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Clinical Cases and Studies

Clinician, Society and Suicide Mountain: Reading Rogerian Doctrine of Unconditional Positive Regard (UPR)

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Abstract

Carl Rogers has become a legendary personage in the mental health field. Rogers (1957) “has been cited in the literature over a thousand times, in professional writings originating in 36 countries” (Goldfried, 2007, p. 249). Clinicians in the behavioral health field (psychiatry, social work, counseling and psychology) are exposed to his teachings about human behavior. Of all the ideas propagated by Rogers, the concept of unconditional positive regard (UPR) has been elevated to the level of a doctrine (Schmitt, 1980). What then is unconditional positive regard? How can clinicians be faithful to the demands of unconditional positive regard in the face of other competing realities such as threat of suicide or terrorism? This paper seeks to discuss the impossible nature of Rogers' UPR, highlighting its inherent linguistic contradiction. Since psychotherapy is culturally normative, the doctrine of unconditional positive regard negates this fundamental principle. In this article, the author takes a critical look at the influence of American philosophy of education on Rogers – he was a product of his culture. Furthermore, this paper asserts that clinicians are guided by societal norms or “conditions” which regulate clinical practice, including unconditional positive regard (Gone, 2011).

Keywords: positive regard, suicidality, education, society, clinician

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Introduction

This paper is focuses on a critical reflection on Rogers’ doctrine of unconditional positive regard. It is a doctrine within the behavioral sciences. Attempts have been made and are being made to impose, albeit unconsciously, the idea that positive regard can in all situations be unconditional (Schmitt, 1980). It appears to be a lofty effort, and Rogers should be acknowledged for attempting to democratize therapy. In attempting to decolonize American psychology from the perceived hierarchical nature of Eurocentric psychology, Rogers showed his bias toward American philosophy of education (Larkin, 1998). That he tried to put a human face to psychotherapy is refreshing, but that he tried to glorify the client is evocative of utopia.

As clinicians, it is relevant to show empathy to clients at all times and in all places. On the other hand, UPR as taught by Rogers, appears infeasible in certain contexts that will be explicated in this paper. There are other values that compete against the value of *unconditional positive regard*. These competing values impinge on the full implementation of the implied demands of unconditional positive regard. In fact, the doctrine of UPR is impossible in a pluralistic world (Schmitt, 1980). Accordingly, there is a lacuna between the semantic representation of Rogers'

concept and the realities of clinical practice. This no doubt accounts for the “claims” and “counter-claims” associated with the doctrine of unconditional positive regard. Grounded in humanism, Rogers' teaching promotes individualism consistent with American socio-cultural worldview. However, this ideological stance may be in conflict with certain norms in traditional societies where communality is paramount (Achebe, 1966). Having given this introductory background, what then is unconditional positive regard?

This paper addresses a cardinal theoretical principle herein described as “doctrine,” and given its canonical status within the behavioral health field, especially counseling, it may be safe to assume that most clinicians know what unconditional positive regard means. However, the interpretations as to what it means may vary from person to person. Schmitt (1980) cites Rogers to have described *unconditional positive regard* in this manner: “if the self-experiences of another are perceived by me in such a way that no-self experience can be discriminated as more or less worthy of positive regard than any other, then I am experiencing unconditional positive regard for this individual” (Schmitt, 1980, p. 238). The term “experiences” as used by Rogers in the context above seems to refer to personal conduct, behaviors or actions. Rogers is talking about a client's individual behavior or “self-experience.” This personal conduct is “perceived” by another individual who happens to be a clinician (therapist).

Rogers chose to use the visual word “perceive,” but clinically speaking, the approximate word to describe what he meant is “*judge*.” Some clinicians may not be comfortable using the word judge (Schmitt, 1980). It is laden with controversy. It appears to connote the idea of “I am better than you.” This seems to be the reason behind the choice of the word “perceive.” Words are windows to meaning. They create meaning. Language speaks for itself (Barthes, 1977/1978). So, the word “judge” may convey the image of moral condemnation, whereas the word “perceive” may appear value-neutral. However, the word “judge” is often times used in describing the process of assessment, evaluation, examination or arbitration. A good literary critic has fine taste. He (she) is able to analyze the features of a text with sound reasoning. This critical process involves the evaluation of the product (text) and the producer, the author (Barthes, 1977/1978). In like manner, the therapist is involved in critical analysis of human behavior and in some ways, the client can be described as a human-text. Of course, a client is fundamentally a person. He (she) is human, but the analogy here is about textual judgment. Essentially, a clinician examines a client's behavior in terms of symptomatology and reaches a conclusion (judgment).

Clinical evaluation or assessment is somewhat value-laden. It is not value-neutral (Fowers, 2012). A clinician or psychotherapist is trained to provide treatment for persons who are not functioning “normally.” This is not an absolute statement. The type and severity of psychopathology may vary from person to person and/or context to context. Clinical training enables psychotherapists to distinguish between what is “normal” and what is “abnormal.” The process of determining what is normal or abnormal entails value judgment. There has to be standards, norms, scales, parameters, measures or ethics regarding behavior evaluation. These norms are predetermined by professional standards. When a clinician does mental status examination, he (she) considers, for example, the client's physical appearance. The clinician may assess whether the client's dressing is appropriate (normal) in relation to age, gender, season, ethnicity or religious affiliation. He (she) may ask follow up questions when clarity is needed. This does not appear to be a value-neutral clinical act, though therapists are trained to be “non-judgmental.”

One of the *ethical challenges* facing clinicians is defining what constitutes a judgmental behavior. There does not appear to be an easy answer. It is complex. Nevertheless, assessment as a therapeutic activity involves making value-judgment. The word “judgmental” emanates from the root word “judge.” So, it appears that evaluating or examining a client's behavior is a “judgmental” activity in terms of its focus on diagnosis. No clinician ever diagnoses

a mental disorder by regarding normal and abnormal behaviors as the same or equal (Schmitt, 1980). There has to be clinical discrimination between healthy (acceptable) and unhealthy (unacceptable) behaviors. Rogers asserts that unequal or "discriminatory" treatment of behaviors generates guilt or pathology in the client hence his proposition of UPR as solution (Schmitt, 1980). The challenge for the clinician is to make these distinctions while still maintaining empathy for the client. Fundamentally, empathy is different from UPR, although there may be overlap sometimes. A clinician can be empathic, while not treating all of the client's behaviors as equal or the same in terms of value or consequence. Further analysis about the overlap of empathy and UPR will be given a more detailed treatment in a different subsection in this paper. Having looked at the definition of unconditional positive regard, where then is the inherent linguistic contradiction?

The term *unconditional* means without any conditions or limits. However, it appears impossible to make any assertion as to providing unconditional positive regard, since psychotherapy is a culturally-normative process (Fowers, 2012). There are external "contingencies" that influence both clinician and client within the therapeutic space (Schmitt, 1980). The linguistic contradiction lies in the fact that culture is normative and given the fact that it shapes the definition of what is "normal" or "abnormal" within psychotherapy, unconditional positive regard therefore becomes implicitly impossible. Psychotherapy is practiced by humans in an imperfect world characterized by pluralism and as such it seems misleading for anybody to make claims of providing "unconditional" positive regard (Herrington, 2011; Schmitt, 1980). It is vital to explicate further the interconnectedness between empathy and UPR, although these constructs are distinct. So, how does empathy overlap with unconditional positive regard (UPR)?

On the Overlapping of Empathy With Unconditional Positive Regard

Farber and Doolin (2011) clarify, "To this day, agreeing on a single phrase to refer to this positive attitude remains problematic" (Farber & Doolin, 2011, p. 59). The concept can be abstract and elusive (Kolden, Klein, Wang, & Austin, 2011). Other words that describe unconditional positive regard include warm acceptance, non-possessive warmth, prizing, affirmation, respect, support and caring (Hill, 2007). In Goldfried (2007), Rogers is cited to have defined unconditional positive regard as the therapist "experiencing a warm acceptance of each aspect of the client's experience" (Goldfried, 2007, p. 251). Acknowledging the obvious semantic complexity in UPR, Hill (2007) has said, "My major concern with UPR is a conceptual one; the construct seems vague and hard to pin down.... UPR seems to overlap considerably with empathy" (Hill, 2007, p. 262). The distinction between UPR and empathy has been dealt with above. The point here is to acknowledge a possible overlap between the doctrine of UPR and the concept of empathy. The former is clinically impossible, while the latter is feasible and is necessary for a client's healing.

Empathy has had a long and indeed controversial history within the mental health professions. Elliott, Bohart, Watson, and Greenberg (2011) have stated, "There is no consensual definition of empathy in psychotherapy" (Elliott et al., 2011, p. 43). It is pervasive and puzzling (Davis, 1996; Katz, 1963; MacKay, Hughes, & Carver, 1990). Elliott et al. (2011) have cited Rogers (1980) to have defined empathy as "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view" (Elliott et al., 2011, p. 44). It is a "complicated multidimensional variable.... Attempts to simplify the empathy construct have been unsuccessful and in some cases misleading" (Pedersen, Draguns, Lonner, & Trimble, 1996, p. x).

Empathy may involve a collaborative exploration of meaning between the therapist and client; it can be "a part of the total interaction between two people and not as a personality trait or variable of one person" (Pierce, 1971, p.

120). According to Hill (2007), Rogers (1957) explained empathy as the act of sensing the client's experience: “To sense the client's private world as if it were your own, but without ever losing the “as if” quality. To sense the client's anger, fear, or confusion as if it were your own, yet without your anger, fear, or confusion getting bound up in it” (Hill, 2007, p. 262). Hill (2007) has argued that Rogers was perhaps talking about “cognitive” empathy rather than “emotional” empathy. From a semantic point of view, the word “sensing” can be used interchangeably with the word “feeling.” Perhaps the act or process of empathy can involve all the senses (touching, seeing, hearing, smelling and tasting). It is also possible to have an overlap of both cognitive and emotive experiences (Presbury, Echterling, & McKee, 2008). Now, do genes play a role in character development as in being empathic?

Presbury, Echterling, and McKee (2008) have argued that people are genetically wired to be empathic. This biological predisposition accounts for the ability of individuals to connect with others (Presbury, Echterling, & McKee, 2008). For example, in stressing the influence of oxytocin, these authors posited, “Researchers have conjectured that this hormone (oxytocin) is responsible for healthy relationships in humans. Our attachment to others, our desire to mate and nurture children, and our ability to interact on a social level may be greatly influenced by how much oxytocin is available in our brains” (Presbury, Echterling, & McKee, 2008, p. 52). Also Feeney and Noller (1996) citing Bowlby (1973) have stated, “Given strong parallels between human attachment behavior and similar attachment behavior shown by nonhuman primate species, attachment behavior is adaptive, having evolved through a process of natural selection. That is, attachment behavior offers infants a survival advantage, protecting them from danger by keeping them close to the primary caregiver (usually the mother)” (Feeney & Noller, 1996, p. 3). There seems to be a strong genetic foundation for understanding how individuals develop the capacity to show empathy to others whether in clinical or non-clinical settings. Notwithstanding the biological basis for empathy development, there are still individuals whose actions or judgments reflect a deficiency of empathy.

In this vein, Davis (1996) argued that various theories regarding human temperament are useful in understanding human empathy. Individual variation in temperament is genetically determined (Presbury, Echterling, & McKee, 2008). Accordingly, “those high on affect intensity respond more angrily to frustrating stimuli, more sadly to depressing stimuli, but also more joyfully to pleasant stimuli (Davis, 1996, p. 66). Since temperament is connected to how individuals respond to external stimuli, it seems reasonable that persons with high level “affect intensity” or “arousability” will tend to show corresponding empathy to others (Davis, 1996, p. 66). However, it is important to take cognizance of the fact that adverse environmental factors can impede this innate capacity to show empathy to others (Davis, 1996).

Accordingly, some studies have been carried out to show the relationship between genetic disposition and environmental influences (Davis, 1996). For example, some research studies have looked at the quality of mother-child relationship and how this might influence the capacity for empathy in adulthood. These studies examined the depth of attachment in mother-child relationships.

The children in these studies were between 12 and 18 months old. Subsequently, these children were later observed after three years. Davis noted, “As expected, the securely attached children significantly surpassed nonsecure children on a number of different measures of “peer competence”. Most relevant to our discussion is that secure children were rated as more sympathetic [empathic] to their peer's distress” (Davis, 1996, p. 71).

Furthermore, research studies focused on “affective quality of family relations” as one of the pillars for empathy development investigated the issue of abuse in the family (Davis, 1996). Davis, citing studies done by Hinchey and Gavelek (1982), Straker and Jacobson (1981), and Main and George (1985), argued that abuse (physical,

sexual or emotional) impairs the child's ability to show empathy. Although the results from these studies point to a positive relationship between childhood-abuse experiences and later impairment in functional capacity to show empathy, it is important to note that there are exceptions.

There are several examples of individuals who have demonstrated genuine empathy for others, even their enemies, in spite of horrendous experiences of abuse by fellow humans. Historical examples include (not an exhaustive list) Nelson Mandela, Martin Luther King, Mother Theresa and Mahatma Gandhi (King, 1963). Practitioners of Animal Assisted Therapy have also observed that children who have been abused tend to show "intuitive" empathy toward animals that have been abused- the argument being that they can connect emotionally or empathize with these abused animals due to their own history of abuse (Shallcross, 2011). This "intuitive empathy" is sometimes referred to as emotional intelligence. The more emotional intelligence (EI) a person has, the more the capacity to understand the suffering of others. As Shallcross has rightly observed, children who have been abused tend to understand in a profound way the feelings of other abused children. Again, this is not a doctrine as there may be exceptional cases where the reverse could be the case.

Presbury, Echterling, and McKee (2008) have acknowledged the role of Goleman (1995) in laying the foundation for understanding what is called "Emotional Intelligence" [EI]. Blume (2006) as cited in Presbury, Echterling, and McKee (2008) identified four major aspects of EI that are vital to effectiveness in social interactions: emotional expression, facilitation, interpretation and regulation. In adapting the work of Salovey et al. (2000), Presbury, Echterling, and McKee (2008) classified EI skills into two forms: self-skills and other skills. The self-skills involve emotional competence related to recognizing emotion in one's own physical and psychological states. It also involves experiencing congruence between what one feels and what one expresses. On the other hand, other skills pertain to identifying emotion in other people with accuracy; recognizing incongruence between their statements and their emotional states (Presbury, Echterling, and McKee, 2008). From the data presented so far on empathy, it is clear that it is closely related to unconditional positive regard. They do overlap on occasion, but they are not the same construct. Empathy for a client is possible, but it should not be confused with the doctrine of UPR. At this point in this discussion, it is crucial to take a closer look at the cultural foundation of psychotherapy. How is UPR culturally embedded?

UPR as a Culturally-Normative Construct

McAuliffe (2008) defined culture as "the attitudes, habits, norms, belief, customs, rituals, styles, and artifacts that express a group's adaptation to its environment- that is, ways that are shared by group members and passed on over time" (McAuliffe, 2008, p. 8). Culture is normative. Psychotherapy, like education, is often geared toward behavioral change in individuals, whether old or young. Education, in some ways, involves socialization process (Fafunwa, 1974). Through psychoeducation clients may gain insight regarding their maladaptive behaviors and learn new skills with which to maintain healthier life styles.

Therefore, unconditional positive regard as a construct, within psychotherapy, is dependent upon other cultural imperatives (Gone, 2011). Fafunwa (1974) described education in this manner:

> Every society, whether simple or complex, has its own system for training and educating its youths, and education for the good life has been one of the most persistent concerns of men throughout history. However, the goal of education and the method of approach may differ from place to place, nation to nation, and people to people (Fafunwa, 1974, p. 15).

Education is a mirror of a people's culture, although this is not always the case (Fafunwa, 1974). As Fafunwa (1974) has argued, education entails "the aggregate of all the processes by which a child or young adult develops the abilities, attitudes and other forms of behaviour which are of positive value to society in which he lives; that is to say, it is a process for transmitting culture in terms of continuity and growth and for disseminating knowledge either to ensure social control or to guarantee rational direction of society or both" (Fafunwa, 1974, p. 17). Psychotherapy, as a form of education, can be said to be part of what Fafunwa (1974) has called "the aggregate of the processes" through which the behavior of members of any society is "normalized." The setting for this behavior modification may vary from time to time. Therapy can be done at homes, schools, counseling offices, worship places, work places or parks and in modern times, it can be done over the internet or through telecommunication. Since psychotherapy, like other educational processes, is geared toward either behavior modification or maintenance, it cannot be unconditional (Gone, 2011). To assume that therapy can be unconditional or that the therapist can practice his craft without a cultural road map is to make the clinician powerless (Schmitt, 1980). Perhaps, echoing Barthes (1977/1978), one may say it implies the death of the therapist. This construct insinuating the death of the therapist in psychotherapy will be expounded further in another subsection.

In this vein, Presbury, Echterling, and McKee (2008) have stated, "Some counselors still claim to be "non-directive" in their approach to their work with clients... such a declaration is usually founded on a misconception of the term that Carl Rogers originally used to describe his approach. They believe that Rogers meant that the counselor is passive, possessing no plan and remaining unintentional as to where the relationship must go" (Presbury, Echterling, & McKee, 2008, p. 54). The author of a therapy session is the clinician. He (she) is in charge. There is no ambiguity that there exists an unequal relationship between the therapist and the client. Even in the professed "non-directiveness" of the client-centered approach, the therapist is the originator of therapy. He (she) has influence and that influence is backed by cultural or value-based experiences that impact the therapeutic encounter. However, Rogers' UPR, within the client-centered approach, seems to suggest the death of the therapist (Barthes, 1977/1978).

Psychotherapy can be viewed as a cultural process (Pickren, 2009). In his article "Is psychological science a-cultural?" Gone (2011) argued as follows:

> I argue that psychological science is not, has never been, and indeed cannot in principle be a-cultural. Instead, like all forms of knowing, psychological science emerges at particular historical moments to achieve particular goals that are motivated by particular interests. Throughout much of the history of psychological science, these and interests were tied to ideologically suspect agendas that contemporary psychologists are right to repudiate... I propose that psychological science can in fact be so disentangled; nevertheless, the resulting methods are never adopted or deployed outside of culturally constituted interests, objectives, and motivations, thereby requiring ongoing critical engagement with the subtexts of disciplinary knowledge production (Gone, 2011, p. 234).

As Gone (2011) has clearly argued above, it is this writer's persuasion that psychotherapy is a cultural production and its essence lies within a particular cultural context. Prevailing sociological factors at any given time in history impact how clinicians interpret behavior. The ever-changing nature of societal values accounts for the necessity for revising the diagnostic manual produced by the American Psychiatric Association. The current edition of the diagnostic manual is called the DSM-IV-TR. Whenever such revisions take place, there are usually visible changes as to methods of practice and/or definition of abnormality. These revisions are reflective of social change. In carrying out their functions, clinicians adhere strictly to the diagnostic manual. It will be unethical, and perhaps illegal, to provide clinical intervention without compliance with the clinician's code of ethics. While there are various pro-

fessional organizations related to mental-health practice, the norm is to follow the guidance provided by the DSM-IV-TR or the ICD.

For example, Ibrahim and Dykeman (2011) argued that the American Psychiatric Association requires a "cultural formulation [understanding of client cultural identity and context] to be completed with a client before a diagnosis is given" (Ibrahim & Dykeman, 2011, p. 387). According to this view point, any treatment provided a client requires sensitive attention to the cultural norms of that individual. In other words, there is a cultural guideline, road map or condition to be followed in order to bring about wellness, balance, normality or even "conformity" on the part of the client. To claim that the clinician, a conditioned cultural product, can provide unconditional positive regard, knowing full well his/her jurisdiction, is at best impossible (Schmitt, 1980). It is impossible, because the clinician is a person who happens to be a therapist by training. He (she) has values, and these values or beliefs shape that clinician's view of reality. This is essentially why clinicians are reminded to guard against personal biases in psychotherapy. From where do these biases arise? They emanate from cultural or socialization processes. Furthermore, there are values (for example mandatory reporting) that clinicians by law must uphold in order to keep their licenses. These are external variables that exist in every clinical encounter.

One may wish that these 'contingencies' (Schmitt, 1980) do not exist, but they do. They are conditions that regulate every therapist- client relationship.

UPR and the Hierarchical Nature of Psychotherapy

Rogers was concerned about the hierarchical nature of therapy, especially as it seemed to confer too much authority on the clinician. Therefore, in adopting the person-centered approach, it appears that Rogers was trying to introduce the concept of egalitarianism to psychotherapy (Larkin, 1998). It is this perception of therapy, especially psychoanalysis, as dictatorial that warranted Skinner's critical response. Ulrich, Stachnik, and Mabry (1966) cite Skinner to have stated the following regarding the dictatorship of the clinician:

> The solution that Rogers is suggesting is thus understandable. But is he correctly interpreting the result? What evidence is there that a client ever becomes truly self-directing? What evidence is there that he ever makes a truly inner choice of ideal or good? Even though the therapist does not do the choosing, even though he encourages "self-actualization" – he is not out of control as long as he holds himself ready to step in when occasion demands – when, for example, the client chooses the goal of becoming a more accomplished liar or murdering his boss. Supposing the therapist does withdraw completely or is no longer necessary – what about all the other forces acting upon the client? Is the self-chosen goal independent of his early ethical and religious training? of folk-wisdom of his group [culture] (Ulrich, Stachnik, & Mabry, 1966, p. 315).

As Larkin (1998) has noted, "The psychotherapy that Rogers created was uniquely American- the first viable alternative to European psychoanalytic therapy" (Larkin, 1998, p. 248). In the United States, there are no Lords, Queens or Kings. Of course, this does not mean that the US is a classless society. There is still social stratification: upper class, middle class, lower class etc. The Founding Fathers of this nation envisioned a society where citizens will be treated equally. This is laudable. So, Rogers must have received several doses of this idea of equality, either through his family or schools attended. He is a son of America (Kirschenbaum, 1979). In locating Rogers as a reflection of his time, Brown (2007) argued, "Rogers was, as are we all, a creature of his identities and social locations. He was a Euro American man, middle-class, heterosexual, of Protestant heritage, able bodied, highly

educated; in other words, a member of the dominant elites to whom, during his lifetime, few doors [if any] were systemically closed" (Brown, 2007, p. 258). If, for example, he had been born in China, perhaps his understanding of human behavior and how to manage it, would have been shaped by his Chinese cultural environment. If the clinician's philosophy is conditioned by social-cultural forces, it seems contradictory to propagate the doctrine of unconditional positive regard within the sphere of clinical practice (Gone, 2011).

The therapist and the client have their own sense of power or autonomy. The therapist can choose to refer his/her client to another clinician. On the other hand, the client may choose to terminate therapy. In spite of this sense of autonomy, available both to clinician and client, psychotherapy is neither therapist-centered nor client-centered. In fact, a realistic treatment plan is multi-centered, because it takes into account the needs of the therapist, client and the society at large. Larkin (1998) has posited, "... no psychotherapy can be truly democratic..." (Larkin, 1998, p. 249). Clinicians practice their profession according to their field of expertise. In the United States, psychotherapists are licensed to practice within particular states. Even so, they are bound by the laws of those states where they practice.

The power of the state to issue or withdraw a professional license is a means of control. This process ensures that licensees (clinicians) follow the law as it relates to mental health practices. Given this dialectical scenario, the clinician has to keep one eye on unconditional positive regard and the other, on societal norms. Accordingly, unconditional positive regard is impossible given the fact that clinical practice is highly regulated (Gone, 2011).

Individualism, Meaning-Making and Unconditional Positive Regard

Larkin (1998) has argued that in founding the client-centered approach, Rogers was trying to counter the authoritarian or hierarchical nature of Eurocentric psychology. Rogers "solution" was the idea of training non-directive, figure-head therapists who would allow their clients to be the sole interpreters of their own reality (in Ulrich, Stachnik, & Mabry, 1966). In response to Rogers' idea of ending therapeutic tyranny, Skinner is cited as saying, "In the end, let his teachers and counselors 'wither away,' like the Marxist state" (in Ulrich, Stachnik, & Mabry, 1966, p. 316). The word 'wither' as herein used is strong, but metaphorical. It may denote death, powerlessness or invisibility. Skinner is not suggesting the literal death of teachers or counselors, just as Barthes (1977/1978) is not suggesting the literal death of authors. The issue here is authority. In Rogerian thinking, the death of the therapist in terms of power and control brings about the resurrection of the client. Death in the therapist produces life or meaning in the client. This act of "death" or invisibility is initiated by the therapist as a way of promoting therapeutic egalitarianism. When the authority of the therapist is suspended as in death, the client is empowered to rescript his/her own story within the context of therapy. But to what extent does the therapist die? How long? The therapist awakens to societal reality (life) as soon as the client suggests harm to self or others as a solution to his (her) issue. At this point, when it clear that the client's self interpretation of his (her) reality impinges on the law, the therapist asserts his authority by invoking limitations as to meaning. In issues relating to suicidality, it is not just a matter of the therapist's own value system (that is his (her) belief in UPR), but also a matter of the will of society at large. The force of the law is like the trumpet blast that arouses the therapist from his/her transient death (Barthes, 1977/1978).

If these social conditions are influential enough to trigger a measure of "being in charge" or authoritative finality in the therapist, it seems misleading, at least to this writer, for claims to made about UPR. Unconditional positive

regard implies zero external contingencies (Schmitt, 1980) and there is no evidence that any clinician ever practices in this manner.

There is an Igbo proverb that asks the rhetorical question, “Shall I feed a child to his/her death for the fact that the child is my re-incarnation?” While this writer does not believe in reincarnation, as taught within the canons of African Traditional Religion, this Igbo proverb asks a very important ethical question. It brings to limelight the matter of balance, good judgment and timing. Whom shall the therapist please? The therapist's act of UPR toward the client requires also a measure of consideration for self. He [she] should care about not losing his/her license, right? (Knapp & Vandecreek, 2007). The therapist takes care to follow ethical standards without which a lawsuit may occur. As long as unconditional positive regard is practiced within the framework of sociological and ethical considerations it is illogical to describe it as unconditional. There is no form of therapy without agenda (Gone, 2011; Pickren, 2009). Perhaps, it is important to ask who sets the agenda, for whom and in what context?

Lakes, López, and Garro (2006) acknowledged the clinical relevance of Kleiman's (1995) notion of culture as “what is at stake in the local social worlds” and Mattingly and Lawlor's (2001) idea about “shared narrative” between clinician and client (Lakes, López, & Garro, 2006, p. 391). The authors have suggested, “The single greatest contribution of culture is that it guides the clinician to examine the client's social world to identify what is at stake or what matters for the individual client” (Lakes, López, & Garro, 2006, p. 391). What is at stake in the client's daily lifestyle mirrors the value system of the larger society. Paying close attention to these at-stake issues, helps the clinician to evaluate the influence of cultural practices on the client. The client's behavior (interests, skills, values, beliefs, rituals) is shaped by cultural norms, although there may be peculiarities from person to person or family to family. Since the client needs the therapist to validate his/her story, and this validation occurs in the context of cultural norms or conditions, it becomes impossible to lay any rational claim to unconditional positive regard.

Human behavior is guided by social contract or norms specific to a particular culture (National Advisory Mental Health Council, 1996). These norms are subject to social change depending on the collective will of the people. Therefore, it is only reasonable and realistic that the clinician has to conduct his (her) practices with due respect to “what is at stake” in the client's social world. Society is a system and so is the family to which a client belongs. The ‘going on’ of culture shapes social groups (Dewey, 1922). There has to be social intelligibility between the clinician and the client. Lakes, López, and Garro (2006) citing Mattingly and Lawlor (2006) has opined, “When clinical encounters are successful it is because the practitioner and client are able to read each other well or create a shared narrative” (Lakes, López, & Garro, 2006, p. 383). This implies that therapy is collaborative, ‘co-constructive’ and cannot just be about the client's view of reality. It is not just client-centered. Furthermore, Benish, Quintana, and Wampold (2011) have suggested that the efficacy of any clinical intervention is determined by the degree of congruence between the therapist's explanation of illness and the client's interpretation of illness and suffering. These reviews or assessment, like unconditional positive regard, is culturally determined. This is the basis for the conditionality of Rogers' UPR.

Accordingly to Watson (2006) has argued, “Person-centered therapists emphasize the subjective nature of experience and in so doing implicitly communicate to clients that their experience is idiosyncratic and only one of the many ways of construing events” (Watson, 2006, p. 14). However, in stressing the connectivity or interdependence of society and the individual Beloff (1973) opined, “It follows that the relationship between society and the individual is always a two-way affair; history may be seen as the sum total of individual human actions but none of those

actions would have any meaning outside the historical context in which they occurred" (Beloff, 1973, p. 212). In others words, the client exists in relation to other people in his/her community. It is not "all about him/her," that is the client. On the reverse, it is also not about the therapist's value system or society's rigid demands. Unconditional positive regard within the person-centered approach emphasizes ambiguity or infinitude of meaning (Watson, 2006). In other words, it is the client that solely creates the meaning of events in his/her life. In this vein, the clinician needs to interpret the client's reality without reference to external norms or conditions. But as Beloff (1973) has argued, the client's behavior cannot be evaluated without reference to cultural or historical contexts or conditions.

Furthermore, Watson (2006) has suggested, "Person-centered therapists work hard to restrain themselves from imposing their values or expectations on their clients in order to maximize clients' autonomy and self-expression within the therapeutic relationship" (Watson, 2006, p. 14). This is a laudable goal not only for person-centered therapists, but also for all therapists (Knapp & Vandecreek, 2007). The problem, however, is the tendency for some clinicians to assume value-neutrality. To "try very hard to restrain themselves from imposing their values" does not equal zero occurrence.

When a mental health professional is trained, he/she receives a world view – a value system that guides his/her conduct in therapy and out of therapy. It is simply not practicable to assume that person-centered therapists do not influence their clients. While the goal of therapy is not the imposition of the therapist's value system on the client, therapists, even the 'non-directive' ones influence clients in one way or the other. Accordingly, it appears impossible to assert unconditional positive regard on the grounds of being non-directive. In hinting about this issue, Farmer (1969) has stated, "I have not found many authors who attempt to discuss candidly just what their values and associated feelings are, although these have an inevitable bearing on their carefully outlined technical procedures and philosophies of management [therapy]" (Farmer, 1969, p. 131). This leads to issue of client suicidality – a mountain facing every clinician, especially those who hold tenaciously to the doctrine of unconditional positive regard.

UPR and the Question of Suicidality

Beauchamp (1985) as cited by Boylan and Scott (2009) has described suicide as involving the following: "the person intentionally brings about his or her death; the person is not coerced by others to take the action, and death is caused by conditions arranged by the person for the specific purpose of bringing about his or her own death" (Boylan & Scott, 2009, p. 269). This definition could also be modified to include the premeditated act of killing self and others as in cases of suicide bombers. There are several reasons behind suicide attempts by a client. They may include the desire to show hostility toward the therapist or others; it may also be an inappropriate way of eliciting sympathy from the clinician; it may be a manipulative way of making demands on the clinician, for the purpose of control (Tenenbaum, 1964).

It is not uncommon for clinicians to encounter ethical dilemmas in the course of performing their duties. In those instances where their codes of ethics do not give clear guidance as to what practitioners should do, they have to be guided by their moral compass (Knapp & Vandecreek, 2007). While unconditional positive regard is vital in strengthening the therapeutic relationship, it can be tested by situations that warrant the clinician to align with the law. In those instances, it seems appropriate that clinicians may be morally obligated to warn those who may be in harm's way as a result of a client's reported intent to harm self or others. When a client poses a threat to self

or society, the clinician's act of suicide-reporting is predetermined by societal norm or condition – that is the law (Boylan & Scott, 2009). The mandatory act of suicide-reporting on the part of the clinician indicates that clients' behaviors do not carry the same value. A client's behavior is assessed or reviewed through the application of external norms or conditions. This behavior on the part of the therapist shows conditionality.

There is no such thing as a blanket *acceptance* of a client's behavior without reference to other competing values (Schmitt, 1980). Schmitt (1980) argues that the self and behavior are connected. It is the self that produces the behavior whether appropriate or inappropriate. Accordingly, any judgment or evaluation of behavior simultaneously impacts the self or person. When a client, for example, is a threat to self, this behavior is deemed inappropriate or unsafe. This action is judged unsafe, but additionally, the client is likely to be lawfully hospitalized. So, the client (self) and his (her) behavior are linked.

In the article, "Time for Full Disclosure With Suicidal Patients," VandeCreek (2009) stresses the importance of full disclosure to clients who have attempted suicide in the past. According to Vandecreek, clients, especially those that have suicide ideation, should be educated about suicide risks from the beginning of therapy. Through the use of informed consent, the clinician and the client will be afforded the opportunity to talk candidly about the implications of suicide.

It is not uncommon for clients to sometimes place impossible expectations on their therapists. They may assume that their therapists are perfect. There may be an assumption of absolute confidentiality within the therapeutic environment, which does not exist. Part of the clinician's role as the professional in charge of the therapeutic process is to tell clients that "threats" of suicide may be reported to the police. It is crucial to reiterate that the warmth provided by the therapist, within the therapeutic space, is conditional on other social variables, for example, public safety. When the safety of a third party is under threat by a client, the clinician is under legal obligation to report the matter to law enforcement authorities (Boylan & Scott, 2009).

Cook (2009) has stated, "Prominent legal cases against universities related to college student suicides (e.g., MIT) and mandatory leaves from the university for suicidal students (e.g., George Washington University), as well as the tragedies at Virginia Tech University and Northern Illinois University, have heightened administrative scrutiny on university counseling centers" (Cook, 2009, p. 470). This is the reality of suicide risk in today's society. It is a reality that no therapist, whether in private, community, hospital, school or higher education setting, can afford to ignore. When "suicidal students" are "mandated" to vacate their campuses for the sake of public safety, it is misleading to make any claim as to the possibility of unconditional positive regard. It is not impossible (Schmitt, 1980).

Furthermore, suicidality relates also to instances where people may seek to harm self and/or other through the means of suicide-bombing:

> The attacks of 9/11 did far more than destroy buildings and kill thousands of innocent people. They interrupted routine patterns and tugged at our socialization fabric, not simply in New York City, Washington, DC, and Shanksville, Pennsylvania, but across the country as well. They shattered a sense of security and perceptions of invulnerability among residents of the United States and the Western world (Silver, 2011, p. 427).

It is a changed world. We live in a post-9/11 reality. In the midst of the security challenges posed in a world of terrorist extremism, how can clinicians practice the doctrine of unconditional positive regard? The need for national safety in the US, and indeed around the world, has brought pressure on issues of personal freedom. There is a

heightened sense of security surveillance in the United States. Certain communications are monitored; there are new visa rules. At the airports, travelers have to undergo thorough screening before boarding. Several other scholars have written about the impact of 9/11 terror attack not only on the public, but also on the behavioral sciences (Fischhoff, 2011; Ginges, Atran, Sachdeva, & Medin, 2011; Huddy & Feldman, 2011; Morgan, Wisneski, & Skitka, 2011; Nickerson, 2011; Watson, Brymer, & Bonanno, 2011). The amount of research that has been carried out on the subject of terrorism post 9/11 attests to the seriousness of the matter.

So, clinicians face an ethical dilemma related to balancing the need for unconditional positive regard (a doctrinal impossibility) and the greater burden of public safety. In instances where a client shares information that points to a possible terrorist attack, a clinician will be under moral obligation to alert law enforcement authorities. It is impractical to expect a clinician to act otherwise, especially if he or she is under legal obligation to report the suspected terror plot. This clinical tension has to be acknowledged so as to tame the illusion of unconditional positive regard in therapy. Suicide-bombing for the purpose of terrorism is a social of reality of the 21st century. In view of this mountain, it is this writer's submission that unconditional positive regard is idealistic and cannot be actualized in clinical practice (Cresswell, 2009; Schmitt, 1980). While it may be argued that unconditional positive regard is idealistic and perhaps necessary for effective clinical temperament, it has become doctrinal (Schmitt, 1980). It is taught as a clinical reality. Indeed, it is assumed to be the true mark of a clinician. The confusion, one must admit, lies in promoting value equality, the sense that a client's behaviors (appropriate or inappropriate) should be received with the same response by the therapist (Rogers, 1951). This is impractical. However, a clinician can demonstrate empathy for a client while holding the client accountable for unacceptable behavior. This is not what Rogerian doctrine advocates. It advocates a value-neutral treatment of a client's behavior (Schmitt, 1980). While there is an overlapping of meaning within UPR and empathy, there is a difference in terms of application.

Conclusion

This paper is by no means the resolution of the challenges raised by Roger's doctrine of UPR, but rather, it is an attempt at continuing the conversations around it. In this current effort, this writer has given critical attention to the fundamental conflict existing between the linguistic representation of UPR and its actual clinical production (Barthes, 1977/1978). The claims of UPR are impossible when situated within a cultural framework and if it cannot be reconciled with the question of normativity, its foundation is far from solid.

Carl Rogers is legendary, but the UPR doctrine is impossible (Schmitt, 1980). There is little or no doubt that humanistic processes are crucial in empowering the client. Empathy for the client is vital in building a cordial therapeutic relationship. Clients may lower their defenses when they feel listened to or understood. In this sense, therapy becomes client-sensitive and not client-centered. As this writer has argued above, clinical encounters involve multi-dimensions bordering on the therapist, client and society. These three aspects are interrelated. However, the leadership of the clinical encounter belongs to the therapist. This fact does not limit or hinder the necessity to care genuinely for the client. The ability to show care for others, especially those in need of clinical care, is critical in therapeutic work. So, Rogers has influenced other clinicians in the matter of developing healthy therapeutic relationships. However, Rogers' UPR as a doctrine is inherently contradictory and impossible given the fact that psychotherapy is cultural-embedded.

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