CAMFT Letter to the Editor, AB1775, from Robert Weiss

Clinical Alert: Where Do You Stand Regarding Imminent Changes to Client Confidentiality (AB1775)?

I remember being endlessly instructed and reminded in graduate school (well over two decades ago) that the protection of client confidentiality was among the most elemental facets of a productive and meaningful psychotherapeutic relationship—that without the safety and trust provided by client confidentiality there is no true clinical path to healing. This teaching actually follows ethical standards tracing back to the Roman Hippocratic Oath! Today, barring certain exceptions codified in state and federal law, clinicians can actually be held legally liable for breaches in client confidentiality. These legal exceptions, whereby clinicians can and sometimes must break confidentiality, center on the prevention of imminent direct harm to the client or others.

The legal concept of being forced to break client confidentiality, regardless of whether we personally or professionally wish to do so, is known as our "duty to warn." While any heated debate regarding our duty to warn may seem odd to therapists who have grown up with this as a norm, even casual research will reveal that our profession experienced great turmoil over the last century, debating whether we should *ever* turn over client information to legal and other authorities. For the most part this extensive and often acrimonious debate centered on the fact that confidentiality within the clinical relationship is in great part what makes psychotherapy *a safe haven* for effective healing. After much thrashing about, the compromise that was eventually reached was that we do have a duty to warn, but only in cases of *imminent direct harm* to the client or others. And yes, this compromise has created a bit of a high-wire balancing act for some therapists, as we attempt to protect client privilege while also working to keep safe both the client and anyone who might come in contact with that client.

Currently, all 50 states each have enacted some form of duty to warn laws. The wording of these laws varies slightly from state to state, but the basic principle is relatively consistent: If there is a need to prevent *imminent direct harm,* then we are permitted and possibly even required to break client confidentially.

Until 2014 and the advent of CA Assembly Bill 1775 (AB1775), client confidentiality except in cases of imminent direct harm has been tightly protected in the state of California. In fact, the last significant change to therapist-client privilege occurred nearly 40 years ago, in 1976, with *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976), a case tried before the CA Supreme Court, with the court finding that "mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient."

Thirty-eight years later, enter AB1775, a law that further reduces therapist-client confidentiality. Surprisingly to me, AB1775 was not sponsored by the legal system or even an overeager politician. Instead it was underwritten by the membership dollars we provide to our own clinical leadership organization—the California Association of Marriage and Family Therapists. In other words, CAMFT proposed, promoted, and signed off on new legislation that limits therapist-client confidentiality.

Apparently AB 1775 was crafted by CAMFT's legal team in an effort to address certain meaningful concerns increasingly being brought to them by CAMFT members, primarily issues related to the digital world opening a window into the viewing, streaming, and downloading of illicit imagery. One source within CAMFT recently told me that approximately 30% of current calls to CAMFT's legal team involve some variation of the following question: "Do I need to report a client who tells me that he or she has viewed child pornography?" So it appears that AB1775 was a well-intentioned but clinically misguided attempt to clarify when a therapist should and should not break confidentiality.

Understanding AB1775

Prior to AB1775, the Child Abuse and Neglect Reporting Act mandated that therapists report suspected cases of child neglect and/or child abuse (including sexual abuse and sexual exploitation). Under the act, sexual exploitation referred to, among other things, *depicting a child in, or knowingly developing, duplicating, printing, or exchanging a film, photograph, videotape, negative, or slide in which a child is engaged in an act of obscene sexual conduct.* Failure to report under the act was deemed a misdemeanor.

The new law, AB1775, states that sexual exploitation also includes *knowingly downloading, streaming, or accessing, through any electronic or digital media, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct.* The bill was signed by the Governor and filed with the Secretary of State on August 22, 2014.

On the surface it would seem that the new law does what it is intended to do—ensuring that men and women who create and share illicit imagery via electronic means are reported to the legal authorities. I mean, child porn, yuck, right? Let's turn these offenders over to the legal system instead of hand-holding them in therapy while they further harm our children and society. And in truth it does make sense to update an old law that spoke to the analog world of film and video, extending and clarifying that law for the digital age, thereby removing any question about what clinicians should and should not report. And who wouldn't support such a black and white, readily spelled out law, clearly meant to protect our children from harm?

However, after careful discussion with several members of the current CAMFT board, the legal team at NASW-CA, and leading members of APA across the nation, along with hundreds of other clinicians who've weighed in on my AB1775 blog (published on PsychCentral.com), I have found common agreement that *this law as written is profoundly unsound*. And here's why: AB1775 is *not* merely an update to an existing law meant to protect children from direct harm (such as the harm wrought when child porn is created and distributed). Instead, AB1775 is a brand new law that requires therapists to report anyone who views (not merely creates or distributes) an illicit child image—even once. And that is a profound difference.

From a clinical perspective, consider the following case and how it might be handled pre- and post-AB1775.

Todd is a 35-year-old married contractor with two toddler-aged children. He is entering therapy for the first time, seeking "help around his sexuality." In my office he tearfully tells me that during the course of the past several months he has been viewing illicit online images of boys aged 12 to about 14, experiencing both arousal and confusion. He says he has no experience with or interest in being sexual with a child, that he feels no sexual attraction to males in general, and that he has always enjoyed his adult heterosexual relationships, including the one with his wife. He further reports that the mere thought of what he has been viewing disgusts him and fills him with shame, but that he still sometimes finds himself looking at this stuff. Later in the interview Todd reveals, with great struggle, that he was molested by a teacher several times at a day-camp when he was 12 and again at 13, and he wonders if that might in some way relate to his current behavior and confusion. He desperately wants my insight and help, and to never look at these images again.

So how might I handle this case pre- and post-AB1775?

Pre AB1775:

After extensive questioning and evaluation (but still in our initial session), I would contract in writing with Todd to not look at any such images in the future, to permanently delete all such images and links (and to call my office to let me know he has done so after the fact), and to put a "parental control" filter on his computer, giving me the access code in our next session. I might ask to see his wife along with him to ensure that their children are not at risk (either from viewing what Todd has looked at on his computer or from any direct form of harm). I might also consider sending Todd out for further testing regarding both his sexual arousal to minors and the veracity of his statements to me. For the most part, however, I would be clinically tuned-in to the likelihood that his viewing of these images is a mirror manifestation of his unaddressed and unresolved childhood sexual trauma. I would absolutely plan to treat this early-life trauma over time, but not before ensuring he is no longer viewing such imagery or putting himself or others at risk in any way.

Post AB 1775, which takes effect in January of 2015 (two options):

1. Todd never comes into therapy because he looked up therapist reporting requirements online, and he therefore knows that if he tells me what he has been doing I will have to immediately notify the authorities.
2. Todd comes into my office, briefly glances at my HIPPA responsibilities but doesn't read them in any meaningful way, and then signs-off on them. I review the HIPPA laws again upon our greeting, but he tells me that he hasn't done anything wrong so he's not worried about them. He then follows through with an extensive assessment, tells me his full story, and I tell him that I must report him to the authorities.

On the surface, opposing a law like AB1775 is not a popular stance, as the suggested changes ostensibly protect children and teens from active, in-person sexual abuse. However, as surprising as this may be to many readers (and the legal system), if you review the research on this topic there is no credible evidence linking the viewing of child pornography—even the intentional viewing thereof—to contact

offenses against minors. Probably the best and most extensive study on this topic, conducted primarily in Switzerland by Swiss and German researchers, concluded: "Consuming child pornography alone is not a risk factor for committing hands-on sex offenses." In fact, this study found that less than 0.05 percent of child porn viewers without a prior hands-on child sex offense went on to commit a hands-on child sex offense (1 out of 220). The study's lead researcher, Frank Urbaniok, has stated the matter quite clearly, telling members of the press unequivocally that "the motivation for consuming child pornography differs from the motivation to physically assault minors." This evidence has been repeated in other studies, with the results cogently and fully discussed by Dr. Michael Seto in his very useful 2014 book, *Internet Sex Offenders*.

In one other very brief example of the ethical challenges this law brings, I want to point out the following regarding our existing reporting laws vs. AB 1775:

> *Jeff, a new 48-year-old client comes into my office for the first time and tells me that he is feeling disturbed because he raped a stranger last night while he was high and drunk and wandering through the city. He states that he doesn't remember who she was or where it occurred but he feels bad about it.*

Q: Do I have a duty to warn and report Jeff to the authorities?
A: No.

> *Jeff, a new 48-year-old client comes into my office for the first time and tells me that he is feeling disturbed because he viewed some child porn on his computer last night while he was drunk. He doesn't remember it well, but he feels bad about it.*

Q: Do I have a duty to warn or report Jeff to the authorities?
A: Under AB 1775, yes.

Hmmmmm.

So, to be clear, AB1775 forces therapists to enter into the legal system individuals who are *not an imminent danger* to themselves or others, simply because they have told us they viewed child porn (even if they did so only once). And we must do so immediately, without any further clinical assessment or attempt to discern if the client is causing or will ever cause direct harm to an identified victim. And lest this letter be viewed as an offender advocacy attempt, I want to acknowledge here the tremendous harm caused to minors who are drawn into the porn industry at any level. For that crime there is no excuse. Yes, the minor exhibited online is harmed, of that there is no question. And yes, those who persistently and consistently view this kind of abusive content should be required to undergo clinical assessment and treatment and possibly legal sanctions. That said, the government is perfectly capable of finding, arresting, and prosecuting those who create, distribute, and repeatedly view child pornography. In fact, nationwide sting operations have been in place for well over a decade. Demanding that psychotherapists break confidentiality and report their clients to legal authorities even in cases where no actual contact has been sought or made is not only unnecessary, it puts a small yet undeniable

tear in the fabric of our profession.

Sadly, this bill was passed with the full knowledge and support of CAMFT's leadership. The question now is what we, as California therapists and members of CAMFT, should do about it.

- First, we need to directly solicit change via the CAMFT board and legal department, working as a collective of concerned clinicians to regain our previous level of discretion and therapist-client confidentiality. This means that we need to push CAMFT (with the already existing support of NASW-CA, the California APA, the California Clinical Social Work Society, and the American Society of Sex Educators and Therapists) to amend AB1775.
- Second, if we as therapists feel we need help and training with the identification and treatment (or reporting) of sexual problems arising in our increasingly digital world, then our clinical professional organizations should respond with continuing education requirements in the areas of digital media and human sexuality. This would be a much better solution than simply saying we are under-informed so we should just hand these men and women over to the legal system.
- Third, I strongly suggest that in the future all CAMFT members be informed via email (and not buried in some newsletter) about potential legal changes that might affect our work. Frankly, how CAMFT handles things like CEUs and written exam qualifications worries me a whole lot less than a bunch of lawyers, working hand-in-hand with the legal system, who are making decisions that affect every clinician in the state.

In truth, AB1775 is a well-intentioned but poorly worded law that can easily be fixed with revised wording. And this will occur if we advise our legislators this is the best course of action. Knowing this, CAMFT's leadership needs to approach the elected representatives who pushed this law through and say, "Hey, we made a mistake when we supported this law, and we think it needs to be amended. Could you please help us with this? We think the law should state that creating and/or distributing illegal imagery must be reported, as must a person who is looking at child porn who seems likely to commit a hands-on offense, but that therapists can choose to maintain confidentiality with clients who have viewed illegal imagery but are assessed as unlikely to commit in-person harm." If our leaders are not willing to step up and do this, then perhaps we need new leadership.

With great respect for our profession and those we are bound to protect,
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