The "therapeutic relationship:" emergence, eclipse, and transformations of a social technology

A "relação terapêutica": surgimento, obscurecimento e transformações de uma tecnologia social

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Abstract

This essay situates the history of "the relationship" as a therapeutic technology within the broader context of changing social relations in the twentieth-century United States. More specifically, it outlines the emergence and subsequent diffusion of practices that aim to cultivate a social bond between therapist and patient that may serve as a psychotherapeutic tool. The article highlights the transformations of this technology as its institutional and epistemic foundations became challenged. Initially conceived as an "artificial" social relation designed to help with "personal adjustment," the therapeutic relationship was soon also deployed by non-experts and became a model for more healthful social relations. More recently, it has been fashioned as collaborative and combined with a range of other methods.

Keywords: history of psychotherapy; therapeutic relationship; social technology; social relations.

Resumo

O artigo identifica a história da "relação terapêutica" como uma tecnologia inserida em um contexto mais amplo de relações sociais marcadas por mudanças, nos EUA do século XX. Mais especificamente, sintetiza o surgimento e a subsequente difusão de práticas voltadas para o cultivo do vínculo social entre terapeuta e paciente que podem servir como ferramenta psicoterapêutica. O artigo destaca as transformações dessa tecnologia à medida que passam a ser contestados os alicerces institucionais e epistemológicos da psicoterapia. Em princípio concebida como uma relação social "artificial", criada para colaborar com o "ajuste pessoal", a relação terapêutica não tardou a ser aplicada também por não especialistas e se tornou um modelo para relações sociais mais saudáveis. Nos últimos tempos, passou a figurar como prática colaborativa e a ser associada a uma série de outros métodos.

Palavras-chave: história da psicoterapia; relação terapêutica; tecnologia social; relações sociais.

The historiography of psychotherapy is as fractured as the field whose stories it recounts (Marks, 2017; Rosner, 2018). Intellectual histories, particularly, often confine themselves to one psychotherapeutic school or tradition. Given the bewildering variety of psychological therapies that have emerged since the late nineteenth century, the acrimonious debates that have long haunted the field, together with the fact that psychotherapy as a practice was never dominated by a single profession, this is not altogether surprising. Any profession that is arguably under threat – and if it is only the threat of a competitive marketplace – is inclined to turn to its own history to dignify its origins and foreground its distinguishing features. Yet the resulting narratives are not only limited because of their omissions, but also due to the communalities they underplay. It is perhaps fair to say that the historiography of psychotherapy tends to unwittingly reproduce the tensions within the field it studies while often leaving unexamined areas of agreement among psychotherapists and processes of intellectual exchange between the quarrelling factions and competing professional groups. The focus on theoretical differences and fractured movements, in other words, has diverted attention away from the often only implicit background assumptions grounding these disputes, investing them with significance in the first place – and the historical transformations they themselves undergo.

This essay, by contrast, is concerned with the history of what psychotherapy researchers as well as the majority of practitioners today regard as a crucial common or "non-specific factor" in any form of psychotherapy: the therapeutic relationship (e.g., Norcross, Lambert, 2019). More precisely, I am interested in the evolution of practices that cultivate a "specific" social relation between the psychotherapist and the patient or client so that the relationship itself may serve as a "means" of therapy. My aim is twofold. First, by drawing together the scattered historiography on the topic, I reconstruct aspects of this history to put into relief consequential shifts in the conceptualizations and uses of the therapeutic relationship over the course of the twentieth century. Second, the essay puts to the test the notion that the "therapeutic relationship" can be productively understood as a social technology so as to overcome some of the mentioned limitations intellectual histories of psychotherapy have not just imposed on the field in general, but on the historical investigation of relational practices in particular.

The therapeutic relationship as social technology

Why posit that the therapeutic relationship is best understood in terms of a therapeutic technology or, even more broadly, as a social technology? This methodological move may seem provocative, especially since relational practices are all too readily placed in binary opposition to psychotherapeutic techniques, narrowly defined. For many contemporary psychotherapists, "technique" has become synonymous with a set of clearly defined procedures – that is, increasingly codified in treatment manuals and guidelines – whereas "the relationship" refers to the elusive emotional bond that is forged between therapists and their clients over the course of treatment. This distinction has become more salient in the wake of the evidence-based practice movement, which has led to tensions between psychotherapists who conceive of psychotherapy as the consistent, empirically grounded application of a set

of techniques and an opposing group who point to the significance of healing relationships, which, they say, lie at the heart of therapeutic practice (see Norcross, 2001).

This understanding of technique, however, is problematic for both historical and conceptual reasons. Historically, questions about what kind of relations psychotherapists should entertain with their patients have long been at the center of technical debates in psychotherapy. Indeed, the controversies that have erupted over such questions have often proved divisive. Far from being separate from or opposed to psychotherapy's technical aspects, the therapeutic relationship has evolved as one.

Certainly, the word "technology" still evokes the idea of a targeted, highly structured, efficiently organized procedure, often involving technical instruments, and, as such, seems hardly suited to capture a complex interpersonal dynamic; nor does it seem to get at the tacit practical knowledge and skills psychotherapists often draw on as they interact with their patients. As the psychoanalyst Donna Orange (2011) has pointed out, for instance, a therapist's "personal style" cultivated over time to evolve into a kind of practical wisdom or virtue, as opposed to the strict observance of technical rules, significantly shapes his or her interpretative practice.

In the history and sociology of science, however, the word "technology" is applied more broadly. The sociologist Nikolas Rose, for instance, drawing on the work of Michel Foucault, invokes the term not only to refer to a wider range of activities, but also to the tangible and intangible components of the conditions that must fall into place to guide and sustain them (Rose, 2007, p.16). Rose (1996, p.88) is interested in "complex technical forms … – ways of combining persons, truths, judgments, devices, and actions into a stable, reproducible, and durable form." From a Foucauldian perspective a discussion of techniques and technologies is of course linked to questions about the exercising of power or, in Rose's case, more narrowly, problems related to governing individuals and populations. Though despite Foucault's incisive analysis of "technologies of power," especially in the context of psychiatry and the penal system, his usage of the term is highly ambiguous throughout his oeuvre (Behrent, 2013). On the one hand, its connotations allowed Foucault to effectively problematize techniques of domination, while on the other hand he employed it in an affirmative manner to divert attention away from questions concerning the presumed "nature" of subjectivity to the practices through which, he argued, different forms of subjectivity are constituted. "Technology" was never thought of as imposing an order upon a subject (or process) that is "alien" to whatever it is applied to, a violation of its essence. This fundamental ambiguity became strikingly exposed in his late work, as he embarked on an investigation of what he termed "technologies of the self" or "ethical techniques of the self" in late antiquity and early Christianity – techniques one deliberately engages in to modify oneself to attain a more ideal state of being (Foucault, 1988). In this context, Foucault emphasized the word's Greek root *tékhnē*, meaning craft, craftsmanship, or art, making his usage of "technology," as Michael Behrent (2013, p.91) has noted, "virtually synonymous with 'aesthetics'". In a similar vein, historians of the natural sciences have pointed to the role of creativity in the knowledge production process in the experimental sciences. The outcomes of technical procedures, these authors contend, are not necessarily predictable, technologically mediated processes; rather, far from being closed-ended, they

often allow for and sometimes even foster creativity as they nonetheless aim for durability and reproducibility (e.g., Rheinberger, 2001; Pickering, 2010).

Conceiving of relational practices in terms of a technology in this broader sense thus allows for a consequential shift in focus. It directs attention to the evolution of practices and forms of practical knowledge that do not necessarily derive from or align with a body of theoretical knowledge. Technologies can be transposed to different contexts, to some extent at least, independent of their theoretical underpinnings and original rationales. Such an approach, therefore, not only deemphasizes disputes between the different psychotherapeutic schools, it also broadens its scope beyond psychotherapy to the use of psychotherapeutics by other health professions as well as non-professionals (enriching the historiography of psychotherapy, in other words, with viewpoints and questions related to the history of knowledge; see Dupré, Somsen, 2019). At the same time, it can serve to highlight the ethical and political ambiguities of psychotherapeutic practices, which may function as a means of social control and normalization, on the one hand, and, on the other, as technical procedures individuals deliberately engage in to transform their state of being.

The focus on theoretical differences has indeed not only hampered the historiography of relational practices, but also the analysis of their ethical-political dimensions. In the case of mainstream (North American) psychoanalysis, the delayed broader recognition of relational and interpersonal theories, the shift from a so-called "one-person" to a "two-person" psychology in the last three decades of the twentieth century, obscured the fact that orthodox Freudianism is also best understood as a relational practice, as I argue in the following section. And, taking cues from the early critical theorists, the assessment of the social and political significance of relational "practices" has similarly been overshadowed – and to some extent warped – by disputes concerning this broader theoretical shift and the pending demise of Freudian drive theory (see also Herzog, 2017). Theodor W. Adorno and Herbert Marcuse, especially, have argued that a biologically grounded drive theory still retained Freud's critical impulses whereas the emerging relational theories, grounded in the social sciences, squandered these insights and with them the recognition of "negativity," or as conservative critics such as Philipp Rieff would have it, the cultural imperative of the "renunciation" of instinctual demands (e.g., Adorno, 1946-1997; Marcuse, 1965; Rieff, 1966). (Ironically, later generations of the Frankfurt School, most prominently Axel Honneth, have turned instead to relational theories to underwrite their own brand of critical theory.) Such assessments, based on theoretical tenets and their anthropological implications, often forgo more important questions about "how" relational techniques were employed in practice. The rough overview and periodization presented here is therefore, first and foremost, intended as an invitation to further investigate the history of relational practices in psychotherapy and bordering fields.

The clinical encounter as method

What tends to obscure the origins of relational practices – which entail a systematic concern with how patients respond to their psychotherapists and vice versa – is the conviction that the effectiveness of psychoanalytic treatment is based on its ability to

provide those in treatment with insights into the workings of their unconscious. On this account, "interpretation" is the central technique of psychoanalysis on which its success ultimately rests. The idea that psychoanalysis enabled patients to gain self-knowledge was of course critical to psychoanalysts' self-understanding. As the historiography of psychoanalysis has amply shown, however, this is not the full story.

For instance, in 1924, in one of the first monographs devoted to psychoanalytic technique, two of Freud's closest collaborators at the time, Otto Rank and Sándor Ferenczi, suggested that "repetition" – the experience provided through the psychoanalytic situation – was crucial for therapeutic success, and not "remembering," aided by the psychoanalyst's interpretations. Though this argument proposed a shift in how psychoanalysts should think about their practice – one that would eventually reverberate throughout the helping professions – it was consistent with the procedure outlined by Freud.

Like others before him, the founder of psychoanalysis had noticed that interpretations were often not enough to bring about a cure. Successful treatments involved a "working through" of patients' "defenses" – a process that entailed a reflexive element by which the patient's prior reactions were re-examined (e.g., Freud, 1912, 1914). In this context, Freud had famously introduced the concept of transference: remnants of past affect-laden responses, mostly to parental authority figures, that were now directed toward the therapist. In other words, the attachment that formed over the course of therapy, the therapeutic encounter itself, became the subject of interpretations. As such it was eventually conceived both as a clinical heuristic for the therapist and a learning experience for the patient.

Seeing method in the clinical encounter was not alien to medical thinking at the start of the century. During what the medical historian Edward Shorter (1993) described as the modern period in the history of the doctor-patient relationship, the clinic was a prominent site for both the art of caring and the application of medical knowledge. Unlike their colleagues treating the physically ill, however, psychoanalysts could not put their faith in the developing rapport as an emotional adjuvant to therapy. Patients' emotional reactions could take on negative tones and, as it were, get in the way of therapy. What drew psychoanalysts' interests and concern were such "resistances:" overt hostility or what appeared to be inflated positive reactions ("transference love") on the side of the patient, although they eventually harnessed these reactions for therapeutic purposes.

How such interpersonal dynamics should be interpreted, of course, was a subject of considerable debate within psychoanalytic circles (see Greenberg, Mitchell, 1983). At their theoretical core, these debates related to the difficulty of discerning past from present – or perhaps, more broadly, structure from content – in the therapeutic relationship. A therapist's beliefs about what exactly shaped a patient's conduct in therapy had far-reaching implications for how they plied their trade.

In the United States particularly, those who most closely aligned themselves with Freud exhorted their followers to adopt a "neutral" stance vis-à-vis the moral, social, and theoretical implication of the unconscious materials brought forth during analysis. Psychoanalysts were also advised to carry out the procedure under the condition of abstinence; to frustrate their patients' unconscious longings. What started out as a sparse set of recommendations and veiled warnings about the method's emotional hazards took on the form of technical

axioms and, starting from the 1940s, became a litmus test for psychoanalytic orthodoxy (White, 2001; Hale, 1995). With the practice of psychoanalysis restricted to physicians, a rather rigid way of conducting analyses became the gold standard, as abstinence and neutrality received a strong epistemological justification. The psychoanalyst's functioning as a blank screen, devoid of outwardly visible emotional reactions, was believed to be the precondition for the undistorted emergence of past experiences during analysis and ensure the accuracy of the psychoanalyst's interpretations (Koch, 2017). The "transference relationship" had to be kept "pure," Phyllis Greenacre (1954, p.670) for instance argued, so as "not to contaminate the field of surgical operation."

Psychoanalysts readily admitted, however, that not all patients tolerated this type of treatment, nor was it indicated for all forms of mental suffering. What is more, a considerable number of psychoanalysts – and by some accounts Freud himself – did not adhere to the technical prescription of passivity and took on more "active" roles as therapists (see Roazen, 1992; Leider, 1983). The actual reach of the practice of passivity was therefore limited. Nevertheless, this form of therapy exerted its influence as an ideal that future psychoanalysts would be exposed to during their training. Given the institutionally policed boundaries between psychoanalysis proper and its modified forms, efforts to further develop and refine so-called "active techniques," pioneered by Ferenczi, Rank, Wilhelm Stekel, C.G. Jung and many others, had to be undertaken outside the purview of the powerful American Psychoanalytic Association.

This view of the psychotherapeutic encounter had broad conceptual implications. Since the "transference relationship" was allegedly unique to psychoanalysis, unlike any other social relation, it could not be understood in relational or social scientific terms. This, in turn, fostered an inward, diachronic perspective and reductionist interpretations of transference phenomena, namely, as mere repetitions of childhood experiences or, as later psychoanalysts would have it, an outward projection of the patient's mental structures (White, 2001). Only in the 1960s did concepts such as the "therapeutic alliance" or "real relationship" – aspects of the therapeutic relationship that could not be reduced to transference – gain currency among psychoanalysts in the United States (see, e.g., Greenson, Wexler, 1969; Freedman, 1972).

Adjustment and social relations

An earlier generation of physicians with a keen interest in the psychotherapeutic innovations coming from Europe had been less reluctant, though, to expand the scientific basis of psychoanalysis and modify its techniques. During the interwar years, two broad trends emerged that led to increased experimentation with different relational techniques and their diffusion. First, psychotherapy served growing segments of the population, particularly children and hospitalized psychiatric patients. Second, there was increasing concern not just with treating, but also with preventing mental health problems, which was fomented by the mental hygiene movement.

Co-founded by the former asylum patient Clifford Beers in 1909, the National Committee on Mental Hygiene initially set out to solicit support for reforming the desolate

conditions in state mental hospitals. Though under the influence of the Swiss-born psychiatrist Adolf Meyer, the committee's efforts soon shifted from raising the standards of care in asylums to the prevention of mental disorder, especially its less severe forms, in the general population (Pols, 1992; see also Harrington, 2019). In 1913, Meyer became the first director of the Phipps Clinic at Johns Hopkins University, and from this prominent position decisively shaped the course of psychiatry in the United States until his retirement in 1941. Influenced by philosophical pragmatism and evolutionary theory, Meyer conceived of milder forms of mental illness as "habit disorders," as chronic maladjustments to the social environment, involving both psychological and biological reactive patterns (Meyer, Lief, 1948; see Lamb, 2014).

To more effectively prevent adjustment problems in adulthood, mental hygienists began to focus their efforts on their early detection and treatment in children. After the end of the First World War, model child guidance clinics were founded in cities across the United States, employing a growing number of psychiatric social workers and nurses. The war had given the movement greater legitimacy and a new set of urgent causes. In 1919, the first school of psychiatric social work opened at Smith College in Northampton, Massachusetts, with the express purpose of "educating women" in supportive clinical roles to treat "mental and nervous disorders resulting from the war," though it was taken for granted that "this class of disorders was by no means confined to war conditions" (Neilson, 1919, p.1). The school's program also incorporated in its course of study classes in "normal psychology" and sociology to instill in future practitioners a greater sensibility toward the social conditions faced by persons under their care (p.1).

Founded shortly thereafter in 1925, the Child Guidance Clinic in Philadelphia and the affiliated Pennsylvania School of Social Work became important conduits for the ideas of Otto Rank (Kramer, 1995; DeCarvalho, 1999). The clinic was headed by Frederick Allen, a student of Meyer's and early champion of interprofessional care, and employed the social worker Virginia Robinson and her colleague and life-companion Jessie Taft, who integrated Rankian principles into "social case work." Taft had met Rank during his first visit to the USA in 1924 and later translated some of his works. She was also instrumental in helping Rank immigrate to New York, in 1934, and securing him an appointment at her institute shortly before his premature death in 1939 (Lanzoni, 2018, chapter 5; on Rank see also Lieberman, 1984).

Taft, Robinson, and Allen, who were all eventually analyzed by Rank (Lanzoni, 2018), became identified with "relationship therapy," as the approach developed in Philadelphia came to be known. In a case study included in her 1933 monograph *Dynamics of therapy in a controlled relationship*, Taft (1933) describes the short-term therapy of a neglected girl. Taft's general treatment approach was to limit any preconceived notions about what "materials" should be discussed in therapy, leaving it, instead, as much as possible to the child how she wanted to make use of the time. Like Ferenczi and Rank before them, Taft and her colleagues emphasized the experiential, emotional aspects of therapy and deemphasized its potential for delivering intellectual insights. This meant that the therapist had to be trained in empathically recognizing the client's as well as her own affective reactions (Lanzoni, 2018).

It deserves emphasis that this type of therapy, which sought to actively engage clients by affirming and responding to pre-conceptual modes of experience, found application and was refined in the context of child psychotherapy. More influentially, around the same time in Great Britain, Melanie Klein would modify psychoanalytic techniques, and with them therapeutic relations, along similar lines (Hughes, 2019). In the US, reflecting a gendered division of labor, techniques that were to lead to greater intellectual insight became associated with a male-dominated profession, whereas therapists who stressed experiential aspects were often women of comparatively lower professional standing. For instance, both Rank and Taft agreed that, since relationship therapy required "empathic identification," it was best carried out by a woman, an ideal mother figure. Taft later suggested that men, especially those who had undergone medical training, might be reluctant to refrain from controlling their patients (Lanzoni, 2018, p.141).

Other psychoanalysts, both recent immigrants as well as physicians trained in the US, often with Meyer's support, expanded psychoanalytic theory and practice to account for the social determinants that may lead to "maladjustment." Perhaps most influentially, beginning in the 1920s and until his death in 1949, the psychiatrist Harry Stack Sullivan, who had garnered a reputation as a skilled clinician treating hospitalized patients, undertook theoretical as well as institutional efforts to fuse clinical psychiatry with the social sciences (Sullivan 1953; see Wake, 2011). Sullivan emphasized the significance of "interpersonal factors" for psychological development. He would also articulate his understanding of the therapeutic relationship by borrowing ideas from linguistics, sociology, and cultural anthropology. He used the term "parataxis," for instance, to describe a communicative pattern indicating a "distortion" of a present relationship through earlier experiences (Sullivan, 1954). Sullivan and other so-called neo-Freudians, most notably recent émigrés Erich Fromm and Karen Horney, no longer interpreted their patients' behaviors during therapy exclusively in light of their infantile experiences, as they expanded the knowledge base of psychoanalysis beyond psychoanalytic drive theory to include the social sciences (Fromm, 1935; Horney, 1939).

Expert knowledge and dependency

The fissures that would erupt between neo-Freudians and those devoted to the classical technique highlight that there was more at stake than a mere "technicality." Before the political dimensions of the therapeutic relationship would come clearly into view, the societal implications of different relational practices became a topic of some concern among psychoanalysts as early as the 1940s. While classical psychoanalysis, which involved an intense meeting schedule, was lauded as the gold-standard by leading psychiatrists, the steadily increasing average length of analyses – now frequently lasting several years as opposed to months – raised questions about the dangers of sustained transference relationships (Glover, 1955). Within a culture that ostensibly valued self-reliance, the dependency that comes with perhaps any form of psychotherapy was bound to invoke debate.

In psychoanalytic circles, this debate picked up following the publication of *Psychoanalytic therapy* in 1946 (Alexander, French, 1946). In their publication, Franz Alexander, Thomas

French, and their co-authors outlined the methods of short-term psychoanalytic treatment. While they did not question that a full-blown "transference neurosis" and its interpretation may be of value to some patients, they felt it was often unnecessary. To reduce length of treatment and keep in check the dependence on the analyst, inducing a regression was not always warranted, they argued. They also proposed an account – closely resembling the one given by Ferenczi and Rank earlier – of how reviving the past could become therapeutic: The reliving of hurtful experiences in the presence of an empathic listener in the privacy of the consulting room, where patients could confront them more easily, they suggested, often entailed a "corrective emotional experience" (Alexander, French, 1946, p.66). Their proposals were met with criticism by colleagues like Kurt Eissler (1950), who countered that the modified methods would lead not to true independence, only to a superficial fitting in.

One would be wrong to assume, though, that psychoanalysts renounced the idea of adjustment. Rather, the dominant psychoanalytic paradigm of the postwar era, psychoanalytic ego psychology, emphasized the evolutionarily determined adaptive functions of the ego – theorized to operate partially independently, unperturbed by instinctual demands (Hartmann, 1939; see Wallerstein, 2002). Yet a person's capacity to act fully autonomously was not a given; autonomy was not a state, but a long-term goal. The leading psychiatrist, Karl Menninger (1958, p.48-49), captured this prevalent attitude in his illustration of the "general thesis of psychoanalytic treatment" by charting its ideal course for a "relatively mature individual:"

> And we shall remember that, even at this level, something is wrong or the patient would not be seeking treatment. Increasingly, in the course of the treatment he will tend to 'regress' to the lower levels; he will become more and more childlike in his attitudes and in his emotional dependency upon the physician. He will become a child again, and be reborn, so to speak. Then he will grow up again, grow up better than he did before, guided by his now more mature intelligence and the warnings and lessons of his unhappy experiences now better understood.

Carl Rogers, psychologist and inventor of "client-centered therapy," whose work would define the field of counselling, had a different view. Rogers also worked as a child counselor and became familiar with the methods developed at the Pennsylvania School of Social Work through one of his female colleagues, who had been trained there. By many accounts, relationship therapy had a profound influence on him as he developed his own ideas about the principles of psychotherapy, although he never engaged the theoretical views expressed by Rank (Kramer, 1995, 2019; DeCarvalho, 1999; Lanzoni, 2018). Rogers's techniques changed over time, yet he consistently underlined the client's initiative and fashioned the therapist as a facilitator of the change that the former, over the course of therapy, would come to want to enact. In his 1942 book, *Counselling and psychotherapy*, Rogers (1942, p.18) stated his "basic hypothesis:" "Effective counselling consists of a definitively structured, permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation." The encounter with another who was willing to understand and inhabit one's inner world would move clients to better understand themselves. Rogers also posited that his approach was not

a method or technique; rather, he conceived of it as a general attitude or, as he would put in a 1948 conference paper, a "principle … applicable to all human relationships" (quoted in Lanzoni 2018, p.154). As such, he suggested, its use was not restricted to healthcare professionals, nor was it up to them to judge the merits of its outcomes. Expert opinion, Rogers claimed, only created dependency and may function as a means of social control (p.154). At the time, such assertions only drew the ire of the majority of his listeners, among them eminent psychiatrists and psychoanalysts. Tellingly, Taft also disagreed with Rogers's claim regarding the universality of his approach, especially his implication that, as she would write in a letter to a colleague, "anybody can do it" (p.154).

Indeed, despite the factions that had formed in the years leading up to the Second World War, psychotherapists were generally conscious of their unique societal role and expert status – although the kind of knowledge they claimed to possess varied. The psychoanalytic dissidents, for one, supplemented the asynchronous, chronological perspective that the Freudian theory of psychosexual development implied with the synchronous perspective of the social sciences. Meyer's view was that psychiatrists should become agents of the common sense embodied in a culture and its social arrangements (Lamb, 2014). Sullivan (1953) deemed psychiatrists to be experts in social relations, while pointing to the similarities between their methods and those of anthropologists who studied social groups through participant observations. Whereas some psychoanalysts likened the detached style of the neutral psychoanalyst to the objective gaze of an experimental scientist, Alexander and French (1946) saw themselves as practitioners who, like clinicians in other medical specialties, applied and modified general principles and knowledge to individual cases based on their clinical experience. Even Rogers, despite his rhetoric to the contrary, staked out a privileged position for counselors, insofar as they were guided by and set out to effectively harness the general principles shaping all human interactions, while leaving unexamined how power relations originating from without the consulting room might extend within it.

Ultimately, the goal of such relational techniques was guiding development toward greater social adjustment, however that may have been understood in detail. The abstinent, neutral setting propagated by psychoanalytic orthodoxy was designed to produce and exaggerate analysands' dependencies so that they may overcome them. Interpersonal psychoanalysts, on the other hand, hoped to bring about a learning process centered on the present and the interpersonal challenges experienced by the patient. Still, these therapists also sustained a, so to speak, parasitic relationship to the culturally embedded and socially sanctioned roles of therapist and patient, as they self-consciously acted as experts within the medium of a professional relationship.

This convergence is reflected in the presentations at a 1940 section meeting of the American Orthopsychiatric Association during a panel on "areas of agreement in psychotherapy." At this meeting, several prominent therapists, including Allen, Rogers, and the eminent psychoanalyst Robert Waelder, had presented their respective viewpoints. The closing statement of the psychologist Goodwin Watson (1940, p.709) sums up the prevailing consensus, while highlighting the central role all methods assigned to the therapeutic relationship:

> We have found no apparent disagreement on objectives. We all hope to increase the client's capacity to deal with reality, to work, to love, and find meaning in life. For all of us the relationship of therapist and client has been a central factor. We have stressed the need to 'provide a security which fosters spontaneity.' We have seen the treatment relationship as 'social adjustment under artificially simple conditions', but as a 'step in socialization.' We have recognized that as the therapist meets the oft-used patterns of the patient in an unexpected, fresh and revealing way, the patient is stimulated to new growth. We urged that the therapist must so understand his own needs as to prevent their unconscious domination of the relationship. Our identification with the client is an identification controlled in the client's best interest (emphasis added).

Watson's closing remarks succinctly express the ambivalent nature of the relationship as a therapeutic technology: The clinical encounter was a "controlled," artificial social environment; at the same time, however, to become therapeutically useful it had to allow for spontaneity.

Translating relational practices

The war effort and the concurrent expansion of the psychological disciplines during and after the Second World War led to a wider dissemination of relational techniques and knowledge. Because such practices seemed intuitive and fairly easy to grasp, they would be actively promoted, more generally, as a vehicle for the dissemination of interpersonal skills to healthcare workers in various fields. Still during the war, for instance, Rogers (1945) had been tapped by the United Service Organization to present his counselling principles to members involved in the treatment of psychiatric casualties. (Rogers would continue to promote the application of his techniques in non-clinical fields well into the 1980s; Kramer, 2019.) In other contexts, the therapeutic relationship was more frequently discussed under the rubric of "interviewing" – a word which was used near-synonymously with counselling at the time (Rogers, 1942). In the 1940s also, Sullivan (1954) gave lectures on interviewing techniques to listeners from various health professions at the Washington School of Psychiatry. In the posthumously published lectures, he instructed his listeners to create an agreeable atmosphere that promoted openness and was conducive to establishing a trusting relationship, familiarized them with the different emotional phases a patient or client might go through during treatment, and provided advice on how to deal with evasiveness in response to probing questions. The physician Stanley Law discussed similar recommendations along with a number of case histories, demonstrating the utility of such techniques in various fields of medicine, in the 1948 book *Therapy through interview*. And, to name another example, in the 1950s, Hildegard Peplau (1952), a former student of Erich Fromm's, inspired by Sullivan, published her textbook *Interpersonal relations in nursing*, proposing one of the first comprehensive nursing theories that grounded the profession in the social sciences and described the relational techniques Peplau saw at its core (Callaway, 2002; Smith, 2018).

With the founding of the National Institute of Mental Health (NIMH) in 1948 came a more coordinated expansion of "mental health activities," as the promotion of mental

hygiene was now more frequently called (see Bertolote, 2008). These efforts again included a broad range of community initiatives, involving, besides psychiatrists, nurses, social workers, and clinical psychologists, also schoolteachers and recreational workers. Presenting at the annual meeting of the American Psychiatric Association in 1953, the founder and head of the Division of Mental Hygiene at the Johns Hopkins School of Public Health, Paul Lemkau, outlined the rationale and scope of this undertaking: "The function of the public health organizations is to translate hygienic concepts of all kinds from the laboratories and consulting room, where they are evolved, into effective usage by populations." A key role in this translational strategy was assigned to the "more than thirty thousand public health nurses, most of whom are in more or less intimate contact with the families in their communities" and, thus, well-positioned to "help the three thousand to five thousand medical men engaged in this work" (Lemkau, Pasamanick, Cooper, 1953, p.442).

Whether public health nurses or any of the other health workers enrolled in this cause were proficient in applying relational techniques was up to debate, however, and, predictably, challenged by those who had developed and first applied them in the consulting room. In a 1955 governmental report on "Evaluation in mental health," written under the auspices of the NIMH, the authors warned of the hasty application of such techniques in adjacent fields. "Psychodynamic principles are complex," they wryly commented, "and as for making them simpler, 'wishing will not make it so'" (HEW, 1955, p.12). The committee added:

> There appears to be a tendency on the part of some mental health leaders to predigest psychodynamic theory for professionals and laity by stressing 'interpersonal relationships' with a halo effect, often with the result of overselling it with slogans. There are expectations that short periods of exposure to in-service training courses which emphasize 'human relations' can produce condensations of a complex theory and method for easy assimilation. There is a need for critical evaluation of this concept (HEW, 1955, p.12-13; emphasis in the original).

Presenting the sobering outcomes of one of the rare evaluation studies, the report's authors concluded that public health nurses have generally found it difficult to effectively "translate" "purposeful relationship techniques" – and "the complexity of … dealing with interpersonal relationship as a mental health tool" – in ways that enhanced their clinical performance (HEW, 1955, p.13).

The committee's reservations highlight that, at this point in time, relational practices were still held in high esteem, seen as part of a sophisticated technical arsenal. Their "translation" to non-experts and broad application outside the male-dominated professions posed a threat not only because it seemed to devalue psychotherapists' unique expertise. As these techniques traveled from a relatively controlled setting, the "laboratory" of the consulting room, to the decidedly "messier" realities beyond the clinic, they were also transformed.

Flexibilization and institutional change

While relational techniques were being employed in a variety of healthcare settings to foster treatment compliance and, more generally, "social adjustment," several interrelated developments within the clinic and beyond would lead to the critical exposure of the

paternalistic attitudes that often accompanied their use. The civil rights, anti-war, feminist, and gay liberation movements, often buttressed by intellectuals – and later also the consumer movement in health care – drew attention to the normalizing forces at work not just in "total institutions" such as the mental asylum, but also in the seemingly insulated space of the consulting room. Indicative of these broader societal transformations, two key notions that had guided relational practices in the previous decades, "maturity" and "adjustment," were being increasingly questioned by the 1960s.

In a speech delivered at Western Michigan University in 1963, Martin Luther King Jr., for instance, scoffed at contemporary psychologists' concern with "maladjusted individuals." Maladjustment, he suggested, may well be the proper response to unacceptable social conditions and societal practices, such as racial segregation, economic inequality, and religious bigotry. In other words, King and others challenged the tenuous consensus regarding the social realities to which one had to adapt.

The "neutral" stance of psychoanalysts also came to be critiqued both as disingenuous and evasive. What the historian Eli Zaretsky (2015) called psychoanalysis's "maturity ethic" and the conservative cultural critic Rieff (1966, p.24) once described as Freud's "vision of man in the middle," tasked with keeping a precarious balance between social and instinctual demands, no longer appeared as politically neutral. Out of step with changing social mores, North American psychoanalysts were chided for endorsing culturally conservative, particularly heteronormative views (see Zaretsky, 2004; Herzog, 2017). Because psychoanalysis as a profession had been uniquely successful in the United States, then, it was easily identified with the oppressive social norms of the post-war era.

Alternative treatment approaches such as the various humanistic psychotherapies, frequently oriented towards fostering "growth" or "self-realization" (as opposed to "maturity" or "ego strength"), which began to rapidly increase in number from the 1950s onward (Harper, 1975), seemed to offer more open-ended, less normatively charged forms of self-transformation. Office-based psychoanalytic practice itself would become more variable and open to experimentation during the last third of the century, as object relations theory and psychoanalytic self-psychology, through the influence of Otto Kernberg and Heinz Kohut, respectively, became more accepted within mainstream psychoanalysis in the United States (Makari, 2008).

These shifts in influence occurred at a time, of course, when the health professions in general, particularly the ways patients interacted with providers, were undergoing far-reaching changes. The increasing technologization of medical practice, the medicalization of various aspects of everyday life, along with the ethical failings of the profession, which now captured a broader audience, provoked a critical backlash and lastingly undermined paternalism in medicine (Shorter, 1993). Changes to malpractice law, moreover, now offered legal possibilities to redress emotional harm caused by a therapist's transgressions during the course of treatment, exposing the long-standing problems of sexual exploitation and other forms of now so-called "boundary violation" in psychotherapy (Gabbard, 2009; Kim, Rutherford, 2015).

Psychotherapy not only had to respond to outside pressures, however; there were numerous efforts originating from within the field to reform its institutions and fundamentally

transform therapeutic practices. Self-proclaimed radical psychiatrists, for instance, shunned any pretense of neutrality. Given the political turmoil of the era, remaining "neutral" no longer seemed a defensible option (Richert, 2019). Clinicians, inspired by the New Left, founded groups and organizations such as the Radical Psychiatry Center or the Radical Therapist Collective, whose motto proclaimed that "therapy means change not adjustment," and began to experiment by establishing so-called encounter groups, a variant of group therapy in which the role of the therapist was eliminated altogether (Staub, 2014, p.97). This was also a rejection of the artificiality of the psychoanalytic transference relationships and their psychodynamic offshoots, which now appeared to be deliberately designed to eschew questions of power and politics (Staub, 2011). Similarly, feminist psychotherapists sought first to abolish and then to diminish the power differential between therapists and their clients (see Rice, Rice, 1973). Like Rogers, they questioned their own professional status, claiming that a client really is "his or her own expert" (Rader, Gilbert, 2005, p.427). But since their critique unfolded within the broader context of a reckoning with patriarchal power structures, they were more likely to fundamentally question the preconceived roles of therapists and clients.

Although similar attempts can at least be traced back to 1932, when Ferenczi (1988) tried his hand at what he called "mutual analysis," in the 1960s and 1970s, the therapeutic relationship would more persistently become a field for experiments that rendered the social roles of patient and therapist less distinct. Besides unapologetically political therapists, also many mainstream psychologists and psychiatrists began to experiment with other relational techniques, often incorporating less individualistic forms of psychotherapy into their practice, such as group therapy, or by permanently expanding the therapeutic dyad by turning to family therapy or promoting therapeutic communities, whose members were often encouraged to be confrontative, frank and open in their assessments of their peers (Weinstein, 2013; Clark, 2017).

Collaborative therapeutic relationships

In short, the uses of the therapeutic relationship became partially detached from the social roles and institutions that had previously defined it as well as from the bodies of knowledge that legitimated its use, making the handling of "the relationship" more flexible, adaptable to patients' immediate needs. At the same time, however, as a social technology, the therapeutic relationship again came to reflect the changing institutional realities and the new demands placed upon it. Because the societal norms surrounding patient-provider relations changed, the therapeutic relationship could no longer be deliberately wielded as an instrument to openly promote adjustment to the presumably stable and inevitable realities of the social world, or foster a kind of maturity that entailed a coming-to-terms with one's own limitations. For the therapeutic relationship to become a model of the socialization process, for the conflict between personal desires and societal demands to become manifest, the power differential between patient and therapist had to be on display within the relationship. With a growing emphasis on patient rights and personal autonomy – as a given, not as a long-term therapeutic aim – the asymmetry of the therapeutic relation

became less pronounced. As psychotherapists became reluctant to take on the role of the "generalized other" and could no longer count on a shared understanding of what constitutes "healthy" development or behavior, they more consistently strived to build a strong "therapeutic alliance," a congruence between the therapist's and patient's ideas concerning the aims and means of the therapeutic process. The concept of the therapeutic or working alliance was first developed by the psychoanalyst Ralph Greenson (1967) and later influentially expanded by the psychologist Edward Bordin (1979) to include the emotional bond developing between therapist and patient as its third component. The great extent to which the concept was adopted by various psychotherapeutic schools indicates that what psychotherapists now sought to establish and cultivate with their patients or clients was a collaborative relationship. As such, it could be placed in the service of a wide range of therapies independent of the theory of mental functioning a therapist happened to endorse. These uses of the therapeutic relationship were not necessarily grounded in psychodynamics or, more broadly, knowledge derived from the study of human relations. This also meant that the emotional bond to the therapist no longer served to "reveal" something to the patient, nor were psychotherapists necessarily concerned with understanding relational dynamics. More so than before, establishing and maintaining a functioning therapeutic relationship was considered a skill or craft or, as it came to be known in psychotherapy research, a "non-specific" factor of any form of psychotherapy and even non-psychological therapies that involved relational practices.

Its changing epistemic status, for instance, is on display in how the therapeutic relationship was initially conceived within the context of cognitive-behavioral therapy. In their seminal *Cognitive therapy for depression*, published in 1979, Aaron T. Beck and his colleagues delineated their practice from treatments that "centered" on the relationship:

> Initially, the therapist tries to engage the patient in a therapeutic alliance of collaboration. In contrast to 'supportive' or 'relationship' therapy, the therapeutic relationship is used not simply as 'the' instrument to alleviate suffering but as a vehicle to facilitate a common effort in carrying out specific goals. In this sense, the therapist and the patient form a 'team' (Beck et al., 1979, p.54; emphasis in original).

Here, the relationship is no longer the most "tangible element" of the psychotherapeutic transaction, as Menninger posited in the 1950s, but primarily a "vehicle," the medium through which the treatment is administered. At the same time, however, the recommendations go beyond simply building rapport. The cognitive-behavioral psychotherapist is still encouraged to foster a "particular kind" of relationship with the patient, one that is collaborative in nature. Beck, who was trained as a psychoanalyst and had become disenchanted with the method in part also due to negative experiences during his training analysis, proposed a form of interaction that was empirically rooted in the present and modeled on the collaborative research process (Rosner, 2014). The patient was to contribute "the 'raw' data for this inquiry," whereas the therapist's "contribution was to guide the patient about what data to collect and how to utilize these data therapeutically" (Beck et al., 1979, p.54). Moreover, later generations of cognitive-behavior therapists again became more concerned with what contributed to a functioning therapeutic relationship,

with one such approach drawing heavily on the work of interpersonal theorists such as Sullivan (see, e.g., Safran, 1990; Okamoto et al., 2019).

Through its various new uses – and the example just quoted demonstrates this as well – the therapeutic relationship became steered toward experiences outside the consulting room. No longer conceived as a simplified socialization process, it became more often thought of as a practice-ground for patients hoping to better cope with ongoing struggles. It was in this sense that the relationship became more "real," seemingly less artificial. This placed new demands on therapists. Not only did they have to fulfil a broader range of functions, as collaborators, empathic listeners, witnesses, or at times even provocateurs (see, e.g., Ellis, 1962); to be effective, their affective reactions had to be believable, the emotional bond they formed with their patients authentic. As the anthropologist and psychoanalyst Kate Schechter has put it, "the relationship" became a highly sought-after, yet often elusive good for psychotherapists (see Schechter, 2014).

The potential emotional harms of such relationships, it soon became clear to many in the helping professions, were not restricted to patients. In 1974, the psychoanalyst Harald Freudenberger observed among highly engaged clinicians what he influentially termed "staff burn-out," a state of emotional and physical exhaustion. The notion, although often criticized as vague, has more recently caught on to describe similar mental health problems in a range of occupations. In the field of psychotherapy, other concepts such as "empathy" or "compassion fatigue," and its corollary, "empathy resiliency," have more recently been proposed to capture the unique health risks for those employing relational techniques in their practice.

Final considerations

The relationship between clinician and patient is no longer consistently conceived of and targeted as the primary medium of psychotherapeutic interventions, and changing methodological standards and shifting norms about what constitutes good science have surely played a part in this. Yet as this cursory history has shown, relational techniques had already lost some of their appeal through their wide dissemination and subsequent democratization before such changes took hold. Among the reasons why the origins of "the relationship" as a social technology have become obscured over time is the professional devaluation of such techniques during the postwar years as they became employed by a broader range of practitioners, a significant portion of them women. At the same time, influential authors such as Rogers began stressing the non-technical aspects of the therapeutic relationship, the supposed immediacy of mutual understanding and empathy as essential ingredients to client-centered therapy.

Still, during the first half of the last century, the implicit basis for the application of the therapeutic relationship as a social technology was the assumption that such techniques revealed not only a personal truth to the patient, but also universal truths about the nature of human relations. To provide patients as well as therapists insight into the latter, however, most practitioners stressed that in the therapeutic encounter the rules of social interactions had to be suspended. Paradoxically, then, the therapeutic relationship was not a

genuine social relation. But as personal transformation became an end in itself, therapeutic relationships were increasingly seen as possibly providing more genuine experiences. No longer only wielded by mental health experts, "the relationship" could become, besides being a tool for social adjustment, a method for instigating social change.

To the extent that the goal of psychotherapy has shifted from "healthy" character development, personal maturation, or even social liberation to coping with life's stresses and personal enhancement, the perils of iatrogenic dependency have become steadily less of a concern in recent decades. Attaining autonomy or expanding personal freedoms can no longer be unambiguously declared the overarching aim of psychotherapy, since an individual's autonomy is no longer seen as the long-term aim of psychotherapeutic interventions. It is now taken for granted that the individual entering the consulting room is autonomous, and, for the "worried-well" at least, the goals of psychotherapy have become amenable to self-declared personal needs. The flexibilization of the therapeutic relationship has also come with new insecurities, indicated by societal debates about its perennial dangers and the need to negotiate and draw boundaries around what constitutes the treatment and what transcends it.

The question arises, though, to what extent such changes have limited the reach of the therapeutic relationship as a normalizing social technology. Although not all psychotherapies today operate under the assumption that our emotional bonds to significant others are constitutive for mental life, psychotherapists still employ the therapeutic relationship to provide a model for how one should relate to oneself and the world. The collaborative relationships common today, then, still function as a means of socialization, albeit in variously modified forms. They offer patients and clients opportunities to engage in exercises to make the best uses of their autonomy. What this looks like in practice, though, varies. The "responsibilization" of the individual, which undoubtedly occurs through psychotherapy and is often seen as aligned with neo-liberal regimes of governance (e.g., Rose, 1996), takes on different forms depending upon the types of relationships offered to and sometimes also forced upon patients or clients. Historians of psychotherapy are thus called upon to investigate what types of persons suffering from which types of mental health problems have become ensnared in which types of therapeutic relationships, and why. The fact that numerous terms referring to various interpersonal aspects of the clinical encounter are still widely used by healthcare professionals, finally, shows the persisting need – even during our present psychopharmacological era – to draw attention to and reflect upon what socially conditions patient-provider interactions.

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