 [1927]: 105–134).

13. As shown later, Sullivan’s interest in homosexuality was related to his broader interest in what he defined as “schizophrenia.” Past studies have focused on different aspects of Sullivan’s clinical practice. Anton T. Boisen, for example, emphasized Sullivan’s approach to patients’ sense of guilt and responsibility, as well as to the role of concealment in psychosis. See Anton T. Boisen, *Out of the Depths: An Autobiographical Study of Mental Disorder and Religious Experience* (New York: Harper & Brothers, 1960); Hendrika Vande Kemp, “Harry Stack Sullivan (1892–1949): Hero, Ghost, and Muse,” *The Psychotherapy Patient*, 13 1/2 (2004): 7–61.

14. Researchers have disagreed about when Sullivan began his practice in “Sullivan’s Ward.” See Clarence G. Schulz, “Sullivan’s Clinical Contribution During the Sheppard-Pratt Era—1923–1930,” *Psychiatry*, 41 (1978): 117–128; Kenneth L. Chatelaine, *The Formative Years of Harry Stack Sullivan* (Washington, DC: University Press of America, 1981), 442; Perry, *Psychiatrist of America*, chap. 23; Robert W. Gibson, “The Application of Psychoanalytic Principles to the Hospitalized Patient” in Ann-Louise Silver, ed. *Psychoanalysis and Psychosis* (Madison, WI: International University Press, 1989), 183–205. The clinical records at Sheppard-Pratt, which I examine in this article, did not indicate when Sullivan started the ward.

15. Chatelaine, *Formative Years*, 442; Kenneth L. Chatelaine, “Harry Stack Sullivan (The Real Sullivan and What Sullivan Really Said)—Founder of Interpersonal Psychiatry: An Introduction to His Life and Theoretical Contributions,” unpublished, 10; Michael Stuart Allen, “Sullivan’s Closet: A Reappraisal of Harry Stack Sullivan’s Life and His Pioneering Role in American Psychiatry,” *Journal of Homosexuality*, 29, no. 1 (1995): 1–18; Bert Hansen, “Public Careers and Private Sexuality: Some Gay and Lesbian Lives in the History of Medicine and Public Health,” *The American Journal of Public Health*, 92, no. 1 (2002): 36–44; Mark J. Blechner, “The Gay Harry Stack Sullivan, Interactions Between His Life, Clinical Work, and Theory,” *Contemporary Psychoanalysis*, 41, no. 1 (January 2005): 1–19.

16. See, for example, Harry Stack Sullivan, “Discussion (for A. A. Brill, “Schizophrenia and Psychotherapy”),” *American Journal of Psychiatry*, 86 (1929): 538–541, see 540 in particular: Harry Stack Sullivan, “Cultural Stress and Adolescent Crisis” in Sullivan, *Schizophrenia*, 321–351 (originally published as a chapter, “Male Adolescence,” in Harry Stack Sullivan, *Personal Psychopathology: Early Formulations* [New York: Norton, 1972], 182–244). *Personal Psychopathology* was written between 1929 and 1933; Harry Stack Sullivan, “Sociogenesis of Homosexual Behavior (an address read before the Section of Sociology and Psychiatry, The American Sociological Society, Washington, DC),” December 27, 1929, Washington School of Psychiatry archive, Washington, DC (hereinafter WSP), 1–2. See also “File: Interview with Benjamin Weininger, M. D., December 1, 1987,” Michael Stuart Allen private archive, San Francisco (hereinafter MSA; I thank Michael Stuart Allen for generously giving me full access to his Sullivan sources), in which Weininger claimed that he tried homosexual relations to understand schizophrenia because Sullivan suggested to him a close connection between schizophrenia and homosexuality. This was in the first few years of the 1930s following Sullivan’s resignation from Sheppard-Pratt. Indeed, it was not unusual for Sullivan’s contemporary psychiatrists to see a close connection between homosexuality and schizophrenia. See, for example, George W. Henry & Hugu M. Galbraith, “Constitutional Factors in Homosexuality,” *American Journal of Psychiatry*, 13, no. 6 (1934): 1249–1267, in which the authors argued “in general it may be said that the psychotic

reactions of the whole homosexual group tend to be paranoid and schizophrenic in nature” (p. 1264). On the other hand, many psychoanalysts considered homosexuality relevant to neuroses. See, for example, Sigmund Freud (James Strachey, ed.), *Introductory Lectures on Psycho-Analysis* (New York: Norton, 1963), 381–384 (Lecture 20: The Sexual Life of Human Beings, originally published in 1917); Paul Schilder, “On Homosexuality,” *Psychoanalytic Review*, 16 (1929): 377–389, see 387 in particular. Robert G. Kvarnes, ed., *A Harry Stack Sullivan Case Seminar* (New York: Norton, 1976) also acknowledged Sullivan’s comment on homosexuality. See 209 in particular.

17. Michael Stuart Allen, “The Island of Dr. Sullivan,” *The Gay & Lesbian Review*, 7 (Winter 2000): 16–19 (quote from p. 19).

18. It is not clear under what circumstance their relationship started. A few friends of Sullivan claimed to know about their encounter, but their assertions are inconsistent. Some insisted that Inscoe was Sullivan’s patient at Sheppard-Pratt. Others believed that Sullivan found him in a catatonic state in front of a friend’s house in Washington DC, Sullivan took Inscoe first as a housekeeper to help him improve (Sullivan believed in the therapeutic value of plain, light labor), and then, most likely, the two became lovers. In a completely different story, Helen Swick Perry claimed during her interview with Michael Stuart Allen in 1987 that she understood that Inscoe was a male hustler before he came to live with Sullivan. This suggests that they first met as a prostitute and a customer in the Baltimore red-light district. Ruthwin J. Evans, who worked at Sheppard-Pratt from 1926 to 1953, claimed that “Jimmie was never a patient at Sheppard Pratt.” Clifton Read, Sullivan’s friend, said “HSS found Jimmie wandering around Baltimore, lost but he was absolutely confident . . . that things would work out for him/be taken care of . . . HSS decided that he’d be wonderful to have around.” I could not locate Inscoe’s record among the clinical records at Sheppard-Pratt. See Helen Swick Perry, *Psychiatrist of America*, 209; “File: Interview with Helen Swick Perry, September 23, 1987,” MSA; “File: Evans, J. Ruthwin (interview with Ruthwin J. Evans, date unspecified),” Helen Swick Perry private archive, Cambridge, MA (hereinafter HSP; I thank Stewart E. Perry for generously giving me access to Helen Swick Perry’s Sullivan materials); “File: Interview with Clifton Read, January 14, 1989,” MSA.

19. For more information about Sullivan’s personal interest in the issue of homosexuality in the latter half of the 1920s, see Allen, “Sullivan’s Closet,” 8.

20. The following discussion is based on an analysis of the 1,853 clinical files at Sheppard and Enoch Pratt Hospital, Baltimore (hereinafter SEP), June 1922 to April 1930, serial numbers from 4325 to 6377 (not include missing 107 files and 93 files whose contents were either mostly missing or not accessible because they were transferred to newer files due to readmission).

21. Gerald N. Grob, *Mental Illness and American Society, 1875–1940* (Princeton, NJ: Princeton University Press, 1983), chapters 5, 6.

22. Bliss Forbush and Byron Forbush, *Gagehouse: The Evolution of the Sheppard and Enoch Pratt Hospital* (Philadelphia: Lippincott, 1971), chap. 2.

23. Ives Hendrick, “Our Generation of Psychiatrists: Changes in Our Words and Changes in Our Thinking” in Robert W. Gibson, ed., *Crosscurrents in Psychiatry & Psychoanalysis: Being the Papers and Discussions Presented on the Occasion of the Seventy-Fifth Anniversary of the Sheppard and Enoch Pratt Hospital, Sheppard and Enoch Pratt Hospital, Towson, Maryland* (Philadelphia: Lippincott, 1967), 23–35.

24. Between 1923 and 1928, 982 out of 1160 clinical files (84.7 %) indicated patients’ middle-class background (e.g. economic condition “comfortable,” etc.).

25. Lawrence J. Friedman, *Menninger: The Family and the Clinic* (New York: Knopf, 1990), 39.

26. A hospital doctor held brief interviews with a patient soon after admission, which were recorded in the first three parts. These interviews aimed to uncover the patient’s general attitude and behavior. At that time, the patient was asked for family and

personal histories. In most cases, family members and close friends also were invited to offer these histories. In interviews, a doctor assessed patients' nationality, personality (bright, cheerful, talkative, etc.), medical history (physical and mental), delivery condition, educational history, sexual development and function (history of sexual relation and masturbation), occupational history, and onset of symptoms. Physical and mental examinations followed set formats apparently designed for the clarification of symptoms, which varied from fever, headache, and muscle pain to delusion and hallucination. Clinical observations were made daily during the first week of hospitalization and, after that, once a week. Usually they consisted of four or five sentences describing patients' activities, such as their participation in occupational classes.

27. From 1926 to 1930, conferences began with the presentation of personal and family histories, physical and mental examinations, and clinical observations by the doctor in charge of a patient. Several other doctors were present, and most often one of them, usually an assistant physician, started the interview. Then, more experienced doctors joined in the conversation, and finally, Sullivan. The length of the conversation varied, from about 20 min to an hour. When it was over, the patient left the room, and the doctors discussed possible diagnoses and prognoses. Sullivan made the final decision when he was in attendance.

28. When doctors found a prognosis favorable, they kept a patient for another month or so for occupational therapy, recreational activities, and brief interviews on a regular basis. Then they held a second conference to review the patient's progress. When they came up with a pessimistic prognosis, they recommended transfer to a state hospital or a sanitarium for custodial care. In such a case, a patient and his or her family had to decide what happened next. Some followed the recommendation, whereas others preferred at-home care.

29. Perry, *Psychiatrist of America*, chap. 23; Clarence G. Schulz, "Sullivan's Influence on Sheppard Pratt," *Journal of the American Academy of Psychoanalysis*, 15 (1987): 247–259.

30. Sullivan, "The Relation of Onset to Outcome," 236. In this article, he claimed "about two hundred and fifty [schizophrenic] patients have been subject to more or less elaborate investigation" during his 7 years at Sheppard-Pratt, but he went on to say that he limited the discussion in the article to "the first hundred" patients to "simplify this orientation." Then he argued that 78 out of these hundred cases were acute, and 48 out of these 78 cases showed "marked improvement." The criteria for the selection of these hundred cases, as well as what he meant by "elaborate investigation," are not clear.

31. There are only 13 missing files out of 222 files of patients admitted in 1928 and 17 out of 304 in 1929.

32. Clinical Record, SEP, Nos. 6106, 5898, and 5921.

33. Chatelaine, *Formative Years*, 455.

34. As discussed earlier, Sullivan had 14 special interviews with 7 patients in 1926 and with 13 patients in 1927. There are 2 patients before 1926 whose files include records of special interviews, whereas two patient files from the period 1928–1929 include such records.

35. Clinical Record, SEP, No. 5428.

36. Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (New York: Basic Books, 1981). See also Henry L. Minton, *Departing from Deviance: A History of Homosexual Rights and Emancipatory Science in America* (Chicago: The University of Chicago Press, 2002); Vernon A. Rosario, *Homosexuality and Science: A Guide to Debate* (Santa Barbara, CA: ABC-CLIO, 2002), on psychiatry's treatment of homosexuality.

37. Clinical Record, SEP, No. 5428.

38. Clinical Record, SEP, No. 5428.

39. Chatelaine, *Formative Years*, 455.

40. Bernard Robbins papers, Bernard Robbins Institute, Boston University, Folder No. 9, Sec. #1. I thank Benjamin Harris of the Department of Psychology at the University of New Hampshire for generously supplying the document.
41. William Alanson White, *Outline of Psychiatry* (New York: Journal of Nervous and Mental Disease Pub. Co., 1909), 220.
42. Clinical Record, SEP, No. 5428.
43. Clinical Record, SEP, No. 5426.
44. Sigmund Freud, *Three Essays on the Theory of Sexuality* (New York: Basic Books, 1962), originally published in 1905. See also Harry Stack Sullivan, "Review (of Anomaly, *The Introvert and His Social Adjustment*, London, Tindall & Cox, 1927," *American Journal of Psychiatry*, 7 (1927): 532–537.
45. Clinical Record, SEP, No. 5426.
46. Harry Stack Sullivan, *The Psychiatric Interview* (New York: Norton, 1954), 12–13.
47. Clinical Record, SEP, Nos. 5426, 5533, and 5586.
48. Clinical Record, SEP, Nos. 5889 and 6146.
49. Sullivan, "Schizophrenic Individuals," 223. See also his comment in "Stenographic Report," 24. In this report, Sullivan admitted that these special interviews were "highly personal" and described his selected patients as "my people."
50. Harry Stack Sullivan, "Projected Book on Schizophrenia," WSP, 1926.
51. See, for example, Harry Stack Sullivan, "Mental Disorders" in Sullivan, *Schizophrenia*, 297–307 (originally published in *Encyclopaedia of the Social Sciences*, 10 [New York: Macmillan, 1933], 313–319).
52. Harry Stack Sullivan, *Conceptions of Modern Psychiatry* (New York: Norton, 1953), 5–6.
53. Sullivan said in a conference for another patient who stayed at Sheppard-Pratt from July 1928 to May 1929 "I have never seen her until to-day" (Clinical Record, SEP, No. 5915). Although Ross M. Chapman thought it was important for all the doctors to know all the inpatients, some of the doctor's comments suggest this was not always the case.
54. Clinical Record, SEP, No. 6156.
55. Clinical Record, SEP, No. 6156.
56. Clinical Record, SEP, No. 6156.
57. Clinical Record, SEP, No. 6156.
58. Clinical Record, SEP, No. 6117.
59. See, for example, Harry Stack Sullivan, "Erogenous Maturation," *Psychoanalytic Review*, 8 (1926): 1–15; Harry Stack Sullivan, "Discussion (for A. A. Brill)," *American Journal of Psychiatry*, 86 (1929): 538–541.
60. Clinical Record, SEP, No. 6156.
61. Clinical Record, SEP, No. 6156.
62. Clinical Record, SEP, No. 6156.
63. Sullivan, "Schizophrenic Individuals," 46.
64. Harry Stack Sullivan, "Peculiarity of Thought in Schizophrenia" in Sullivan, *Schizophrenia*, 26–99 (originally published in *American Journal of Psychiatry*, 82 [1925]: 21–86); Sullivan, "The Onset of Schizophrenia"; Sullivan, "Schizophrenic Individuals as a Source of Data for Comparative Investigation of Personality"; Harry Stack Sullivan, "The Common Field of Research and Clinical Psychiatry" in Sullivan, *Schizophrenia*, 140–156 (originally published in *Psychiatric Quarterly*, 1 [1927]: 276–291); Harry Stack Sullivan, "Tentative Criteria of Malignancy in Schizophrenia" in Sullivan, *Schizophrenia*, 158–183 (originally published in *American Journal of Psychiatry*, 84 [1927]: 759–782).
65. See notes 8, 9, and 10.
66. Hornstein, *To Redeem One Person*, 127.
67. Sullivan, "The Common Field of Research and Clinical Psychiatry," 151.

68. For example, Sullivan called a 15-year-old schizophrenic patient by his first name throughout the patient's stay at Sheppard-Pratt, both in special interviews and conferences. Although he eventually gave a pessimistic prognosis, Sullivan carried out at least six individual interviews with this patient. See, Clinical Record, SEP, No. 5570.

69. Clinical Record, SEP, No. 4995.

70. Clinical Record, SEP, No. 6141.

71. Clinical Record, SEP, No. 5662.

72. Clinical Record, SEP, No. 5729 (clinical observation).

73. Clinical Record, SEP, No. 5729 (conference report).

74. Clinical Record, SEP, No. 6182 (conference report).

75. Clinical Record, SEP, No. 6182 (conference report).

76. Clinical Record, SEP, No. 6141 (conference report).

77. Clinical Record, SEP, No. 6156.

78. Clinical Record, SEP, No. 5950.

79. Clinical Record, SEP, No. 5999 (conference report).

80. Clinical Record, SEP, No. 6146.

81. On the development of the diagnostic manual, see Horatio M. Pollock, "Progress and Present Status of Statistics of Mental Disease," *Mental Hygiene*, 11 (1927): 156–161; Horatio M. Pollock, "Better Statistics of Mental Disease," *Mental Hygiene*, 2 (1928): 81–84; Gerald N. Grob, "Origins of *DSM-I*: A Study in Appearance and Reality," *American Journal of Psychiatry*, 148, no. 4 (April 1991): 421–431. The first standard manual was published as *Statistical Manual for Hospitals for Mental Disease* by the National Committee for Mental Hygiene in 1923. A condensed version appeared in U.S. Bureau of the Census, *Patients in Hospitals for Mental Disease*, 1923 (Washington, DC: Department of Commerce, 1926), 40–42.

82. Sullivan, although in a critical manner, used Kraepelin's terminology for the classification of schizophrenia in his educational analyses at Chestnut Lodge Hospital as late as 1942 and 1943. See Harry Stack Sullivan, *Clinical Studies in Psychiatry* (New York: Norton, 1956), 307–314.

83. See, for example, Lawson G. Lowrey, "A Study of the Diagnoses in Cases Seen at the Psychopathic Department and Hospital of the Boston State Hospital," *American Journal of Psychiatry*, 77 (1920–1921): 437–449.

84. Clinical Record, SEP, No. 5950.

85. Clinical Record, SEP, Nos. 5891, 5915, and 5869.

86. Harry Stack Sullivan, "Affective Experience in Early Schizophrenia," *American Journal of Psychiatry*, 84 (1927): 463–483. Also in 1929, Sullivan confirmed that "everything that is spoken is recorded" during special interviews. See his comment in "Stenographic Report," 26.

87. Sullivan, "Affective Experience," 472.

88. Clinical Record, SEP, Nos. 6156 and 5889.

89. Clinical Record, SEP, No. 5907 (staff conference). This quote is particularly interesting because a significant proportion of the schizophrenic patients at Sheppard-Pratt were Jews and Catholics. I examined the files of 62 "schizophrenic" patients Sullivan treated (which include 24 patients who had special interview[s] with Sullivan and those who did not have special interviews but had unusually long, intensive interviews during staff conferences) and found that 11 of them were Catholics and 7 were Jews.

90. Clinical Record, SEP, No. 5639.

91. Clinical Record, SEP, No. 5950.

92. Clinical Record, SEP, No. 6146 (conference report).

93. These 572 patients were all who had clear records of a diagnosis and status at discharge between 1927 and 1929.

94. U.S. Bureau of the Census, *Patients in Hospitals for Mental Disease* (Washington, DC: Government Printing Office, 1926, 1933, 1935).

95. Forbush, *Gatehouse*, chap. 7.

96. The percentage of patients diagnosed as schizophrenia was 30.1% in 1923, 20.6% in 1931, and 20.0% in 1933. The second largest population, that of those who were diagnosed as manic-depressive, was 17.7%, 14.3%, and 12.9%, respectively. See U.S. Bureau of the Census, *Patients in Hospitals for Mental Disease*.

97. Psychiatrists during the first decades of the twentieth century often pointed out the necessity of introducing effective treatment for this arguably most severe form of mental illness. See, for example, Horatio M. Pollock, "Dementia Praecox as a Social Problem," *Mental Hygiene*, 3 (1919): 575–179; Edith M. Furbish, "The Social Significance of Dementia Praecox," *Mental Hygiene*, 6 (1922): 288–299.

98. Bernard Robbins papers.

99. Chatelaine, *Formative Years*, 451–452.

100. "File: Sapir, Philip and Jean (interview with Jean Sapir, August 1972)," HSP; "File: Interview with Helen S. Perry, September, 1987," MSA.

101. Clinical Record, SEP, No. 6146.

102. Chatelaine, *Formative Years*, 449.

103. Clinical Record, SEP, No. 5889.

104. Forbush, *Gatehouse*, chap. 8. This was what he wrote to the president of the hospital board.

105. Clifton Read, "Harry Stack Sullivan: A Remembrance (undated)," MSA, 20.

106. Chatelaine, *Formative Years*, 452.

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