The Psychotherapeutic Relationship, Personal Life, and Modern Culture

In this article, I draw on the social psychology implicit in the sociological works of Émile Durkheim to explain the therapeutic efficacy that has been linked by much empirical research with the development of a positive patient-therapist bond in treatment.

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ABSTRACT:
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This paper examines the psychotherapeutic relationship in the context of *personal life,* viewed as an emergent and distinctive sphere of privacy, intimacy, and individuality associated with the 'modern' cultural system of post-Enlightenment, urban-industrial and post-industrial societies. The author draws on social psychological concepts found in the works of the French sociologist Émile Durkheim on the division of labor, the social conditions of suicide, and the psychosocial foundations of religion to explain the therapeutic efficacy that has been linked by much empirical research with the development of a positive patient-therapist bond in a variety of psychotherapeutic treatments. The paper aims to challenge and assist psychologists to think beyond the customary range of theoretical perspectives by viewing this well-established finding of psychotherapy research from an interdisciplinary standpoint.

Keywords: relationships, psychotherapy, culture, modernity

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This essay describes and explores connections between three areas not often considered in conjunction by psychologists. The first is the *psychotherapeutic relationship,* by which I mean the social bond that develops between a client and therapist over the course of their therapy sessions. In this, I draw on my knowledge of psychotherapy research, the field that I have been devoted to for more than 40 years (e.g., Howard & Orlinsky, 1972; Orlinsky, Grawe & Parks, 1994; Orlinsky & Howard, 1978, 1986; Orlinsky, Rønnestad & Willutzki, 2004).

The second area is that of *personal life:* the sphere of intimate, face-to-face relationships with close family members, best friends, lovers and partners. These relationships are embedded in the individual's self, and from there radiate like the spokes of a wheel. They influence and reflect our personalities, define who we are, and are the source of our keenest joys and deepest sorrows. From a sociological perspective, the relationships of personal life constitute a 'social circle', and the totality of innumerable overlapping circles of intimate relationships comprises a major sector of the social structure in modern societies. Collectively, they stand in contrast to the *impersonal* economic, political and social relations we have with others every day—in shops, at the office, and everywhere else where we 'do business'.

It is relatively easy to see connections between personal life and psychotherapy. When serious problems arise in personal life, due either to frustrations or failure in one's intimate relationships, or to anxiety, inhibitions or symptoms in one's self, it is not uncommon for educated people or those who otherwise are familiar with modern media to seek help through psychotherapy; and, if the patient forms a good working relationship with the therapist, then that therapeutic relationship in effect becomes part of the patient's personal life—even, while it lasts, a central part of personal life. However, when therapy is not voluntarily sought—if the client is compelled to go for treatment (e.g., by a court of law), or is pressured to do so (e.g., by an unhappy spouse or parent), or is referred for treatment without sufficient explanation (e.g., by a primary care physician)— the therapist's first task must be to persuade the client that some personally valued goal may be attained, 'there really can be something in it for him'. If the involuntary client does not or cannot become interested as a voluntary participant, an effective therapeutic relationship cannot take form.

«The quality of the therapeutic bond consistently predicts, and probably contributes to, the clinical outcome of therapy. However, the reasons why it does so are not much discussed – partly, because current assumptions about therapy are misleading»

There is, of course, an important difference between the therapeutic relationship and other relationships in one's personal life. Ordinary personal relationships are *mutual,* as important in the personal lives of our partners as they are in our own. By contrast, while the therapeutic relationship may become an important addition to the patient's personal life, it is *not* part of the therapist's personal life, but of the therapist's *professional* life.

The third area of interest is *modern culture,* or to be more precise, *modern society and culture.* By this I refer to the essentially urban-industrial bureaucratic type of 'mass' society that emerged in the 19th century Europe in the wake of the Industrial Revolution (e.g., Berger, Berger & Kellner, 1973; Durkheim, 1893, 1897, 1912; Marx & Engels, 1972; Parsons, 1964, 1966; Simmel, 1964; Weber, 1958, 1964; Zaretsky, 1973), variants of which are now found on all continents. By 'modern culture' I mean the assumptions, beliefs and values that developed in the Enlightenment and since have become the dominant cultural pattern in modern societies, both in 'the West' and elsewhere. (However, as Mannheim's (1940) concept of the 'contemporaneity of the non-contemporaneous' showed, historically older elements of traditional social and cultural forms typically persist alongside those that are considered distinctively 'modern'.)

Modern culture emphasizes concepts and values like rationality, objectivity, punctuality, efficiency, secularism, materialism, and individualism. Associating this cultural pattern with the term 'modern' emphasizes its difference from the 'traditional' culture of the rural, agricultural, socially hierarchical, and religiously oriented societies that previously characterized most of humanity, as well as from so-called 'primitive' cultures of relatively isolated, indigenous, kinship and clan-based tribal societies.

This third topic of 'modernity' is linked with the topic on 'personal life' by the fact that personal life emerged as a distinct and distinctive sector of social relations in the context of modern societies, precisely to complement and counterbalance the emergence of impersonal relations in economic, political and other social institutions. Intimate face-to-face attachments have always been part of human life, but in past times the relationships that stand out now as distinctively personal were more diffusely interwoven and continuous with relations in the small, local community where one was born and typically lived for the rest of one's life (e.g., Laslett, 1971). In that world, the individual's wellbeing depended greatly on his perceived position in the community, and his perceived prospects for life not just in this world but in the worldto- come. The individual's close relationships were also less enduring due to the unpredictability and brevity of the average person's life. Marriages were arranged on the basis of economic, political and social advantage, rather than personal choice. Children often did not survive their earliest years, nor did spouses always survive childbearing or childrearing years. These conditions discouraged deep emotional investment in this-worldly relationships.

Life in this respect is radically different for most who live in the large-scale, urban, industrial or post-industrial societies of the present, where marriages are based on choice and love; parents and children survive together for decades; and personal meaningfulness and fulfillment depends greatly on the vicissitudes of a few longlasting, emotionally deeply-invested personal relationships. It is understandable that professional help may be sought at times of distress and problems in these core personal relationships, either because those relationships are not happening as hoped,

because they are not going well, or because the individual cannot meet her own or others' expectations.

The Psychotherapeutic Relationship

As a reviewer of and contributor to psychotherapy research for more than four decades, I have seen the gradual but firm establishment of several widely accepted facts based on extensive replication of findings in many studies. One is that psychotherapeutic treatment is generally effective, when compared to control conditions — although, like any other kind of treatment, not for every patient and not to the same extent for all patients; and a second fact is that most of the treatments that have been compared have shown *approximately equivalent* results (e.g., Lambert & Ogles, 2004; Lipsey & Wilson, 1993). The weight of evidence suggests a broad equivalence in effectiveness, which was named the «Dodo Bird effect» (Rosenzweig, 1936) after Lewis Carroll?s (1865) tale of *Alice's Adventures in Wonderland,* where the Dodo Bird famously proclaims «All have won so all shall have prizes». A third fact is that the *client's motivation and ability to participate* in therapy are major determinants of clinical outcomes. Clients with good interpersonal skills, who are cognitively adaptive and emotionally receptive, are the most likely to benefit from therapy, whereas (sad to say) poorly functioning clients who may need help the most, sadly often benefit the least (e.g., Orlinsky, Rønnestad & Willutzki, 2004). A fourth firmly established fact is that success or failure in therapy is consistently predicted by the quality of the therapeutic relationship experienced by patients (e.g., Horvath & Greenberg, 1994, Norcross, 2002). The client?s experience of a strong, positive bond with the therapist predicts and promotes a favorable outcome. The client?s experience of a weak therapeutic bond typically produces little effect, and an ambivalent or hostile therapeutic relationship can result in client deterioration. Various therapeutic techniques or procedures also have strong empirical support, but these must typically operate in the context of a positive patient- therapist relationship? such as what Beck (1976), for one, described as «collaborative empiricism,» or Bordin (1979) called the «working alliance.»

I see the therapeutic relationship as shaped by two sources (Orlinsky, 2009; Orlinsky & Howard, 1987): the therapeutic contract, defined by the formal social roles of client and therapist; and the therapeutic bond, formed from the person-toperson connection between the individuals as they engage in their respective roles. The therapeutic contract specifies the goals and methods of treatment; defines the social norms for role appropriate behaviors by the client and therapist; and settles arrangements concerning schedule, duration, location and fees for the therapy sessions. By contrast, the therapeutic bond reflects the informal but vital attachment that develops between the client and therapist on a person-to-person basis as they interact over time.

The real, flesh-and-blood persons who interact as client and therapist inevitably have characteristics and qualities as individuals, over and above the characteristics that are directly relevant to their roles. Those personal qualities inevitably influence how they view each other, how they «project» themselves to one another, and how they perform

their roles with one another. As persons, they may be of the same or opposite gender; may be approximately equal or differ widely in age; may come from similar or different social backgrounds, and as adults may belong to the same or different social classes and subcultures. Together with variations in temperament and life experience, these characteristics are bound to influence the person-to-person bond that forms in the therapeutic relationship: the rapport that develops between them as individuals, reflected in how well they communicate – are they «on the same wavelength» or do they just «talk past» each other? – and reflected in the –personal chemistry? and –emotional climate? of the relationship. The therapeutic bond is also reflected in their teamwork: how much personal investment the individuals have in their respective roles, and how well their typical leadership styles mesh with respect to taking initiative and control?do they –dance? well together, or –step on each other?s toes??

Most researchers recognize that the quality of the therapeutic bond consistently predicts, and probably contributes to, the clinical outcome of therapy. However, the reasons why it does so are not much discussed—partly, I believe, because current assumptions about therapy are misleading. A widely accepted but largely implicit view assumes that therapy consists basically of the application of specific therapeutic techniques or procedures, and that the efficacy of therapy inheres in those procedures. Clients are viewed mainly as bearers of diagnosable disorders, and therapists are viewed narrowly as more or less skillful administrators of the correct procedures for treating those disorders. Unfortunately, this view does not take account of, nor does it fit very well with, six decades of accumulated research.

An alternative view, that I think better fits the facts, holds that the effectiveness of therapy derives primarily from the client's experience of a 'remoralizing', resourceenhancing, motivational relationship with a therapist who provides both support and challenge—in proportions, and at times, that suit the patient's needs and abilities. The therapist's procedures can also have an impact, but their main effect is the contribution they make to the patient's experience of the therapeutic relationship.

The model of therapy as a technical procedure administered by the therapist corresponds to a medical or pharmacological view of treatment. It fits well with the assumptions of the public agencies and ministries that support healthcare research and services. More broadly, it also fits with the individualistic and objectivist, mechanistic assumptions of 'modern culture', which I believe accounts for its implicit plausibility and its persistence in the face of contradictory evidence. The alternative model of therapy as a healing relationship is grounded not so much on modern cultural assumptions as on certain facts of human species-biology.

Our species evolved a survival strategy that requires rapid adaptation to environmental conditions through the detection and processing of relevant information; i.e., through enlarging the capacity to learn from the environment. This required the development of a larger, more complex brain suited for learning and, consequently, a larger head—which posed a problem for our mammalian biology, since the infant's head must still pass through the birth canal without risking too much harm to the mother who will

nurse it. The solution to this is that human children are born in a semi-embryonic state, and still need more than a decade of additional physical and psychological development before attaining basic adult functionality.

The newborn human is completely incapable of survival on its own. More than any other mammalian species, human infants depend for survival on the existence of an enduring network of supportive, nurturing, protective relationships—and, as the work of Bowlby and other attachment researchers has shown—the only 'instincts' a human is born with are rudimentary reflexes that enable it to form a bond with care-givers, and communicate to them basic states of contentment and distress. Infants are born pre-adapted to an environment comprised of human relationships; and, for many 'formative' years that follow, individual survival depends on the nurture, discipline, and education provided through those relationships.

«Durkheim's views converge with the ideas based on ethology and attachment theory about the primacy of relationships. It requires a community of caregivers, organized in families, to ensure an infant's survival and development into a responsible adult»

Persons grow, and their lives take form, through participation in stable, intimate face-to-face relationships that occur within social and cultural communities which are relatively cohesive and coherent. From this perspective, it is not surprising to learn that *relationships* which are experienced by a distressed person as genuinely caring and securely protective are effectively therapeutic.

Personal Life in Modern Societies

This leads back to the idea of 'personal life' as the primary domain in modern societies where individuals find relatively stable, intimate face-to-face relationships. Broadly speaking, social structures in modern urban-industrial societies tend to differentiate into four distinct though interrelated institutional sectors: *economic, political,* and *communal* sectors, and a sphere reserved for private life of individuals which I call the *personal* sector.

The *economic sector* includes the occupational system, the systems of production and distribution, and the organizations and markets through which they operate. In this context, individuals are primarily workers and consumers, and function as more or less interchangeable units of economic activity. The *political* sector comprises all the

institutions of governance, from local to national, including legislative, executive and judicial bodies, political parties and elites, and civil agencies performing basic law-enforcement and other public functions. In this context, individuals are primarily citizens, and as such are also more or less interchangeable units of political activity—as voters, tax payers, and so on. A third area of social relations that is distinct but more or less interwoven with the economic and political sectors is the *communal sector,* which includes the various organizations that constitute 'civil society', ranging from the system of social classes, ethnic groups, and religious communions to voluntary interest groups, clubs, charitable organizations or neighborhood associations. In this context, individuals are *members* of a particular class, ethnicity, church, and possibly voluntary organizations, and this membership provides the individual with a social identity based primarily on group affiliation as distinct from individual personality.

The distinctive domain of social relations in modern societies, where individual identity or 'personality' truly matter, is the *sphere of private or personal life.* Here, and here alone, individuals are irreplaceable selves rather than interchangeable units, and relationships are *personal* rather than *impersonal.* The core of private or personal life is constituted by relatively enduring, intimate, face-to-face attachments with individuals we have come to call significant others. Attachments to 'significant others' are significant in the two-fold sense of being emotionally important as well as being a major source of meaning in life.

It is also characteristic of personal life that the number of significant attachment most people have is limited. During childhood and adolescence, the most prominent attachments normally are with members of the family one is born into?which sociologists call one?s «family of orientation». During adolescence and youth, one?s most important attachments typically are with 'best friends' and lovers (if one is lucky enough to have a 'best friend' and a lover). During adulthood, close friends and childhood family members remain important but the most central attachments are typically with one?s spouse or life-partner, one?s children; and, after one?s children are grown, with the new families that they create. Transitions from childhood to adolescence, from youth to adulthood, from adulthood to later life, also challenge the personal capacities and personality development of individuals.

Because people do not have a large number of personal relationships at any given time in life, those attachments—including whether or not one *has* them, and how satisfying or distressing they are? become very important for one?s personal wellbeing. With «all our eggs in one basket» (so to speak), we are highly vulnerable to stress if the eggs break. When distressing experiences overwhelm the individual?s resources for coping that can be found in oneself or one?s intimate circle, it may be really helpful to include a positive therapeutic relationship in one?s personal life. Psychotherapists are specialists in repairing the psychological damage that can occur *in, to,* or *from* the relationships of personal life.

I do not want to leave the impression that personal life is the only important source of fulfillment and meaning for individuals. An individual may be personally invested in

his occupational role, and derive a great sense of satisfaction and meaning in one's professional identity— as I do today, thanks to the honor bestowed by my colleagues in Oslo. Even more important for some people is the personal bond of communion they experience through membership in a religious community, which then is not merely part of their social life but a deep part of personal life as well. I would also emphasize that while the four domains of social structure that I've spoken of—the economic, political, communal, and personal sectors—are typical of modern societies generally, they vary among countries in the extent of differentiation, are interrelated in complex ways, and all affect the life of every person.

Social Integration and Individual Well-Being

Thus far I have only briefly suggested why the relationships of personal life so strongly influence the individual, and why the therapeutic bond can have a similar effect when it develops optimally. To explain this more fully, I will draw on concepts based on work by the French sociologist and ethnologist, Émile Durkheim (1893, 1897, 1912). Durkheim wrote at the end of the 19th and beginning of the 20th centuries, following an age that glorified individualism and materialism to an extant that led many theorists to view individual biological organisms alone as'real' entities, and think of societies as merely secondary entities based on voluntary contractual arrangements between individuals. Durkheim, by contrast, viewed society as an independent, primary reality distinct from and superordinate to the individuals in it, and offered empirical demonstrations of this in studies of the division of social labor, the incidence of suicide, and the origins of religion.

Durkheim?s views converge with the ideas based on ethology and attachment theory about the primacy of relationships in human species-biology. It requires a community of caregivers, organized in families, to ensure an infant?s survival and development into a responsible adult. Like other primates, we are born, develop and thrive only as members of a collectivity. This human collectivity exists prior to one?s birth, exerts a supportive and constraining influence throughout one?s life, and continues to exist beyond the individual?s death. Durkheim cited these three criteria?priority, influence, and continuity? as defining characteristics of «social facts» representing an order of reality distinct from, independent of, and external to that of individuals. The collectivity is an emergent reality that arises through the ongoing interactions of its members? their collaborations, competitions, exchanges, and communication with one another; and a society continues to exist, as a reality over and above that of its individual members, as long as its institutions, language and traditions are recreated through collaboration, competition, exchange and communication among its members.

In debating against the extreme individualist positions of 19th century writers like Spencer, Durkheim's language often took an equally extreme but opposite tone in emphasizing the independent reality of society, and led some of his readers to dismiss his views as 'mystical'. Durkheim himself recognized this and tempered his language in

footnotes that he added to his text. He understood that individuals and collectivities are interdependent orders of reality, and that their joint existence depends on maintaining an effective balance between them.

Durkheim recognized this need for balance between the collectivity and the individuals most clearly in his analysis and interpretation of suicide rates in society. He described three types of social conditions that are 'suicidogenic'—which he termed 'egoistic', 'altruistic', and 'anomic'— and also recognized a fourth type that he called 'fatalistic' suicide, but did so only in a footnote that is overlooked. These four types reflect the extreme states of two fundamental dimensions of structural integration characteristic of all collectivities— social cohesion and social control.

Durkheim called the extreme states of social cohesion egoism, where there is too little cohesion, and altruism, where there is too much. Egoistic suicides are suicides of ennui, of emptiness, lack of purpose and boredom with life. By contrast, the altruistic type of suicide occurs in conditions where there is an excess of social cohesion, where individuals experience themselves as emotionally enmeshed and submerged in a group or community. Altruistic suicides are suicides of honor and self-sacrifice. The optimal social milieu is one where a balance prevails between social involvement and individual identity.

Similarly, Durkheim called the extreme states of social control anomie, where there is too little control, and fatalism, where there is excessive control. Anomie is lawlessness or lack of regulation, where individuals experience no reasonable limits to their desires and aspirations, and consequently are never able to rest content and feel secure in their lives. At the opposite extreme, 'fatalism' refers to situations of extreme regimentation, such as occurs under oppressive totalitarian regimes in gulags, concentration camps, and similar settings. Fatalistic suicides are suicides of despair, of subjective escape from objective circumstances that are unbearably frustrating or painful. Again, the optimal milieu is one where a balance prevails between social order and personal autonomy.

Social cohesion and social control are essential for the integration and continuity of whole societies and the institutions and groups within them—but, in tracing the evolution of societies from relatively simple tribal groups in Australia, Oceania and North America to the complex urban-industrial societies of late 19th century Europe, Durkheim distinguished between two different modes of social integration, which he called 'mechanical solidarity' and 'organic solidarity'. 'Mechanical solidarity' is a mode of social integration (i.e., cohesion and control) based on the affirmation by individuals of a shared identity and co-inherent being. Another term for this is personal communion. By contrast, 'organic solidarity' is a mode of social integration based on the division of labor between members of the society; that is, on the complementarity of their respective functions. Another term for 'organic solidarity' is functional interdependence.

Personal communion and functional interdependence are modes of social integration present in all societies, but in proportions that vary greatly from earlier to later times.

In relatively simple societies, the division of social labor is limited and the predominant mode of integration is 'mechanical solidarity' or personal communion. Functional interdependence exists, but typically is limited to the different social functions ascribed to men and women, and to different clans or castes.

As societies grow in scale and complexity, the division of social labor (or differentiation of social functions) becomes more extensive, and occasions for direct face-to-face interaction among all members of society are no longer an everyday occurrence, but require special gatherings on specified 'holy days' or holidays that allow them to celebrate, commemorate, or mourn together as one people. The predominant form of social integration is *functional interdependence* through complex systems of intermediate organizations and markets. *Personal communion* based on direct relations between persons is usually limited to the relationships of personal life, and therefore these relationships are all the more important.

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The economic, political and communal sectors in urban-industrial mass societies are clearly and extensively differentiated, with *impersonal* social relations the general norm; and, to balance these, a fourth 'residual' sector of private or *personal life* emerges, centered on nuclear family and 'elective' relationships of intimate friendship and love. Social solidarity through *personal communion* with others occurs now in small, intimate circles and settings like family dinners, reunions, and meetings with close friends. In the economic, political, and community sectors, individuals are not unique personalities but more or less functional 'cogs in a machine', leaving individuals dependent on their private personal relationships to affirm their unique, irreplaceable *self-identity*. *Egoism* and *anomie* are the prevailing forms of social pathology, expressed in individual pathologies of depression and anxiety. Relationships that sustain individual wellbeing and growth are both fewer and more fragile, due in part to the strains placed on them by being needed so much.

A term that Durkheim used to describe an intense and buoyant sense of *personal community* is "morale". This word is defined variously as «the general level of confidence or optimism felt by a person or group of people, especially as it affects discipline and willingness»; «the confidence, enthusiasm, and discipline of a person or group at a particular time,» with synonyms like «confidence, self-confidence, self-esteem, spirit, team spirit, enthusiasm»; «the state of the spirits of an individual or group, as shown in the willingness to perform assigned tasks, confidence, cheerfulness,

and discipline.» A related term (also French in origin) is *élan,* defined in dictionaries as «energy, style, and enthusiasm,» and «vigor and enthusiasm, often combined with self-confidence and style».

The importance of this energizing *morale,* which Durkheim (1912) vividly described as «collective effervescence» (a shared, thrilling enthusiasm and excitement) is well known in the sports world as the "team spirit" that lifts individual players to their best performances, and the "home field" or "home court" motivational advantage created by the enthusiastic chants and cheers of fans. Durkheim observed that intensive interaction between individuals assembled together and concentrating on a common enterprise tends to generate a strong sense of connection and energy among them? one that is not present when individuals are dispersed in their everyday lives. Durkheim described this in his book *The Elementary Forms of the Religious Life* (1912/1968):

> There are occasions [he wrote] when this strengthening and vivifying action of society is especially apparent. In the midst of an assembly animated by a common passion, we become susceptible of acts and sentiments of which we are incapable when reduced to our own forces; and when the assembly is dissolved and when finding ourselves alone again, we fall back to our ordinary level, we are then able to measure the height to which we have been raised above ourselves ... (pp. 240–241)
>
> But it is not only in exceptional circumstances that this stimulating action of society makes itself felt; there is not, so to speak, a moment in our lives when some current of energy does not come to us from without. The man who has done his duty finds, in the manifestations of every sort expressing the sympathy, esteem or affection which his fellows have for him, a feeling of comfort, of which he does not ordinarily take account, but which sustains him, none the less. The sentiments which society has for him raise the sentiments which he has for himself. ... It thus produces, as it were, a perpetual sustenance of our moral nature ... (p. 242).

By «moral nature» I believe Durkheim meant what nowadays would be called *personality;* or, as I will define it (based on Erikson, 1959), the *integrity of one's inner sense of self together with its roots in bodily wellbeing, deep emotional attachments, and good conscience.* What we now call 'psychopathological' states, by contrast, may be described in termes of moderate (or occasionally drastic) division or disintegration in one's sense of self, through deprivation or disturbance in the bodily roots of self, through frustration or failure in one's emotional attachments, or through guilty lapses or loss of good conscience, seriously limiting one's ability to effectively self-manage or constructively cope with the demands and opportunities present in one's life.

The conditions of modern society and culture that we live in influence all these aspects of personality. Some social milieus are benign, providing a supportive balance of group involvement *and* personal identity, of social responsibility *and* individual autonomy. These occur mainly in the context of *personal life.* Other social milieus are less

supportive, creating chronic stresses on a daily basis (as in highly routine factory or office work), or acute stress (as in long-term unemployment)— although, inevitably, how each person responds to such stress will vary.

Psychotherapy, Personal Life and Modern Culture

The topics of psychotherapy, personal life, and modern culture converge at this point. The psychotherapeutic relationship is a curious hybrid of *personal* and *impersonal* elements—one, moreover, that reflects modern individualistic values in theory but in practice, when it is effective, exemplifies the experience of *personal communion*. The therapeutic relationship is highly personal for the patient whose problems, failures and intimate yearnings are its main concern. For therapy to succeed, the therapist too must be personally engaged in the relationship, must be attuned and responsive, caring and committed. When clients experience empathic attunement and personal rapport in the therapeutic relationship, the bond with the therapist offers clients an opportunity to experience a *microcosm of 'mechanical solidarity'*—of solidarity through *personal communion*—which works to restore the client's morale and motivate the client to learn to cope better with the challenges and make better use of the opportunities their personal lives present.

To help clients experience a good therapeutic relationship, therapists need to have exceptional interpersonal skills, because they have to connect on a personto- person basis with clients who are typically anxious, defensive, demoralized, or withdrawn. This often happens indirectly by engaging clients in the technical procedures that therapists confidently use and believe in. The energy, commitment, understanding, and patience of the therapist in using these procedures enables the client to experience the therapeutic bond as a limited but genuinely meaningful form of *personal communion*.

Yet while the therapeutic relationship may become part of the patient's personal life, for therapists it is a profession and as such is part of the economic sector, a realm that is basically *impersonal*. Therapists are *not* like friends; they accept clients *impartially* on a need-to-serve basis, and do not select only those who seem attractive or appealing. They do not invite clients to be part of their own personal life, and cannot allow their own needs as persons to influence the therapeutic relationship. The great privilege of modern psychotherapists is that their work, at its best and for the most part, is not 'alienated labor' (Marx, 1844). The great skill of modern psychotherapists is an ability to engage patients on a person-to-person basis, within the context and confines of their contractual roles—to balance the *personal* and *impersonal* aspects of the therapeutic relationship—and to recreate, in that, a partial yet important healing experience of *personal communion* to help individuals in modern societies to repair or reconstruct their personal lives.

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