ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
CLAUDIA MOREHEAD
Deputy Attorney General
State Bar No. 205340
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6482
Facsimile: (916) 731-2117
Attorneys for Complainant

**BEFORE THE
BOARD OF PSYCHOLOGY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against: ERIC R. BERGEMANN, Ph.D. 3171 Los Feliz Boulevard, Suite 307 Los Angeles, California 90039 Psychologist License No. PSY 23775, Respondent.	Case No. 600-2019-000342 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Antonette Sorrick ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Psychology ("Board").

2. On September 2, 2010, the Board issued Psychologist License Number PSY 23775 to Eric R. Bergemann, Ph.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2936 of the Code states:

The board shall adopt a program of consumer and professional education in matters relevant to the ethical practice of psychology. The board shall establish as its standards of ethical conduct relating to the practice of psychology, the "Ethical Principles of Psychologists and Code of Conduct" published by the American Psychological Association (APA). Those standards shall be applied by the board as the accepted standard of care in all licensing examination development and in all board enforcement policies and disciplinary case evaluations.

. . . .

5. Section 2960 of the Code states:

The board may refuse to issue any registration or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee if the applicant, registrant, or licensee has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:

(a) Conviction of a crime substantially related to the qualifications, functions or duties of a psychologist or psychological assistant.

(b) Use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or dangerous drug, or any alcoholic beverage to an extent or in a manner dangerous to himself or herself, any other person, or the public, or to an extent that this use impairs his or her ability to perform the work of a psychologist with safety to the public.

(c) Fraudulently or neglectfully misrepresenting the type or status of license or registration actually held.

(d) Impersonating another person holding a psychology license or allowing another person to use his or her license or registration.

(e) Using fraud or deception in applying for a license or registration or in passing the examination provided for in this chapter.

(f) Paying, or offering to pay, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of clients.

(g) Violating Section 17500.

(h) Willful, unauthorized communication of information received in professional confidence.

(i) Violating any rule of professional conduct promulgated by the board and set forth in regulations duly adopted under this chapter.

(j) Being grossly negligent in the practice of his or her profession.

(k) Violating any of the provisions of this chapter or regulations duly adopted thereunder.

(l) The aiding or abetting of any person to engage in the unlawful practice of psychology.

(m) The suspension, revocation or imposition of probationary conditions by another state or country of a license or certificate to practice psychology or as a psychological assistant issued by that state or country to a person also holding a license or registration issued under this chapter if the act for which the disciplinary action was taken constitutes a violation of this section.

(n) The commission of any dishonest, corrupt, or fraudulent act.

(o) Any act of sexual abuse, or sexual relations with a patient or former patient within two years following termination of therapy, or sexual misconduct that is substantially related to the qualifications, functions or duties of a psychologist or psychological assistant or registered psychologist.

(p) Functioning outside of his or her particular field or fields of competence as established by his or her education, training, and experience.

(q) Willful failure to submit, on behalf of an applicant for licensure, verification of supervised experience to the board.

(r) Repeated acts of negligence.

REGULATORY PROVISIONS

6. California Code of Regulations, title 16, section 1394, states:

For the purposes of denial, suspension, or revocation of a license or registration pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license or registration under the Psychology Licensing Law (Chapter 6.6 of Division 2 of the Code), if to a substantial degree it evidences present or potential unfitness of a person holding a license or registration to perform the functions authorized by his or her license or registration or in a manner consistent with the public health, safety, or welfare. Such crimes or acts shall include but not be limited to those involving the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of that law.

(b) Conviction of a crime involving fiscal dishonesty.

7. California Code of Regulations, title 16, section 1396, states:

A psychologist shall not function outside his or her particular field or fields of competence as established by his or her education, training and experience.

AMERICAN PSYCHOLOGICAL ASSOCIATION ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

8. American Psychological Association Ethical Principles of Psychologists and Code of Conduct ("APA Ethical Principles") (2003, 2010, and 2017), Standard 2.01, Boundaries of

Competence, states:

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

. . . .

9. APA Ethical Principles, Standard 3.04, Avoiding Harm, (2003 and 2010) states:

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

10. APA Ethical Principles, Standard 3.04, Avoiding Harm, (2003, 2010, and 2017) states:

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04a.

11. APA Ethical Principles (2003, 2010, and 2017), Standard 3.10, Informed Consent, states:

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person

is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

12. APA Ethical Principles (2003, 2010, and 2017), Standard 6.01, Documentation of Professional and Scientific Work and Maintenance of Records, states:

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

13. APA Ethical Principles (2003, 2010, and 2017), Standard 6.02, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work, states:

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

14. APA Ethical Principles (2003, 2010, and 2017), Standard 10.01, Informed Consent to Therapy, states:

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

15. APA Ethical Principles (2003, 2010, and 2017), Standard 10.05, Sexual Intimacies with Current Therapy Clients/Patients, states:

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

16. APA Ethical Principles (2003, 2010, and 2017), Standard 10.10, Terminating Therapy, states:

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

AMERICAN PSYCHOLOGICAL

ASSOCIATION RECORD KEEPING GUIDELINES

17. American Psychological Association Record Keeping Guidelines (2007), Guideline 1, Responsibility for Records, states:

Psychologists generally have responsibility for the maintenance and retention of their records.

18. American Psychological Association Record Keeping Guidelines (2007), Guideline 2, Content of Records, states:

A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist's jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees.

19. American Psychological Association Record Keeping Guidelines (2007), Guideline 5, Maintenance of Records, states:

> The psychologist strives to organize and maintain records to ensure their accuracy and to facilitate their use by the psychologist and others with legitimate access to them.

COST RECOVERY

20. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

21. On or about August 29 2013, Patient 1[1] had her first appointment with Respondent for individual psychotherapy. Respondent diagnosed her with Major Depressive Disorder and Generalized Anxiety Disorder.

22. On or about October 11, 2013, in session, Patient 1 and Respondent were putting books away when he took his left index finger and slowly stroked the back of her hand from her knuckles to her wrist two times in a row. Patient 1 perceived that the touching was not accidental. She then left his office, but before she could get very far down the hallway, Respondent opened his door and called her back into his office. When she came back in, Respondent told her he wanted to make sure she was going to be all right while he was away on vacation. This incident planted the seeds of her feelings of affection and attraction towards Respondent because she felt he really cared about her. His touching of her hand caused a strong emotional and physical reaction whereby she experienced an orgasm that lasted five days.

23. On or about April 27, 2016, Patient 1 sent an e-mail to Respondent in which she disclosed her romantic and sexual feelings for him. On or about the following day, in session, Respondent barely addressed her feelings for him.

24. On or about September 6, 2016, in session, Patient 1 again brought up her sexual attraction to Respondent. She told him it was an uncomfortable and painful attraction that was

[1] The patient's name is omitted in order to protect her right of privacy.

getting in the way of her treatment and making her sick. He responded by stating that it was okay for her to fantasize about being close to him, that she deserved to let herself feel good, and that if thinking about being close to him made her feel good, then she should allow herself to have those positive feelings.

25. On or about September 10, 2016, Patient 1 told Respondent via e-mail how she was still uncomfortable with what she had told him about her feelings for him and that it was hard for her to realize that her feelings were okay. Respondent responded via e-mail that he had a "very positive" reaction to what Patient 1 said and how she felt, and they would continue to talk about it more.

26. On or about October 4, 2016, Patient 1 confessed to Respondent the sexual reaction she had to him when he stroked her hand three years earlier. Respondent asked her to describe the length and intensity of the feelings. She described them, even though she was embarrassed and mortified to do it.

27. On or about Tuesday, October 11, 2016, in session, Patient 1 discussed her embarrassment about her sexual attraction to Respondent. Respondent stated, "Would it make you feel any better if I told you that I feel the same way?" He told her he thought she was beautiful, attractive, and desirable, and that there was a part of him that wanted to be with her sexually. He further told her that it was only due to psychotherapy boundaries that he could not be with her. He explained that it was clear that she had a need to feel desired and that is why he told her.

28. In or around mid-October 2016, Respondent encouraged Patient 1 to tell him about her sexual fantasies of him. In or around November 2016, her sexual fantasies became the central focus of treatment. Respondent suggested she tell him more about her fantasies about him and get more into specifics. He told her to write down her fantasies about him and bring them to the next sessions.

29. On or about Friday, November 4, 2016, in session and in response to a sexual fantasy, Respondent told Patient 1, "You want me to ravish you." She responded, "Yes." In response to another sexual fantasy, Respondent told her "That sounds like an idyllic scene" and that her body

looked different and that she looked "sultry." He also stated "I can feel my desire for you rushing through my body. I can feel the adrenaline."

30. Respondent told Patient 1 he was flattered and humbled that she chose to work through her feelings with him. Patient 1 told him she was afraid to disclose her sexual reaction three years earlier because she was afraid he would avoid touching her hand again. In response, he asked if he would like to hold hands. Patient 1 said, "I didn't think this was okay." Respondent said, "I think it's okay." They then engaged in a grounding exercise that involved sitting on the floor across from each other, engaging in synchronized breathing, cupping their hands together, and making eye contact.

31. Patient 1 was upset that she could not be with Respondent physically. Respondent told her that he shared her feelings of sexual attraction, and that although they could not be together physically, they could still be together mentally, emotionally, and spiritually. When Patient 1 replied, "Please don't say that if you don't really mean it because my heart can't take it," Respondent responded by cupping his hands together and stated, "I would never lie to you. I would never be careless with your heart. I will hold it tenderly in my hands." As Patient 1 walked out of his office that day, instead of opening the door for her, Respondent kept his hands cupped and stated, "I don't want to open the door for you because I don't want to stop holding your heart!"

32. On or about November 11, 2016, in session, Respondent told Patient 1 that he had felt "exhilarated" by one of her e-mails, but also sad because of the inherent heartbreak of their situation and the fact that the two of them could not be together. He admitted he knew he was causing her pain and did not want to.

33. On or about November 17, 2016, in session, Patient 1 told Respondent more sexual fantasies about the two of them. She asked him if it was okay for her to be sharing and he said, "it's more than OK, it's fun." She told him she liked sharing the fantasies, but the rejection from him was painful. He told her that he was not rejecting her, and that if it were not for the bounds of psychotherapy, they could be having wild passionate sex right now. They hold hands at her request. They sat across from each other on the floor holding hands until the end of the session.

Whenever Patient 1 expressed concern over whether having these discussions was okay, Respondent would tell Patient 1 that he believed "exploring her sexual fantasies is a good and beneficial way to proceed."

34. On or about November 20, 2016, Patient 1 told Respondent that it was "unbearable to not know what it would be like to have you inside of me" and "I'm afraid if I stop telling you these things, I won't be able to feel my body anymore." Respondent told her that sounded reasonable.

35. On or about November 22, 2016, Patient 1 e-mailed Respondent that her life was hell and she was drinking alcohol. She said he did not understand her obsessive thoughts about him.

36. On or about December 2, 2016, Patient 1 told Respondent that she was suicidal over her feelings for him and that the suicidal thoughts were becoming more obsessive.

37. On or about December 16, 2016, in session, Patient 1 expressed concern about the appropriateness of sharing her sexual feelings with him. He reiterated that her desire for him was a wonderful expression of her aliveness and should be celebrated. He read a poem to her, which he had read to her multiple times before and which she interpreted to be sexual in nature.

38. On or about January 5, 2017, Patient 1 sent an e-mail to Respondent telling him she wanted to earn more money to see him more and what could she say to him in session so that she could get him to express desire for her again so that she could feel good for a day.

39. On or about February 13, 2017, at 7:28 a.m., Patient 1 sent an e-mail to Respondent letting him know that she was not eating, was not sleeping, and was throwing up due to her emotional pain. She also shared that she was "flooded with new waves of suicidal thoughts." Approximately twelve hours later, at 6:50 p.m., Respondent responded to the e-mail by saying, "Okay [Patient 1], thanks for letting me know how you are feeling. We will work together tomorrow. I'll see you then."

40. On or about February 14, 2017, in session, Patient 1 expressed suicidal thoughts indicating that she "Desire[d] to buy a gun. Even looking to do so." Respondent noted that she did not have a present intent to carry this out and she had not bought a gun.

41. In or around that same month, Patient 1 continually e-mailed Respondent saying that

she needs to stop seeing him, but she was scared to leave.

42. On or about February 21, 2017, in session, Patient 1 read a letter to Respondent in which she begged him to stop torturing her with his inconsistencies. She asked him to stop avoiding his own feelings about her by repeatedly telling her he was not really "rejecting" her sexually because he does want her. She told him to have the decency to reject her outright. Respondent angrily blurted out, "Fine! I'm rejecting you!" Patient 1 felt hurt.

43. On or about February 28, 2017, in session, Patient 1 told Respondent that she was in an addiction cycle with him. He responded, "Are you saying that all addictions are bad? You can be addicted to being kind."

44. On or about March 2, 2017, Patient 1 e-mailed Respondent stating, "I just want to be clear that what I'm going through is not like an addiction to being kind. It's a situation that's causing me a great deal of pain. It's like an addiction that had me looking online to buy a gun recently because ending my life seemed like a preferable option to dealing with the pain."

45. On or about March 10, 2017, Patient 1 skipped her session with Respondent because her second therapist and friends urged her not to see him. They believed her seeing Respondent was unhealthy for her.

46. On or about March 17, 2017, Respondent informed Patient 1 that he would no longer read and respond to her e-mails because she had "taken therapy outside the office." He suggested seeing him twice per week instead.

47. On or about March 24, 2017, Respondent told Patient 1 that she could not continue to see two therapists and she needed to choose one. He realized that it was no longer good for her to see two therapists at the same time.

48. On March 29, 2017, despite her attraction to Respondent and inner turmoil, Patient 1 had her last session with him and stopped seeing him for therapy.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

49. Respondent is subject to disciplinary action under Code section 2960, subdivisions (j), (o), and (p), California Code of Regulations, title 16, section 1396, APA Ethical Principles,

Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5, in that he was grossly negligent in the practice of his profession in his care and treatment of Patient 1. The circumstances are as follows:

50. Paragraphs 21 through 48 are incorporated herein by reference as if fully set forth herein.

51. Respondent committed an extreme departure from the standard of practice when he made comments of a sexual nature to Patient 1, sexualized therapy, and committed boundary violations. He made her sexual fantasies about him a central focus of treatment. The day Patient 1 went into more sexual fantasies with him was the day he did a grounding exercise with her. During the grounding exercise, they sat on the floor across from one another, touched their hands together, and looked into each other's eyes. He told her that he was sexually attracted to her and that he wanted to be with her sexually, but could not act on it due to the boundaries of the psychotherapy relationship.

52. Respondent committed an extreme departure from the standard of practice when he failed to recognize the symptoms of Borderline Personality Disorder during his treatment of Patient 1. He failed to treat her with the appropriate therapy for that disorder. He also engaged in excessive emailing with Patient 1 that only exacerbated her symptoms in the later part of their treatment (2016-2017). He further failed to appropriately address the erotic transference.[2]

53. Specifically, only after Patient 1 stopped seeing Respondent for therapy and after Patient 1 filed a lawsuit against him, Respondent came to the conclusion that Patient 1 has a Borderline Personality Disorder. Psychological treatment for Borderline Personality Disorder is different from that of treatment for Major Depressive Disorder and Generalized Anxiety Disorder, which were the diagnoses that Respondent assigned to Patient 1. As a psychologist trained in assessing and treating personality disorders, Respondent failed to recognize Patient 1's Border

[2] Transference is a term used to describe a phenomenon in which a client redirects emotions and feelings, often unconsciously, from one person to another. This process may occur in therapy, when a person receiving therapy applies feelings toward, or expectations of, another person onto the therapist and then begins to interact with the therapist as if the therapist were the other individual. Erotic transference, a type of transference, occurs when a client develops romantic or sexual feelings for their therapist.

Personality Disorder diagnosis and resulting symptoms and personality character, which led her to fixate on her erotic transference with him.

54. Respondent proceeded with having her discuss and share her sexual fantasies with him. Although this is how the transference is worked through in therapy and is not contraindicated, when Patient 1 continued to obsess about him, send excessive e-mails crying out for help, express her pain (emotional and physical), and express suicidal ideation and plans, Respondent should have recognized at that point that treatment and continual exploration of her sexual fantasies of him was not helping her. He failed to recognize and respond to the psychological deterioration of Patient 1 during the last few months of treatment. Patient 1 was struggling significantly and a referral to another clinician was necessary.

55. The indications that Patient 1 was struggling significantly during therapy and a referral to another clinician was necessary, include, but are not limited to the following:

a. On or about September 6, 2016, she told him that her uncomfortable and painful attraction towards him was getting in the way of her treatment and it was keeping her sick;

b. She told him for years she kept her feelings inside and it felt like choking her throat and squeezing her chest, which was very difficult for her.

c. She told him via e-mail, dated October 3, 2016, that she was having heart palpitations, worsening anxiety, trouble getting breath and choking and squeezing.

d. Aside from talking to Patient 1's second therapist on two occasions, Respondent did not consult with other colleagues for help with her case.

e. Respondent told her in an e-mail, dated October 17, 2016, that he was failing her in so many ways.

56. It is essential for a therapist to maintain a neutral and non-judgmental position and maintain appropriate boundaries as erotic transference is worked through. However, if erotic transference is not addressed appropriately in treatment, then it can become problematic. Further, if the therapist uses the erotic transference to sexualize therapy or relishes the seemingly romantic attention for their own benefit, then the patient can be harmed in the process.

57. In an interview with an investigator for the Board, Respondent denied having any countertransference with Patient 1, which is not possible, as every therapist has some type of countertransference with his or her client. It is a normal part of therapy and is used in the therapeutic process as a tool for understanding the client's way of relating to others. Respondent does not have a full understanding of the concept of countertransference and how to utilize it and handle it within the therapeutic frame.

58. Respondent committed an extreme departure from the standard of practice concerning his record keeping of his care and treatment of Patient 1 as follows:

a. Between approximately March 11, 2016, and approximately November 3, 2016, he failed to write progress notes.

b. There is no Informed Consent Document signed by Patient 1.

c. There is no written Treatment Plan for Patient 1. Respondent allegedly verbally agreed on a treatment plan with Patient 1. However, the verbal agreement on the treatment plan is not documented in his progress notes.

d. There are no progress notes for each and every contact that he made with Patient 1, including via e-mail, telephone, or in-person session.

e. There are no copies of HIPPA forms, privacy/limits to confidentiality, billing for missed sessions, telephone or e-mail contacts, or how to be contacted in an emergency.

f. Most of Respondent's progress notes do not have the year listed. The notes only have the month and date listed, which make it difficult to know the exact date and year that a session occurred.

g. On August 6, 2014, at 7:56 p.m., Patient 1 sent an e-mail to Respondent stating that she was having a lot of thoughts about death and that it was hard to think of a reason to stay alive. On August 6, 2014, at 8:18 p.m., Respondent e-mailed Patient 1 and offered ways to cope with her emotional pain, including breathing and grounding exercises. However, there is no documentation in his progress notes noting this episode of suicidal ideation and how he assessed for plan, means, and intent or what intervention he provided, if any.

h. On August 22, 2016, Respondent e-mailed Patient 1 to tell her that her sister contacted

him because she was so concerned about her well-being and the fact that she had been crying all weekend. There was no documentation in Respondent's progress notes documenting this collateral contact.

i. In or around October of 2016, Patient 1 told Respondent about the intense sexual reaction she had when he brushed her hand in 2013. Respondent did not chart the foregoing disclosure or her five-day orgasm.

j. Respondent failed to chart his e-mail response dated October 5, 2016 wherein he stated that "Just in case it's helpful, from my end everything is okay between us regarding what you shared with me yesterday. I'm glad you did. We'll talk more on Friday." As a result, he does not know if his e-mail referenced the session where Patient 1 shared her five-day orgasm with him.

59. Respondent committed an extreme departure from the standard of practice concerning his assessing and treating Patient 1's suicidality as follows:

a. Consistent with Patient 1's diagnosis of Major Depressive Disorder and Borderline Personality Disorder, Patient 1 experienced suicidal ideation throughout her treatment with Respondent. On August 6, 2014, at 7:56 p.m., Patient 1 sent an e-mail to Respondent stating that she was having a lot of thoughts about death and that it was hard to think of a reason to stay alive. On August 6, 2014, at 8:18 p.m., Respondent e-mailed Patient 1 and offered ways to cope with her emotional pain, including breathing and grounding exercises. However, there is no documentation in his progress notes noting this episode of suicidal ideation and how he assessed for plan, means, and intent or what intervention he provided, if any.

b. On February 13, 2017, at 7:28 a.m., Patient 1 sent an e-mail to Respondent letting him know that she was not eating, was not sleeping, and was throwing up due to her emotional pain. She also shared that she was "flooded with new waves of suicidal thoughts." Approximately twelve hours later, at 6:50 p.m., Respondent responded by stating, "Okay [Patient 1], thanks for letting me know how you are feeling. We will work together tomorrow. I'll see you then." There was no documentation in Respondent's progress notes of this e-mail or Patient 1's declaration of suicidal ideation, nor his response to it. There is no documentation that he

telephoned her or followed up with Patient 1. Respondent failed to follow up with her after originally receiving her e-mail to assess for suicidality and intervene at that time if necessary. He waited until the following day on February 14, 2017, when he saw her in session, which is not standard practice.

60. Respondent committed an extreme departure from the standard of practice concerning excessive treatment and failure to terminate therapy as follows:

a. Respondent failed to refer Patient 1 to other therapists or psychologists once he determined that his work with her was no longer helpful or therapeutic. Instead, he continued to treat her. He also failed to seek adequate consultation from a colleague about Patient 1's case.

b. There was overwhelming evidence that Patient 1 was not progressing in her treatment with Respondent, especially during the last year of her treatment with him. Her e-mails indicated that she was significantly struggling in between their sessions as well as during her sessions with him due to her obsession and sexual attraction towards him. Patient 1 told Respondent about her thoughts and conveyed to him that she felt like she was in an addiction situation with him. He responded, "Are you saying all addictions are bad? You could be addicted to being kind." In her e-mails to Respondent, Patient 1 expressed her concerns about how she was so dependent on him, obsessed with him, and physically ill due to her preoccupation with him. She expressed that their therapy was not helping her.

c. Aside from his brief consultation with another therapist toward the end of treatment, there is no documentation of Respondent seeking out peer consultation with another clinician about Patient 1's case and the difficulties he was coming up against with her erotic transference. In cases where the patient is not making progress and the therapy is more a detriment than aid, then in-depth consultation or a referral to another clinician is necessary.

61. Respondent's acts and/or omissions as set forth in Paragraphs 21 through 48, and Paragraphs 51 through 60, inclusive above, whether proven individually, jointly, or in combination thereof, constitute gross negligence pursuant to Code section 2960, subdivisions (j), (o), and (p), California Code of Regulations, title 16, section 1396, APA Ethical Principles, Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10, and APA Record-Keeping

Guidelines, Guidelines 1, 2, and 5. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

62. Respondent is subject to disciplinary action under Code section 2960, subdivisions (r), (o), and (p), California Code of Regulations, title 16, section 1396, APA Ethical Principles, Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5, in that he committed repeated negligent acts in his care and treatment of Patient 1. The circumstances are as follows:

63. Paragraphs 21 through 48, and Paragraphs 51 through 60, are incorporated herein by reference as if fully set forth herein.

64. Respondent departed from the standard of practice when he failed to obtain informed consent for therapy and inform Patient 1 of the nature and anticipated course of therapy. There is no Informed Consent Document signed by Patient 1. There is no written Treatment Plan for Patient 1. Instead, Respondent allegedly verbally agreed on a treatment plan with Patient 1. However, the verbal agreement on the treatment plan is not documented in his progress notes.

65. Respondent's acts and/or omissions as set forth in Paragraphs 21 through 48, Paragraphs 51 through 60, and Paragraph 64, inclusive above, whether proven individually, jointly, or in combination thereof, constitute repeated acts of negligence pursuant to Code section 2960, subdivisions (r), (o), and (p), California Code of Regulations, title 16, section 1396, APA Ethical Principles, Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Functioning Outside Field of Competence)

66. Respondent is subject to disciplinary action under Code section 2960, subdivision (p), California Code of Regulations, title 16, section 1396, and APA Ethical Principles, Standard 2.01, in that Respondent functioned outside his field of competence in his care and treatment of Patient 1. The circumstances are as follows:

67. Paragraphs 21 through 48, and Paragraphs 51 through 60, are incorporated herein by

reference as if fully set forth herein.

68. Respondent's acts and/or omissions as set forth in Paragraphs 21 through 48, and Paragraphs 51 through 60, inclusive above, whether proven individually, jointly, or in combination thereof, establish that Respondent functioned outside his field of competence in violation of Code section 2960, subdivision (p), California Code of Regulations, title 16, section 1396, and APA Ethical Principles, Standard 2.01. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Rules of Professional Conduct)

69. Respondent is subject to disciplinary action under Code section 2960, subdivision (i), in that Respondent violated APA Ethical Principles, Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10. The circumstances are as follows:

70. Paragraphs 21 through 48, and Paragraphs 51 through 60, are incorporated herein by reference as if fully set forth herein.

71. Respondent's acts and/or omissions as set forth in Paragraphs 21 through 48, and Paragraphs 51 through 60, inclusive above, whether proven individually, jointly, or in combination thereof, constitute breaches of the APA Ethical Principles, Standards 2.01, 3.04. 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10. Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Violation of Laws and Regulations Governing the Practice of Psychology)

72. Respondent is subject to disciplinary action under Code section 2960, subdivision (k), in that Respondent violated laws and regulations governing the practice of psychology, including Code section 2960, subdivisions (i), (j), (o), (p), and (r), and California Code of Regulations, title 16, section 1396. The circumstances are as follows:

73. Paragraphs 21 through 71 are incorporated herein by reference as if fully set forth herein.

74. Respondent's acts and/or omissions as set forth in Paragraphs 21 through 71, inclusive above, whether proven individually, jointly, or in combination thereof, constitute violations of the laws and regulations governing the practice of psychology under Code section

2960, subdivision (k), including Code section 2960, subdivisions (i), (j), (o), (p), and (r), and California Code of Regulations, title 16, section 1396. Therefore, cause for discipline exists.

SIXTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping)

75. Respondent is subject to disciplinary action under Code section 2960, APA Ethical Principles, Standards 6.01 and 6.02, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5. The circumstances are as follows:

76. Paragraphs 21 through 48, and Paragraphs 51 through 60, are incorporated herein by reference as if fully set forth herein.

77. Respondent's acts and/or omissions as set forth in Paragraphs 21 through 48, and Paragraphs 51 through 60, inclusive above, whether proven individually, jointly, or in combination thereof, constitute inadequate and inaccurate recordkeeping pursuant to Code section 2960, APA Ethical Principles, Standards 6.01 and 6.02, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5. Therefore, cause for discipline exists.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

78. Respondent is subject to disciplinary action under Code section 2960, APA Ethical Principles, Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5, for unprofessional conduct. The circumstances are as follows:

79. Paragraphs 21 through 77 are incorporated herein by reference as if fully set forth herein.

80. Respondent's acts and/or omissions as set forth in Paragraphs 21 to 77, inclusive above, whether proven individually, jointly, or in combination thereof, constitute unprofessional conduct pursuant to Code section 2960, APA Ethical Principles, Standards 2.01, 3.04, 3.10, 6.01, 6.02, 10.01, 10.05, and 10.10, and APA Record-Keeping Guidelines, Guidelines 1, 2, and 5. Therefore, cause for discipline exists.

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PRAYER

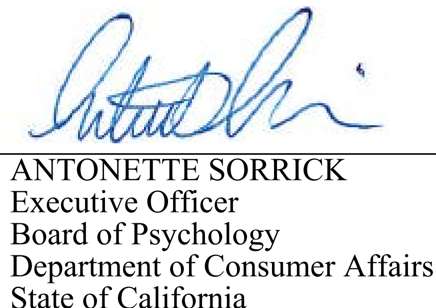
WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Psychology issue a decision:

1. Revoking or suspending Psychologist License Number PSY 23775, issued to Respondent Eric R. Bergemann, Ph.D.;

2. Ordering him to pay the Board of Psychology the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: January 7, 2022



ANTONETTE SORRICK
Executive Officer
Board of Psychology
Department of Consumer Affairs
State of California

Complainant

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