Sullivan had many specific, practical ideas about how to approach the very difficult, schizoid, or borderline patient. As a result, students brought to him their sickest and most troublesome patients who either would not talk or could not explain in any clear, relevant way what had happened to them as they grew up or precisely how they felt about significant issues. Sullivan felt that schizoid patients had often been raised in such an atmosphere of ambiguity and double-talk—where deep feelings were denied or explained away by meaningless chatter—that they were led away from experiencing the truths of their world. Facts that they may have once seen clearly in early childhood were later buried or distorted to fit in with adult needs and prescriptions. The result was a blurring of memory, a forgetting of episodes that failed to fit into family myths, and an apparent acceptance of rationalizations or untruths in order to please significant adults or at least to avoid their rage and threatening disapproval. Words ceased to have real meaning. Other people’s ideas could not be trusted, but one’s own perceptions were also suspect or dangerous. Without consensual validation or parental affirmation, clear observations and authentic feeling responses were repressed, resulting in vagueness, confusion, and amnesia. This made it very difficult for the therapist to get an accurate picture of what really went on in the patient’s past so that he could understand the present. Thus, it was hard to get the thorough developmental history
that Sullivan thought was absolutely necessary as a sound background for treatment. He felt that taking a good history was in itself therapeutic, since it led the patient to rediscover and reevaluate his past with an experienced and impartial new person as a guide. The theory could indicate where to dig and help to decipher the archaic language engraved on tablets from childhood in order to disclose hidden truths that would illuminate current problems in living. Old assumptions and myths had to be documented and reexamined with “benevolent skepticism” to see if they fit the new facts. It was like an archeologist’s exploration of the past in order to better understand the present.

Sullivan realized that most sick people were unable to give clear, pertinent histories at the beginning of treatment. The initial overview was important for the basic orientation of the therapist. It would give him some idea as to the central problems and help guide the patient’s future detailed inquiry—when the patient was somewhat more trustful and the analyst more aware of which troubled areas needed to be investigated first. Whenever the patient “did not know what to talk about” or blocked due to anxiety, Sullivan would suggest that the analyst use the opening to go back once again to ask, “When did this anxiety first occur” or “What was going on in your life at that point in time?” One could always inquire into obscure areas of history that needed to be clarified. This recurrent inquiry was more meaningful to the patient if it was connected with the content of a recent hour or a current problem. History then became more relevant, not just didactic or of theoretical importance. Sullivan felt the patient needed to be shown what kind of material was relevant by the demonstration of its pertinence during therapy. The analyst was interested in just the kind of material that the parents had forced into repression. To pursue obscured data, the analyst often found himself “bird dogging”—sniffing out emotionally laden areas, seeing discrepancies in the available data that needed to be clarified, and sensing that more lay behind a given story than appeared at first. Every explanatory hypothesis suggested by either patient or analyst had to be questioned, documented, tried out in therapy or real life to see if it fit, if it “rang true,” “if it elucidated obscure areas of conflict.” Constructs had to become useful in a practical, pragmatic, and non-theoretical approach. Preconceived notions were always to be challenged, because they might be camouflage for a more basic issue that caused too much anxiety for the patient to face alone.

When working with either supervisees or patients, Sullivan would accept no cliches, no generalizations, no fancy or ambiguous technical terminology. When one offered a theory about what was happening with a patient, Sullivan would frequently ask, “As illustrated by what?”