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Dr. Bruce Mapes Wins PPA Presidential Election

Dr. Bruce E. Mapes

Dr. Bruce E. Mapes was the winner of the recent election for the presidency of PPA. He will serve as president-elect starting in June and will be president for the 2014-15 program year. Dr. Mapes has served in many positions within our association. He is currently the chair of the PennPsyPAC Board of Directors and a member of the Succession Development Task Force and the Budget and Finance, Child Custody, Ethics, and Forensic and Criminal Justice Committees. He is past chair of the Public Interest Board, board liaison to the Executive Committee, and secretary-treasurer of the Pennsylvania Psychological Foundation Board. Dr. Mapes maintains a private practice with an emphasis on forensic work. He is qualified as expert in Juvenile, Family, Criminal, and Orphans Courts. He had received his PhD from the University of Pennsylvania in 1974. Dr. Mapes stated, "As external forces converge to change the future trajectory of psychology for practitioners, academicians, and researchers, PPA will play a critical role in positioning psychology to adapt

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Child Protective Services Law: Reform or Reaction?

Following the scandals at Penn State University, the Pennsylvania General Assembly appointed a task force to review the child abuse laws of Pennsylvania and make recommendations for changes. Their 400-page report was released in November 2012 (see http://www.childprotection.state.pa.us/Resources/press/2012-11-27%20Child%20Protection%20Report%20FINAL.pdf).

Now the Pennsylvania House and Senate must take these and their own recommendations and put them into bills which could eventually become law. The current strategy is to amend the Child Protective Services Law through a series of separate bills, as opposed to one comprehensive bill. The Children and Youth Committee of the Pennsylvania House of Representatives has already held several public hearings on child abuse bills. As of late March, more than 60 bills have been introduced and many more will be later. In order to become law, many of these bills will be considered, perhaps amended, and voted out of committee and then sent to the full House, where they may be amended again. The same type of process will occur in the Senate. Both chambers must pass the same bill. If they pass it with different amendments, the chamber of origin must vote to concur in the other chamber's version; if they nonconcur it goes to a conference committee to work out the differences.

Of the many areas being considered, the areas that PPA is focusing on are expanding the identification of child abuse (including expanding its definition) and keeping rational requirements on mandated reporters.

As has been noted previously, Pennsylvania has the lowest rate of identifying child abuse in the nation, except in the area of sexual abuse, where the identification rate approximates the national average.[1] PPA is joining with other advocacy groups to promote definitions of child abuse and procedures that help ensure that children will actually be protected.

Much attention is also focusing on mandated reporters. There are bills that would make the failure to report child abuse a felony. Another bill would have the failure to report child abuse result in the automatic loss of licensure. Other proposals would require reports when reporters learn of suspected abuse in their personal lives (not just their professional roles),

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[1]Pennsylvania also has a process by which cases of neglect may be referred to a voluntary General Protective Services System. No statewide data is kept on the number of the children served by this system. However, it is likely that Pennsylvania is not nearly so deviant in protecting children as the official statistics would suggest.

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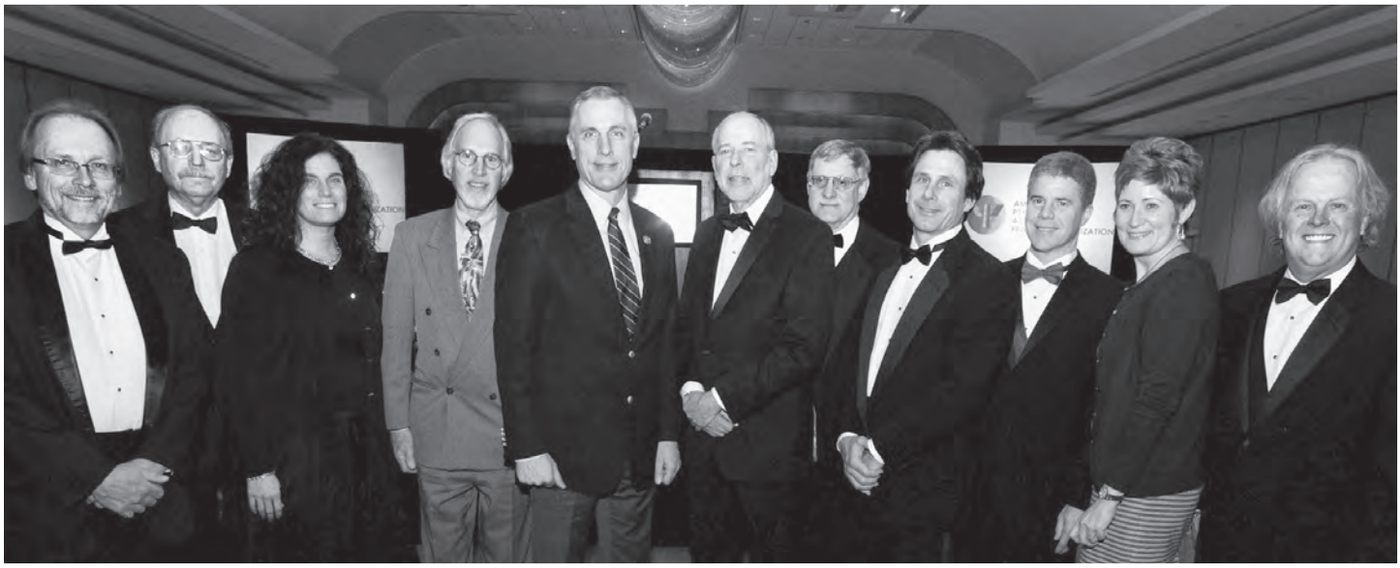

At a reception prior to the black tie dinner in Washington, DC, the attendees at the State Leadership Conference gathered to meet with Rep. Tim Murphy. Pictured left to right are Adam Sedlock, Dr. Joe Cvitkovic, Rachael Baturin, Tom DeWall, Rep. Murphy, Drs. Don Bersoff, Sam Knapp, Vince Bellwoar, Brad Norford, Patty Fox, and David Palmiter.

Fundraiser for Psychologist Representatives Held in Washington, DC

Forty three psychologists (including eight from Pennsylvania) attended a recent fundraiser for the three psychologists who are representatives in the United States House of Representatives: Drs. Timothy Murphy (R-PA), Judy Chu (D-CA) and Alan Lowenthal (D-CA). Psychologists from Pennsylvania raised more than $8,000 (which was more than any state has ever contributed to one of these national fundraising events for psychology). The assistance of the psychologist-legislators will be needed more than ever given the difficult issues that psychologists are facing.

The attendees from Pennsylvania were Drs. David Palmiter, Vince Bellwoar, Brad Norford, Joe Cvitkovic, Samuel Knapp, Ms. Rachael Baturin, Mr. Adam Sedlock, and APA President Dr. Don Bersoff.

Dr. Murphy is chair of the Subcommittee on Oversight and Investigations of the House Energy and Commerce Committee, but retains a great interest in mental health issues. He was a strong supporter of mental health parity and has introduced a bill to get psychologists included in HITECH incentive funds (which would make grants available to psychologists who wish to adopt electronic health records). Dr. Murphy spoke to psychologists about the bipartisan hearings he recently held on mental health and violence. He urged psychologists to appreciate the important contributions they can make on public policy. In addition to his congressional responsibilities, Dr. Murphy also serves as a Lt. Commander in the U.S. Navy Reserve, where he treats soldiers suffering from PTSD and TBI. Dr. Murphy is starting his sixth term in Congress.

Dr. Chu is the first woman of Chinese descent to serve in the U.S. Congress. In her remarks before psychologists, Dr. Chu described her experiences when she was a young psychologist working with women who had been abused. It was therefore with a special sense of gratification that she was a major force in the reauthorization of the Violence against Women Act while a member of Congress. During our conversations, Dr. Chu expressed concern over the reductions in access to mental health services under Medicare caused by recent reimbursement reductions. Dr. Chu is starting her third term in Congress.

Dr. Lowenthal came to Congress with a very impressive list of accomplishments as a California state senator. Although he is a fiscal conservative, he has a deep passion for social justice and equal opportunity. Dr. Knapp had a chance to speak with him briefly and asked what he could do to help diffuse the partisanship in Congress. He noted that, as an institution, Congress has a very rigid hierarchy, and first-year members have little influence or authority. However, he and a newly elected Republican representative from California struck a first blow for bipartisanship by insisting on having their seats in Congress next to each other – breaking the informal tradition of having Democrats and Republicans sit on opposite sides of the chamber.

This fundraiser was held on March 10 in conjunction with the State Leadership Conference held by the American Psychological Association's Practice Organization. After a brief reception, the attendees moved into a banquet room where seven attendees sat at tables with eight place settings, thereby permitting legislators to travel from table to table so that every attendee would have an opportunity to speak with them directly.

Members of Congress understandably look to the psychologist-legislators for leadership when it comes to behavioral health issues. Their leadership will be especially important as we tackle major problems such as Medicare funding for psychologists and access to mental health treatment for Medicare beneficiaries.

Should the Circumstances Under Which Abuse Is Reported Be Expanded?

Two of the proposals being considered in bills before the Pennsylvania legislature would expand greatly the circumstances under which mandated reporters must make reports of suspected child abuse and make the failure to report suspected abuse a felony and an automatic loss of licensure. Each of these areas will be discussed separately.

Expanding the Reporting of Abuse

Currently reports of child abuse are mandated only if the mandated reporters see the child in their professional capacity or if the child has contact with the agency, institution, or organization where the professional works. Even so, the large majority (about 86%) of reports of suspected child abuse in Pennsylvania are not substantiated (far below the national average of 77%).[1]

However, bills have been introduced in the Pennsylvania legislature that would require reporting any time a mandated reporter learns of abuse from a child (even if not in their professional role), if the mandated reporter learns of abuse from a perpetrator of abuse, or if a child makes a believable statement that a relative or friend of the child is being abused.

PPA opposes expanding the reporting requirements in situations where the link between the child and mandated reporter is lost. The nexus between the mandated reporter and the child is important in ensuring the reasonableness of the report. It is hard enough making determinations in some of the cases when the child is actually before the mandated reporter; it is too difficult to make these determinations when the child is never seen by the mandated reporter.

PPA does not support the requirement that psychologists must report confessions of abuse by perpetrators of child abuse (unless they present a danger to commit future abuse). Paradoxically, such proposals inadvertently reduce the ability of psychologists and other mandated reporters to protect children. Health care professionals are required under federal law (HIPAA) to inform all patients of the limits to confidentiality before treatment begins. Psychologists would have to inform all patients that if they report past instances of abusing children, they must report them to law enforcement agencies for prosecution. Consequently, perpetrators would either drop out of treatment or refuse to discuss issues freely, thus inhibiting the success of treatment. In any event, the interests of society in learning the identity of the perpetrator will not be advanced. Furthermore, this requirement may actually inhibit the ability of psychologists to help protect children because even non-abusing parents would be reluctant to discuss any problematic parenting behavior out of fear that it could generate a report to law enforcement officials. Consequently, the ability of psychologists to help non-abusing parents improve their parenting skills would be compromised.

Making the Failure to Report a Felony

Other proposals would allow district attorneys to file felony charges against psychologists or other mandated reporters who fail to report suspected child abuse. In addition, licensing boards would be required to automatically revoke the licensees of such professionals. Our concern is that an increase in penalties on mandated reporters will begin to make reports of abuse in marginal situations out of a sense of self-protection, thus flooding the system with unfounded reports that should never have been made.

Most members of the public and the General Assembly are aware of the reports of a mandated reporter at Penn State who failed to intervene or report when witnessing an active sexual assault

PPA opposes expanding the reporting requirements in situations where the link between the child and mandated reporter is lost.

in progress. However, from the standpoint of a mandated reporter, the most difficult decisions seldom deal with "red light" cases (where the presence of abuse is as clear as the colors on a traffic light). Instead, the most difficult decisions deal with marginal cases when it is not clear if the information is sufficient enough to rise to the level of "reason to suspect." A reporter might encounter a case where ten psychiatrists, psychologists, or pediatricians looking at the same case would be split down the middle as to whether it warrants a report of child abuse or not. PPA asks whether it is really a felonious act, on par with bank robbery, for a health care professional to make a decision which in hindsight a child welfare worker thinks was wrong, even though many competent and conscientious professionals would agree with the original decision.

Furthermore, it is unfair to put such a high penalty on mandated reporters given the complexity of reporting laws. Even the highly knowledgeable witnesses before the Pennsylvania Task Force on Child Protection often disagreed on what certain provisions of the Child Protective Services Law meant. Pennsylvania's Office of Children, Youth, and Families has not been forthcoming on how it interprets many provisions of the reporting statute. In addition, psychologists have reported to PPA that the information they received from Children and Youth has varied – one worker telling a psychologist that a report should be made, with another worker telling another professional reporting on the same case that the report should not be made.

The proposed increase in penalties fails to recognize that the major reason that reports of abuse are low is because

[1] **The percentage of reports that are founded has been steadily decreasing over the last 35 years for reasons that are not obvious. In the early 1980s, about 45% of the reports of suspected child abuse from psychiatrists and psychologists were founded; in 2011 it was 15%.**

mandated reporters have learned, over the years, that most of their reports of abuse (even cases where they are very convinced that there is definite and severe abuse), end up being considered unfounded. In other words, substantiation rates drive reporting rates.

Numerous studies have been done concerning the reasons that mandated reporters have failed to make a report. For example, Jones et al. (2008) reported that pediatricians sometimes failed to report suspected child abuse because "they thought CPS would dismiss without investigation" (p. 4). Similarly Bryant and Baldwin (2009) reported that school counselors often reported frustration about getting CPS to substantiate cases. As Children and Youth investigators fail to substantiate abuse in more and more situations, mandated reporters learn through experience that the criteria for abuse are more and more restrictive, thus leading to a decrease in reports. If a psychologist, or a pediatrician, or schoolteacher makes a report of child abuse based on a symptom pattern, and Children and Youth fail to identify that child as abused, and if this pattern of reporting and non-substantiation occurs repeatedly, the mandated reporters learn through experience that Pennsylvania has an idiosyncratic definition of abuse that does not conform to national professional standards, and will eventually stop reporting such cases.

Finally, legislators need to consider the burden on professionals who work with children. Increasing penalties against mandated reporters makes work with children that much more difficult and stressful, thus decreasing the number of professionals who are willing to work with children. PPA has written letters and met with legislators to encourage a more rational approach to protecting children.

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Should Pennsylvania Mandate Continuing Education in Child Abuse?

One proposal to address the under-reporting of suspected child abuse in a bill before the House of Representatives is to mandate continuing education for all health care professionals. PPA supports the general concept of mandating education in child abuse reporting if it is done appropriately.

Currently, the State Board of Psychology mandates three hours of continuing education in ethics every two years, and this may include mandated reporting laws. If Pennsylvania were to mandate continuing education in child abuse for health care professionals, we believe it would be best to defer to the licensing boards on how to integrate that mandate within their existing continuing education requirements.

Furthermore, PPA has asked that any continuing education mandate should be flexible enough to address the continuing education needs of psychologists who do not treat children. A recent study by our association showed that about 41% of our members treat children on a regular basis (59% do not); thus there would be limited utility in requiring training in child abuse for all licensed psychologists. It may be more appropriate to mandate education on the mandated reporting laws of Pennsylvania, so that psychologists who work primarily with older adults could, for example, learn about the Older Adult Reporting Law, which is more relevant to their work (see Knapp, Baturin & Tepper, 2010, for a review of mandated reporting laws in Pennsylvania).

In addition, we would want any mandate to avoid duplicate obligations on professionals who hold educational certifications and must already take continuing education through the Pennsylvania Department of Education. We would hope that any requirement on licensees would fulfill any requirement placed by the Department of Education or vice versa.

Finally, PPA believes that mandatory continuing education will make a meaningful impact only if it is combined with other changes in the Child Protective Services Law, including changes that would result in a greater rate of substantiation of cases of abuse that are reported. As PPA noted in its written testimony to the Pennsylvania Task Force on Child Protection, we believe that the Child Protective Services Law in Pennsylvania is too narrow or is being interpreted too narrowly, thus allowing many abused children to go unprotected. In short, what often happens is that health care professionals make reports of child abuse, but most of those cases end up being unfounded, which depresses future reporting by the professionals. Any benefit of educating mandated reporters would be diluted if, in day-to-day practice, Pennsylvania continues to interpret neglect and non-accidental injuries in a highly restrictive manner that varies substantially from national norms.

Reference

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CHILD PROTECTIVE SERVICES LAW: REFORM OR REACTION?

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when they hear of abuse second-hand (or third-hand; e.g., a child reports that a friend of his or her is being abused), or when they learn of past abuse from any person, including a perpetrator who reports abuse that happened in the long distant past, even if there is no current threat to any child. Furthermore, there are proposals to require all prospective health care licensees to have training by the Department of Public Welfare on child abuse. Additional training would be mandated every biennium for all licensees. The accompanying articles discuss these issues in more detail.

Unfortunately, the debate appears to be overly influenced by the circumstances of the Penn State scandal. To the average Pennsylvanian or the average legislator, the discussion of child abuse brings up images of serial sexual predators and mandated reporters who do not do their job. The logical response is to get tough on mandated reporters and to tighten up laws on sexual abuse.

However, those more involved with the child protective services system see another aspect that is not commonly discussed in the media. This is the narrative of mandated reporters who have been making reports (especially of neglect, physical abuse, and emotional abuse) for many years, only to have their reports dismissed, and that non-sexual abuse deserves as much attention as sexual abuse. This is not to discredit the dominant (Penn State) narrative entirely. There is underreporting by mandated reporters and there are loopholes in sexual abuse laws. But these are far less salient problems than the average citizen (and legislator) believes.

PPA PRESIDENTIAL ELECTION

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to the changes and to take advantage of new opportunities... . PPA can be positioned not only to improve public access to a wider range of psychological services, but also to increase the visibility of psychologists in every community."

Dr. David Zehrung

Dr. Brad Norford

Dr. David A. Rogers

Dr. Marie C. McGrath

Dr. Vince Bellwoar

Re-elected treasurer was **Dr. David Zehrung**. He has served as treasurer for the past two years and is a member of the Budget and Finance and Technology Implementation Committees. He has chaired the Bulletin and Electronic Media Coordination Committees and served on the Nondues Revenue Task Force. He earned a PhD in clinical psychology from George Mason University in 1997, and currently works at the Lebanon VA Medical Center as well as maintaining a private practice.

Dr. Brad Norford was re-elected chair of the Communications Board. He is the director of Bryn Mawr Psychological Associates, a private group practice with specialization in child, adolescent, and family therapy. He gained a PhD in clinical-community psychology from the University of South Carolina in 1991. His PPA activities have included chairing the Committee on Technology Implementation as well as the PennPsyPAC Board, on which he has served for 14 years.

Elected to another term as chair of the Internal Affairs Board was **Dr. David A. Rogers**, of Hershey. In addition to chairing that board, he has chaired the CE Committee for four years and served on it for many years. He is also a member of the Convention and Insurance Committees. He has made many CE presentations over the past 25 years and conducted hundreds of public presentations nationally and internationally. He is the clinical director of Hershey Psychological Services and has been in private practice since 1988.

Dr. Marie C. McGrath was re-elected chair of the School Psychology Board. She is also a member of the Early Career Psychologist Committee and the Pediatric Mental Health Task Force. In addition to being a licensed psychologist she is a Pennsylvania and nationally certified school psychologist. She is an associate professor at Immaculata University and a contracted school psychologist at the Chester County Intermediate Unit. She earned a PhD in school psychology from Temple University.

All of the positions except president-elect are for the two-year period of June 2013 to June 2015. **Dr. Vince Bellwoar** will be president of the association for the 2013-14 program year. PPA congratulates this year's winners and appreciates the participation of all members who ran for office. The fact that we have contested elections of highly qualified candidates speaks to the health of PPA as an organization.

CPT and ICD: What Are They? Where Do They Come From?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Dr. Sam Knapp

The Current Procedural Terminology (or CPT) codes are developed by the American Medical Association (AMA) to ensure a common parlance and unitary language for describing services and procedures by physicians and other health care professionals. The CPT coding manual is copyrighted and published by AMA. CPT I Codes are the five-digit codes used to describe medical procedures; CPT II Codes are supplemental codes used to facilitate data collection about the quality of services provided; and CPT III Codes are for experimental procedures where data is still being gathered. HIPAA requires the standardized use of ICD and CPT codes across insurers. Although CPT codes were widely used before the HIPAA requirement, this HIPAA requirement ended the use of local codes.

A panel of the AMA (the Editorial Panel) creates the CPT codes, although it accepts advice from advisory panels. The Editorial Panel consists of 17 members including 11 physicians nominated by specialty groups within AMA; one physician each from the Blue Cross/Blue Shield Association, America's Health Insurance Plans (a trade association), the Centers for Medicare and Medicaid Services (CMS), and the American Hospital Association; and two other members from the advisory committees to the Editorial Panel. One of the advisory committees is the Health Care Professional Advisory Committee, which consists of 12 organizations whose members are eligible to use CPT codes (audiologists, chiropractors, registered dieticians, nurses, occupational therapists, optometrists, physical therapists, physician assistants, podiatrists, psychologists, social workers, and speech therapists).

The deliberation process is secret. There is no public comment period for the adoption of these codes and no consumer input. All participants are obligated to follow strict standards of confidentiality, and the punishment for breaking confidentiality is to be removed from the process. The AMA is under no obligation to accept the recommendations of groups impacted by the changes in the CPT codes.

Although the Editorial Panel recommends the particular CPT codes, another committee within AMA, the Relative Value Scale Update Committee (RUC; rhymes with truck) recommends Medicare fees to CMS. The recommendations of RUC are based, to a large extent, on surveys conducted by impacted organizations on the relative work effort involved with the procedure. CMS typically accepts 90% to 100% of the recommendations of the RUC. Often commercial insurers set fees by paying a percentage of what Medicare pays.

Medicare payments are based on the resource-based relative value scale (RBRVS), which consists for three factors: work product, practice expense, and professional liability. Work product involves the time, technical skill, and mental effort required to perform a certain procedure. For physicians as a whole, work product consists of 48%, practice expense consists of 47%, and professional liability insurance consists of 4% of the RBRVS. For psychologists the work product is almost 70% of the RBRVS and professional liability is around 1%. Because the portion of the practice expense component for psychologists is so much lower than for physicians, minor changes in the reimbursement formula can impact psychologists quite differently from physicians.

The American Psychological Association (APA) has a representative on the Heath Care Professional Advisory Committee and had input into revising the CPT codes and the RUC process. Representatives from APA are bound by the very strict standards of confidentiality concerning their participation in the process. I have spoken briefly with APA representatives who can describe their involvement only in general terms. Participation in the process should not be interpreted to mean agreement with the recommendations concerning CPT codes or acceptance of payment.

The deliberation process is secret. There is no public comment period for the adoption of these codes and no consumer input.

Diseases are classified according to the ICD (International Classification of Diseases), which was developed by the World Health Organization (an affiliate of the United Nations) to gather information world-wide about the prevalence and incidence of diseases. The United States uses the ICD-cm-9, which means it is the 9th edition of the ICD. The cm refers to "clinical modification," which is a modification of the ICD for the United States. The rest of the world uses the ICD-10, and the United States will adopt it by October 1, 2014.

Currently, the diagnostic numbers in the DSM-IV correspond to the ICD-9 codes (with a few exceptions). So psychologists can use the DSM-IV coding system and still conform to the ICD-9 system almost all of the time. However, at this time, the coding system in the DSM-V does not correspond to the numbers that would be used in the ICD-10. Although psychologists may wish to learn about the DSM-V as a way to keep abreast of new developments in the area of diagnostics, they will continue to bill only with the ICD-9 (DSM-IV-TR) numerical codes even after the DSM-V is released. Psychologists and other health care professionals will begin coding with the ICD-10 in October 2014.

Personal Perspectives on Diversity and Multiculturalism: The Devil's Advocate

Ray Naar, PhD, ABPP

Dr. Ray Naar

I enjoyed Dr. Palmiter's presidential perspective on multiculturalism (Palmiter, 2012), and Dr. Slattery's article, "Can't We All Just Get Along?" (Slattery, 2012). My remarks, which may be judged less than 100% politically correct by some readers, are not meant to challenge, but to add to these two fine contributions. Furthermore, I would like to make it clear that I am addressing myself only to one aspect of a psychologist's activities. I mean "psychotherapy."

To put this article in context, I will follow Dr. Palmiter's example and also use stages of "my own journey." I was born into a Sephardic family in Salonicca, Greece, and attended a marvelous French school imbued with Voltairian spirit. My parents were very loosely religious and it was, for me, a natural and non-traumatic drift into agnosticism. Until the age of seventeen, when I was interred in a concentration camp, I was not aware of the difference between Orthodox and non-Orthodox Jews and had never heard Yiddish spoken. Until our liberation from the camp, I had never seen an African (i.e. a Black person). The first Black person I ever saw was an African American soldier among those who gave us a second chance at life. He seemed ten feet tall and the most beautiful being I had ever seen. I don't believe or remember (that was 68 years ago) that I or my fellow inmates were even aware that not all of these super-beings were of the same skin color. I should add that I had met very few Catholics and did not know how Catholicism differed from Greek Orthodoxy, the prevailing religion in Greece.

Six months after immigrating to the USA, I joined the Regular Army, remained in the Army for several years and became familiar with the culture in the military and with what, for lack of a better word, I will call Main Street American culture. I obtained a PhD in clinical psychology in 1966, and for the past 47 years my time has been devoted to practicing psychotherapy (90%) and teaching psychotherapy at local universities (10%). Conservatively, up to this year, I must have touched the lives of 4,000 people. Approximately 15% of my practice have been and still are Black, and the rest all shades of White with a smattering of Latinos, a few Hindus and a couple of Japanese. From a religious standpoint, I saw a very large number of Catholics, Protestants, and both Orthodox and non-Orthodox Jews. In 1968, three colleagues and I signed a contract with the Diocese of Pittsburgh and devoted eight hours a week for several years to the treatment of nuns. I have also treated a fair number of lesbians and gay men, individually and in couples.

> *... I felt uneasy about my lukewarm attitude toward the popularity of courses on diversity and multiculturalism.*

As I look, in retrospect, to the past 47 years, I am fairly pleased with the results of my work. I derive my satisfaction from the feedback of my patients, my own observations, my reviews of the 2,650 charts which I had created between 1966 and 1999, and from several incidents which remain in my memory and still occur from time to time. I remember fondly the Black psychologist who called me for an appointment and said, "I took my internship with you 37 years ago and I always thought that if I ever need to talk to someone, I will call you. I need to talk to someone and I'm calling you." I still have lunch twice a year with two nuns who were my patients and terminated therapy 43 years ago. Recently, a patient whose name I had forgotten wanted me to review her book. My religious patients (including a Lubavitcher rabbi and his wife) almost always know about my agnosticism, partly because they are referred by other patients. I do not advertise my services. I also request that, as part of the intake process, my patients ask me whatever personal questions they wish to ask with the understanding that I may not be willing to answer some of them.

During the past year or two, I felt uneasy about my lukewarm attitude toward the popularity of courses on diversity and multiculturalism. Was I missing something? Could I become a better therapist if I familiarized myself with other cultures? I attended a couple of presentations on the subject. Although I found them quite interesting, I doubt that what I learned has made me a better therapist. I felt better and then wondered what was it that made me a fair to middling therapist with patients from unfamiliar cultures. After much introspection and several interviews with former patients, I identified three types of behavior in which I and, probably, the great majority of my fellow therapists already engage:

1. I try to listen, not just to the words but the real message that the patient sends. I have discovered the obvious, i.e. that a rose is a rose no matter by what name. Despair, sadness, joy, fear, feelings of inferiority and happiness do not differ from culture to culture. I try to communicate to my patients that I resonate to what they are saying and feeling although I often do not understand why they are saying and feeling what they say they feel. This kind of empathic listening, which I found so helpful is, of course, what Carl Rogers advocated and modeled for so many years and in so many of his writings. I found that the reaction to being listened to attentively and at a deep level is pretty much the same in an Orthodox Jewish woman, a Catholic nun, or an Indian engineer.
2. I am deeply respectful and acceptant of cultural beliefs and ensuing behaviors, even if they are totally contrary to mine, even if I do not understand them. It is important for me to create an atmosphere within which patients from a different culture feel

free and comfortable discussing aspects of their culture that differ from mainstream American culture without embarrassment, and even if their interlocutor is not familiar with what they are talking about. I remember my early immigrant days in the USA, 62 years ago. I remember how often I wished to have someone not only explain to me American customs and traditions, but also someone to whom I could explain my customs and traditions and who would try to listen and to appreciate them. This leads me to the third behavior I try to engage in.

3. I am not afraid to ask questions. I stated earlier that I want to be able to resonate to what my clients are saying and feeling even if I do not understand why they say and feel that way. It helps tremendously, however, when I do understand why they say and feel certain things. So, if I do not understand, I ask. I have never encountered a patient who resented my asking. On the contrary, most of them appreciate the interest I show and enjoy "educating" me.

I imagine that the readers of this article will shrug and say *in petto*, "So what is new?" Of course, they will be right. What is perhaps new is the realization that if a therapist truly engages in these three types of behavior, courses and training in diversity and multiculturalism, while certainly enriching, can be redundant and do not necessarily make us better therapists. I found it much more useful to study and try to understand, own up to, and try to modify my conscious and unconscious negative attitudes, which stem from my own culture and are not due to culture attributes with which I am not familiar. There is also the danger of being patronizing when we know so much about our patients' cultures while they may know so little about ours.

I stated at the beginning of this article that my comments are an addition to Dr. Palmiter's and Dr. Slattery's articles and certainly not a rebuttal. I will, however, comment on Dr. Slattery's last sentence. Creating an accepting and respectful environment does not and perhaps should not always lead to a celebration of our differences. The day after I read the issue of the *Pennsylvania Psychologist* to which I refer, I read a news item in *Newsweek* about a 30-year-old female member of an Asian tribe who died of epilepsy and that medical treatment was withheld from her for religious reasons. I can understand why. I can resonate to her family's anguish and pain but I cannot "celebrate" this kind of cultural tradition. I can understand the reasoning behind and the emotions associated with the treatment of women in certain cultures but I cannot and would not celebrate such traditions. To paraphrase Dr. Slattery, I will say that one can accept and respect the beliefs and feelings of some of our patients on certain issues, but it is not wrong to be angry and experience negative attitudes toward such beliefs and feelings. I will go a step further. I can conceive of cases where I could find myself unable to accept or understand a patient's feelings or beliefs. It only happened once when what I thought was abuse of the wife was justified by both spouses on religious beliefs. Without being critical of their beliefs, I referred them elsewhere.

It is good to remember that whenever some ethnic and cultural traditions are difficult for us to accept, respect, or empathize with, this is because of what we attribute to such traditions and not inherent in the tradition itself. I will continue to learn about other cultures because it enriches my life, but I will take even more time learning about myself and my conscious and unconscious attitudes, accept them if I think them appropriate, and try to change them if they are toxic.

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References

Palmiter, D. J. (2012, December). Presidential perspective: Positive multiculturalism. *Pennsylvania Psychologist*, 2, 7.

Slattery, J. M. (2012, December). Can't we all just get along? *Pennsylvania Psychologist*, 19.

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