

BEFORE THE
BOARD OF BEHAVIORAL SCIENCES
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

MIRIAM B. COLLINS

Marriage and Family Therapist
No. MFC 6940,

Respondent.

OAH No.: L2007050905

Case No.: MF-2005-556

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Behavioral Sciences as its Decision in the above-entitled matter.

This Decision shall become effective June 6, 2008.

IT IS SO ORDERED May 7, 2008.

BOARD OF BEHAVIORAL SCIENCES
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By



rfm

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Agency Case No. MF-2005-556

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PROPOSED DECISION

Daniel Juárez, Administrative Law Judge (ALJ), Office of Administrative Hearings, heard this matter on October 22, 23, 24, 25, 29, 2007, and February 15, 2008, at Los Angeles, California.

Christina A. Thomas, Deputy Attorney General, represented Paul Riches (Complainant), Executive Officer of the Board of Behavioral Sciences.

Joel B. Douglas, Attorney at Law, Bonne, Bridges, Mueller, O'Keefe & Nichols, represented Miriam B. Collins (Respondent). Respondent was present on each day of hearing.

The parties submitted the matter on for decision on February 15, 2008.

FACTUAL FINDINGS

1. On or about November 30, 2006, Complainant, in his official capacity, filed the Accusation. This action then ensued. Respondent, through her counsel, filed the Notice of Defense on or about January 5, 2007.

The Parties' Contentions

2. Complainant contends Respondent, a marriage and family therapist, acted with gross negligence and incompetence while treating a patient (the patient is referred to herein by the initials, B.M., to preserve the patient's confidentiality). (Bus. & Prof. Code, § 4982, subs. (d) & (e).) Complainant also contends Respondent, through her therapy, intentionally or recklessly caused B.M. emotional harm. (Bus. & Prof. Code, § 4982, subd. (i).) Complainant further contends Respondent performed services beyond the scope of her

license and failed to keep adequate records. (Bus. & Prof. Code, § 4982, subds. (l), (s), & (v).) For these alleged violations, Complainant seeks revocation of Respondent's marriage and family therapist license and recovery of the costs of investigation and prosecution. (Bus. & Prof. Code, § 125.3.)

3. Respondent contends she treated Patient B.M. appropriately and in accordance with the standard of care. Respondent further contends she kept appropriate records and did not intentionally or recklessly cause B.M. emotional harm. Respondent denies Complainant's charges and seeks dismissal of the Accusation.

Respondent's Licensure and Background

4. The Board issued marriage and family therapist license number MFC 6940 to Respondent on October 7, 1975. The license expired on May 31, 1994, due to non-payment of renewal fees, but it was renewed on June 2, 1994. Respondent's license is currently renewed through May 31, 2008. Absent the instant Accusation, there is no history of discipline against MFC 6940 since its issuance.

5. Respondent received a Master of Arts degree in Marriage and Family Therapy from Azusa Pacific College in May 1975. She received a Certificate of Training in Psychoanalysis in June 1999 and a Doctorate in Psychoanalysis from the Los Angeles Institute and Society for Psychoanalytic Studies in October 2001. Respondent has maintained a private practice since 1975. Respondent has also held various positions within Kaiser Permanente Hospital's weight loss programs in Panorama City, California; her present position is Lifestyle Educator and Behaviorist. From 2000 to 2003, Respondent created and instructed a class entitled "Diversity and Congruence in Psychoanalysis" at the Los Angeles Institute and Society for Psychoanalytic Studies. From 1987 to 2003, Respondent was an oral examiner for the Board of Behavioral Sciences. In that capacity, she examined and evaluated candidates seeking licensure as marriage and family therapists.

The Treatment of Patient B.M.

6. Respondent began treating Patient B.M., a middle-aged woman, in approximately September 2000. B.M. had had problems maintaining an appropriate body weight. Prior to meeting Respondent, B.M. had lost a significant amount of weight. B.M. sought therapy from Respondent to help her maintain her weight and deal with any emotional issues that might have been contributing to B.M.'s weight problems. Respondent began seeing B.M., one therapy session per week, using the psychoanalytical mode of therapy.¹

¹ The parties defined psychoanalysis similar to the definition contained in the New Oxford American Dictionary, Second Edition (2005), wherein it states, psychoanalysis is a "system of psychological theory and therapy that aims to treat mental disorders by investigating the interaction of conscious and unconscious elements in the mind and bringing repressed fears and conflicts into the conscious mind by techniques such as dream interpretation and free association."

B.M. was aware that Respondent was a psychoanalyst and that Respondent was providing her psychoanalytical therapy. Respondent did not have B.M. fill out any forms or initial paperwork at the outset of the therapeutic relationship.

7. Soon after beginning therapy, on a date undetermined by the evidence, B.M. asked Respondent, and Respondent agreed, to increase the session frequency. Throughout most of the professional relationship, Respondent saw B.M. approximately five times per week; at times it increased to six times per week. Respondent agreed to the increase in session frequency because five and six times per week is not unusual in psychoanalysis and Respondent believed that by seeing her more often, Respondent could deal with more than just B.M.'s emergency issues, instead she could deal with a wider array of B.M.'s emotional issues.

8. As the therapy progressed, Patient B.M. began exhibiting signs that she was significantly emotionally troubled with issues that went well beyond body weight. Respondent eventually diagnosed B.M. with borderline personality disorder. During most sessions, B.M. became unreasonably angry toward Respondent. B.M. would yell, scream, use expletives, and verbally attack Respondent. In a short time, B.M. began angrily accusing Respondent of, among other things, not helping B.M. deal with her emotional problems. B.M. would angrily and vulgarly yell at Respondent, asserting, among other things, that the therapy was not helping her. Respondent would allow B.M. to vent her anger. After expressing herself, B.M. would consistently apologize for her outbursts and emotionally urge Respondent to continue therapy with her. On several occasions, B.M. would also accuse Respondent of sexually seducing her. Patient B.M.'s accusations were unjustified, without reason, and a symptom of her psychological problems.

9. Patient B.M. developed a sexual obsession over Respondent. On many occasions during the therapeutic relationship, B.M. would leave Respondent up to 15 messages per day. B.M. would continuously make sexual comments and express her desire to have sex with Respondent, scream, yell, and be unnecessarily confrontational over a myriad of issues. B.M.'s anger and frustration were never justified. Respondent never invited B.M.'s sexual advances. Over time, Respondent began setting limits on the number of phone messages B.M. could leave, charging B.M. for every message over one or, alternatively, informing B.M. that Respondent would erase any additional message. However, at various times after setting such a limit, Respondent would nonetheless listen to more than the first message. At hearing, B.M. agreed her feelings toward Respondent were inappropriately obsessive. B.M. thought she would "die" without Respondent in her life and agreed that Respondent was "all [B.M.] would think about."

10. B.M.'s obsessions continued throughout the therapeutic relationship. She would make disturbing, lewd, and overt sexual advances toward Respondent, including threatening to vomit or masturbate during therapy and threatening suicide in grotesque and vulgar ways. B.M. would make such threats whenever Respondent would fail to act on her advances (Respondent never accepted any of B.M.'s advances), or when the issue of terminating the therapy was discussed. For example, in December 2001, B.M. threatened to

masturbate while in session. In the midst of one session, B.M. took something out of her purse and appeared to put an item down the inside of her pants. B.M. told Respondent that she placed something inside her vagina, but, from Respondent's own observations, Respondent did not believe B.M. had actually done as she had said. On another occasion, while in session, B.M. told Respondent she had placed a mini tape recorder inside her vagina. Respondent did not believe B.M., but Respondent told B.M. that if she had, she needed to take the recorder out and the session had to stop. On other occasions, B.M. would threaten to lie down in Respondent's driveway, or she would threaten to shoot herself in her genitalia, or otherwise bring a firearm to the sessions. Respondent would respond by advising B.M. that Respondent would have to inform the proper authorities if B.M. intended to carry out her threats. Each time, B.M. would eventually retract her threats, apologize, and plead with Respondent to continue sessions.

11. On a date undetermined by the evidence, B.M. began audio-taping the sessions with Respondent's agreement. B.M. would replay the taped sessions, isolating some of Respondent's statements out of context, and arguing with, and accusing Respondent of, for example, inappropriately disclosing personal information or of saying things with the intention of sexually seducing B.M. In March 2001, Respondent described herself as "furious" that B.M. used the tapes to "abuse" Respondent. In April 2002, Respondent prohibited B.M. from further taping the therapy sessions.

12. Throughout a significant portion of the therapeutic relationship, B.M. made contradictory requests regarding the continuation of therapy. B.M. would tell Respondent that she could not afford the sessions or that she felt too attached to Respondent. But, B.M. would then consistently plead for the therapy to continue. B.M. would change her mind frequently, sometimes more than once in the same day. Respondent's notes show that in February 2001, B.M. first expressed a desire to end therapy with Respondent, followed by an emphatic request to continue the therapy. This pattern continued from February 2001 until the last session in April 2003. Respondent's notes show numerous specific conversations regarding ending and continuing therapy between B.M. and Respondent in February, October, November, and December 2001, and again in January, October, and November 2002.

13. Respondent would honor B.M.'s request to terminate the therapy, but she would then agree to continue it, based on B.M.'s urgings and after considering the therapeutic dynamics (those dynamics are discussed more specifically in Factual Finding 15). Respondent believed that B.M.'s requests to terminate therapy, and then her retractions, were part of B.M.'s emotional problems. Respondent believed she understood B.M.'s psychological problems and that, with continued therapy, Respondent could help B.M. deal with those emotional issues that were contributing to her anger and unstable actions. In reaching this conclusion, Respondent noted that, while in therapy with her, B.M. had maintained her weight and had made progress in dealing with family issues. Overall, Respondent believed B.M. had made therapeutic progress. Respondent's notes show many occasions in which B.M. and Respondent discussed the patient's problems without the patient's outbursts.

14. At various points during the therapy, Respondent became concerned with the therapeutic dynamics between herself and Patient B.M. Specifically, Respondent was concerned whether she was making progress with the patient, and whether she was exacerbating B.M.'s psychological problems by continuing the therapy sessions. In several annotations within B.M.'s records, Respondent documented her own feelings of anger, frustration, and uncertainty in dealing with B.M., noting B.M.'s very difficult and off-putting behaviors. In addition, in November 2000, Respondent wrote that she had spoken to someone identified by the initials "C.S." Respondent wrote the following, "spoke to CS about whether I am seductive with her [B.M.] . . . can I be contributing to her torment." Respondent did not explain who C.S. was or what that individual told her. In April 2002, Respondent wrote, "I am believing now that I can not help her." She also wrote, "[i]t appears I am not helping her. I can't continue to see her and take her money when I believe finally that I can not help her." In that same month, Respondent consulted with a colleague, whom Respondent identified by the initials "L.B." L.B. told Respondent that if Patient B.M. was harassing and threatening her, then treatment could not be accomplished. L.B. advised Respondent that if Patient B.M. believed the therapy was not helping, then Respondent should terminate the therapy. Also in April 2002, Respondent called the California Association of Marriage and Family Therapists organization (CAMFT). Respondent spoke to an attorney at CAMFT to ask if terminating B.M.'s treatment would be seen as abandonment. The CAMFT attorney told Respondent that it would be a disservice to the patient if Respondent continued to see the patient when the patient's goal was to harm her. CAMFT advised Respondent that she need not withstand B.M.'s abuse. CAMFT also advised Respondent to speak to a clinical consultant on how to best terminate the relationship and regarding referrals. In June 2002, Respondent communicated with a colleague, Joyce McDougall, who advised Respondent, among other things, that Respondent should use her own professional judgment to decide whether to continue treating B.M.

15. Respondent considered these consultative opinions, and eventually decided, after a rigorous analysis, to continue seeing B.M. because she felt the patient was making therapeutic progress and she believed she would continue making progress if therapy continued. Throughout the time that B.M. asked for therapy to stop and to start, she had maintained her weight and was making progress in familial issues that had presented. Sessions continued, and in February 2003, Respondent wrote, "I'll continue to see [B.M.] as long as she want [sic] to continue seeing me, but I won't encourage her to continue." Finally B.M. and Respondent had their last session on April 9, 2003, and their last contact was on April 24, 2003. Patient B.M. is currently seeing another therapist, approximately four to five times per week. B.M. has seen this subsequent therapist for approximately five years. B.M. has developed an unreasonably strong attachment and sexual attraction toward this other therapist, similar to that which she had with Respondent.

16. At hearing, B.M. blamed Respondent for fostering, within B.M., an inappropriate dependency on Respondent. Among other instances she recalled, B.M. pointed to one occasion in or about January 4, 2001, wherein Respondent cursed at B.M. telling her to "shut the fuck up." In her own testimony, Respondent admitted to this event, describing it as an inappropriate remark she should not have made. Overall, B.M. accused Respondent of

causing her emotional harm because she believes Respondent's therapy was not productive and Respondent should have terminated the therapy sooner. The evidence did not support B.M.'s assertions.

17. During her testimony, Patient B.M. admitted to committing dishonest acts in the past. On a date uncertain, but nonetheless established by the evidence, B.M. had asked Respondent if Respondent would agree to see her for a reduced fee, or no fee, yet accept partial payment from B.M.'s insurance as payment in full, thereby forgiving B.M.'s co-pay obligation. Respondent, correctly seeing this as insurance fraud, refused. Also, B.M. admitted that, on occasion, she had audio-taped persons without their permission. The evidence did not establish the specific circumstances in which she had done so. During her examination, B.M. was unwilling to concede any point that would tend to favor Respondent, no matter how minor; also, her tone of voice and her responses to questions were overly defensive. As such, and in addition to the admitted acts of dishonesty, the veracity of B.M.'s testimony was questionable.

18. At hearing, B.M. informed the ALJ that B.M. was uncertain as to the accuracy of her memory, and thus, her testimony; she wanted to review her testimony, in writing, after the hearing, and correct any errors she found. Her request was denied.

Respondent's Records Regarding Patient B.M.

19. Respondent kept a significant number of process notes in B.M.'s case. Those notes contained Respondent's own thoughts and concerns that came out of B.M.'s therapy sessions. The notes were meant for Respondent's use. As a psychoanalyst, Respondent was taught to keep such notes to assist her in her therapy and treatment of patients. Respondent's records did not contain notes that documented specific therapeutic progress in a dedicated portion of B.M.'s records. Respondent would, instead, glean progress, and other information, from her process notes, wherein she would document Respondent's own thoughts and what B.M. would say and do during sessions. Respondent's process notes constituted the extent of Respondent's records regarding Patient B.M. Those notes contained historical information regarding Patient B.M.'s personal and treatment history. There was no evidence that these records contained B.M.'s personal contact information, though the evidence established that Respondent could and did contact B.M. telephonically and by mail. At hearing, Respondent argued that her process notes were sufficient to constitute adequate notes for those of a licensed marriage and family therapist who practices psychoanalysis. There was no evidence of a formal written treatment plan, but Respondent argued that the plan she followed depended on the subject matters pursued by the patient while engaging in the process of "free association."²

² The parties defined "free association" similar to the definition contained in the New Oxford American Dictionary, Second Edition (2005), which reads, "the mental process by which one word or image may spontaneously suggest another without any apparent connection. a psychoanalytic technique for investigation of the unconscious mind, in which a relaxed subject reports all passing thoughts without reservation."

The Opinions of Dr. Darlene Skorka

20. Complainant proffered the opinions of Dr. Darlene Skorka. Dr. Skorka, a licensed psychologist, has been in private practice since 1977. She was an associate clinical professor from 1986 to 2000 at the Department of Psychiatry and Biobehavioral Sciences at the UCLA School of Medicine. From 1974 to 1985, Dr. Skorka was a clinical psychologist with Kaiser Permanente Hospital in Los Angeles, California. From 1975 to 1985, she was an assistant clinical professor at the Fuller Graduate School of Psychology. She has been a member of the American Psychological Association since 1968 and a member of the California Psychological Association since 1975. Skorka has worked as an expert consultant for the Board of Behavioral Sciences from 1989 to the present, and for the Board of Psychology from 1983 to the present. Dr. Skorka is familiar with, but does not practice, psychoanalysis. In her own practice, Dr. Skorka uses the cognitive-behavioral mode of therapy.³ Dr. Skorka has written several articles and presented on topics including ethics and clinical supervision.

21. Dr. Skorka reviewed, among other things, Respondent's records in this case and wrote a report, dated February 28, 2006, detailing her opinions. Her testimony was consistent with her written report. Overall, Dr. Skorka found Respondent's treatment and records fell below the standard of care, constituted gross negligence, and at times, constituted incompetence.

22. Dr. Skorka opined that Respondent should have terminated B.M.'s therapy sooner than she did because, at approximately the second year of therapy, there was no evidence of therapeutic progress. Skorka wrote, "[i]t is the therapist's responsibility to evaluate whether the client is making progress, and if not, then to consider termination." Dr. Skorka opined that Respondent failed to consider the appropriateness of therapy, given Patient B.M.'s complaints that Respondent was not helping, and B.M.'s numerous requests to terminate therapy. Skorka opined that Respondent's failure to terminate the therapy was an extreme departure from the standard of care and constituted gross negligence.

23. Dr. Skorka also opined that, contrary to the standard of care, Respondent allowed the intensity of B.M.'s transference⁴ to disrupt the therapy. Further, Dr. Skorka found that Respondent's recorded feelings of anger, fear, and uncertainty about B.M. showed Respondent's counter-transference⁵ and a lack of objectivity. Dr. Skorka agreed that patients

³ The parties agreed the cognitive-behavioral mode of therapy focuses on treating psychological disorders by looking at a patient's thoughts and altering behavior patterns set in the patient's mind to ultimately change a person's behavior.

⁴ The parties agreed the concept of transference is when a patient attaches feelings held toward one person (usually an authority figure from childhood) onto the therapist.

diagnosed with borderline personality disorder are notoriously difficult to treat. Nonetheless, even with these difficulties, Skorka concluded that Respondent should have ended the therapy at the end of the second year. Skorka found that Respondent overstepped her professional boundaries by telling B.M. to “shut the fuck up.” Dr. Skorka concluded that such a statement may have emotionally harmed B.M. and was evidence that Respondent’s own feelings were contaminating the therapy. Skorka explained that when a therapist “concludes that her own countertransference issues interfere with the therapy, then she should terminate therapy.” Respondent failed to terminate therapy, despite what Skorka saw as evidence of Respondent’s lack of objectivity and failure to adequately protect the therapeutic boundaries from transference and counter-transference. Therefore, Dr. Skorka concluded, Respondent’s actions constituted an extreme departure from the standard of care, gross negligence, and incompetence.

24. Dr. Skorka opined that Respondent failed to set consistent therapeutic limits, in violation of the standard of care. Skorka pointed to instances where Respondent listened to more than one telephone call, after limiting calls to one, and to Respondent’s failure to terminate therapy after B.M.’s requests and after obtaining such advice from some of the consultants she contacted. Skorka further pointed to Respondent’s own records wherein Respondent questioned her ability to help B.M. Skorka agreed that a therapist must use his or her clinical judgment to decide when and how to set therapeutic limits, but still opined that Respondent’s failure to set consistent limits constituted an extreme departure from the standard of care, gross negligence, and was indicative of incompetence.

25. Dr. Skorka opined that the frequency of B.M.’s sessions were excessive. According to Skorka, the common, acceptable frequency, in the profession, is one session per week; two times per week is highly unusual and might only be appropriate to deal with a temporary crisis. Skorka conceded that there was no specific limit to the number of sessions that are appropriate, and that a therapist should also look to the patient, to see if the patient is complaining about session frequency. In this case, Dr. Skorka pointed out that the session frequency may have served to exacerbate B.M.’s attachment to Respondent and increase the costs of therapy, a source of anxiety for B.M. Skorka believed Respondent was professionally obligated to consider whether the session frequency was more of a problem than a help. Dr. Skorka presumed Respondent failed to consider these issues regarding session frequency, and she opined that the frequency of sessions was excessive and constituted an extreme departure from the standard of care, gross negligence, and was indicative of incompetence.

26. Lastly, Dr. Skorka concluded that Respondent’s records were inadequate to meet the standard of care because Respondent failed to document, among other things, B.M.’s history, prior psychotherapy, relevant medical information, the financial costs of treatment, and the limits of confidentiality. Also, Skorka determined that Respondent’s records were additionally inadequate because Respondent failed to document B.M.’s

⁵ The parties agreed the concept of counter-transference is the emotional reaction of the therapist/analyst to whatever the patient is contributing at that time.

therapeutic progress. Skorka wrote that a therapist should keep records that “generally [contain] progress notes . . . [documenting] what is going on during the sessions and [evaluating] the progress being made.” Skorka found Respondent’s notes constituted process notes, but not progress notes. She explained that “[p]rocess notes are different from progress notes in that the former are more reflective and speculative regarding the therapist’s perceptions,” while progress notes document the patient’s progress in a more objective fashion. For all of these reasons, Skorka opined that Respondent’s records were inadequate, and constituted an extreme departure from the standard of care and gross negligence.

The Opinions of Dr. Daniel Paul

27 Respondent proffered the opinions of Dr. Daniel Paul. Dr. Paul is a licensed clinical psychologist. He received his doctorate in Clinical Psychology from the University of California at Los Angeles in 1969. He was a Post-Doctoral Fellow at New York University, where he obtained a Certificate in Psychotherapy and Psychoanalysis in 1972. Dr. Paul received a Certificate in Psychoanalysis from the Los Angeles Institute and Society for Psychoanalytic Studies in 1982. He has been a member of the International Psychoanalytic Association since 1991. From 1978 to the present, Dr. Paul has been a faculty member of the Los Angeles Institute and Society for Psychoanalytic Studies. From 1988 to the present, Dr. Paul has also been a faculty member of the Wright Institute of Los Angeles, teaching in the Wright Institute’s post-doctoral psychotherapy program. He has published a significant number of scientific papers on various topics including psychoanalysis, malignant regression, narcissism, depression, and abuse. In his work, Dr. Paul has taught and supervised marriage and family therapists and candidates for degrees in marriage and family therapy, among others. He has maintained a private practice in Beverly Hills, California since 1969.

28 Dr. Paul reviewed Respondent’s records and was familiar with Respondent’s treatment of Patient B.M. He disagreed with each of Dr. Skorka’s conclusions. Paul explained that Respondent’s treatment and records regarding B.M. met the standard of care. Dr. Paul opined that, as a marriage and family therapist who was practicing psychoanalytical therapy with Patient B.M., Respondent provided appropriate care and treatment, properly considered the issues of transference and counter-transference, and kept more than adequate records of B.M.’s treatment. Additionally, Dr. Paul criticized Dr. Skorka for failing to consider the distinctions between the cognitive-behavioral mode of therapy and the psychoanalytical mode. Some of those distinctions are set forth in Factual Findings 30, 32, and 33.

29. Drs. Paul and Skorka did agree that a patient diagnosed with borderline personality disorder is extremely hard to treat. Such patients, explained Dr. Paul, present with unreasonable anger, express irrational hatred and rage, and are unstable. Paul agreed that B.M. presented such a personality. Dr. Paul noted that B.M.’s assertions, that she was not getting better while in Respondent’s care, were not supported by Respondent’s records. Paul saw progress in B.M. throughout Respondent’s treatment. He pointed to the fact that B.M. maintained her weight while in therapy with Respondent, and was able to accept

criticism from her children, an issue that had been a source of emotional trouble for B.M. in the past. He also noted various sessions throughout the therapeutic relationship wherein B.M. was able to appropriately discuss her emotional problems with Respondent. Paul did concede that, with a patient like B.M., progress followed an unsteady trajectory, wherein a gain made one week, would be followed by regression, and then another gain thereafter.

30. Dr. Paul found that Respondent's documented strong feelings about B.M. (anger, frustration, fear) were healthy and appropriate to describe in her process notes. Dr. Paul explained that, distinct from the cognitive-behavioral mode of therapy, in psychoanalysis, an analyst's notes are intended to educate and describe therapeutic dynamics for the analyst's benefit, not necessarily to document objective progress. Paul believed that if Respondent felt counter-transference (Dr. Paul asserted that counter-transference was ubiquitous in the psychoanalytical treatment of patients, particularly those diagnosed with borderline personality disorder), it was incumbent upon her to document those feelings and consider the impact those feelings might have on the therapy. Further, Dr. Paul opined that Respondent's notes show that she considered the transference and counter-transference that was at play, and that Respondent made her own judgment about continuing the therapy, a judgment that he considered reasoned and appropriate. Paul also pointed to Respondent's consultations with colleagues and CAMFT, and Respondent's self-analysis that led to her continuing the treatment, as instances where Respondent considered her own feelings and those of B.M. before deciding to continue treating B.M. Dr. Paul saw no evidence that Respondent was not objective in her sessions and overall treatment of B.M.

31. Dr. Paul opined that Respondent set appropriate boundaries and limited B.M. in ways that were protective of herself, the therapy, and B.M. Paul noted that Respondent set numerical limits on phone calls, and confronted B.M. when B.M. made suicidal threats or references to bringing firearms to sessions. Paul did concede that Respondent did not follow through on all of her limit setting, as Dr. Skorka also found. However, Dr. Paul viewed those instances as times when Respondent appropriately changed her viewpoint on which limits were important to maintain. Dr. Paul opined that Respondent used her therapeutic discretion and professional judgment to decide that, in those moments, it was more appropriate to listen to more than one phone message, or continue therapy even though Respondent may have stated the opposite to B.M. earlier. Paul opined that Respondent acted appropriately with B.M. at all times, and maintained professional boundaries. Paul found that Respondent did not violate the standard of care or that she committed acts of gross negligence or incompetence.

32. Dr. Paul concluded that seeing Patient B.M. between five and six times per week was appropriate and common when using the psychoanalytical mode of therapy, as opposed to the cognitive-behavioral mode. Dr. Paul explained that in psychoanalysis, distinct from cognitive-behavioral treatment, more frequent sessions provides the therapist with more opportunities to deal with non-emergency emotional issues and to provide the patient more of an opportunity to express his or her problems through free association, a process which generally protracts therapy. Contrary to Skorka's view that the session frequency may have exacerbated B.M.'s attachment to Respondent, Paul opined that making

herself more available to B.M. served to better deal with the emotional reasons why B.M. was attaching herself to Respondent so obsessively. Paul again emphasized that generally, persons with borderline personality disorder would require significant time to deal with such issues, due to their difficult personalities, and so continuing therapy for many years is common and expected when treatment is via the psychoanalytical mode of therapy.

33. Dr. Paul opined that Respondent maintained excellent analytical records that contained the appropriate information needed by psychoanalysts. Paul found Respondent's notes contained B.M.'s history and progress throughout the many pages of her process notes, even though that information was not kept in a dedicated section of the records. Dr. Paul asserted that, in his review of psychoanalytical records from other practitioners, Respondent's notes were the most specific and voluminous. He found that the notes contained all of the pertinent information Respondent would need to provide effective and appropriate psychoanalytical therapy.

34. Lastly, regarding Patient B.M., Paul found no evidence that Respondent performed services beyond her abilities and competency as a licensed marriage and family therapist.

Respondent's Self-Assessment and Credibility

35. Respondent believed she treated B.M. to her best abilities. After B.M. started becoming more difficult to deal with, Respondent considered, on many occasions, whether she was helping B.M. and whether she should continue therapy. Respondent felt she was using her process notes appropriately by documenting her fears and anxieties related to B.M., and that she analyzed the transference and counter-transference that was apparent to her. Respondent always felt she was objective in her treatment of B.M. Overall, Respondent felt she was helping B.M., that she understood B.M.'s problems, and that she maintained appropriate limits and boundaries at all times.

36. Based on her demeanor at hearing and the manner, clarity, and reasonableness with which she set forth her testimony, Respondent's testimony was deemed credible. She did not express any bias against B.M. and discussed B.M.'s difficult personality with professionalism and compassion. Respondent explained the reasons for her actions in a balanced manner that fairly considered her professional obligations in juxtaposition with the difficulty of working with Patient B.M.

The Costs of Prosecution

37. In light of the Order below, it is unnecessary to find whether the Board of Behavioral Sciences' prosecution costs incurred through the work of the California Department of Justice's Office of the Attorney General were reasonable.

LEGAL CONCLUSIONS

1. Cause does not exist to suspend or revoke Respondent's marriage and family therapist license, MFC 6940, pursuant to Business and Professions Code section 4982, subdivisions (d) and (e), for acts of gross negligence or incompetence, as set forth in Factual Findings 1-37 and Legal Conclusions 6-19.

2. Cause does not exist to suspend or revoke Respondent's marriage and family therapist license, MFC 6940, pursuant to Business and Professions Code section 4982, subdivision (i), for intentionally or recklessly causing emotional harm to a client, as set forth in Factual Findings 1-37 and Legal Conclusions 6-19.

3. Cause does not exist to suspend or revoke Respondent's marriage and family therapist license, MFC 6940, pursuant to Business and Professions Code section 4982, subdivisions (l) and (s), for performing services beyond the scope of Respondent's license or competence, as set forth in Factual Findings 1-37 and Legal Conclusions 6-19.

4. Cause does not exist to suspend or revoke Respondent's marriage and family therapist license, MFC 6940, pursuant to Business and Professions Code section 4982, subdivision (v), for failing to keep records consistent with sound clinical judgment and the standards of the profession, as set forth in Factual Findings 6-21, 26-28, 33, 35, and Legal Conclusions 6, 9, 12, and 17.

5. Cause does not exist to grant Complainant the costs of prosecution, pursuant to Business and Professions Code section 125.3, as set forth in Factual Findings 1-37 and Legal Conclusions 1-4 and 6-20.

Statutes and Regulations

6. Business and Professions Code section 4982 states in pertinent part;

The board may . . . suspend or revoke the license or registration of any registrant or licensee if the . . . licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:

[¶] . . . [¶]

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

[¶] . . . [¶]

(i) Intentionally or recklessly causing physical or emotional harm to any client.

[¶] . . . [¶]

(l) Performing, or holding oneself out as being able to perform, or offering to perform . . . any professional services beyond the scope of the license authorized by this chapter.

[¶] . . . [¶]

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

[¶] . . . [¶]

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

7. California Code of Regulations, title 16, section 1845 states in pertinent part:

As used in Section 4982 of the code, unprofessional conduct includes, but is not limited to:

(a) Performing or holding himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.

8. Business and Professions Code section 125.3 states in pertinent part:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department [of Consumer Affairs] . . . upon request of the entity bringing the proceeding, the administrative law judge may direct a licentiate 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.

[¶] . . . [¶]

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case.

Case Law

9. Complainant must prove his case by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) Clear and convincing evidence means the evidence is “so clear as to leave no substantial doubt” and is “sufficiently strong to command the unhesitating assent of every reasonable mind.” (*Mathieu v. Norrell Corporation* (2004) 115 Cal.App.4th 1174, 1190 [citing *Mock v. Michigan Millers Mutual Ins. Co.* (1992) 4 Cal.App.4th 306, 332-333].)

10. Gross negligence is defined as “the want of even scant care or an extreme departure from the ordinary standard of conduct.” (*Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175, 1185-1186.)

Discussion

11. Complainant did not prove the allegations in the Accusation by clear and convincing evidence to a reasonable certainty. The evidence failed to support the opinions of Complainant’s expert, Dr. Skorka. To the contrary, Respondent’s process notes, the testimony of Respondent, Patient B.M., and Dr. Paul lent significant support to Respondent’s contentions that she treated B.M. appropriately, in accordance with the standard of care, and that her records met the statutory standard.

12. Contrary to Dr. Skorka’s opinion and B.M.’s allegations, the records did not establish a lack of therapeutic progress. B.M. maintained her weight while seeing Respondent. B.M. was able to deal with family issues that had been a problem for her. In concert with Dr. Paul’s testimony, the records did show that on many occasions, throughout the therapy, B.M. and Respondent were able to discuss B.M.’s emotional problems, despite B.M.’s regular outbursts. B.M.’s accusations that the therapy was not helpful could not be taken as truthful, given B.M.’s admissions to past dishonest acts, B.M.’s admission that her memory was possibly inaccurate, and the overall questionable veracity of her testimony. Respondent’s notes, questioning her ability to assist B.M. (Factual Finding 14), were appropriate given B.M.’s difficult personality and her accusations, but they were only evidence that Respondent appropriately assessed the productivity of the therapy, not that she agreed progress had not occurred and was not occurring.

13. Respondent’s consultations with colleagues and CAMFT also showed an appropriate assessment process by Respondent. Respondent reasonably explained why she considered those opinions, but decided to continue therapy. Furthermore, the advice proffered by CAMFT was directed at Respondent’s question about abandonment. That question is different from whether the therapy itself is productive and helpful to B.M. The

evidence proved Respondent's assessment of these factors was rigorous and that she came to a reasonable conclusion.

14. The evidence proved the frequency of the sessions was within the standard of care for psychoanalytical therapy. Dr. Skorka's opinion that the standard in the profession is one session per week was persuasively disputed by Dr. Paul's explanation that psychoanalysis works differently. Dr. Skorka failed to rebut Dr. Paul's explanation and Complainant failed to proffer evidence to dispute Dr. Paul's opinion. Moreover, Dr. Skorka agreed that there is no pre-set limit on session frequency.

15. Both Drs. Paul and Skorka agreed that limit-setting requires the therapist's discretion. Respondent set limits on B.M.'s behaviors. She responded appropriately to B.M.'s suicidal threats and placed limits on her excessive telephone calls. The limits Respondent set were reasonable and appropriate. While Dr. Skorka was correct that, on several occasions, Respondent disregarded the limits she set, the evidence as a whole did not prove that in doing so, she disrupted the therapy or damaged the patient. Respondent used her discretion when deciding to disregard a limit she had set, and provided adequate reasoning for her professional decision.

16. Respondent did not allow any negative feelings she may have had regarding B.M. to cause her to lose her therapeutic objectivity or to otherwise contaminate the therapy. Respondent's process notes candidly described Respondent's frustrations and concerns, but those feelings, particularly with the difficulties presented by Patient B.M. would be reasonably present in any person. There was no evidence that those feelings expressed by Respondent were ever shared with B.M. Respondent's consultations and her testimony at hearing established that, despite the issues of transference and counter-transference that were present, Respondent remained objective toward Respondent and compassionate in her therapeutic approach. Respondent did admit that the one instance where she had cursed at B.M. was inappropriate, but that instance alone does not merit license discipline.

17. Pursuant to the pertinent statutory provision, Respondent's records must be "consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered." (Bus. & Prof. Code, § 4982, subd. (v).) Dr. Skorka opined that important information was missing. However, a review of Respondent's notes showed that they contained B.M.'s history, relevant medical information, and evidence of therapeutic progress. Respondent undoubtedly had sufficient personal information with which to contact her and bill her. Also, Dr. Paul provided a reasonable opinion, contrary to Dr. Skorka's, that Respondent's notes contained the necessary information that Respondent would need to conduct psychoanalytical therapy, consistent with the standards of psychoanalytical therapists. Complainant offered no evidence that the distinction raised by Dr. Paul, distinguishing the standard of the profession as it relates to psychoanalysis, was wrong or otherwise unrecognized. Therefore, Respondent's records met the statutory standard set forth in Business and Professions Code section 4982, subdivision (v).

18. There was no evidence that Respondent performed services beyond the scope of her license and competency.

19. Due to Patient B.M.'s very difficult behaviors, Respondent had what appears to have been a very trying and challenging case. The evidence overall established that Respondent acted appropriately in treating Patient B.M. and that, despite B.M.'s assertions to the contrary, Respondent's actions as a therapist were not the cause of emotional harm suffered by B.M., if any.

20. Given these conclusions, the Accusation cannot be sustained and any costs of prosecution cannot be awarded. (Bus. & Prof. Code, § 125.3, subd. (a).)

ORDER

The Accusation against Respondent Miriam B. Collins, Marriage and Family Therapist license number MFC 6940, is dismissed.

Dated: March 17, 2008



DANIEL JUAREZ
Administrative Law Judge
Office of Administrative Hearings

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8 **BEFORE THE**
9 **BOARD OF BEHAVIORAL SCIENCES**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:
13 MIRIAM B. COLLINS
5812 Alcove Ave.
No. Hollywood, CA 91607
14 Marriage and Family Therapist No. MFC 6940
15 Respondent.

Case No. MF-2005-556

A C C U S A T I O N

16 Complainant alleges:

17 PARTIES

18 1. Paul Riches (Complainant) brings this Accusation solely in his official
19 capacity as the Executive Officer of the Board of Behavioral Sciences (Board), Department of
20 Consumer Affairs.

21 2. On or about October 7, 1975, the Board issued Marriage and Family
22 Therapist license No. MFC 6940 to Miriam B. Collins (Respondent). Said license expired due to
23 non-payment of renewal fees on May 31, 1994 and was subsequently renewed on June 2, 1994.
24 The Marriage and Family Therapist license will expire on May 31, 2008, unless renewed.

25 JURISDICTION

26 3. This Accusation is brought before the Board, under the authority of the
27 following laws. All section references are to the Business and Professions Code unless otherwise
28 indicated.

1 4. Section 4982 states:

2 "The board may refuse to issue any registration or license, or may suspend or
3 revoke the license or registration of any registrant or licensee if the applicant, licensee, or
4 registrant has been guilty of unprofessional conduct. Unprofessional conduct shall include, but
5 not be limited to:

6

7 "(d) Gross negligence or incompetence in the performance of marriage
8 and family therapy.

9 "(e) Violating, attempting to violate, or conspiring to violate any of the
10 provisions of this chapter or any regulation adopted by the board.

11

12 "(i) Intentionally or recklessly causing physical or emotional harm to any client.

13

14 "(l) Performing, or holding oneself out as being able to perform, or offering to
15 perform, or permitting any registered trainee or registered intern under supervision to perform,
16 any professional services beyond the scope of the license authorized by this chapter.

17

18 "(s) Performing or holding oneself out as being able to perform professional
19 services beyond the scope of one's competence, as established by one's education, training, or
20 experience. This subdivision shall not be construed to expand the scope of the license authorized
21 by this chapter.

22

23 "(v) Failure to keep records consistent with sound clinical judgment, the standards
24 of the profession, and the nature of the services being rendered."

25 5. Section 118, subdivision (b), of the Code provides that the
26 suspension/expiration of a license shall not deprive the Board of jurisdiction to proceed with a
27 disciplinary action during the period within which the license may be renewed, restored, reissued
28 or reinstated.

1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence or Incompetence)

3 8. Respondent has subjected her license to discipline pursuant to section
4 4982 of the Code on the grounds of unprofessional conduct, for violating section 4982,
5 subdivisions (d) and (e) of the Code, in that Respondent was grossly negligent or incompetent, as
6 follows:

7 a. As a marriage and family therapist, Respondent is responsible for
8 maintaining records of her patients. A primary reason that records are kept is for the benefit of
9 the client. Such records include a history, prior psychotherapy, relevant medical information,
10 medication, and symptoms. Additionally, proper charting includes progress notes, which
11 document the sessions and evaluate the patient's progress. B.M.'s file failed to contain
12 documentation of an initial work up or informed consent regarding the parameters of the therapy.

13 b. Respondent knew or should have known that session frequency is
14 generally once per week for ongoing, regular therapy. Respondent knew or should have known
15 that individual sessions over two times a week are unusual and should be evaluated for
16 appropriateness. Respondent failed to evaluate the appropriateness of the therapy sessions. B.M.
17 developed intense feelings of attachment and anger toward Respondent. Respondent failed to
18 evaluate the therapeutic value of continuing at this level and whether the frequency of the
19 sessions contributed to B.M.'s intense and ambivalent feelings.

20 c. Respondent knew or should have known that a patient's treatment should
21 continue only as long as the patient is making progress and is benefitting from the sessions.
22 Respondent treated B.M. for over two years. Respondent ignored B.M.'s questions regarding her
23 perception of getting worse and interpreted B.M.'s feelings as normal in the context of therapy.
24 Respondent failed to evaluate B.M.'s progress and whether to terminate therapy.

25 d. Respondent knew or should have known that B.M. was experiencing
26 transference and the fact that B.M. had become excessively dependent on Respondent, perceiving
27 her as a mother figure. At one point in their sessions, B.M. told Respondent that she might be a

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1 lesbian. Respondent in turn referred her to a lesbian bar. Respondent failed to evaluate cause of
2 B.M.'s dependence and failed to properly manage her transference.

3 e. Respondent knew or should have known how to set proper limits for
4 therapy, including frequency of sessions and outside contact. Respondent initially encouraged
5 B.M. to tape her sessions and leave telephone messages. B.M.'s telephone calls increased in
6 frequency and became verbally abusive. Respondent failed to properly set limits and effectively
7 address B.M.'s inappropriate behavior or threats of inappropriate behavior (i.e. threats of suicide,
8 vomiting or threatening to masturbate during sessions.)

9 f. Respondent knew or should have known that objectivity is necessary to
10 prevent the therapist's needs, wants, and issues from contaminating the therapeutic process. The
11 standard of care for a therapist that experiences strong feelings or reactions toward a patient is to
12 evaluate whether to continue therapy. Respondent documented strong feelings and anger toward
13 B.M., yet failed to evaluate whether to continue treating B.M.

14 SECOND CAUSE FOR DISCIPLINE

15 (Intentionally or Recklessly Causing Emotional Harm)

16 9. Respondent has subjected her license to discipline pursuant to section
17 4982 of the Code on the grounds of unprofessional conduct, for violating section 4982,
18 subdivision (i) of the Code, in that Respondent intentionally or recklessly caused emotional harm
19 to B.M., as more fully set forth above in paragraphs 7 and 8.

20 THIRD CAUSE FOR DISCIPLINE

21 (Performing Services Beyond Scope of License)

22 10. Respondent has subjected her license to discipline pursuant to section
23 4982 of the Code on the grounds of unprofessional conduct, for violating section 4982,
24 subdivisions (l) and (s) of the Code, in that Respondent performed services beyond the scope of
25 her license in the treatment of B.M., as more fully set forth above in paragraphs 7 and 8.

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